Lorraine T. Benuto · Melanie P. Duckworth
Akihiko Masuda · William O'Donohue *Editors*

Prejudice, Stigma, Privilege, and Oppression

A Behavioral Health Handbook

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ISBN 978-3-030-35516-6 ISBN 978-3-030-35517-3 (eBook)
https://doi.org/10.1007/978-3-030-35517-3

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The registered company address is: Gewerbestrasse 11, 6330 Cham, Switzerland

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An Introduction to Prejudice, Stigma, Privilege, Oppression, Discrimination, and Clinical Science

Lorraine T. Benuto, Melanie P. Duckworth,
Akihiko Masuda, and William O’Donohue

Abstract

Clinical psychology as a profession could be justifiably accused of neglecting or at best only obliquely addressing prejudice, stigma, privilege, oppression, and discrimination. Admittedly, it is not clear that any behavioral health profession or health profession for that matter has done any better. While there is no doubt that these problems have existed for centuries and currently exist in manifold ways, the profession of clinical psychology has been relatively indirect at dealing with these. For example, clinical psychologists, with the possible exception of feminist therapists, have not developed standardized and valid measures of the extent to which their clients’ presenting problems may be due to prejudice and discrimination. However, unfortunately, feminist therapies have also not been sufficiently studied through randomly controlled trials to determine their efficacy and safety (see Chambliss). Clinical psychologists have not developed interventions that directly ameliorate the effects of these problems on our clients. This book provides an overview of potential ways to mitigate this issue.

Keywords

Prejudice · Stigma · Privilege · Oppression · Discrimination · Psychology · Psychotherapy

Clinical psychology as a profession could be justifiably accused of neglecting or at best only obliquely addressing prejudice, stigma, privilege, oppression, and discrimination. Admittedly, it is not clear that any behavioral health profession or health profession for that matter has done any better. While there is no doubt that these problems have existed for centuries and currently exist in manifold ways, the profession of clinical psychology has been relatively indirect at dealing with these. For example, clinical psychologists, with the possible exception of feminist therapists, have not developed standardized and valid measures of the extent to which their clients’ presenting problems may be due to prejudice and discrimination. However, unfortunately, feminist therapies have also not been sufficiently studied through randomly controlled trials to determine their efficacy and safety (see Chambliss). Clinical psychologists have not developed interventions that directly ameliorate the effects of these problems on our clients. No effective prevention technologies regarding these phenomena have been developed and validated. The diagnostic manual we use is oriented toward individual problems; however, still there is no diagnostic category for something along

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L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_1

the lines of "psychological problems due to the effects of prejudice, or discrimination, or stigma, etc." Nor is there a category of mental disorder for someone who is virulently prejudiced—a KKK member embracing the standard beliefs of the Klan would be not diagnosable as mentally disordered by virtue of those beliefs which seem not only false but also disordered. Admittedly, these issues might be becoming increasingly difficult even to talk about, let alone theorize about or study, partly because of the importance and complexity of these problems but partly also because there is increased scrutiny and consequences for speech or positions that are regarded by some as problematic. Scholarly debate has been chilled due to the uncivil and hostile acts or problematic campus speech codes (see thefire.org). This book aims to provide a forum for providing discussion on these important topics in a clinically relevant manner. It attempts to help understand how clinical psychologists ought to conceptualize and respond to the prejudice and oppression in clinical and other professional contexts.

Cultural sensitivity seems to be the major response of our profession to these problems (Frisby & O'Donohue, 2018). There seems to be the perhaps unstated notion that if professionals are trained to be "culturally sensitive" or "culturally competent," then at least the majority of the problems associated with prejudice and discrimination will be overcome. However, even conceptually, the effectiveness of this promise is none too clear. First, it is important to see that cultural sensitivity programs often do not deal directly with prejudice, discrimination, stigma, privilege, and oppression. These focus much more on alleged facts about a particular culture or a small subset of cultures, for example, Asian Americans may be collectivistic or may hold more stigma regarding mental illness than those in the majority culture; however, this does not deal directly with prejudice toward these individuals (see chap. Huang & Nagayama Hall, this volume); cultural sensitivity is at least somewhat an orthogonal concern. Second, there is little empirical evidence that, over the last several decades, progress has been made in the science of cultural sensitivity: there are still conceptual problems in defining culture (for example, those that fall under the category Latinx—one culture—or perhaps many different cultures that may actually share few overlapping commonalities, e.g., Brazilians do not even speak Spanish. (O'Donohue & Benuto, 2010)). There is equivocal evidence at best that cultural tailoring interventions have improved clinical outcomes (e.g., Huey & Tilley, 2018; Benuto & O'Donohue, 2015); and there is little evidence that cultural sensitivity can even be taught (Benuto, Casas & O'Donohue 2018; also see Frisby & O'Donohue, 2018 for a more extended treatment of problems with this construct). In addition, there is a concern that the sophistication of understanding these cultures has been problematic, which can lead to its own kind of stereotyping—for example, "Hispanic-American males are 'macho.'" Given the oblique and stagnant nature of this approach, a fresh and a more genuine approach aimed at making substantive progress for these serious problems is needed.

In this book, we attempt to construct a foundation by exploring basic issues regarding these phenomena. Basic scientific information about prejudice is reviewed, the current status of many of the major minority groups are explored (some are unfortunately missing because despite repeated effort, we could not find chapter authors), and chapters examine the possible role of prejudice and oppression in our institutional structures such as the Diagnostic and Statistical Manual and our professional organizations (see Frisby this volume). It is also important to note that this book examines the status of the profession with respect to these issues. It critically examines the evidence that the profession has responded adequately to these social problems. It examines the problems of underrepresentation of many minority groups in the profession. It also covers current related issues rocking our college campuses such as safe spaces, micro-aggressions, privilege, and trigger warnings.

Definitions of Prejudice, Discrimination, and the *isms*

According the Merriam-Webster dictionary (n.d.-a), prejudice is defined as: "Injury or damage resulting from some judgment or action of another in disregard of one's rights preconceived judgment or opinion; an adverse opinion or leaning formed without just grounds or before sufficient knowledge; an instance of such judgment or opinion; an irrational attitude of hostility directed against an individual, a group, a race, or their supposed characteristics." Conversely, per the Merriam-Webster dictionary (n.d.-b), discrimination is defined as: "the act, practice, or an instance of discriminating categorically rather than individually; the act of making or perceiving a difference." Both prejudice and discrimination are often viewed as repercussions or elements of the *isms* (e.g., racism, sexism). Harrell (2000; pp. 43) defined an *ism* as, "A system of dominance, power, and privilege based on [racial] group designations; rooted in the historical oppression of a group defined or perceived by dominant-group members as inferior, deviant, or undesirable; and occurring in circumstances where members of the dominant group create or accept their societal privilege by maintaining structures, ideology, values, and behavior that have the intent or effect of leaving non-dominant-group members relatively excluded from power, esteem, status, and/or equal access to societal resources."

Implications of Prejudice, Discrimination, and the *isms*

The implications on those who experience prejudice and discrimination are substantial. While an extensive discussion of the implications of prejudice and discrimination is not provided here, due to the fact that each chapter in this book contains an extensive discussion of how prejudice and discrimination impact different populations, suffice to say that the impact is substantial. The extant literature has clearly indicated that there are implications on both mental and physical well-being. For example, perceived racial discrimination at work was associated with poor self-rated health (Fujishiro, 2009; Molina et al., 2019). Fujishiro examined data from 22,412 respondents in seven states and found that participants who reported being treated worse than other racial groups in the workplace had poorer health. Even more alarmingly, researchers found that perceived discrimination is related to risk of cardiovascular event (Everson-Rose et al., 2015). Thus, when engaging with individuals who report a history of experiencing discrimination, psychologists should be aware of the potential physical health ramifications of these experiences and prepared to provide appropriate referrals.

Behavioral Health Implications: Pursuits in Applied Psychology

In addition to the implications that prejudice, discrimination, and the *isms* have on physical health, emotional and behavioral health are undoubtedly impacted across racial, ethnic, and cultural groups. For example, Lowe, Tineo, and Young (2018) collected data from 141 Muslim American college studies and found that perceived discrimination was related to depression and anxiety and that a strong cultural identify moderated this relationship. Similar findings have been documented among Asian Americans—Bowie Chau, and Juon (2018)—that among Asian Americans, experiences with discrimination and unfair treatment were associated with greater odds of being depressed. These findings extend to African Americans. A meta-analysis of the research on the relationship between perceived discrimination and Black men indicated a positive relationship among this population (Britt-Spells, Slebodnik, Sands, & Rollock, 2018). Additionally, perceptions of unfair treatment are associated with more symptomology among African American women; more specifically, regularly being treated with less courtesy, being insulted or called names, and receiving poorer service are psychologically burdensome to African American women (Nadimpalli, James, Yu, Cothran, & Barnes, 2015). Finally, among Latinx populations, perceived discrimination was associated with psychological distress, suicidal ideation, state anxiety, trait anxiety, and depression (Hwang & Goto, 2009). An additional important point of consideration is with regard to intersectionality. While economic status may be hypothesized to act as a protective factor against discrimination (and via mediation or moderation the associated sequalae), for racial minorities, improving one's economic prospects unfortunately does not reduce the frequency of encounters with discrimination or unfair treatment (Colen, Ramey, Cooksey, & Williams, 2018).

Similar findings to those described above extend to other cultural groups. Specifically, a relationship between gender discrimination and anxiety and depression has been identified. Researchers have gone as far so to demonstrate a relationship between the wage gap (a form of discrimination) and depression and anxiety. Platt, Prins, Bates, and Keyes (2016) quantified and operationalized the wage gap in order to explain the gender disparity in depression and anxiety disorders using data from a nationally representative sample of 22,581 working adults. The results from their study indicated that perhaps structural forms of discrimination are related to the development of anxiety and depression (Sutter & Perrin, 2016).

The above research is expanded upon the associated chapters throughout this book. The purpose of this section was to offer a cursory overview of the manner in which prejudice, discrimination, and the *isms* impact populations that clinical psychologists are likely to encounter. Clinical psychologists should be mindful (across the many contexts in which they might work) that prejudice, discrimination, and the *isms* have a substantial impact on the physical health, emotional well-being, and behavioral health of many minority populations in the United States. In the role of clinician, clinical psychologists may wish to assess for experiences of perceived discrimination and/or unfair treatment and provide appropriate interventions if needed. Depending on the presentation of the client and referral to primary care may also be merited. Clinical psychologists may also work in academic settings and encounter studies who have a history of perceived discrimination and/or unfair treatment; in such settings, psychologists may wish to be prepared to provide an appropriate referral if it seems that behavioral health services are needed.

Definitions and Theories of Stigma

Because of its obvious importance, stigma has been a focus of research in the field of applied psychology for many decades (Haghighat, 2001; Kurzban & Leary, 2001; Major & O'Brien, 2005). According to many scholars, most theories of stigmatizing process in psychological science can be traced to Goffman's seminal work (Goffman, 1963). Goffman (1963) theorized stigma as a process of global devaluation of an individual or a group of individuals who are deemed to possess a deviation attribute from the normative perspective. Accordingly, Jones et al. (1984) defined stigma as a "mark" that sets a person apart from others by associating the marked individuals with undesirable characteristics. Similarly, deviance theory proposed by Elliott, Ziegler, Altman, and Scott (1982) conceptualized stigma as a form of deviance that leads others to judge a certain individual or group of individuals as being illegitimate for participation in an interaction. Finally, Crocker, Major, and Steele (1998) postulated that stigmatized people are believed to possess some attributes that devalue the individual in a particular social context regardless of the presence of an obvious "mark."

To date, there are several other notable theories of stigma that view stigma more broadly, including its effects on individuals and their environments (Major & O'Brien, 2005). These theories can be collectively called a social cognitive approach (Corrigan, 2000; Fiske, 2005; Major & O'Brien, 2005), which includes labeling theory (Link & Phelan, 2001). In general, the social cognitive approach views stigma as a cognitive structure (e.g., schema) constructed by an individual through social interactions to make sense of the world (Crocker & Lutsky, 1986). Once elaborated, these cognitive structures become effective means in categorizing, labeling, comparing, and evaluating information about other groups of individuals (Link & Phelan, 2001). In this light, stigma is theorized to serve as a socially shaped and cost-effective tool in providing a quick and easy notion of a given person based on the person's categorized group (Macrae, Milne, & Bodenhausen, 1994), for the purpose of quickly and automatically solving specific problems in the context of a particular social environment (Haghighat, 2001; Kurzban & Leary, 2001).

How Stigma Can Affect the Pursuit of Applied Psychology

One of the limitations of the above-mentioned theories is the difficulty in applying them to the development and refinement of interventions (Corrigan & Penn, 1999; Hayes et al., 2004). This is in part because these theories do not directly address variables that can be systematically manipulated to alter stigmatizing attitudes and behaviors. Social cognitive psychologists have also noted that there is a gap between these theories and extant stigma reduction interventions; That is, protest, education, and contact-based intervention, interventions that are commonly used as stigma reduction strategies, are relatively independent of theories of stigma (Hayes et al., 2004), and their mechanisms of change are generally unknown (Penn & Corrigan, 2002).

How Does Stigma Differ from Prejudice?

Furthermore, some researchers have questioned the feasibility of extant stigma reduction interventions that are designed to directly change stigmatizing and prejudicial thoughts and behaviors in form and frequency (Bargh, 1999; Wilson, Lindsey, & Schooler, 2000). This is mainly because of the pervasive, rigid, and automatic nature of stigma and prejudice (Greenwald & Banaji, 1995; Macrae, Bodenhausen, Milne, & Jetten, 1994; Moxon, Keenan, & Hine, 1993; Watt, Keenan, Barnes, & Cairns, 1991). According to a contemporary behavior analytic model of complex human behavior, stigma and prejudice involve normal and adaptive human language/verbal abilities that have been "inappropriately" applied (Lillis & Levin, 2014; Masuda, Hill, Morgan, & Cohen, 2012). Colloquially speaking, stigmatization is the psychological process of objectifying and deindividualizing self or others because of their participation in normal verbal processes of categorization, association, and evaluation (Hayes, Niccolls, Masuda, & Rye, 2002). This broad definition implies that bias and discrimination can be applied to any verbally categorized groups of individuals (i.e., social categorization), both positive or negative, such as "White," "gay," "Muslim," "woman," "poor," "addict," "handicapped," and so on. This definition also implies that ordinary language/verbal processes make acts of bias and discrimination possible.

If stigmatization is viewed as a contextually shaped verbal behavior (cognitive process), several notable implications are derived. First, the process of stigmatization can be pervasive and automatic mainly because cognitive process can occur in virtually every sociocultural context automatically (Hayes et al., 2002; Hayes, Barnes-Holmes, & Roche, 2001). Second, stigma and prejudice are inherently rigid (Major & O'Brien, 2005). As with the case of any cognitive schemata, new ideas are met with resistance when they are not consistent with extant stereotype-consistent beliefs (Macrae, Bodenhausen, et al., 1994; Moxon et al., 1993), and efforts to suppress stigmatizing thoughts can paradoxically increase their frequency and intensity (Wenzlaff & Wegner, 2000). Furthermore, the process of stigmatization and prejudice can have an evolutionarily adaptive value. That is, the automatic and derived nature of stigmatizing process allows an individual to more easily navigate complex sociocultural interactions (Kurzban & Leary, 2001; Macrae, Milne, & Bodenhausen, 1994). These arbitrary categorization and association are learned early in childhood and continue throughout one's lifetime (Hayes et al., 2001; Pauker, Ambady, & Apfelbaum, 2010; Pauker, Williams, & Steele, 2016).

Controversies

As implied above, a major controversy in the applied side of this topic is that extant stigma reduction interventions, such as protest, education, and contact-based intervention (see Corrigan

& Penn, 1999; Dalky, 2012), may not adequately reflect the accumulated body of evidence in stigma research and applied implications derived from it. Findings from psychological science research suggest that directing challenging stigmatizing beliefs is not only futile, but also counterproductive (see Corrigan & Penn, 1999; Plaut, Thomas, Hurd, & Romano, 2018) and that targeting specific forms of stigma in content or frequency may be too peripheral without targeting their underlying cognitive process (Lillis & Levin, 2014; Masuda et al., 2012; Masuda, Donati, Schaefer, & Hill, 2016). One alternative effort for undermining the cognitive process is the enhancement of meta awareness, the repertoire of intentionally noticing cognitive process of stigma without acting on them for the purpose of undermining the rigid distinction of "us vs. them" (Langer, 1989). Furthermore, following an applied behavior analytic framework (Miltenberger, 2012), such as differential reinforcement of alternative behavior for undermining a target behavior, the promotion of functionally incompatible behavioral alternative, such as empathy and the sense of sameness, may be more fruitful than attempting to directly challenge stigmatizing beliefs (Levin et al., 2015; Masuda et al., 2007).

Cultural Privilege

In the context of equity and social justice, the concept of cultural privilege has become a flashpoint, with members of dominant in-groups arguing that any supposed privilege they enjoy is a result of effort and merit and members of non-dominant out-groups pointing repeatedly to the privilege that is not earned but conferred based on socially constructed hierarchies that has been codified at all levels of governmental regulation and in the policy documents and administrative manuals of our private and public institutions. For so long, the United States has touted itself as a cultural melting pot, a descriptor that implies cultural inclusiveness but, more accurately, reflects acculturation and assimilation imperatives imposed by dominant in-groups and embraced by non-dominant out-groups as a strategy for managing the fragility of in-group members and avoiding individual and institutional harms that occur in response to efforts to maintain and celebrate diverse cultural identities (Liu et al., 2019). In light of the reality that dominant United States cultural identities include whiteness, maleness, and high socioeconomic status, public discussions of cultural privilege often revolve around the comfort of these identities and often devolve into laments regarding the hardships faced by members of dominant in-groups rather than discussions of the flagrant inequality of hardships faced by persons who hold dominant cultural identities relative to persons who hold non-dominant cultural identities. These inequalities include pay and hiring disparities (Thomas et al., 2018), unequal access to education (American Psychological Association (APA), 2012; Kuchynka et al., 2018), unequal access to and receipt of healthcare (Paradies et al., 2015; Pietrse, Todd, Neville, & Carter, 2012), disproportionate contact with the justice system (Hall, Hall, & Perry, 2016; National Council on Crime and Delinquency, 2007), and disproportionate experiences of individual and institutionalized violence (Hall et al., 2016; Herrero, Rodríguez, & Torres, 2017; Inter-American Commission on Human Rights, 2018).

The concept of cultural privilege is beginning to take hold at a societal level, with discussions of the unearned advantage of holding privileged identities and the unearned disadvantage of not holding such identities occurring in primary, secondary, and college classrooms, in town hall meetings, and on the floors of our nation's most venerated governing institutions. To ensure student understanding of the concept of privilege, the National Association of School Psychologists (NASP), in an article titled *Understanding Race and Privilege*, provides a straightforward definition of privilege as "unearned advantages that are highly valued but restricted to certain groups" (NASP, 2016, p. 2). This NASP article delineates the disparities that are part and parcel of cultural privilege:

> Unearned advantages are those that someone receives by identifying or being born into a specific group. It is important to note that the groups who have received these advantages have not earned them due to their own hard work but rather their affiliation (e.g., being born into a wealthy family provides privileges that others do not have, such as accessing education as well as mental health and medical services; White Americans are more likely to walk into a mall without the suspicion of stealing). Equally important to note is the reality that while some benefit from unearned advantages, others are victims of unearned disadvantage. Unearned entitlements are things of value that all people should have; however, they are often restricted to certain groups because of the values of the majority culture that influence political and social decisions. (p. 2)

It must be acknowledged that, in the context of clinical service delivery, the concept of cultural privilege has not received much research attention. Pamela Hays (2008) has forwarded a definition of privilege and a model of cultural privilege that is among the most comprehensive approaches to evaluating the many cultural identities that can confer privilege in a given context. Referencing the pioneering work of feminist and racial activist Peggy McIntosh, Hays defines privilege as "the advantages one holds as a result of membership in a dominant group" (p. 6). In forwarding the ADDRESSING model, Hays (2001, 2008) provides a concrete strategy by which clinicians may increase their awareness of their cultural heritage and the privilege conferred by the cultural identities they hold. Specifically, Hays tasks clinicians with determining their cultural privilege in relation to **a**ge, developmental **d**isabilities, **d**isabilities acquired later in life, **r**eligion and spiritual orientation, **e**thnic and racial identity, **s**ocioeconomic status, **s**exual orientation, **i**ndigenous heritage, **n**ation of origin, and **g**ender. Hays' work represents a significant contribution to a larger move toward the integration of culture into every aspect of psychological service provision. In producing the current version of the model authors provided a definition of culture and a structure for evaluating the relevance of culture to clinical assessment and diagnosis, to the therapeutic interaction, to the likelihood that empirically supported psychological interventions will result in comparable benefit to persons who hold diverse cultural identities. Although not without controversy (see La Roche, Fuentes, & Hinton, 2015), the approach to culturally informed case formulation forwarded with in the DSM-5 serves to emphasize culture as a variable to be explored *with intention* rather than something that can be assumed to be captured and addressed in the normal course of psychological assessment and treatment without intentional consideration.

Like discussions of prejudice, discussions of privilege must be undertaken with an exquisite respect for the complexity of interpersonal engagement and the challenges that sometimes arise when group membership is not shared and when prejudgments are made around unshared cultural identities. Effective address of the discriminatory practices that have maintained the cultural privilege enjoyed by members of dominant in-groups will require that persons participating in discussions of cultural privilege and associated discriminatory practices: (1) examine the intersecting cultural identities they hold; (2) challenge their conceptions related to the earned and unearned advantages that contribute to their place in the world relative to persons who hold other cultural identities; (3) develop a stronger appreciation for the advantages of a culturally diverse population defines by inclusiveness rather than acculturation; and (4) generate personally relevant and personally achievable actions in support of cultural equity and inclusion. Although each of us is likely to experience some discomfort as we attempt to meet these requirements, the challenge of becoming self-aware and translating that to a prosocial awareness of the other may be the greatest challenge. Particularly appreciated are the recommendations that have been forwarded by Hays (2001, 2008), La Roche and Maxie (2003), La Roche et al. (2015), Duckworth, Iezzi, Vijay, and Gerber (2009), and the NASP (2016) in relation to seeing clearly the moments of cultural privilege we experience, understanding the impact of our privilege on persons who hold different, non-privileged cultural identities, and expanding the societally defined cultural center to include and to respect as equal those cultural identities that have heretofore been relegated to the borders of our lives. It is hoped that this discussion of privilege serves as a catalyst for examination of the multiple, intersecting cultural identities each of us holds: recognition of the benefits experienced in relation to certain centered (i.e., societally valued) identities, even when those benefits are not intentionally or consciously pursued; recognition of the oppression experienced by members of culturally diverse, non-dominant groups as a function of intentional and unintentional efforts to maintain the unearned benefits associated with holding one or more privileged identities; and full participation in social action that will raise the voices, societal value, and sociopolitical power of persons who hold diverse cultural identities.

The Future and the Scholarly Agenda

There are many issues that need more attention. What follows is a partial listing of some of the major unresolved issues:

1. *Relationship between science, morality, and politics.* First, it is fair to say that everyone ought to have an interest in these phenomena because these phenomena affect everyone, although in different ways, and in different magnitudes. Many are victims of discrimination and prejudice. Humans all hold stereotypes. Many individuals can be said by some definition to hold some level of prejudicial views toward some group or groups. Most would agree that minimizing these is essential for an improved, more just and healthier society. Nearly all would also agree that the presence of these causes negative effects (e.g., stress, depression, difficulty accessing healthcare) in the individual that fall squarely in the wheelhouse of clinical psychology and other health professionals.

   But the next level of detail has proven to be much more refractory. What is a valid consensual definition of prejudice? Is it wholly or at least partially subjective—entirely in the eye of the beholder? Is "reverse prejudice" (prejudice against the majority culture) a valid subtype of prejudice, or not? Is someone who is anti-abortion, and thus against what others regard as women's legitimate reproductive rights, sexist or misogynist—or simply expressing a valid and diverse opinion? A necessary but not sufficient condition for a valid measure of prejudice is such an accurate definition, but unfortunately, the field has no valid measure of prejudice in general or of specific subtypes (e.g., O'Donohue & Caselles, 1993 analysis of some of the difficulties in defining and measuring the construct of homophobia). Similar types of issues emerge with the other constructs in the field. The philosopher of science, Thomas Kuhn has said something quite apt regarding how the complexity of phenomena may impact scientific progress:

"[T]he insulation of the scientific community from society permits the individual scientist to concentrate his attention upon problems that he has good reason to believe he will be able to solve. Unlike the engineer, and many doctors, and most theologians, the scientist need not choose problems because they urgently need solution and without regard for the tools available to solve them. In this respect, also, the contrast between natural scientists and many social scientists proves instructive. The latter often tend, as the former almost never do, to defend their choice of a research problem–e.g., the effects of racial discrimination or the causes of the business cycle–chiefly in terms of the social importance of achieving a solution. Which group would one then expect to solve problems at a more rapid rate?" (Kuhn, 1970, p. 164).

Kuhn sees the problems of applied psychology are often simply more complex and the scientist's tools are often simply not developed sufficiently to solve these. The questions above also suggest that the study of these phenomena may be in what Kuhn (1970) calls a "pre-paradigmatic" state: there is little agreement on fundamentals such as definitions, measurement, the best methodologies for studying the phenomena, and so on.

Part of the complexity, though, is that these phenomena seem to be inherently multidisciplinary. However not just multi-disciplinary in strictly a scientific science. Certainly, many diverse scientific disciplines are relevant to the study of prejudice: psychology, sociology, anthropology, economics, to name a few, all have potential methods to provide information. But the multi-disciplinary nature of prejudice and discrimination transcends the sciences—history as a liberal art is involved in understanding these phenomena, as these have a complex worldwide history. Morality is also involved, as these phenomena are also moral phenomena—to act in prejudicial manner is also an immoral act, one in which "ought" statements become involved—not simply the "is" statements of science (Hempel, 1965). Politics also is involved—discrimination is seen as politically unjust, and an improved, just society would minimize such acts. But politics is only partly a science and is also a discipline involving values—for example, decisions regarding what ought to be valued and what values are superordinate.

The general point is that these phenomena are complex—and this complexity has had something to do with the difficulty in making progress on these. It is interesting, although beyond the scope of this chapter, to ask what general approaches have made the most progress regarding ameliorating these. For example, the political realm from the Emancipation Proclamation, to the various civil rights acts in the 1960s, to decisions made by the Supreme Court (e.g., Brown v. Board of Education) seems to have outstripped the beneficial impact that the sciences and particularly applied psychology has had. Such considerations can influence how one decides to allot one's scarce time and energy: how does one parse one's time and effort regarding researching these phenomena or becoming politically active in some way? Or is it best to blend these as some liberation scientists have suggested?

Priority of these problems; funding, clinically, some subtypes have higher priority? Do the problems associated with prejudice, discrimination, stigma, and oppression have the appropriate priority in the training curricula in applied psychology? in federal and private funding mechanisms? in the research agendas of scholars? in our clinical case formulations? Do some forms of prejudice and discrimination have more priority than others? For example, is prejudice against minorities more important than prejudice toward majority culture individuals? Is prejudice against those groups who generally have higher poverty rates a higher priority than groups that are not? Do current events impact priorities—even so which ones and why? These questions are complex but need to be discussed and clarified.

Are these phenomena all of the same kind or are some sui generis? Are all prejudices of the same kind or are some idiosyncratic? For example, is prejudice against an ethnic group essentially the same as prejudice against a sexual minority or are there important differences? Is ageism the same kind of phenomena as prejudice against Muslims? Is the (alleged) prejudice against women in an anti-abortion stance the same kind of prejudice as those held by say a KKK member? Is prejudice a categorical variable (one either is or is not) or does it have degrees—one can be slightly prejudiced or highly prejudiced (and can these degrees be validly measured)? Can a person be prejudiced on Monday due to some acts; not prejudice on Tuesday—but prejudiced again on Wednesday—that is, is being prejudiced a trait variable or a state variable? How ought prejudice be comprehensively described—is it simply Person x is (or is not) prejudiced or is it Person x holds prejudicial views a,b, against group G?—what philosophers call a 3 place predication (Person, Behavior, Target)?—or is it even more complex: At time t, person x behaves in y fashion with respect to group z and g at time t is properly regarded as prejudiced for reasons a,b,c.? These are basic questions which can be regarded as important as they involve basic questions about the nature of prejudice.

Human nature—can prejudice be eradicated? Is prejudice something that is inherent in human nature. Pinker (2002) among others have criticized psychologists for what he views as a naïve assumption that humans are blank slates. In contrast to this view is the view that humans have evolved and we have a nature—that is, tendencies. Is it in our nature, for example, to see the world in terms of in-groups and out-groups and to favor our perceived in-groups? If this or something along these lines is the case, how does this condition what we view as realistic goals for minimizing prejudice?

Identity politics and unintended effects Increasingly and perhaps related to political views (see O'Donohue, this volume), people are seen through the lens of identity politics—people identify (and perhaps are seen increasingly by others) as members of groups, such as Latinx, gay, elderly, Muslim, and so on, as well as their intersectionality. This may have some helpful benefits but does it come at a perhaps unintended cost—for example, does it create in-group–out-group categorizations that can serve as the basis for increased prejudice and discrimination instead of less? Is it contrary to what Dr. Martin Luther King called for in his "I have a dream speech"—for his children to not be seen by the color of their skin but by the content of their character?

The complexity of adjudicating and false claims and unwanted chilling effects The phenomena associated with prejudice and discrimination are also phenomena that are involved in criminal, civil, and other regulatory adjudication. How can social science aid in just outcomes in these arenas? Is our science sufficiently developed that robust regularities have been found that can aid the trier of fact in these situations? It is also important to note that while these adjudications are meant to give justice to those aggrieved, it is unclear the extent to which these actually accomplish this. Are these adjudications inappropriately burdensome for the complainant? Have outcomes in these (say Title IX) investigations actually been reasonable—or is there reason to believe that the burden of proof has been too high or too low (see O'Donohue, 2020)? For example, there is some evidence that Title IX investigations, although intending to help women seek justice for sexual discrimination, have resulted in an inordinate number of negative consequences for African American males—there are nearly 80 Title IX judgments that subsequently courts have overturned (O'Donohue & Schewe, 2020). Can we also understand how false claims can originate and identify these? There have been infamous cases involving Tawana Brawley, Jussie Smollett, a University of Virginia fraternity, and the Duke Lacrosse team, to name a few.

Are all new constructs related to these phenomena useful? The case of microagressions Sue (2013) has advanced the construct of microaggression and states:

> Microaggressions are about experiential reality and about listening to the voices of those most oppressed, ignored, and silenced. Those voices tell stories of the many hurts, humiliations, lost opportunities, need for change, and the often unintentional microaggressions endured as they struggle against an unwelcoming, invalidating, and even hostile campus climate and society (D. W. Sue, 2013). People of color, for example, often have their lived racial realities about bias and discrimination met with disbelief by our society. They are often told that they are oversensitive, paranoid, and misreading the actions of others. They are asked, "Aren't you mind-reading? Aren't you distorting the truth? Where is your evidence?" In essence, Lilienfeld is applying the accepted scientific principle of *skepticism* to the study of microaggressions, which may unintentionally dilute, dismiss, and negate the lived experience of marginalized groups in our society. (pg. 70).

On the other hand, Lilienfeld (2017) states:

> The microaggression concept has recently galvanized public discussion and spread to numerous college campuses and businesses. I argue that the microaggression research program (MRP) rests on five core premises, namely, that microaggressions (1) are operationalized with sufficient clarity and consensus to afford rigorous scientific investigation; (2) are interpreted negatively by most or all minority group members; (3) reflect implicitly prejudicial and implicitly aggressive motives; (4)

> can be validly assessed using only respondents' subjective reports; and (5) exert an adverse impact on recipients' mental health. A review of the literature reveals negligible support for all five suppositions. More broadly, the MRP has been marked by an absence of connectivity to key domains of psychological science, including psychometrics, social cognition, cognitive-behavioral therapy, behavior genetics, and personality, health, and industrial-organizational psychology. Although the MRP has been fruitful in drawing the field's attention to subtle forms of prejudice, it is far too underdeveloped on the conceptual and methodological fronts to warrant real-world application. I conclude with 18 suggestions for advancing the scientific status of the MRP, recommend abandonment of the term "microaggression," and call for a moratorium on microaggression training programs and publicly distributed microaggression lists pending research to address the MRP's scientific limitations.

These obviously are two starkly different views. How does one adjudicate between these? Is it true that being skeptical or even neutral regarding microagressions itself problematic? These two positions show the complexity of these phenomena.

What is evidence-based practice—problems with implicit bias The notion of evidence-based practice has swept healthcare in the past few decades. Part of the rationale for this is the view that science is needed to actually determine if and the degree to which some intervention is effective: anecdotes, case studies, and pre–post data are not sufficient. Rather, randomly controlled trials, and replications of these, involving double blinds, manualized treatments, valid outcome measures assessing effectiveness and safety, and follow-ups to assess for recidivism are what is necessary. The American Psychological Association has produced the well-known Chambliss report which lists several dozen interventions for various problems that have met similar criteria.

Unfortunately, there does not seem to be the same emphasis in this domain. This ought to change. It is not sufficient to just "do something" because the problem is significant and urgent. Interventions can be iatrogenic and ineffective interventions can give the impression that "at least something was done," although it is none too clear why this is good if the actual impact on the target problem is unclear.

Implicit bias is a case in point. Although it is increasingly utilized by both institutions in the private and public sector, scientific studies raise questions about the validity of the Implicit Association Test, the causal relationship between so-called implicit biases, and the ability of any intervention to significantly change any putative implicit biases in a positive direction (e.g., Blanton et al., 2009; Mitchell & Tetlock, 2017). Despite the valid concerns that arise from these data and conceptual critiques, there is little evidence that the utilization of implicit bias training is being slowed. Part of the problem seems to be a lack of commitment to evidence-based practice and this needs to be corrected, as the problems are too important to just "do something" as opposed to "do something effective."

References

American Psychological Association, Presidential Task Force on Educational Disparities. (2012). *Ethnic and racial disparities in education: Psychology's contributions to understanding and reducing disparities*. Retrieved from http://www.apa.org/ed/resources/racial-disparities.aspx

Bargh, J. A. (1999). The cognitive monster: The case against the controllability of automatic stereotype effects. In S. Chaiken & Y. Trope (Eds.), *Dual-process theories in social psychology* (pp. 361–382). New York, NY: Guilford Press.

Benuto, L., & O'Donohue, W. (2015). Is culturally sensitive cognitive behavioral therapy an empirically supported treatment?: The case for hispanics international journal of psychology and psychological therapy, 15(3).

Benuto, L., Casas, J., & O'Donohue, W., (2018). Training psychologists to be culturally competent providers: A systematic review of the literature. *Training and Education in Professional Psychology*, https://doi.org/10.1037/tep0000190

Blanton, H., Jaccard, J., Klick, J., Mellers, B., Mitchell, G., & Tetlock, P. (2009, May). Strong claims and weak evidence: Reassessing the predictive validity of the IAT. *Journal of Applied Psychology, 94*(3), 567–582.

Britt-Spells, A. M., Slebodnik, M., Sands, L. P., & Rollock, D. (2018). Effects of perceived discrimination on depressive symptoms among Black men residing in the United States: A meta-analysis. *American Journal of Men's Health, 12*(1), 52–63. https://doi-org.unr.idm.oclc.org/10.1177/1557988315624509

Colen, C. G., Ramey, D. M., Cooksey, E. C., & Williams, D. R. (2018). Racial disparities in health among non-poor African Americans and Hispanics: The role of acute and chronic discrimination. *Social Science & Medicine, 199*, 167–180. https://doi-org.unr.idm.oclc.org/10.1016/j.socscimed.2017.04.051

Corrigan, P. W. (2000). Mental health stigma as social attribution: Implications for research methods and attitude change. *Clinical Psychology: Science and Practice, 7*(1), 48–67.

Corrigan, P. W., & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist, 54*(9), 765–776.

Crocker, J., & Lutsky, N. (1986). Stigma and the dynamics of social cognition. In S. C. Ainlay, G. Becker, & L. M. Coleman (Eds.), *The dilemma of difference: A multidisciplinary view of stigma* (pp. 95–121). Boston, MA: Springer US.

Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In D. T. Gilbert, S. T. Ffiske, & G. Lindzey (Eds.), *The handbook of social psychology* (Vol. 2, pp. 504–553). Academic Press, New York.

Dalky, H. F. (2012). Mental illness stigma reduction interventions: Review of intervention trials. *Western Journal of Nursing Research, 34*(4), 520–547. https://doi.org/10.1177/0193945911400638

Duckworth, M. P., Iezzi, T., Vijay, A., & Gerber, E. (2009). Cultural competency in the primary care setting. In L. C. James & W. T. O'Donohue (Eds.), *The primary care toolkit: Practical resources for the integrated behavioral care provider* (pp. 63–76). New York, NY: Springer.

Elliott, G. C., Ziegler, H. L., Altman, B. M., & Scott, D. R. (1982). Understanding stigma: Dimensions of deviance and coping. *Deviant Behavior: An Interdisciplinary Journal, 3*(3), 275–300.

Everson-Rose, S. A., Lutsey, P. L., Roetker, N. S., Lewis, T. T., Kershaw, K. N., Alonso, A., & Roux, A. V. D. (2015). Perceived discrimination and incident cardiovascular events the multi-ethnic study of atherosclerosis. *American Journal of Epidemiology, 182*, 225e234.

Fiske, S. T. (2005). Social cognition and the normality of prejudgment. In P. Glick & L. A. Rudman (Eds.), *On the nature of prejudice: Fifty years after Allport* (pp. 36–53). Malden, MA: Blackwell Publishing.

Frisby, C. & O'Donohue, W. (2018). Cultural competence in applied psychology. Hoboken, NJ: Springer.

Fujishiro, K. (2009). Is perceived racial privilege associated with health? Findings from the behavioral risk factor surveillance system. *Social Science & Medicine, 68*(5), 840–844. https://doi-org.unr.idm.oclc.org/10.1016/j.socscimed.2008.12.007

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice Hall.

Greenwald, A. G., & Banaji, M. R. (1995). Implicit social cognition: Attitudes, self-esteem, and stereotypes. *Psychological Review, 102*(1), 4–27.

Haghighat, R. (2001). A unitary theory of stigmatisation: Pursuit of self-interest and routes to destigmatisation. *British Journal of Psychiatry, 178*(3), 207–215. https://doi.org/10.1192/bjp.178.3.207

Hall, A. V., Hall, E. V., & Perry, J. L. (2016). Black and blue: Exploring racial bias and law enforcement in the killings of unarmed black male civilians. *American Psychologist, 71*(3), 175–186.

Harrell, S. P. (2000). A multidimensional conceptualization of racism-related stress: Implications for the well-being of people of color. *American Journal of Orthopsychiatry, 70*(1), 42–57. https://doi-org.unr.idm.oclc.org/10.1037/h0087722

Hayes, S. C., Barnes-Holmes, D., & Roche, B. (2001). *Relational frame theory: A post-Skinnerian account of human language and cognition*. New York, NY US: Kluwer Academic/Plenum Publishers.

Hayes, S. C., Bissett, R., Roget, N., Padilla, M., Kohlenberg, B. S., Fisher, G., … Niccolls, R. (2004). The impact of acceptance and commitment training and multicultural training on the stigmatizing attitudes and professional burnout of substance abuse counselors. *Behavior Therapy, 35*(4), 821–835. https://doi.org/10.1016/s0005-7894(04)80022-4

Hayes, S. C., Niccolls, R., Masuda, A., & Rye, A. K. (2002). Prejudice, terrorism and behavior therapy. *Cognitive and Behavioral Practice, 9*(4), 296–301. https://doi.org/10.1016/s1077-7229(02)80023-2

Hays, P. (2008). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy*. Washington, DC: American Psychological Association.

Hays, P. A. (2001). *Addressing cultural complexities in practice: A framework for clinicians and counselors*. Washington, DC: American Psychological Association.

Hempel, C. (1965). Aspects of scientific explanation. New York: The Free Press.

Herrero, J., Rodríguez, F. J., & Torres, A. (2017). Acceptability of partner violence in 51 societies: The role of sexism and attitudes toward violence in social relationships. *Violence Against Women, 23*(3), 351–367.

Huey, S. J., & Tilley, J. L. (2018). Effects of mental health interventions with Asian Americans: A review and meta-analysis. *Journal of Consulting & Clinical Psychology, 86*(11), 915–930.

Hwang, W.-C., & Goto, S. (2009). The impact of perceived racial discrimination on the mental health of Asian American and Latino college students. *Asian American Journal of Psychology, S*(1), 15–28. https://doi.org/10.1037/1948-1985.S.1.15

Inter-American Commission on Human Rights. (2018). *African Americans, police use of force, and human rights in the United States*. Washington, DC: Organization of American States.

Jones, E. E., Farina, A., Hastorf, A. H., Markus, H., Miller, D. T., & Scott, R. A. (1984). *Social stigma: The psychology of marked relationships*. New York, NY: WH Freeman.

Kuchynka, S. L., Salomon, K., Bosson, J. K., El-Hout, M., Kiebel, E., Cooperman, C., & Toomey, R. (2018).

Hostile and benevolent sexism and college women's STEM outcomes. *Psychology of Women Quarterly, 42*(1), 72–87.

Kuhn, T. S. (1970). *The structure of scientific revolutions* (2nd ed.). University of Chicago Press: Chicago, IL.

Kurzban, R., & Leary, M. R. (2001). Evolutionary origins of stigmatization: The functions of social exclusion. *Psychological Bulletin, 127*(2), 187–208. https://doi.org/10.1037/0033-2909.127.2.187

La Roche, M. J., Fuentes, M. A., & Hinton, D. (2015). A cultural examination of the DSM-5: Research and clinical implications for cultural minorities. *Professional Psychology: Research and Practice, 46*(3), 183–189.

La Roche, M. J., & Maxie, A. (2003). Ten considerations in addressing cultural differences in psychotherapy. *Professional Psychology: Research and Practice, 34*(2), 180–186.

Langer, E. J. (1989). Minding matters: The consequences of mindlessness–mindfulness. In *Advances in experimental social psychology* (Vol. 22, pp. 137–173). Elsevier: San Diego, CA.

Levin, M. E., Luoma, J. B., Vilardaga, R., Lillis, J., Nobles, R., & Hayes, S. C. (2015). Examining the role of psychological inflexibility, perspective taking, and empathic concern in generalized prejudice. *Journal of Applied Social Psychology, 46*, 180. https://doi.org/10.1111/jasp.12355

Lilienfeld, S. O. (2017). Microaggressions: Strong claims, inadequate evidence. *Perspectives on Psychological Science, 12*, 138–169.

Lillis, J., & Levin, M. (2014). Acceptance and mindfulness for undermining prejudice. In A. Masuda (Ed.), *Mindfulness and acceptance in multicultural competency: A contextual approach to sociocultural diversity in theory and practice* (pp. 181–196). Oakland, CA: New Harbinger. Oakland, CA: Context Press.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363–385. https://doi.org/10.1146/annurev.soc.27.1.363

Liu, W. M., Liu, R. Z., Garrison, Y. L., Kim, J. Y. C., Chan, L., Ho, Y. C. S., & Yeung, C. W. (2019). Racial trauma, microaggressions, and becoming racially innocuous: The role of acculturation and White supremacist ideology. *American Psychologist, 74*(1), 143–155.

Lowe, S. R., Tineo, P., & Young, M. N. (2018). Perceived discrimination and major depression and generalized anxiety symptoms: In Muslim American college students. *Journal of Religion and Health*. https://doi-org.unr.idm.oclc.org/10.1007/s10943-018-0684-1, *58*, 1136.

Macrae, N. C., Bodenhausen, G. V., Milne, A. B., & Jetten, J. (1994). Out of mind but back in sight: Stereotypes on the rebound. *Journal of Personality and Social Psychology, 67*(5), 808–817.

Macrae, N. C., Milne, A. B., & Bodenhausen, G. V. (1994). Stereotypes as energy-saving devices: A peek inside the cognitive toolbox. *Journal of Personality and Social Psychology, 66*(1), 37–47. https://doi.org/10.1037/0022-3514.66.1.37

Major, B., & O'Brien, L. T. (2005). The social psychology of stigma. *Annual Review of Psychology, 56*(1), 393–421. https://doi.org/10.1146/annurev.psych.56.091103.070137

Masuda, A., Donati, M. R., Schaefer, L. W., & Hill, M. L. (2016). Terrorism as an act in context. In M. Taylor, J. Roach, & K. Pease (Eds.), *Evolutionary Psychology and Terrorism* (pp. 124–148). New York, NY: Routledge.

Masuda, A., Hayes, S. C., Fletcher, L. B., Seignourel, P. J., Bunting, K., Herbst, S. A., … Lillis, J. (2007). Impact of acceptance and commitment therapy versus education on stigma toward people with psychological disorders. *Behaviour Research and Therapy, 45*(11), 2764–2772. doi:S0005-7967(07)00114-3 [pii]. https://doi.org/10.1016/j.brat.2007.05.008

Masuda, A., Hill, M. L., Morgan, J., & Cohen, L. L. (2012). A psychological flexibility-based intervention for modulating the impact of stigma and prejudice: A descriptive review of empirical evidence. *Psychology, Society & Education, 4*(2), 211–223.

Merriam-Webster. (n.d.-a). Merriam-Webster Since 1828 Dictionary, prejudice. Retrieved from: https://www.merriam-webster.com/dictionary/prejudice

Merriam-Webster. (n.d.-b). Merriam-Webster Since 1828 Dictionary, discrimination. Retrieved from: https://www.merriam-webster.com/dictionary/discrimination

Miltenberger, R. G. (2012). *Behavior modification: Principles and procedures* (5th ed.). Belmont, CA: Wadsworth/Thomson Learning.

Mitchell, G., & Tetlock, P. (2017). Popularity as a poor proxy for utility: The case of implicit bias. In S. O. Lilienfeld & I. D. Waldman (Eds.), *Psychological science under scrutiny: Recent challenges and proposed solutions* (pp. 164–195). Wiley-Blackwell. xxv, 371 pp.

Molina, K. M., Estrella, M. L., Durazo-Arvizu, R., Malcarne, V. L., Llabre, M. M., Isasi, C. R., … Daviglus, M. L. (2019). Perceived discrimination and physical health-related quality of life: The Hispanic Community Health Study/Study of Latinos (HCHS/SOL) sociocultural ancillary study. *Social Science & Medicine, 222*, 91–100. https://doi-org.unr.idm.oclc.org/10.1016/j.socscimed.2018.12.038

Moxon, P. D., Keenan, M., & Hine, L. (1993). Gender-role stereotyping and stimulus equivalence. *The Psychological Record, 43*(3), 381–394.

Nadimpalli, S. B., James, B. D., Yu, L., Cothran, F., & Barnes, L. L. (2015). The association between discrimination and depressive symptoms among older African Americans: The role of psychological and social factors. *Experimental Aging Research, 41*(1), 1–24. https://doi-org.unr.idm.oclc.org/10.1080/0361073X.2015.978201

National Association of School Psychologists. (2016). *Understanding race and privilege* [handout]. Bethesda, MD: Author.

National Council on Crime and Delinquency. (2007). *And justice for some: Differential treatment of youth of color in the justice system*. Oakland, CA: Author. Retrieved from http://www.nccdglobal.org/sites/default/files/publication_pdf/justicefor-some.pdf

O'Donohue, W., & Benuto, L. (2010). The many problems with cultural sensitivity. *Scientific Review of Mental Health Practice, 7*(2), 34–37.

O'Donohue, W., & Caselles, C. E. (1993). Homophobia: Conceptual, definitional, and value issues. *Journal of Psychopatholy and Behavorial Assessessment, 15*, 177–195.

O'Donohue, W., & Dyslin, C. (1996). Abortion, boxing and Zionism: Politics and the APA. *New Ideas in Psychology, 14*(1), 1–10.

Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pietrse, A., … Gee, G. (2015). Racism as a determinant of health: A systematic review and meta-analysis. *PLoS One, 10*(9), 1–48. https://doi.org/10.1371/journal.pone.0138511

Pauker, K., Ambady, N., & Apfelbaum, E. P. (2010). Race salience and essentialist thinking in racial stereotype development. *Child Development, 81*(6), 1799–1813. https://doi.org/10.1111/j.1467-8624.2010.01511.x

Pauker, K., Williams, A., & Steele, J. R. (2016). Children's racial categorization in context. *Child Development Perspectives, 10*(1), 33–38. https://doi.org/10.1111/cdep.12155

Penn, D. L., & Corrigan, P. W. (2002). The effects of stereotype suppression on psychiatric stigma. *Schizophrenia Research, 55*(3), 269–276.

Pietrse, A. L., Todd, N. R., Neville, H. A., & Carter, R. T. (2012). Perceived racism and mental health among Black American adults: A meta-analytic review. *Journal of Counseling Psychology, 59*(1), 1–9.

Platt, J. M., Prins, S. J., Bates, L. M., & Keyes, K. M. (2016). Unequal depression for equal work? How the wage gap explains gendered disparities in mood disorders. *Social Science & Medicine, 149*, 1–8. https://doi-org.unr.idm.oclc.org/10.1016/j.socscimed.2015.11.056

Plaut, V. C., Thomas, K. M., Hurd, K., & Romano, C. A. (2018). Do color blindness and multiculturalism remedy or Foster discrimination and racism? *Current Directions in Psychological Science, 27*(3), 200–206.

Sue, D. W. (2013). Race talk: The psychology of racial dialogues. *American Psychologist, 68*, 663–672.

Sutter, M., & Perrin, P. B. (2016). Discrimination, mental health, and suicidal ideation among LGBTQ people of color. *Journal of Counseling Psychology, 63*(1), 98–105. https://doi-org.unr.idm.oclc.org/10.1037/cou0000126

Thomas, R., Yee, L., Cooper, M., Krivkovich, A., Konar, H., Starikova, I., … Robinson, N. (2018). *Women in the workplace 2018*. Washington, DC: LeanIn.Org and McKinsey & Company.

Watt, A., Keenan, M., Barnes, D., & Cairns, E. (1991). Social categorization and stimulus equivalence. *The Psychological Record, 41*(1), 33–50.

Wenzlaff, R. M., & Wegner, D. M. (2000). Thought suppression. *Annual Review of Psychology, 51*(1), 59–91. https://doi.org/10.1146/annurev.psych.51.1.59

Wilson, T. D., Lindsey, S., & Schooler, T. Y. (2000). A model of dual attitudes. *Psychological Review, 107*(1), 101–126. https://doi.org/10.1037/0033-295x.107.1.101

Prejudice, Power, and Injustice: Problems in Academia

William O'Donohue

Abstract

Politics deals with the interrelated problems of power and justice. Academics largely hold views of what can be called the political left to these questions of power and justice. It is the political left that wields power in the academy. This can create a bias (perhaps even a "prejudice") toward the minority on the political right. Political ideologies also can influence the definition and understanding of prejudice on many key dimensions. Prejudice is not seen as a fairly ordinary epistemic failing but it is also seen as significant moral failing. The political left with its power in the academy has violated the civil liberties of those that they disagree with; often using the construct of prejudice in these problematic moves. This chapter calls for more justice, tolerance, openness, and a renewed respect for civil liberties on campus by a more critical and thoroughgoing analysis of the construct of prejudice.

Keywords

Political bias · Liberal · Left · Conservative · Right · Prejudice · Totalitarianism · Diversity · Ethics

> "If you have always believed that everyone should play by the same rules and be judged by the same standards, that would have gotten you labeled a radical 50 years ago, a liberal 25 years ago and a racist today." Thomas Sowell.

> "No one will really understand politics until they understand that politicians are not trying to solve our problems. They are trying to solve their own problems—of which getting elected and re-elected are number one and number two. Whatever is number three is far behind." Thomas Sowell.

Political philosophy attempts to examine the interconnected questions of power and justice. Consider the following:

> "Think for a moment about your own political subjugation. You are continually subject to rules not directly of your own making, called laws governing not only you but others; for example how fast you can drive on a highway, what kind of behavior you can exhibit in public, what kinds of treatment of other human beings are permissible, what objects count as "yours" or "theirs" and so forth. These rules are enforced by certain people following the directives of those who create the rules and who set the penalties for breaking them. Thus, you know that if you don't obey the rules you are likely to suffer undesirable consequences which can range from small fines to incarceration and even (in some societies) to death" (Hampton, 1996, pg. 3).

This quote illustrates what will be called for the purposes of this chapter: "the fundamental problem of power and justice." Political commitments, by definition, are attempts to answer the fundamental problem of power and justice. Although there are obviously a wide variety of

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© Springer Nature Switzerland AG 2020

L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_2

political positions, for the purposes of efficient exposition, this chapter will focus on two: the left (or the liberal) and the right or (conservative) positions. Generally, these distinguish positions on important questions from rules that determine the size of government (e.g., level of taxation), to rules regulating economic transactions (e.g., minimum wage laws), to rules governing civil rights (what counts as free speech or religious liberty) to rules on specific issues such as abortion, and to rules that define and attempt to remediate problems associated with prejudice such as employment or housing discrimination. This chapter will also argue that these two political positions also have dramatic and consequential differences in how the construct of prejudice is construed.

Admittedly, even with these two broad political categories, there is much variation—some liberals (e.g., socialists) are more to the left than others (want even higher taxation than more moderate leftists); some conservatives are more libertarian (and those would want a minimal government particularly around issues of morality, such as drug use or prostitution), while other conservatives are more religiously oriented (and would want government to weigh in on drug and prostitution illegalization) and thus usually much less libertarian in their political judgments. Also, additional variation can be due to the multidimensional nature of these two positons: for example, some individuals can be "economic conservatives" (favoring free markets, or lower taxes) but "social liberals" on issues such as abortion or affirmative action. However, this chapter will rely on these two labels, as these have historically had wide usage and many scholars have used these labels to broadly demarcate both political identifications and regularities regarding these.

It is also important to note that the fundamental problem of power and justice applies to many different specific social situations and suggests a diverse and complex array of power relationships as who has power can vary across time and place. For example, on the national political scene, the political leanings of presidents can change every 4 or 8 years; and congressional majorities change even more rapidly. In local government, governors change, and state assemblies change and so on. These also can change in highly different ways: a president may be elected who is liberal while at the same time a branch of congress is elected that is conservative.

There are also significant broad historical trends that reflect dramatic political shifts such as the decrease in power of the Catholic Church in the recent few centuries, the ebb and flow of the power of labor unions, demographic changes that affect the electorate, and so on. Thus, it is vital to not paint the political allegiances of who actually holds power in some specific situation with an overly broad bush or hold outdated caricatures of who actually holds political power. For example, it will be argued in this chapter that in the academy in recent decades, it is not the political right that holds power but it is the political left that holds the power in the academy. This is in sharp contrast to what many, especially those on the left take to be "The Man." Moreover, it will be argued that the political left in the academy has all too often used this power to threaten civil liberties on campus; and, interestingly for the purposes of this chapter, the political left often uses allegations of prejudice to accomplish these problematic ends.

This chapter argues for the following propositions:

1. The relevant data indicate that academics, including academic administrators, are overwhelming politically liberal (see below for a brief literature review).
2. This produces a leftist political bias in academia. Importantly relating to the fundamental problem of power and justice, it is overwhelmingly persons of the political left who are making, interpreting, and enforcing rules, as well as designing and implementing punishments for rule violations. These leftist political biases play a large role in manifold ways in the day-to-day business of the university, affecting who makes the rules, who is hired or admitted, who is fired or expelled, who receives tenure, promotions, or awards, and who is disciplined for what reasons and with what severity.
3. Prejudice, like many constructs, is a difficult construct to define and who defines it is partly a political matter with many significant consequences, including who can enter and stay in

the academy. Thus, in the academy, it is overwhelming the political left that is defining prejudice according to their political preferences as well as controlling most of the implications of this (deciding on rule violations regarding prejudice and proper punishment for such violations.)

4. That research does not indicate that individual of one political orientation are more prejudiced—however, a lot depends on the definition of prejudice.
5. Political positions are intimately connected to moral positions—and this connection is partially responsible for the intensity of political positions. This can be an important factor in liberals' treatment of conservatives in academy—such as the treatment of speakers invited to speak on campus of the political right who are subsequently disinvited; or not allowed to speak by hostile and threatening protests often by mobs when they arrive; or why some (free) speech of the right is regarded as offensive in ways related to prejudice (e.g., sexist, homophobic, racist) and is not permitted and is punished (often severely); and why students or faculty who do not agree with the positions of the political left receive a variety of negative consequences from academic administrators.
6. There can be two construals regarding politics and the academy: (1) that there ought to be more political and intellectual diversity (to borrow a term from the left) including by behaving in more "inclusive" (again, with obvious borrowing) ways toward those of the political right; or (2) there ought to be an increased recognition and rejection of totalitarianism in academia—and in the academy, currently, totalitarianism threats are largely emanating from the political left.

A Case Illustration: Free Speech, Alleged Sexism, and Losing One's Job at Harvard

Let's next examine an illustrative case in academia that sheds light on the fundamental problem of power and justice, as it can play out in academia. Admittedly, this is a single case (but see below and Table 1 for more examples) and it will not be used to support generalizations, but this is an infamous case regarding free speech and academic freedom and illustrates both the role alleged prejudice can play in these matters (in this case, alleged sexism) as well as the severe personal and professional consequences that can arise.

In 2005, Lawrence Summers who had served as Treasury Secretary for President Clinton (and thus is hardly someone of the far right) was the 27th President of Harvard. Summers was forced to resign this position in early 2006 largely because of a speech he gave at the Conference on Diversifying the Science & Engineering Workforce regarding the underrepresentation of women in in tenured positions in science at top universities and research institutions. In the beginning of his speech (the entire transcript can be found at: https://emilkirkegaard.dk/en/?p=2705), Summers indicated that he would be provocative and would consider why underrepresentation occurs. Summers stated:

> "It is after all not the case that the role of women in science is the only example of a group that is significantly underrepresented in an important activity and whose underrepresentation contributes to a shortage of role models for others who are considering being in that group. To take a set of diverse examples, the data will, I am confident, reveal that Catholics are substantially underrepresented in investment banking, which is an enormously high-paying profession in our society; that white men are very substantially underrepresented in the National Basketball Association; and that Jews are very substantially underrepresented in farming and in agriculture. These are all phenomena in which one observes underrepresentation, and I think it's important to try to think systematically and clinically about the reasons for underrepresentation."

Summers then turned to examine three hypotheses to explain this underrepresentation of women in these positions: (1) Women make healthier decisions regarding the willingness to work the 80-hour weeks it often requires to gain these positions; (2) There are differences in intrinsic aptitude regarding certain relevant cognitive abilities between men and women. However, it is important to stress that Summers suggested there were no differences in the *mean* between men and women but rather differences in the *variance*,

Table 1 FIRE and academia

“**Arizona State University: Racial Restrictions on Class Enrollment (2002)** Category: **Cases**, **Due Process** Schools: **Arizona State University** After FIRE was notified of advertised racial restrictions on enrollment in a course on Navajo history, Arizona State University declared that two English classes listed on its website as “for Native Americans only”; would be open to all students. While the university insisted that this declaration reflected a “long-standing practice”; of enrolling students in the classes regardless of race, FIRE uncovered evidence showing the classes were racially segregated for at least eight years.”
“**Brandeis University: Professor Found Guilty of Harassment for Protected Speech** Category: **Free Speech** Schools: **Brandeis University** Brandeis University declared a professor guilty of racial harassment and placed a monitor in his classes after he criticized the use of the word “wetbacks” in his Latin American Politics course. Professor Donald Hindley, a nearly 50-year veteran of teaching, was neither granted a formal hearing by Brandeis nor provided with the substance of the accusations against him in writing before a verdict was reached. Determined not to be branded as a racial harasser simply for using a word in the process of explaining it, Hindley appealed the decision. Provost Marty Krauss pointedly ignored various responsibilities to consult with the Faculty Senate and Krauss’ assertion of arbitrary administrative power angered the Faculty Senate, which has refused to peacefully surrender its bargained-for rights and led to a total meltdown of faculty-administration relations. Hindley has also alleged that he was targeted for his political views including his pro-Palestinian advocacy. The unwillingness of the administration to reach a resolution in this case has led FIRE to place Brandeis University on its red alert list as one of the worst of the worst abusers of liberty on campus.”
“**Brown University: Wrongful Suspension of Religious Student Group** Category: **Religious Liberty** Schools: **Brown University** Brown University inexplicably suspended one of its largest religious student organizations, with shifting and unclear reasons for its decision. Brown ignored requests from Trinity Presbyterian Church’s campus fellowship for an explanation of its suspension and the student group finally sought help from FIRE. Brown University finally lifted its semester-long suspension of the Reformed University Fellowship (RUF) student group after months of public pressure from FIRE.”
“**California Polytechnic State University (Cal Poly): Bias Reporting System Targets “Politically Incorrect” Professors** Category: **Free Speech** Schools: **California Polytechnic State University** California Polytechnic State University (Cal Poly), which has already once been on the losing side of a free speech lawsuit, suspended an unconstitutional program targeting professors and students whose speech is “biased” or not “politically correct.” The program even planned to let students report complaints anonymously, meaning that those deemed “politically incorrect” might never have known whom they had offended or why. Under pressure from FIRE, Cal Poly has promised that any future CARE-Net program (short for Community Advocating REspect) “will not function to suppress controversial, offensive, or any other kind of protected speech.”
“**California State University, Fullerton: Unconstitutional Investigation and Punishment of Sorority Over ‘Inappropriate’ Theme Party** Category: **Free Speech** Schools: **California State University – Fullerton** On August 19, 2014, the Alpha Delta Pi (ADP) sorority at California State University, Fullerton (CSUF) held a “Taco Tuesday”-themed recruitment event, at which many of its members wore Mexican clothing items and costumes. CSUF opened a disciplinary investigation of the sorority due to the perceived insensitivity of its members’ attire at the event. As part of a “Voluntary Administrative Review” process, CSUF declared ADP guilty of disrupting university operations, “[d]isorderly, lewd, [indecent], or obscene behavior,” and “[c]onduct that threaten[s] or endangers the health or safety” of CSUF community members, among other violations. CSUF’s sanctions included requirements that ADP “coordinate a mandatory workshop on cultural competencies and diversity” and the “development of a ‘we are a culture not a costume’ campaign.” FIRE wrote to CSUF on September 26, 2014, calling the conduct charges and sanctions against ADP entirely without merit and unconstitutional, and demanded their complete and immediate dismissal.”

(continued)

Table 1 (continued)

“**Central Michigan University: Assessment of Security Fees for Controversial Speaker** Category: **Free Speech** Schools: **Central Michigan University** In a victory for freedom of expression and freedom of association, Central Michigan University (CMU) agreed to provide security for a speech by author and conservative activist David Horowitz hosted by Campus Conservatives, the Young Americans for Freedom chapter at CMU. CMU had initially refused to provide security without imposing an excessive financial burden on the club. FIRE wrote CMU President Michael Rao, urging CMU to meet its constitutional obligation not to financially burden speech that others might find offensive. FIRE’s letter pointed out that the Supreme Court has declared such burdens unconstitutional.”
“**Student Employee Found Guilty of ‘Racial Harassment’ for Reading a Book** Category: **Free Speech** Schools: **Indiana University – Purdue University Indianapolis** One of FIRE’s most shocking cases in 2008 was that of Keith John Sampson, a student-employee at Indiana University-Purdue University Indianapolis (IUPUI) who was found guilty of racial harassment for merely reading the book Notre Dame vs. the Klan: How the Fighting Irish Defeated the Ku Klux Klan during his work breaks. Thanks to FIRE’s involvement and the extensive media coverage of the case, the finding against Sampson was eventually overturned and his school record was cleared, but the story behind this incident is still disturbing.”
Missouri State University: Political Litmus Test in School of Social Work Category: **Freedom of Conscience**, **Religious Liberty** Schools: **Missouri State University** Emily Brooker sued Missouri State University (MSU) after she was threatened with expulsion and charged with violating MSU’s “Standards of Essential Functioning” for refusing to lobby the Missouri legislature on behalf of homosexual adoption. The lawsuit was settled in her favor. An outside investigation of the School of Social Work found ideological coercion on the part of the faculty against dissenting students and noted the chilling effect of its actions and policies on the school’s intellectual atmosphere.
“**University of Delaware: Students Required to Undergo Ideological Reeducation** Category: **Freedom of Conscience** Schools: **University of Delaware** Following an intense campaign led by FIRE and national media attention, the University of Delaware dropped an ideological reeducation program that was referred to in the university’s own materials as a “treatment” for students’ incorrect attitudes and beliefs. The program’s stated goal was for the approximately 7000 students in Delaware’s residence halls to adopt highly specific university-approved views on politics, race, sexuality, sociology, moral philosophy, and environmentalism. The residence life education program made mandatory, among other things, one-on-one meetings between students and their Resident Assistants (RAs) where students were asked intrusive questions, such as “When did you discover your sexual identity?” FIRE informed the school that forcing university views on students through this comprehensive manipulation of the residence hall environment was morally repugnant as well as unconstitutional, a clear assault on individuals’ freedom of conscience. With the assistance of the Delaware Association of Scholars, FIRE quickly persuaded former President Harker to eliminate the program. Since that initial victory, however, there have been continued attempts to reinstate the coercive elements of the ResLife program.”
“**University of South Carolina: Mandated Orthodoxy in the Classroom** Category: **Free Speech**, **Freedom of Conscience** Schools: **University of South Carolina Columbia** FIRE protested University of South Carolina Professor Lynn Weber’s imposition of a political litmus test in order to succeed in “Women’s Studies 797: Seminar in Women’s Studies,” which was required of students who sought to earn a graduate certificate in Women’s Studies. Professor Weber’s “Guidelines for Classroom Discussion” required students to “acknowledge that racism, classism, sexism, heterosexism, and other institutionalized forms of oppression exist” and agree that “we are all systematically taught misinformation about our own group and about members of other groups.” The guidelines amounted to a loyalty oath to the professor’s ideology. USC President Andrew A. Sorensen defended them, however, because to him they were not “rules” but merely a way to promote “civility.” many other professors nationwide, however, have adopted Weber’s assumptions as “rules,” threatening the academic freedom and freedom of conscience of their students.”

(continued)

Table 1 (continued)

"**Washington State University: Use of Dispositions Theory to Enforce Ideological Orthodoxy** Category: **Freedom of Conscience** Schools: **Washington State University** Washington State University (WSU) repealed partisan evaluative criteria used to punish a student whose views on diversity and gun control differed with those of other professors at WSU. Student Ed Swan had received poor evaluative teaching marks on his "dispositions" criteria, which had "required students to have a commitment to vague ideological concepts such as "appreciat[ing] and valu[ing] human diversity," sensitivity to "community and cultural norms," and respecting "others' varied talents and perspectives." Swan was penalized for admitting that he opposes gun control and does not believe that white privilege and male privilege exist, and was forced to sign a contract submitting him to more ideological litmus tests. FIRE intervened on behalf of Swan so he could have a clear a path to graduation, first convincing WSU to not use "dispositions" in an unconstitutional manner; WSU eventually revamped the dispositions evaluation forms that contained the unconstitutional requirements."
"**Wichita State University: Student Government Denies Recognition to Libertarian Group Because It Defends Free Speech** Category: **Cases**, **Free Speech** Schools: **Wichita State University** On April 5, 2017, Wichita State University's Student Government Association (SGA) denied official recognition to a prospective chapter of Young Americans for Liberty (YAL) based on its views, after nearly an hour of debate. The SGA began its meeting by questioning YAL president Maria Church on the group's beliefs and political stances. When debating the resolution to recognize YAL, the only topic discussed was the expression of YAL's national parent organization and the actions of YAL chapters at other universities. SGA senators repeatedly advocated against recognizing the chapter on the grounds that YAL (correctly) believes that the First Amendment protects "hate speech," that other chapters have invited Milo Yiannopoulos to speak on campus, and that the national YAL organization has not effectively denounced" hate speech." SGA members called YAL a "hate group" and claimed that its presence on campus would pose a threat to other students. On April 7, FIRE wrote to Wichita State University demanding that the university reverse the SGA's unconstitutional viewpoint-based decision. Following FIRE's letter, WSU Vice President for Student Affairs Teri Hall petitioned the SGA's judicial branch to overturn the SGA's decision. On April 12, the Supreme Court of the Wichita State University Student Government held that the refusal to recognize YAL violated its members rights, and granted the group official recognition."

that is, he suggested that men were overrepresented at the very bottom of the distribution as well as the very top. Moreover, Summers argued that these elite positions in the academy require such elite abilities often at 3 or 4 standard deviations from the mean. Finally, Summers suggested that the third explanation is the most popular view, that is, that sexist socialization and discrimination in hiring was also responsible for such differences. Summers stated:

> The most controversial in a way, question, and the most difficult question to judge, is what is the role of discrimination? To what extent is there overt discrimination? Surely there is some. Much more tellingly, to what extent are there pervasive patterns of passive discrimination and stereotyping in which people like to choose people like themselves, and the people in the previous group are disproportionately white male, and so they choose people who are like themselves, who are disproportionately white male. No one who's been in a university department or who has been involved in personnel processes can deny that this kind of taste does go on, and it is something that happens, and it is something that absolutely, vigorously needs to be combated.

Interestingly, Summers—to his eventual peril—regarded this possible explanation as less important than the other two hypotheses. He stated:

> ". . . Gary Becker very powerfully pointed out in addressing racial discrimination many years ago. If it was really the case that everybody was discriminating, there would be very substantial opportunities for a limited number of people who were not prepared to discriminate to assemble remarkable departments of high quality people at relatively limited cost simply by the act of their not discriminating, because of what it would mean for the pool that was available. And there are certainly examples of institutions that have focused on

> increasing their diversity to their substantial benefit, but if there was really a pervasive pattern of discrimination that was leaving an extraordinary number of high-quality potential candidates behind, one suspects that in the highly competitive academic marketplace, there would be more examples of institutions that succeeded substantially by working to fill the gap. And I think one sees relatively little evidence of that. So my best guess, to provoke you, of what's behind all of this is that the largest phenomenon, by far, is the general clash between people's legitimate family desires and employers' current desire for high power and high intensity, that in the special case of science and engineering, there are issues of intrinsic aptitude, and particularly of the variability of aptitude, and that those considerations are reinforced by what are in fact lesser factors involving socialization and continuing discrimination. I would like nothing better than to be proved wrong, because I would like nothing better than for these problems to be addressable simply by everybody understanding what they are, and working very hard to address them."

It is worth emphasizing what Summers did not claim. First, he did not claim that this underrepresentation of women was a desirable state of affairs; in fact, the substance of his remarks as well as their context suggested the opposite: that this imbalance ought to be understood so to the extent that it is due to injustice, it ought to be remediated. Second, he did not say he knew the answer to what caused this imbalance: but rather, these hypotheses ought to be considered, debated, and further investigated. Moreover, Summers did not claim that women were not as good at science as men. He instead claimed that one hypothesis is that women might be less likely to be very good or very bad at science than men—that is, they are less likely to be at the tail ends of the distribution.

Summer's remarks resulted in a number of individuals, particularly at Harvard, but also nationally, claiming that Summer's remarks were sexist, offensive, and for some, even traumatizing. Charges of sexism are, of course, charges of prejudice against women. There were numerous protests by faculty and students, a subsequent vote of no confidence by Harvard faculty, and even an eventual apology by President Summers. A few months later, Summers resigned. Summers concluded:

"There is a great deal of absurd political correctness. Now, I'm somebody who believes very strongly in diversity, who resists racism in all of its many incarnations, who thinks that there is a great deal that's unjust in American society that needs to be combated, *but it seems to be that there is a kind of creeping totalitarianism in terms of what kind of ideas are acceptable and are debatable on college campuses.*" (italics added).

What is concerning is that Summer's remarks—even if these could be shown to be false—were regarded not as a part of the standard process of scholarly inquiry and thus protected by academic freedom or even the First Amendment. Rather, his remarks were regarded beyond the pale—as proscribed prejudicial speech. Moreover, his remarks were not judged in the standard ways of judging claims common to scholars—for example, of being poorly argued, of overlooking some key data, as having strengths x and weaknesses y, needing more severe testing, and so on and thus, the final judgment was not that Summer's remarks were false, or poorly argued. What is totalitarian about the response is that the construct of prejudice with its considerable weightiness is brought to bear to judge and condemn his remarks—speech that someone of an opposing viewpoint may hate because they disagree with it, is illegitimately transformed into hate speech, thus justifying someone's termination.

What are some of the major concerns that result from this incident?

1. That the power in academia is held and wielded by the political left. If one wants to "speak truth to power," one is not speaking to the political right but to the political left.
2. That free speech is not consistently protected in academia and in fact free speech that is contrary to what the political left believes is proscribed and severely punished.
3. That the alleged infraction can be cashed out as some form of prejudice, in this case, sexism, and this allegation of prejudice then is seen as a very serious moral, epistemic, and professional failing.

4. That such alleged "infractions" are regarded as so serious that consequences such as job loss, and severe reputational damage are judged as legitimate or even necessary. The possible lesson learned for academic administrators is that if one wants to keep his or her job, one needs to make sure one does not say anything that offends the political left. This is a very unfortunate lesson.
5. That such consequences can accrue only after a relatively low threshold is crossed: Summers was a Democrat and a political liberal/moderate, and as such, the speech expressed agreement with many leftist political views (e.g., the importance of diversity as such), but his positions were obviously insufficiently leftist. In some cases, the political difference is not between the left and the right; but the left and the farther left.
6. That in some important respect what is happening is a form of mob rule—the protests, the claims of traumatization, and so on have significant political and practical impact. Principles of free speech and academic freedom are overridden by this "activism" of the political left.
7. That such an incident can have a chilling effect on academic scholarship and impedes the growth of knowledge.

This incident is not isolated in recent years on college campuses. This incident is reflective of other kinds of problematic behavior of the political left in academia. A partial list of some of these problems includes the following:

- Disinviting conservative speakers from speaking on campus, or if they arrive on campus, not allowing them to speak by disruptive political protests, and even threats or actual assaults (see Table 1). It might be useful to view the youtube.com video entitled "Black Lives Matter protesters disrupt Milo Yiannopoulos speech at DePaul University."
- There are problematic admission policies for students based on leftist conceptions of social justice that involve certain racial quotas that are defined by the left. For example, recently, the group Students for Fair Admissions filed a lawsuit claiming that Harvard discriminates against Asian American applicants by holding them to a higher academic standard and using a problematic "personal score" in the admission process that allegedly reflects traits such as courage and likeability that for some unclear reason Asian Americans score the lowest on of all cultural groups. The left's political views see too many Asian Americans students and an insufficient number of certain other minorities.
- Similarly, hiring practices regarding faculty and administrators that are based on leftist priorities emphasizing diversity that are in fact discriminatory toward those of "majority cultures." In addition, at many universities, anyone associated with hiring processes must undergo trainings to combat their "implicit prejudice"—a construct that has dubious scientific merit (see, for example, Mitchell & Tetlock, 2017) but involves allegations of widespread (but perhaps unconscious) prejudice on the part of those involved in the hiring process.
- Charges of "cultural appropriation" on campus based on leftist political ideologies leveled at everything from yoga classes (banned at the University of Ottawa in 2015) to the moral appropriateness of campus cafeterias offering some ethnic foods, to Halloween costumes at Yale.
- Drastic changes of academic curricula at colleges and universities that move away from traditional scholarship involving the demographics of "dead white European males" such as Plato, Shakespeare, Twain, and Kant to what are seen as less prejudicial or privileged writers or works that are defined by leftist criteria.
- The recent development of rules or suggestions in the academy to list preferred pronouns on one's website or email footer based on leftist conceptions that gender has been traditionally and problematically regarded as a binary. For instance, the University of Tennessee's Office of Diversity and Inclusion published a statement urging teachers and students to respect gender neutrality by replacing the gender pronouns "he" and "she" with "ze."
- Requiring individuals to acknowledge their "privilege" based on leftist conceptions of

privilege and who is privileged and what ought to be done with this, as well as the importance of this construct.

- Significant resources on some college campuses allocated to the construction and maintenance of “safe spaces” in which persons from certain minority culture defined by leftist political ideologies can allegedly experience some sort of escape from oppression and prejudice perpetuated by those in majority cultures.
- Based on leftist ideology, the banning certain statues on campus (e.g., of Silent Sam at the University of North Carolina which was yanked down by protestors) or mascots such as University of Illinois’s Chief Illiniwek retired in 2007 due to allegations of cultural insensitivity and perpetuating cultural stereotypes.
- Creation and funding of specialty departments based on leftist ideology such as gender studies, (see also Patai and Koertge (2003) for abuses surrounding feminist studies classes and departments).
- Firings of faculty or staff or expulsions of students due to speech that is deemed prejudicial from a leftist viewpoint such as the Summers case described above. Another illustrative situation occurred at Missouri State University where two graduate students were terminated from mental health graduate programs at the university due to what was viewed by college administrators as their unethical homophobic behavior. In 2006, the university settled a lawsuit for approximately $27,000 with Emily Brooker, who accused the School of Social Work of violating her First Amendment rights by expelling her when she refused to sign a letter supporting same-sex adoption. In a subsequent case in 2014, Missouri State University paid expelled graduate student Andrew Cash about the same amount (although interestingly the settlement also prevented Cash from seeking admission or employment at Missouri State). Cash was terminated from a master’s program in counseling after he tried to complete his internship at a Christian-based counseling agency and told a class that he could not counsel gay couples due to his Christian faith, but instead wanted to refer these individuals to a therapist who had values compatible with same-sex couples.
- Firing faculty or staff or expelling students due to allegations of sexism or inappropriate sexual behavior when there is insufficient due process such as the Duke Lacrosse case (see O’Donohue, in press; Taylor & Johnson, 2007). An article by New (2016) describes several of these reversals. For example, a federal judge in Boston rejected Brandeis University’s attempt to dismiss a lawsuit by a student disciplined over sexual assault allegations. The Brandeis student was accused of sexually assaulting his long-term partner. The appellate judge opined that the university failed to provide sufficient notice of the charges against the student and did not allow him to cross-examine the complainant or his witnesses. The judge also expressed concern that the university allowed the same official, a former lawyer for the U.S. Department of Education’s Office for Civil Rights, who investigated the complaint, to also serve “as prosecutor, judge and jury” in the case. The judge wrote, “Brandeis appears to have substantially impaired, if not eliminated, an accused student’s right to a fair and impartial process,” …and “it is not enough simply to say that such changes are appropriate because victims of sexual assault have not always achieved justice in the past. Whether someone is a ‘victim’ is a conclusion to be reached at the end of a fair process, not an assumption to be made at the beginning.”
- Prejudice by journal editors or journal reviewers against the publication of manuscripts expressing conservative points of views; prejudice against conservatives by reviewers in grant applications (see below).
- Hoaxes using the sometimes nonsense language of the far left published in academic journals illustrating a bias toward leftist positions. Often, these articles also contain references to leftist conceptions of prejudice. One of the most famous cases of such hoaxes was when Alan Sokal, a physics professor at New York University, published an article in *Social Text* an academic journal of postmodern cultural studies called, “Transgressing the

Boundaries: Towards a Transformative Hermeneutics of Quantum Gravity" (Sokal, 1996). To give an illustration of the quality, clarity, and political ideology of the article, consider this quote from the conclusion of the article:

> "Finally, the content of any science is profoundly constrained by the language within which its discourses are formulated; and mainstream Western physical science has, since Galileo, been formulated in the language of mathematics. But *whose* mathematics? The question is a fundamental one, for, as Aronowitz has observed, ``neither logic nor mathematics escapes the `contamination' of the social." And as feminist thinkers have repeatedly pointed out, in the present culture, this contamination is overwhelmingly capitalist, patriarchal, and militaristic: ``mathematics is portrayed as a woman whose nature desires to be the conquered Other." Thus, a liberatory science cannot be complete without a profound revision of the canon of mathematics. As yet, no such emancipatory mathematics exists, and we can only speculate upon its eventual content. We can see hints of it in the multidimensional and nonlinear logic of fuzzy systems theory; but this approach is still heavily marked by its origins in the crisis of late-capitalist production relations. Catastrophe theory, with its dialectical emphases on smoothness/discontinuity and metamorphosis/unfolding, will indubitably play a major role in the future mathematics; but much theoretical work remains to be done before this approach can become a concrete tool of progressive political praxis."

The hoax produced a firestorm, but it is interesting to note one of Sokal's own conclusions from the affair:

> "The results of my little experiment demonstrate, at the very least, that some fashionable sectors of the American academic Left have been getting intellectually lazy. The editors of *Social Text* liked my article because they liked its conclusion: that "the content and methodology of postmodern science provide powerful intellectual support for the progressive political project" [sec. 6]. They apparently felt no need to analyze the quality of the evidence, the cogency of the arguments, or even the relevance of the arguments to the purported conclusion."

- The political ideology of the left has created an Orwellian campus climate in which fear and mistrust have increased. For example, Professor Emerita Inger Enkvist of Lund University, writing in *Göteborgs-Posten*, stated, "Students are encouraged to snitch on their teachers or colleague students, for instance, for sexist or racist attitudes. In this way, a feeling of snitching and fear has developed," she argued, "where everybody is afraid of each other." As another example of such a problematic campus climate created by leftist political ideology, Bret Weinstein, a biology professor at Evergreen State College, experienced prolonged harassment for objecting to the college's "Day of Absence," in which white people were asked to stay off campus for a day. Like Summers, there were repeated calls for his firing and Weinstein was surrounded and berated by student protesters to the extent that Weinstein was informed by the police that it was not safe for him to be on campus. In another well-known incident, the University of Missouri faculty member Melissa Click was filmed assaulting a student journalist who attempted to film a student demonstration and calling for "muscle" to remove individuals from the quad who she deemed insufficiently supportive of her political views.
- Leftist definitions of prejudice are used to cancel campus events deemed insensitive by these definitions. For example, in 2015, the University of Minnesota rejected a proposal for a minute of silence to honor the victims of the September 11, 2001, due to concerns expressed by some that this commemoration might promote Islamophobia. Because Muslims are defined by the left as marginalized, feminists who speak out against the misogyny of Islamic fundamentalism can also be accused of promoting Islamophobia. In 2015, a talk by Iranian-born feminist and ex-Muslim Maryam Namazie at the University of London's Goldsmith College was denounced as a "safe space violation" by the campus Islamic Society as well as by feminist and LGBT groups.

We turn now to data that describe in more detail the political orientations of those who hold power in academia.

Academia and Political Bias

Langbert (2018) in a survey of 8688 doctoral-level professors in 51 of the top-ranked liberal arts colleges in the United States found the 39% of these colleges were “Republican free,” that is, having zero self-described Republicans. In general, of course, Democrats would be politically liberal and Republicans politically conservative. There are so few Republicans in other colleges that Langbert concluded, “Thus, 78.2 percent of the academic departments in my sample have either zero Republicans, or so few as to make no difference.” In an earlier survey, the voter registration of 7243 professors were examined and the results indicated that 3623 were registered Democratic and 314 were registered Republican, for an overall D:R ratio of 11.5:1. There also was interesting variation across academic disciplines. The D:R ratios for subject disciplines were Economics 4.5:1, History 33.5:1, Journalism/Communications 20.0:1, Law 8.6:1, and Psychology 17.4:1. The results also indicated that D:R ratios have increased since 2004, and the age profile suggests that in the future, these will be even higher. These data also supported the established finding that D:R ratios are highest at the apex of the disciplinary pyramids, that is, at the most prestigious, more influential universities had higher D:R ratios. There are also regional effects, with ratios highest in New England. Women also were much more likely to be registered Democrats, at 24.8 to 1. Among men, the ratio is 9 to 1.

Other scholars have also found that most psychologists describe themselves as politically liberal (e.g., see Redding, this volume). In a recent study, Buss and Von Hippel (2018) surveyed members of the Society of Experimental Social Psychology about their voting preferences the 2012 U.S. presidential election: 305 of the 335 (91%) respondents stated that they had voted for Barack Obama, and only 4 (1.2%) indicated that they had voted for Mitt Romney. On social issues such as abortion, gay marriage, and gun control, psychologists were overwhelmingly liberal—their mean rating was within 2 points of the extreme liberal end of an 11-point scale. When asked about their political orientation, 89.3% said left of center, 8.3% said centrist, and only 2.5% said right of center.

In another survey of social psychologists, Inbar and Lammers (2012) surveyed the Society for Personality and Social Psychology discussion list: 85% self-described as liberal, 9% as moderate, and only 6% as conservative (a ratio of 14:1). Importantly, the trend toward leftist political homogeneity increased across cohorts: Whereas 10% of faculty were conservative, only 2% of graduate students and post-docs were. Inbar and Lammers (2012) found a 14:1 ratio of Democrats to Republicans. Importantly, this survey also revealed that 19% reported that they would have a bias against a conservative-leaning paper: 24% against a conservative-leaning grant application; 14% against inviting a conservative to a symposium; and 38%, against choosing a conservative as a future colleague. There are also indications that academics are influenced by ideology when hiring new faculty as well as when evaluating texts. For example, psychologists rated the quality of research methodology differently depending on whether it is framed as conservative or liberal/progressive (Ceci, Peters, & Plotkin, 1985). Ceci et al. (1985) submitted research proposals to 150 Internal Review Boards proposals to investigate “reverse discrimination” were approved only half as often as otherwise identical proposals to investigate discrimination.

Rothman, Lichter, and Nevitte (2005) analyzed surveys of the professoriate from the 1960s through the 2000s, and conducted a regression analysis using research productivity, political attitudes, and several demographic variables to attempt to predict the prestige of the university that employed each professor. They found that the best predictor of prestige is research productivity but the second best predictor was political attitude (i.e., being a conservative reduced one’s prospects), followed by being female, or a religious Christian (both reduced one’s prospects). They found that being African American, gay, or married made no difference. The authors concluded: “multivariate analysis of the available data show that even after taking into account the effects of academic achievement, along with many other individual characteristics, conservatives and Republicans taught at lower quality schools than did liberals and Democrats."

Abrams (2018) conducted a nationally representative survey of 900 college administrators, asking them about their political leanings, and found that on university campuses, liberal administrators outnumbered conservative staff administrators by a 12-to-1 ratio. Only 6% of campus administrators identified as conservative to some degree, while 71 percent classified themselves as "liberal or very liberal." Abrams also found a strong ideological imbalance among university administrators across a range of geographic regions and types of universities, as well as some evidence that the imbalance is somewhat worse at private schools and more selective schools. Interestingly, Abrams's previous research had found that self-identified liberal faculty members outnumber conservatives by roughly a 6-to-1 margin. This means that there is actually less ideological diversity among university administrators than there is among faculty. As Abrams concluded, "A *fairly* liberal student body is being taught by a *very* liberal professoriate — and socialized by an *incredibly* liberal group of administrators."

Abrams' finding is particularly important, as the number of non-academic administrative and professional employees at U.S. colleges and universities has more than doubled in the last 25 years, vastly outpacing the growth in both the number of students and faculty. In fact, the rate of growth in administrators is more than twice as fast as the growth in the number of students or faculty. From 1987 until 2011–2012—the most recent academic year where data are available—universities and colleges added 517,636 administrators and professional (New England Center for Investigative Reporting). Robert Martin, an economist at Centre College in Kentucky who studies university finance, stated, "While the rest of the economy was shrinking overhead, higher education was investing heavily in more overhead." Interestingly, these administrators perhaps in an effort to offset these increased salary costs have focused on hiring lower paid part-time teachers, often without benefits, which is interesting, given the left's standard critiques of some elements of the private sector's practices regarding wages and benefits. Data also indicated that part-time faculty and teaching assistants now account for half of instructional staff at colleges and universities, up from one-third in 1987. Richard Vedder, an economist and director of the Center for College Affordability and Productivity, stated, "I wouldn't buy a used car from a university president. They'll say, 'We're making moves to cut costs,' and mention something about energy-efficient lightbulbs, and ignore the new assistant to the assistant to the associate vice provost they just hired."

Redding (1992, 2001; this volume) has suggested that this political imbalance among university professors and administrators can create a problem of viewpoint diversity: that is, the views of conservatives are less likely to be expressed and any valid points or criticisms from this perspective will be omitted. But two other possible implications ought to be noted: (1) Redding's point is partially expressed in the political idiom of the left—diversity—and its alleged unalloyed positivity (which given the political imbalance may be a perfectly sound rhetorical strategy), but this imbalance can be cashed out in other terms such as discrimination, unfair treatment, and even prejudice against the political right; and (2) but what must be said more strongly is that these data clearly show who holds political power and all that such political power can do in academia. Thus far, we have seen some evidence of some of the possible implications of such political bias and power in academia—for example, a bias against hiring conservatives, a bias regarding evaluating conservative research. However, there are other indications of the negative consequences of such political bias. Ceci and Williams (2018), in a brilliant analysis of the Middlebury College incident where the conservative scholar Charles Murray was not allowed to speak and a (liberal) host was physically assaulted requiring medical treatment, note:

> "Dozens of other speakers [from the right]—for example, Ann Coulter, Milo Yiannopoulos, Heather MacDonald, James Watson, Charles Murray, Tommy Robinson, Christina Hoff

> Sommers, Brett Weinstein, Jordan Peterson, Ben Shapiro, and many others—were cancelled at colleges such as the University of California (UC)-Berkeley (Senju, 2017), University of Toronto (Genuinewitty, 2016), McMaster University (Beatty, 2017), Yale University (Foundation for Individual Rights in Education, 2015b), Evergreen College (Richardson, 2017), Amherst College (Chasmar, 2015), University of Michigan, (Slagter, 2017), Columbia University (Ruptly, 2017), University of Massachusetts (Bettis, 2016), University of Illinois ("U. of I. Cancels Talk," 2017), Claremont McKenna College (Blume, 2017), University of Oregon ("Students Disrupt Speech," 2017), Virginia Tech University (Roll, 2017), College of William and Mary (Bauer-Wolf, 2017a), Texas Southern University (Jaschik, 2017a), and University of Connecticut (Barbash, 2017)."

Ceci and Williams further stated, "These concepts inform dueling claims: (a) the protestors' violence was justified by a higher moral responsibility to prevent marginalized groups from being victimized by hate speech, versus (b) the students' right to hear speakers was infringed upon."

This raises three major concerns: (1) violations of constitutionally protected free speech and relatedly academic freedom—thought necessary for the growth of knowledge; (2) a chilling effect on campus discourse on important social and political issues; and (3) often, the rationale for these prohibitions, like in the Summer's incident described above, has been that the speech involved would be prejudicial. It is important to note that all too often, violence and threatened violence were associated with these cancellations. Alarmingly, a recent Brookings poll revealed that 19% of college students indicated that they support the use of violence to prevent someone from speaking who makes others uncomfortable (Villasonar, 2017). In addition, 74% of self-identified Democrats say that universities should cancel speakers if students threaten violence (Ekins, 2017).

When confronted with problematic speech, there also may be political differences in understanding what tactics are acceptable and which are beyond the pale. The Cato 2017 Free Speech and Tolerance Survey found that more than two-thirds (68%) of Americans say it is not morally acceptable to punch a Nazi in the face. Thirty-two percent, however, say it is morally acceptable. A majority of strong liberals (51%) say it is moral to punch Nazis. However, only 21% of strong conservatives agree. However, it is important to note that the strong liberals' approval of Nazi-punching was not representative of Democrats as a whole. A majority (56%) of Democrats believed it is not morally acceptable to punch a Nazi. Thus, it appears that tolerance of violence as a response to offensive speech and ideas is found primarily on the far Left. In addition, the survey found liberals were more likely to consider upsetting and controversial ideas "hateful" rather than simply "offensive."

In addition, another concern is that of administrative proceedings that are impacted by issues of prejudice and political power in academia. In recent years, an important organization has been created to attempt to reverse some of the injustices that have occurred in these. The Foundation for Individual Rights in Education's (thefire.org) mission is the following:

> "FIRE protects the rights of students and faculty members at America's colleges and universities. These include freedom of speech, freedom of association, due process, legal equality, religious liberty, and sanctity of conscience—the essential qualities of liberty for every American. FIRE defends those whose rights are denied on campus, regardless of identity or viewpoint, and we educate those on and off campus about these rights and their importance."

Table 1 provides a sampling of cases it has undertaken. This table also suggests that the Summers case is not isolated. One can also see from Table 1 that in academia, it is largely the political left infringing on the civil rights of the political right. These problems range from infringements on free speech, to restricting freedom of assembly as well as religious freedom. Also of concern would be the lack of due process in these investigations. Another case that illustrates this is the infamous Duke Lacrosse case in which multiple white male Duke undergraduates were expelled from Duke on allegations from an African American female stripper (see Taylor & Johnson, 2007 for a more extended treatment). There was a rush to judgment based on allegations of sexism, racism, and classism. Duke eventually settled lawsuits with these individuals for harm done to these students by a lack of proper due process. Obviously, more systematic research is needed, but the concern is that this research is very difficult to do. One can do survey research relying on self-report, but there are well-known problems with self-report. University officials will provide little to no information due to the protected nature of personnel matters and thus obtaining both sides would be impossible. However, it is fair to say that the extent to which the due process rights and other civil rights of academics are being impinged upon by those that hold power in academia is a critical matter needing more data.

Is the Political Right More Prejudiced than those on the Political Left?

One view (perhaps a stereotype) is that those on the political right are essentially prejudiced; while those on the political left rarely if ever are; and in fact, the political left is dedicated to uncovering and eradicating prejudice. As we shall see later, this question is complex because it is obviously dependent on an explication of the construct of prejudice—which may differ depending on political orientation. There are many strands of empirical research to attempt to address this question. Some of these are quite problematic. For example, there is a tradition of examining "right wing authoritarianism" (Altemeyer, 1981), but construct validation has proven elusive as well as clear relationships to political conservativism as opposed to other variables. In addition, some authors have also suggested that there is a corresponding construct of "left wing authoritarian" that has been neglected due to the political biases of researchers (e.g., Ray, 1983).

A complete review and analysis of relevant research is beyond the scope of this chapter. However, the relationship between political ideology and negative evaluations may depend upon perceived political differences rather than demographic characteristics. For example, Chambers, Schlenker, and Collisson (2013) hypothesized that prejudice is not confined to a particular political ideology. Rather, the differing values of the political left and the right give rise to different kinds of prejudice, with each political favoring social groups that share their values. In one study, three diverse groups of participants rated the ideological views and their overall impression of 34 different target groups. Those on the political right demonstrated more prejudice against groups that were identified as politically liberal (e.g., African Americans and gays), but less prejudice against groups identified as conservative (e.g., Christian fundamentalists and business people). In two other studies, participants were presented with 6 divisive political issues and descriptions of racially diverse target persons for each issue. Neither leftists' nor rightists' ratings of the target persons were affected by the race of the target, but interestingly, both were strongly influenced by the target's political views. Chambers et al. (2013) concluded that prejudices commonly linked with political ideology are most likely derived from perceived political/ideological differences and not from other attitudes such as racial tolerance or intolerance.

Because many of the most serious charges involve allegations of prejudice, we turn next to an examination of this important construct.

The Meaning of Prejudice and Its Politics

In the United States, those who have made the rules involved in the fundamental problem of power and justice have at key times constructed these rules influenced by prejudice. These rules so constructed have allowed and even encouraged discrimination and oppression against certain groups of individuals. For example, the U.S. Constitution embodied prejudiced views of African Americans and thus allowed slavery to be legally permitted. In addition, it contained sexist views of women that resulted in their disenfranchisement for centuries. Even after the Civil War and the Emancipation Proclamation, prejudice still resulted in Jim Crow laws that made it practically impossible for "free" African Americans to vote, as well as own property, or gain access to education. Unjust laws resulted in the internment of citizens of Japanese descent during World War II. And a variety of treaties and laws resulted in the unjust treatment of Native Americans for centuries. In fact, as late as 1963, Dr. Martin Luther King in the March on Washington outlined the relationship between problematic laws and social justice:

> When the architects of our Republic wrote the magnificent words of the Constitution and the Declaration of Independence they were signing a promissory note to which every American was to fall heir.... It is obvious today that America has defaulted on this promissory note insofar as her citizens of color are concerned. Instead of honoring this sacred obligation American has given the Negro people a bad check; a check that has come back marked "insufficient funds". But we refuse to believe that the bank of justice is bankrupt... So we have come to cash the check—a check that will give us upon demand the riches of freedom and the security of justice.

Others have pointed out that in order for democracy to properly function, every citizen needs to have equal worth in democratic decision-making. However, prejudice undermines this foundational requirement by undermining the worth of some citizens while giving others a privileged political status.

Prejudice is nearly always taken to be a pejorative phenomenon—it is a "bad"—and often a very high of magnitude of moral wrong. Traditionally, this can be fairly easy to see, as prejudice was associated with universally condemned events that have caused much human suffering such as slavery, the Holocaust, denying women voting rights, lynchings, and so on. More recently, in the academy as well as other contexts, prejudicial statements or behaviors are still seen as serious infractions and can result in job loss, stigma, and are viewed as possibly revealing a serious moral flaw.

Those on the Left and Right Hold Differing Conceptions of Prejudice

However, sometimes there is also debate on whether or not some statement or behavior in fact properly falls under the category of "prejudice" or whether the behavior is based on, or associated with, prejudice (e.g., Trump supporters' interest in the border wall based on legitimate concerns about national security or based on prejudice against Latinos?). This is no small point. Sometimes as in the cases we have examined above, current social and political questions get cashed out with charges of prejudicial behavior (perhaps legitimately, but perhaps not). Is an anti-abortion stance a prejudice against women and their reproductive rights or, not—and correspondingly is a pro-abortion stance a prejudice against those of certain religions? Or is prejudice not involved in either position? Is a criticism of some policy of Israel anti-Semitic or not? Are anti-terrorist policies which profile individuals based on their mid-eastern heritage racist or just sound actuarial prediction? Is a pro death penalty position racist or based on something else? And so on….

Prejudice would seem to have at least three categories of failings and perhaps can at least be partially defined by these: (1) there ought to be an *epistemic failing*—the warrant and evidence for the claim is problematic as a legitimate knowledge claim—the epistemic warrant is absent, faulty, or insufficient. Thus, the evidence for claiming, for example, "All xs are ys" is simply epistemically flawed because insufficient xs have not been examined, or some xs have been shown to be not y, and so on. However, it is possible that this epistemic failing is no longer necessary—reporting accurate information can be seen as prejudicial. Some would argue that no matter what the data say, the only nonprejudicial statement is that there is biological equality between groups on favored traits (intelligence, work ethic, criminality, and so on). If differences are asserted, prejudice can be averted only by 3 conditions: (a) the difference is seen as an artifact, for example, the test showing such difference is culturally biased; (b) the difference is a product of prejudice; or (c) the difference is in favor of the unempowered group, for example, it is not prejudicial to assert that males are more violent than women). (2) Prejudicial statements or acts often are *illegal* or proscribed in some other regulative manner, although this relationship is complex.

Third, and very importantly, prejudicial phenomena are also generally taken to be *morally wrong*—and usually severely so. That is, statements can meet the first epistemic condition, (e.g., the epistemically flawed statement "All pants are blue"), but not be seen to be prejudicial—its epistemic warrant is problematic but not all false statements are regarded as morally problematic. Prejudicial statements are. The statement "All Irish are drunks" can be seen to hurt those who are Irish or simply to be unfair to them and thus be ethically problematic. Political beliefs and moral beliefs and factual beliefs are thus intertwined: For example, abortion is an issue of women's rights to do what they choose with their bodies and it is ethically wrong to interfere with this right versus abortion is an issue of killing human beings and it is morally wrong to promote this murder. Factual beliefs can vary from: "science has or has not established the humanness of the fetus" to more meta-propositions like "Impinging on abortion rights of women is a part of the general patriarchal, misogynistic power structure." This may be one reason why there is so much heat in politics—it directly involves a battle of good and evil.

However, the matter is actually more complex. First, some prejudicial statements—despite their problematic epistemic and moral nature—seem to fall under free speech rights which are protected by the Bill of Rights. One may have the legal right (although not the moral) in many contexts to utter "All Irish are drunks." Second, some may dispute whether a statement is in fact prejudicial (Are statements condemning some Israeli policy based on anti-Semitism or based on other legitimate considerations such as a concern for the rights of Palestinians? See discussion below on difficulties defining prejudice) and third, some prejudicial statements would fall under hate speech prohibitions that restrict free speech ("We ought to hurt all xs because they are bad"). Finally, (4) Some prejudicial statements can become particularly problematic when they are used in certain contexts—for example, one may have the free speech right to utter "All x's are bad," but one may not have the right under fair employment laws to base employment decisions on that belief. Prejudicial behaviors can be bad because these can play a causal role in other problematic behaviors, for example, prejudice against GLBTQ plus individuals could lead to violent acts against these individuals.

Of course, there are problematic ways to define prejudice and unfortunately some of these seem to have taken hold in academy. One is to define something as prejudice by its effects on the individual—for example, some alleged behavior is prejudicial by virtue of the fact that some individual claims that it makes him or her "uncomfortable." Thus, if a professor utters something that is at least somewhat—however tenuously— related to certain topics (themselves politically defined) and this makes someone (usually of a particular demographic) feel at least "uncomfortable"—then the professor is guilty of uttering a prejudicial statement. This is problematic for several reasons: (1) It is a relativist definition—what is prejudicial is dependent upon (relative to) an individual's reported response to it—and cannot be judged independently of this. (2) This response is inherently a private experience—and thus subject to biases in self-report; (3) many legitimate utterances can make someone feel uncomfortable (e.g., discussions of death; discussions of problematic historical events; being told one is wrong or one's argument is flawed; another person's discrepant moral or political views) and therefore the criterion of "uncomfortable" clearly is not sufficient or necessary condition for prejudice.

The second issue is related to the fundamental problem of power and justice described above. Are those in power (e.g., in academia, liberals) defining behaviors of conservatives as prejudicial? In a clever turn of speech, the issue becomes is speech that the left hates being defined by them as hate speech? Table 1 suggests that at times this is the case. Speech supporting a pro-life position becomes prejudicial hate speech against women. The phrase "all lives matter" is alleged to be racist. Expressing a desire to hire on merit becomes an example of a microagression. Defending the free market becomes racist, as it is insensitive to economic inequalities allegedly only due to racism.

However, it is not only these larger social problems that may be defined by the left as prejudicial often with serious consequences for the speaker. There appears to be both a chilling effect on speech as well as at times an elimination of faculty who do not conform to leftist positions of prejudice in their speech. It is difficult to assess how potent this is but it appears to be a widespread and high-magnitude phenomena. There are also questions of whether there are subtypes of prejudice, for example, institutional racism, structural racism, implicit bias, and even reverse racism.

O'Donohue (1989) in what is called "experimental semantics" has suggested that "meaning is use" and investigated what variables actually influence individuals to label statements as prejudicial. This study examined the responses of 300 subjects who were presented with five sentences. Each sentence mentioned two groups (e.g., Blacks and Whites) and compared these two groups in some way on some dimension. The group pairings used were males and females; Blacks and Whites; Protestants and Catholics; Christians and Jews; and Whites vs Hispanics. These groups were selected because these represent major exemplars in which the one group (the first mentioned above) is a favored in-group while the second group (mentioned second) is its corresponding out-group. However, the sentences also varied in three other major ways: First, the sentence either had an explicit epistemic justification (e.g., "Science indicates…") or no epistemic justification. Secondly, the sentences varied in the nature of the comparison (e.g., "Whites are more….", "Whites and Blacks are equal", or "Blacks are more…"). Finally, the dimension the groups were being compared was also varied and was either socially important (e.g., intelligence, honesty) or unimportant (e.g., "likes birthdays" or "concerned about the weather"). As would be expected, epistemically unjustified statements evoked the response "prejudice" significantly more than epistemically justified statements. In addition, statements which declared a difference in favor of the socially empowered group also evoked the label of prejudice more frequently. However, interestingly, the importance of the label did not have its hypothesized effect—even when whites were seen on socially unimportant dimensions such as "concerned about the weather" more than Blacks—this still evoked the label prejudice as frequently as socially important dimensions such as "are more honest." This latter finding may be seen as revealing a strong sensitivity to any possible favorable comparison between the empowered versus unempowered group.

Liberals and conservatives differ in their understanding of the construct of prejudice. These differences require more research but appear to include the following:

1. *The political left and the political right differ on what groups can be targets of prejudice.* Those on the political left would focus on a politically favored subset of ethnic minorities, particularly African Americans, Latinx, Native Americans, Asian Americans, and Pacific Islanders; women (although this is complex given recent concerns of the left regarding binaries), and sexual minorities, particularly GLBTQ+. Those on the right would include the ethnic minorities listed above (but in different ways, see below) but also be more likely also concerned about religious freedom as it relates to sexual minorities, for example, an Orthodox Jew's consideration of homosexual behavior as sinful would perhaps not be seen to the person on the political right as homophobic but as a legitimate practice of a citizen's chosen religion. In addition, those on the political right would be concerned about prejudice regarding groups like the religious, for example, anti-Semitism, anti-Catholicism, or anti-Mormonism, (where the left would more typically focus only on Islamophobia and anti-Semitism). In addition, those on the right are much more likely to countenance "reverse prejudice" and claim that some members of minority groups can be prejudiced against majority groups, even majority groups that have power. Thus, for a person on the right but not for a leftist, some women can be prejudiced against men; some African Americans can be prejudiced against whites, and so on.

2. *The left and the right differ on the criteria for defining prejudice.* Leftists as opposed to those on the political right are more likely to accept a person's claimed uncomfortableness, or not feeling safe, or some other negative affective state as an indication that some prejudicial event occurred (see O'Donohue & Redding, 2009 for a further discussion). Those on the political left also can have significantly lower thresholds for defining prejudicial acts. A leftist, for example, would be more likely to see "not acknowledging privilege" as prejudicial while a person on the political right would be much less likely to do so. A leftist would be more likely to judge behavior involving other constructs such as "microaggressions" as prejudicial, but a person on the political right would be more likely to see such constructs as problematically conceptually (see Lilienfeld, 2017) or below the threshold of prejudice.
3. *Leftists would depend on more subjectivist and relativist views of what constitutes prejudice where those on the political right would support more objectivist definitions.* Thus, if a woman simply reports that she felt leered at this, for many of the political left, this would be "her truth" and sufficient for a legitimate charge of sexism. The conservative would be more concerned about the objective facts of the matter: for example, are there witnesses or other pieces of evidence supporting this claim; how long did the look actually last; what exactly was the person looking at; is the complainant overly sensitive to looks or has she made false allegations in the past? and so on.
4. *Leftists see static demographic variables as sufficient for constituting prejudice where no behavior on the part of the accused is necessary; conservatives would reject this.* For some on the political left, an individual's male gender is sufficient for the problematic participation in the patriarchy or "rape culture." Or an individual's whiteness is sufficient for participating in privilege and systemic racism. Those on the political right, on the other hand, one be more likely to suggest that demographic identification is not sufficient for a legitimate charge of prejudice; rather, actual current problematic behavior would be necessary.
5. *Leftists see prejudice as operative in many more situations than those on the political right.* Those on the political left would more likely see "everything is political" while conservatives would be more likely to regard the political as having a much more circumscribed realm. Leftists would more likely see any situation involving a majority culture individual and a minority culture individual as de facto involving prejudice. Leftists would more likely see any male interest in the physical attractiveness of a female as an example of sexually objectifying women and thus sexism. Those on the political left would be more likely to see certain Halloween costumes such as a sombrero as reflecting prejudice. Leftists are more likely to see any statistical disparity as reflective of a prejudicial process where those on the political right are less likely to do so (see the Summers case described above).
6. *Those on the political right are more likely to see other variables beyond prejudice as validly accounting for some phenomena that the left see as prejudicial so that the construct of prejudice does not apply.* For example, in the Summers case above, Summers did not emphasize discrimination but saw differences in variance in certain cognitive abilities as possibly accounting for the underrepresentation of women in tenured positions in the STEM departments.
7. *Leftists and those on the political right see differing burdens of proof as relevant in adjudicating allegations of prejudice.* Leftists in matters where prejudice is alleged would be more likely to place the burden of proof on the accused to prove innocence where those on the political right would be more oriented toward placing the burden of proof on the accuser. This can be seen most clearly in Title IX adjudications involving alleged sexual misconduct on campus. Former President Obama's "Dear Colleague Letter" suggested that in Title IX investigations the complainant should be told by the investigator early in the investigation that he or she was believed. This subsequently was rescinded by the Trump Administration's Secretary of Education Betsy Devos who also greatly expanded due

process rights for the accused in these investigations. Leftists see these steps as making it harder for the sexually assaulted to successfully prove their cases, while those on the right see that the accused would have more constitutional protections in these adjudications.

8. *Leftists can see issues of social justice as even more important than values like truth.* For example, those leftists influenced by postmodernism assert that the construct of truth, especially objectivist construal, is simply a false meta-narrative; one should instead ask "who profits from this claim?" rather than "what evidence provides warrant for this claim?" Furthermore, postmodernists assert that there are more important values than truth, particularly the value of social justice. Thus, for postmodernists, a claim that enhances justice ought to be valued, independently of whether it is seen as "true" or "false" (see O'Donohue, 2013 for more on postmodernism).
9. *Those on the political right can see that other phenomena that they also value such as the free market already have mechanisms that combat prejudice, where those on the political left are more likely to see these same phenomena as either innocuous or as promoting prejudice.* For example, those on the right suggest that capitalism in an organic way penalizes prejudice—for example, if some prejudiced individual refuses to serve some group, then the prejudiced individual's revenue is decreased; or if this prejudiced individual refuses to hire a member of some group, then this individual's business will forgo the talents of the labor of this group. Therefore, for those on the political right if a business in a competitive market economy discriminates, a competitor can take advantage of this and hire or sell to the people against whom discrimination was practiced, thus gaining a competitive advantage. Conservatives also point out that the preferred economic arrangements of the left such as socialism or other statist approaches inherently do not have the same mechanisms for de-incentivizing prejudice because those who are making the commands in the command economy can exert their biases or preferences without similar economic consequences.
10. *Those on the political right and political left disagree with what are productive responses to prejudice and discrimination.* For example, labor unions are typically seen as allied with liberal political views, but these not only destroyed the freedom for individuals to bargaining regarding their personal labor but also reduced black labor rates due to discrimination. Conservatives are more likely to see welfare policies as harming the African American family where liberals are more likely to see the same policies as having beneficial effects.
11. *Those on the political right would be more likely to recognize some benign forms of what would appear to liberals as prejudice*. Conservatives would allow more space for ethnic or sexual humor and liberals much less, if any at all. For example, in the movie *Gran Turino*, the following dialogue takes place:

> **Walt Kowalski**: *[picked up Sue from a confrontation from a gang of young black males and giving her a ride home*] What's the matter with you? You trying to get yourself killed? I thought you Asian girls were supposed to be smart. Hangin' around places like that's an easy way to get you into the obituaries!
> **Sue Lor**: I know, I know! Take it easy.
> **Walt Kowalski**: And who was that goofball you were with, is he a date or something?
> **Sue Lor**: Yeah...well, kind of. His name is Trey.
> **Walt Kowalski**: Well, you shouldn't be hangin' out with him! You should be hangin' out with your own people, with all the other Humongs!
> **Sue Lor**: You mean "Hmong?" No, it's not "Humong," it's "Hmong."
> **Walt Kowalski**: Whatever.

Those on the political right are more likely to see this in context as benign because they can also see that there is genuine affection between the two characters. Liberals are more likely to see this as not humorous at all but as simply the use of inappropriate racist stereotypes.

12. *Those on the political right would more likely see that there are many more false allegations involving prejudice and malicious uses of charges of prejudice*. The recent Jussie Smollett case is less surprising to those on the political right. On the right, there was much more suspicion of allegations

like Dr. Blasey-Ford's against Justice Kavanaugh. Thus, rightists would be more likely to countenance the possibility that a charge of racism as acting out of self or group interest—as a mechanism to gain some desired end such as desired attention, retribution, political gain, or to distract from some other issue, and so on. Where those on the political left would be less skeptical about any allegation of prejudice.

13. *Leftists are more likely to see prejudice as a sufficient condition for some group's lack of advancement in society where conservatives are not.* The right can look to other variables. For example, Thomas Sowell (2001) has suggested that differences in economic achievement between cultural groups have been due to such diverse factors as the relative absence of navigable rivers in the African continent, to having a cultural history of living in cities which increases skill sets related to economic success, to valuing traditional two-parent families. Some polling data are consistent with this: Overall, 64% of Democrats and Democratic leaners indicated that racial discrimination is the main reason why many African Americans cannot get ahead, compared to 28% who say that African Americans who cannot get ahead are mostly responsible for their own condition. On the other hand, most Republicans reject the idea that discrimination is the main reason why African Americans cannot get ahead. 75% indicated that African Americans who cannot get ahead in this country are mostly responsible for their own condition; and just 14% say that racial discrimination is the main reason why many African Americans cannot get ahead. (https://www.people-press.org/2017/10/05/the-partisan-divide-on-political-values-grows-even-wider/)
14. *Those on the political right are also more concerned with allegations and concerns about prejudice being connected with virtue signaling and other posturing than those on the political left.* The right is more likely to be concerned that some professed position regarding prejudice or discrimination simply is inauthentic—a cheap gesture to gain favor or personal advantage (see Duckworth, this volume). For example, the conservative economist Thomas Sowell has repeatedly called certain political leftists such as the Reverend Jesse Jackson and Reverend Al Sharpton as "poverty pimps" and "hucksters," suggesting that their commitment to actually eradicating prejudice may be less than authentic. Sowell has stated:

    "My fellow economist Walter Williams has for years kept track of how much money it would take to lift every American man, woman and child in poverty above the official poverty level. That sum has consistently been some fraction of the money actually spent in "anti-poverty" programs. In other words, if you gave every poor person enough money to stop being poor, that would cost a fraction of what our welfare state programs and bureaucracies cost. Obviously, a lot of anti-poverty money is going to people who are not poor. There are whole classes of people who live off the poor — or rather, off the vast sums of money that are poured out from the public treasury and private philanthropy, in hopes of helping the poor. Those who intercept the money intended for the poor have been aptly called "poverty pimps." The poor are a commodity to these people, who include not only local politicians, community activists and small-time hustlers, but also people with impressive titles and academic credentials, who likewise milk the larger society, in the name of the poor. At the top of the food chain, as it were, are Ivy League professors who rake in big-time research grants to support themselves and their cronies while they are studying, romanticizing or otherwise exploiting the poor."
15. *Leftists and those of the political rights see prejudice as entering in at different points in societal phenomena.* Consider two exam-

ples: (1) school choice (or school vouchers). Those on the political right see this as allowing poor, often ethnic minority, students to have increased opportunities for a quality education by increasing the likelihood that they can afford to go to private schools (like their richer majority culture counterparts) and thus as a political position that is clearly not prejudicial. In fact, conservatives would be more likely to see obstructing this educational choice as being discriminatory against those in the minority cultures. Those on the political left, on the other hand, are more likely to see school vouchers as undermining public schools so that the remaining poor children will experience further decreases in the quality of their education, and hence prejudicial. Those on the right are suspicious that the real motivation for the anti-school choice is to protect public school teachers by not allowing demand for their problematic services to decrease. A second example would be minimum wage: those on the political left would see this as allowing poorer people who disproportionately come from minority culture backgrounds to have increased incomes and thus being against minimum wage laws or being against increasing the minimum wage would be prejudicial. Those on the political right, on the other hand, would suggest that higher wages would inevitably lead to higher unemployment for these individuals, which would be against their interests and hence discriminatory. Thus, for those on the political right, minimum wage increases cause increases in minority unemployment.

16. *Those of the political left are more likely to see many proposals by the political left as counterproductive and* de facto *discriminatory*. For example, the conservative economist Thomas Sowell stated:

    "If we wanted to be serious about evidence, we might compare where blacks stood a hundred years after the end of slavery with where they stood after 30 years of the liberal welfare state. In other words, we could compare hard evidence on "the legacy of slavery" with hard evidence on the legacy of liberals. Despite the grand myth that black economic progress began or accelerated with the passage of the civil rights laws and "war on poverty" programs of the 1960s, the cold fact is that the poverty rate among blacks fell from 87 percent in 1940 to 47 percent by 1960. This was before any of those programs began. Over the next 20 years, the poverty rate among blacks fell another 18 percentage points, compared to the 40-point drop in the previous 20 years. This was the continuation of a previous economic trend, at a slower rate of progress, not the economic grand deliverance proclaimed by liberals and self-serving black "leaders." Nearly a hundred years of the supposed "legacy of slavery" found most black children [78%] being raised in two-parent families in 1960. But thirty years after, the liberal welfare state found the great majority of black children being raised by a single parent [66%]. Public housing projects in the first half of the twentieth century were clean, safe places, where people slept outside on hot summer nights, when they were too poor to afford air conditioning. That was before admissions standards for public housing projects were lowered or abandoned, in the euphoria of liberal non-judgmental notions. And it was before the toxic message of victimhood was spread by liberals. We all know what hell holes public housing has become in our times. The same toxic message produced similar social results among lower income people in England, despite an absence of a "legacy of slavery" there. If we are to go by evidence of social retrogression, liberals have wreaked more havoc on blacks than the supposed "legacy of slavery" they talk about."

17. *Finally, liberals are much more likely to see any perceived example of prejudice as a much more serious matter that requires more serious dispositions*. Students are expelled; faculty are fired; reputations are ruined. See Table 1 for further examples.

> Therefore, there are many dimensions of possible disagreement regarding the construct of prejudice between the political left and the right. It is also important to recognize that each of these specific differences can be *additive* in some particular case—creating for those on the political right somewhat of a perfect storm. For example, cumulatively, a differing definition of prejudice, utilizing a subjectivist approach, with differing burdens of proof, that ignores other possible variables or explanations, and so on, can create a perfect storm in which to defend themselves, a complex and difficult multi-front battle must be engaged. And of course, part of the complexity is that the those deciding the case are most likely also on the political left.

Conclusion

The political left has significant power in academia and needs to learn to wield this power in nonabusive, fair, open, and inclusive ways, particularly in manners that do not interfere with civil liberties, academic freedom, and a positive, healthy campus climate. Prejudice refers to important social and interpersonal phenomena but the construct is difficult to define; and is subject to significant variation in the way the political left and right construe it. More research and conceptual work is needed to better understand the complexities of this construct and to provide clearer, just, politically unbiased, and objective characterizations of this construct, both so that individuals can escape from the harmful experience of prejudice and individuals can escape being unfairly charged or adjudicated for alleged violations related to prejudice. It is unclear if a bipartisan consensus can be reached over the many controversial issues surrounding the construct of prejudice—but hopefully it will be first recognized that this is a desirable goal so that such important work will begin and while it is underway, the political left will curtail some of its excesses involving prejudice on campuses. Of particular importance is when the left yields its power in academia, it ought to also embrace a thoroughgoing commitment to tolerance; particularly it needs to be more tolerant of opposing mainstream political opinion, including the political right's construal of prejudice.

The work of academia has widespread and important repercussions. The work in academia is key to the growth of knowledge and technology, which in turn, can increase the quality of life, provide jobs, and solve important social and technical problems. Academic freedom has been thought to be a key to such progress—that academics can work without fear and follow leads and arguments to where these seem to go—without worry that some external power, especially if it acts in totalitarian ways, may harm them in these pursuits. Unfortunately, it appears that the academy is no longer such a safe space for all; instead, it may be safe only for those that the political left deems ought to be safe.

References

Altemeyer, B. (1981). *Right-wing authoritarianism*. Winnipeg, Canada: University of Manitoba Press.

Buss, D. M., & von Hippel, W. (2018). Psychological barriers to evolutionary psychology: Ideological bias and coalitional adaptations. *Archives of Scientific Psychology, 6*(1), 148–158.

Ceci, S. J., Peters, D., & Plotkin, J. (1985). Human subjects review, personal values, and the regulation of social science research. *American Psychologist, 40*, 994–1002.

Ceci, S. J., & Williams, W. M. (2018). Who decides what is acceptable speech on campus? Why restricting free speech is not the answer. *Perspectives on Psychological Science, 13*(3), 299–323.

Chambers, J., Schlenker, B., & Collisson, B. (2013). Ideology and prejudice: The role of value conflicts. *Psychological Science, 24*(2), 140–149.

Hampton, J. (1996). *Political philosophy*. Westview Press, Washington, DC

Inbar, Y., & Lammers, J. (2012). Political diversity in social and personality psychology. *Perspectives on Psychological Science, 7*(5), 496–503. https://doi.org/10.1177/1745691612448792

Langbert, M. (2018). Homogeneity: The political affiliations of elite Liberal arts college faculty. *Academic Questions, 31*, 2.

Lilienfeld, S. (2017). Microagressions: Strong claims, inadequate evidence. *Perspectives on Psychological Science, 12*, 138–169.

Mitchell, G., & Tetlock, P. (2017). Popularity as a poor proxy for utility: The case of implicit prejudice. In S. Lilienfeld & I. Waldman (Eds.), *Psychological science under scrutiny*. New York, NY: Wiley.

New, J. (2016). Out of balance. Inside Higher Ed. April 14, 2016.

O'Donohue, W. (1989). Experimental semantics: The lexical definitions of "prejudice" and "alcoholic". *The Journal of Mind and Behavior, 10*(1), 21–35.

O'Donohue, W. (2013). *Clinical psychology and the philosophy of science*. Hoboken, NJ: Springer.

O'Donohue, W., & Redding, R. E. (2009). The psychology of political correctness in higher education. In R. Maranto, R. Redding, & F. Hess (Eds.), *The politically correct university: Problems, scope, and reforms*. Washington, DC: AEI Press.

Patai, D., & Koertge, N. (2003). *Professing feminism: Education and indoctrination in women's studies*. New York, NY: Lexington Books.

Ray, J. J. (1983). Half of all authoritarians are left wing: A reply to Eysenck and Stone. *Political Psychology, 4*(1), 139–143.

Rothman, S., Lichter, S. R., & Nevitte, N. (2005). Politics and professional advancement among college faculty. *The Forum, 3*(1), 2.

Sokal, A. (1996). Transgressing the boundaries: Towards a transformative Hermeneutics of quantum gravity. *Social Text, 46/47*, 217–252.

Sowell, T. (2001). The poverty pimp's poem. *Capitalism Magazine*. June 11, 2001,

Taylor, S., & Johnson, K. C. (2007). *Until proven innocent: Political correctness and the shameful injustices of the Duke Lacrosse case*. New York, NY: Thomas Dunne Books.

Villasonar, J. (2017). https://www.brookings.edu/blog/fixgov/2017/09/18/views-among-college-students-regarding-the-first-amendment-results-from-a-new-survey/

Modern Prejudice

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Abstract

Theoretical conceptualizations of prejudice have shifted dramatically over the past century, with prejudice first conceptualized as a natural and normative – and often overtly expressed – response of members of dominant groups to the perceived inferiority of members of nondominant groups. More recently, prejudice has been conceptualized as reflecting those attitudinal and affective responses of dominant groups toward nondominant groups that are subtle and occur outside of awareness as a function of unconscious processes. Shifts in the conceptualization of prejudice have occurred in tandem with shifts in the acceptability of overtly expressed prejudicial beliefs and behaviors; shifts in the general language used to describe prejudicial thoughts, feelings, and behaviors; and shifts in the aims, operational definitions, and methodologies employed in evaluating the occurrence and harmful impacts of prejudice. The sociocultural context is immediately relevant to the identification of dominant in-groups and nondominant out-groups, with the dominance of any in-group typically reflecting both the social privilege and resource advantage associated with one or more characteristics of the in-group. Although prejudicial attitudes can be held by members of dominant in-groups and members of nondominant out-groups, it is the ability to translate prejudicial attitudes into discriminatory behavior that differentiates the two groups. This chapter provides definitions of historic and modern prejudice; a broad overview of the theories that have been forwarded to explain the development and maintenance of prejudicial attitudes, beliefs, and behaviors; a brief review of prejudice as it occurs in relation to specific nondominant cultural identities; and a brief review of the changes in assessment methodologies employed by researchers to assess the occurrence of prejudice.

Keywords

Modern prejudice · Historic prejudice ·
Cultural identity · Intersectionality ·
Assessment of prejudice

Prejudice is the term used most often to capture negative thoughts and feelings toward another person that occur absent of any immediate knowl-

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© Springer Nature Switzerland AG 2020
L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_3

edge of or engagement with the other person and largely consequent to some categorization of the person as "other." These prejudicial thoughts and feelings can then serve to justify behavior aimed at subjugating both the individual and collective will of the other. Theoretical conceptualizations of prejudice have shifted dramatically over the past century, with prejudice first conceptualized as a natural and normative – and often overtly expressed – response of members of dominant groups to the perceived inferiority of members of nondominant groups. More recently, prejudice has been conceptualized as reflecting those attitudinal and affective responses of dominant groups toward nondominant groups that are subtle, that occur as a function of unconscious processes and are consequently deniable, and that contribute to discrimination and oppression through arguments against structural change rather than arguments against the nondominant other (Garth, 1930; Jost & Hunyady, 2002; Kendi, 2016). Shifts in the conceptualization of prejudice have occurred in tandem with shifts in the acceptability of overtly expressed prejudicial beliefs and behaviors; the general language used to describe prejudicial thoughts, feelings, and behaviors; and the aims, operational definitions, and methodologies employed in evaluating the occurrence and the harmful impacts of prejudice. Theories and empirical investigations of prejudice – those originating in the context of historic prejudice and those originating in the context of modern prejudice – are to be viewed as reflecting the societal beliefs and imperatives of the time as well as researchers' beliefs and experiences as members of dominant and nondominant groups (Condit, 2007, 2008; Duckitt, 1992; Garth, 1930; Washington, 2007). This chapter provides definitions of historic prejudice and modern prejudice; a broad overview of the theories that have been forwarded to explain the development and maintenance of prejudicial attitudes, beliefs, and behaviors; a very brief review of prejudice as it occurs in relation to specific nondominant cultural identities; and a brief review of the changes in assessment methodologies employed by researchers to assess the occurrence of prejudice.

Defining Prejudice: A Landscape of Changing Language and Persisting Effects

The word prejudice has its origins in the Latin *praejudicium*, which is defined as "judgment in advance" (Merriam-Webster.com, 2019). Although the denotative meaning of prejudice establishes the word as equally applicable to prejudgments that are favorable and prejudgments that are unfavorable, the word prejudice generally connotes those *negative* judgments made about an individual or group that are often arrived at and maintained in the absence of direct experience with the individual or group. Prejudicial attitudes, feelings, and behaviors assume one cultural identity to be normative and other identities to be nonnormative, undesirable, and/or of potential threat to those who hold the normative identity. Any demographic, geographic, physical, psychological, or social factor can be used to establish difference and dominance. In the United States, the following identities (among others) have been presumed and promoted to be normative identities: white, male, heterosexual, able-bodied, socioeconomically advantaged, and possessing relative youth. The economic and social contracts that stamped these specific identities as "normative" and as deserving of differential influence and power have conferred upon these identities unearned advantage and have enabled some members of these dominant in-groups to harbor negative attitudes and feelings and perpetrate unchecked harms against members of nondominant out-groups (Dixon, Levine, Reicher, & Durrheim, 2012).

The definition of prejudice as judging in advance of a proper evaluation of all existing data or as judging in the absence of direct experience is as appropriate now as it has ever been. It is the change in the expression of prejudice that is captured by the distinction between historic or classical prejudice and modern prejudice. Historic prejudice generally refers to prejudices that were expressed overtly and manifested routinely in the context of individual and collective striving (Allport, 1954). Historic prejudice would capture those racist views regarding the supremacy of whiteness that have been forwarded without apology throughout United States history, including the present moment. Historic prejudice also captures those sexist views regarding the supremacy of maleness that have yet to be excised from our societal unconscious – the store of conventional thought and behavior that is accessed automatically, held as truth, and enacted without careful analysis – or from the conscious practices of our public and private institutions. Modern prejudice is a term that reflects a shift from overt or explicit expressions of prejudice to far more subtle, indirect, and covert expressions of prejudice, largely in response to shifts in social norms related to the acceptability of expressed prejudice (Crandall & Eshleman, 2003; Crandall & Stangor, 2005). Modern racism permits the use of biased selection criteria to exclude black and brown students from undergraduate and graduate education to be accompanied by laments regarding the absence of a pipeline of racially diverse and qualified candidates. Modern sexism intersects with modern racism to permit unequal advancement of women and racially diverse persons to the ranks of business CEOs and senior managers (Thomas et al., 2018) and maintain a gap of 47% between the wage earned by a white male and the wage earned by an Hispanic/Latina woman who hold the same position and responsibilities (Miller & Vagins, 2018). Of course, the current emphasis on modern prejudice does not obviate the occurrence or importance of historic forms of prejudice. While it is true that crosses are being burned less frequently on the lawns of African American property owners, it is also true that uniformed officers employed for the express purpose of serving and protecting United States citizens kill unarmed African American citizens and, in most instances, do so without consequence of prosecution (Inter-American Commission on Human Rights, 2018). At the extremes, modern prejudice represents a shift from complete justification of prejudicial attitudes, feelings, and discriminatory behavior as responses to threats posed by nondominant out-groups to the wholesale disavowal of the detrimental impacts – and sometimes even the occurrence – of the *ongoing* discrimination and oppression members of nondominant out-groups endure (Dixon et al., 2012).

Changes in the language used to describe prejudice go well beyond the shift from historic or overt prejudice to modern or covert prejudice. The past decades have witnessed a shift in the labels applied to the processes that explain prejudice and the persons who embody prejudice. We have moved away from terms such as racism and sexism – used to describe prejudicial beliefs and behaviors toward people with nondominant racial, gender, or sexual identities – to terms such as stereotyping and unconscious or implicit bias (Banaji & Greenwald, 1995). These language changes can be viewed as an attempt to normalize what others consider a pathological orientation toward engagement with difference (Dixon et al., 2012; Kendi, 2019). Sexist persons are to be thought of as acting out of stereotyped depictions of womanhood to which they have been exposed in the larger societal context and are to be regarded as less individually culpable for the impacts resulting from the sexist behaviors they perpetrate. Antisemitic and Islamophobic persons are to be thought of as acting out of the activation of unconscious or implicit biases, applauded for holding no conscious biases, and forgiven due to the unintentional nature of any harms they cause.

The current societal and global context requires the use of precise language to describe prejudicial attitudes, feelings, and behaviors; the generation of culturally informed theories that explain the development and maintenance of prejudicial attitudes and feelings and specify those individual and situational factors that predict the enactment of prejudicial attitudes and feelings; and the conduct of quantitative and qualitative research that examines the causes of prejudice and the individual and societal harms resulting from the enactment of prejudice. The immediately following section presents an overview of theories proposed to explain the occurrence and maintenance of prejudicial attitudes, beliefs, and behaviors.

Theories of Prejudice: An Acknowledged Effort to Understand (and Unacknowledged Effort to Normalize) the Need to Classify and Dominate

Theories that propose to explain the occurrence and maintenance of prejudicial thoughts, feelings, and behaviors abound. The earliest investigations of prejudice occurred in the context of scientists addressing "the problem of racial differences in mental traits" (Garth, 1930, p. 329), with much of the "scientific" inquiry of that time seemingly motivated by the need to *prove* the existence of biologically determined racial differences in intellectual functioning (Garth, 1925; Woodworth, 1916). In fact, Garth (1925) suggests that much of the early twentieth century literature on racial difference reflects the subjective beliefs of the writers, noting that:

> But we shall now note the attitude of these writers toward the question of equality or inequality of races. In fact, as these studies are examined the thing most predominant is a characteristic state of mind, not a new one on the part of professional and lay thinkers, and that is a belief in racial differences in mental traits. The positive belief is pretty thoroughly held by almost all of these theoretical writers. According to them it is a serious mistake to think of all human minds as the same. (p. 343)

Published challenges to the presumption of race-based differences began in earnest during the second half of the 1920s. Based on his review of race psychology articles published in the 5-year period between 1925 and 1929, Garth (1930) concluded:

> What then shall we say, after surveying the literature of the last five years, is the status of the racial difference hypothesis? It would appear that it is no nearer being established than it was five years ago. In fact many psychologists seem practically ready for another, the hypothesis of racial equality. But the problem in either case is the same as it was—to obtain fair samplings of the races in question, to control the factor of nurture, and to secure a testing device and technique fair to the races compared. (p. 348)

Findings from Garth's review can be viewed as marking a dramatic shift in scientific efforts to establish the contribution of environmental factors to racial differences previously presumed to be due to biological factors. World events during the 1930s and 1940s heralded an equally dramatically shift in the conceptualization of prejudice. Over the subsequent 70 years, early and more contemporary theorists have been challenged to explain prejudice at the level of the individual and the group and to propose strategies to reduce prejudice.

Although physical characteristics such as sex and skin color have and continue to be forwarded by some as accounting best for group differences on a host of indices, including intellectual aptitude (e.g., Herrnstein & Murray, 1994), basic genetic research has served to falsify such beliefs at the level of science (Condit, 2007, 2008; DeSalle & Ian Tattersall, 2018), if not at the level of dogma. Beliefs around the biologically-based superiority of one racial group relative to another racial group are prejudicial beliefs. Prejudicial actions taken out of those beliefs – whether they involve affording one group unmerited advantage or affording another group unmerited disadvantage – constitute discriminatory behavior. Most of the theories proposed since the middle of the twentieth century posit that prejudice is the result of individual differences in personality (Adorno, Frenkel-Brunswik, Levinson, & Sanford, 1950) and individual and group concerns about access to resources and social identity (Allport, 1954; Altemeyer, 1988, 1998; Pratto, Sidanius, Stallworth, & Malle, 1994; Sherif, 1966; Tajfel & Turner, 1979, 1986). The reader is referred to Böhm, Rusch, and Baron (2018) for a comprehensive review of psychological theories of intergroup conflict.

First formulated by Adorno et al. (1950) in reaction to the atrocities that defined the Holocaust, the authoritarian personality theory contends that, in response to early socialization, individuals who possess traits consistent with authoritarianism tend to: (1) hold fast and promote adherence to social hierarchies, revering those in authority and viewing those of inferior status as subject to their control; (2) hold fast to accepted doctrine, viewing competing ideologies – and those who forward them – as threatening societal order; and (3) view maintenance of social order and the quelling of perceived threats as warranting and justifying extreme acts of oppression and violence. In the context of the racial/ethnic prejudgments that ignited and fueled the Holocaust, one of history's most horrific examples of racial/ethnic hatred and violence, traits of authoritarianism would lead members of the dominant group to view with mounting suspicion any person or group of persons who differed significantly from the dominant group. A difference in race/ethnicity was sufficient to prejudge Jewish persons as holding a different world view and espousing a different doctrine, as insufficiently respectful of established authority and their "place" on the hierarchy, and as threatening anarchy by virtue of their failure to live according to the established economic and social order. Such prejudgments of threat have served to justify dominant groups' efforts to subjugate and control nondominant groups.

The authoritarian personality theory has been challenged on both theoretical and methodological grounds (Böhm et al., 2018; Duckitt, 2015; Sibley & Duckitt, 2008). The challenges to the authoritarian personality theory that we view as most relevant to the advancement of research on prejudice were those that criticized the theory as being too context specific, explaining prejudice in the context of extraordinary racial/ethnic hatred and violence, and capturing prejudice at the level of psychological pathology rather than at a "normative" level, this last challenge seeming to ignore the fact that – throughout human existence – "normative" prejudice has associated with acts of discrimination, aggression, and extreme violence.

The 1950s heralded the formulation and dissemination of theories that characterized prejudice as a normal response to difference (Allport, 1954) and as a natural, survival-oriented approach to processing information and making decisions about the likelihood that a given individual or group will serve to strengthen one's self and group identities or challenge those identities (Sherif, Harvey, White, Hood, & Sherif, 1961; Sherif & Sherif, 1953; Tajfel & Turner, 1979, 1986). Realistic group conflict theory (Sherif, 1966) emphasized intergroup conflict as driven by competition for resources, with intergroup conflict moderated by the degree to which the attainment of desired resources requires intergroup cooperation. Related theories include social identity theory (Tajfel & Turner, 1979, 1986), which posits that prejudice is a natural outgrowth of the process of categorizing individuals as belonging to an out-group and as threatening the integrity/sustainability of the in-group, and integrated threat theory (Stephan & Stephan, 2000), which posits that intergroup conflict can result from perceived threats to essential/real/structural resources or psychological resources.

To appreciate the true value of these well-established and often researched theories of prejudice, they must be placed in the sociopolitical context that shaped their development and the development of their authors. In the United States, the second half of the twentieth century was defined by highly organized efforts to protest the ongoing colonization of indigenous peoples; place a glaring spotlight on institutionalized racism in the form of discriminatory employment and housing practices and unequal access to education, healthcare, political participation, the rule of law, and basic consumer goods and services; and protest gender inequalities with respect to employment opportunities and compensation and argue for the basic right to physical safety and the power to make health decisions. The prejudice and discrimination that defined the lives of so many out-group members during this period of history might have served as a catalyst for the crafting theories that emphasized prejudice as occasioning the atrocities suffered by African Americans during the Jim Crow era and in response to the Black Power movement; the accusations of subversion and treason against homosexuals during the McCarthy investigations and the police harassment of members of the LGBTQ community that led to the Stonewall Riots; and the physical and psychological violence perpetrated against indigenous peoples in the context of the ongoing theft of native lands and the forced assimilation of indigenous peoples through the culture-killing practices of residential schools. Researchers active during this period of history might have investigated the direct and indirect effect of intrapersonal, interpersonal, political, and social factors on the relation of "normal cognitive-affective responses to difference" to individual-perpetrated and group-perpetrated acts of discrimination and aggression. Instead, the theories of prejudice proffered during the middle and later part of the twentieth century have been criticized as insufficiently comprehensive with respect to the factors addressed by any single theory, as disregarding the sociocultural and sociopolitical events that are likely to have influenced shifts in theory dominance, and as failing to perceive the value of combining different aspects of popular theories into one integrated framework (Böhm et al., 2018; Duckitt, 1992, 2015).

In contrast to many of the theories forwarded during the second half of the twentieth century, Henry and Tator's (1994) theory of democratic racism presents a view of modern prejudice that recognized both the subtlety with which members of dominant in-groups express their prejudicial attitudes and feelings and the very subtle ways in which members of dominant in-groups enacted their prejudices at the level of governmental law and policy. Henry and Tator used the term "democratic racism" to describe individuals who espouse an unwavering commitment to democratic principles and hold prejudicial attitudes toward members of nondominant racial groups. By insisting that any effort to manage racial discrimination by changing the structure of the established democracy serves to undermine that democracy, these individuals use their democratic zeal to resist efforts to end institutionalized racial discrimination. Similar efforts to reframe antidiscrimination efforts as threatening the sanctity of long-standing governmental and institutional structures are underway in the United States and in countries across the world. For example, some argue that efforts to establish wage parity and efforts to ensure a national-wide increase in the minimum wage challenge have the potential to de-stabilize the United States as a capitalist democracy. Of course, ensuring the strength of the United States as a capitalist democracy is a stance that would be championed by many. Unfortunately, support of policies that maintain the strength of our capitalist democracy often serves to passively maintain many of our nation's most sexist, racist, and classist practices. Around the world, arguments in favor of maintaining the status quo serve to ensure that social, political, and economic influence and power are differentially available to members of dominant in-groups and will remain so.

Modern Prejudice in the Context of Single and Intersecting Cultural Identities

Modern prejudice can be expressed in relation to a myriad of cultural factors, including age, developmental and acquired disability, religion, race/ethnicity, socioeconomic status, sexual orientation, indigenous heritage, language, nationality, citizenship status, gender identity and gender expression, and others (Hays, 2008) . This discussion of modern prejudice emphasizes those stereotypes held in relation to certain cultural identities and the translation of such stereotypes into acts characterized as microaggressions and acts of violence. This section also provides a breif review of the impact of modern prejudice on persons who can be considered to hold non-dominant cultural identities as a function of their racial identity, gender identity, sexual orientation, ability/disability status, and religious/spiritual affiliation.

Stereotypes are conceptualized by Greenwald and Banaji (1995) as a set of socially shared beliefs about a group based on some demographic characteristic. These "shared" and widely communicated beliefs have their most immediate and insidious negative effect through what has been termed stereo type threat. Stereotype threat captures the impact of such stereotypes on the self-concept and identity of members of targeted groups (Steele, 1997; Steele & Aronson, 1995). Stereotype threat can be viewed as active when a falsely-held stereotype serves to impact the performance of members of targeted groups. For example, when false beliefs about the inferior math abilities of females contribute a young female high school student's decision to not enroll in an advanced math course despite an academic record that predict successful performance in the course, stereotype threat is in effect. Most disturbing is the fact that the negative impacts of stereotype threat on academic choices and performance often occur outside of active awareness and these impacts are rarely part of calculations made regarding the predicted level of success to be achieved by students who hold culturally diverse identities.

Microaggressions is the term coined by Sue et al. (2007) to describe the different forms of racism experienced by members of nondominant racial groups. These researchers described microaggressions as "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color" (p. 271). Microaggressions are considered to include the following three forms: microassaults, microinsults, and microinvalidations. Microassaults are overt forms of racism, which include verbal and nonverbal behavior that are explicitly racist and intended to harm. Microinsults are often unintentional and unconscious statements which are demeaning, while microinvalidations are statements that negate an individual's experience of racism. Research has established that the experience of microaggressions results in a myriad of negative consequences for the people who hold diverse cultural identities in relation to their gender (Nadal, 2011), sexual orientation (Sue & Capodilupo, 2008), disability status (Keller & Galgay, 2010), and religious affiliation (Nadal, Issa, Griffin, Hamit, & Lyons, 2010).

Race

In the United States, race is one of the socially constructing identities that has been used most effectively to ensure differential access to basic rights and resources. The majority of early research on racial prejudice examined racist beliefs held about African Americans, with much of that research highlighting the prejudical beliefs held in relation to the physical and intellectual abilities of African Americans and in relation to tendecies toward criminal engagement. More recently, research has been undertaken to document the experiences and impacts of racial prejudice and discrimination on involved Asian and Latino populations. Although the empirical literature addressing racism directed at Native Americans and Alaska Natives is small, findings indicate that the physical and psychological harms experienced by these indigenous populations are as signicant as those experienced by other targets of racial prejudice and discrimination (Paradies, 2018). African Americans report having the experience of being exoticized due to certain physical features and sexualized due to false beliefs that have been propogated regarding their sexual anatomy and appitite (Nadal, 2011). African Americans are alternately perceived as superhuman and subhuman, being of inferior intellect and meriting none of the rights and dignities afforded to persons (Hall, Hall, & Perry, 2016; Nadal, 2011; Torres, Driscoll, & Burrow, 2010) (Hall, Hall, & Perry, 2016). African Americans also experience prejudice in the form of being perceived as intellectually inferior (Nadal, 2011; Torres, Driscoll, & Burrow, 2010) and subhuman (Hall et al., 2016). As would be predicted, widely communicated stereotypes regarding African Americans' intellectual abilities has resulted in stereotype threat and the negative impact of stereotype threat on the performance of African Americans has been documented in the context of standardized tests of intelligence and scholastic aptitude (Nadler & Clark, 2011; Nguyen & Ryan, 2008) and academic achievement (Walton & Spencer, 2009).

As targets of stereotypes and microaggressions, African Americans experience a host of deleterious physical (Borrell et al., 2010; Brondolo et al., 2009; Lee, Kim, & Neblett Jr., 2017; Sims et al., 2016), psychological (Brondolo et al., 2009; Carter, 2007; Pietrse, Todd, Neville, & Carter, 2012; Torres et al., 2010; Utsey, Giesbrecht, Hook, & Stanard, 2008), and cognitive (Salvatore & Shelton, 2007) outcomes. Coping with the daily challenge of prejudice contributes to increased alcohol and tobacco use, improper nutrition, hypertension, and higher rates of depression, anxiety, posttraumatic stress responding, and cognitive impairment among African Americans. The stereotype suggesting heightened criminality among African Americans has translated to acts of discrimination and oppression that are especially disturbing (Hall et al., 2016). A significant proportion of African Americans report the experience of being harassed by police officers without cause (Torres et al., 2010). Young African American males are imprisoned at a rate far higher than their representation in the larger U.S. population. African American children are more likely than Caucasian children to be sentenced as adults and comprise 58% of all children sent to serve sentences in adult correctional facilities (National Council on Crime and Delinquency, 2007). The most alarming finding is that African American civilians, both male and female, are more likely to be treated with excessive force and killed by police than white civilians (Edwards, Lee, & Esposito, 2019; Hall et al., 2016). These race-based differences in arrest and incarceration rates are used by members of dominant in-groups to reaffirm their belief in the criminality of non-dominant racial groups. Despite the long history of racism and racial injustice in the United States, evidence that social and economic racism are key factors that drive racial differences in who is arrested, who is prosecuted, who receives what sentence, and who possesses demographic characteristics that can be deemed sufficient to justify murdered is ignored or dismissed (for recent reviews of this literature, see Alexander, 2010, Davis, 2016, and Kendi, 2016).

Asian Americans also experience considerable and varied types of prejudice. Using a focus group methodology, Sue et al. (2007) documented the experience of microaggressions as reported by Asian Americans and categorized their experiences as represented by eighth themes: alien in own land; pathologizing cultural values/communication styles; ascription of intelligence; exoticism of Asian American women; denial of racial reality; invalidation of interethnic differences; second-class citizenship; and invisibility. Asian Americans have the experience of feeling like an alien in their own country when asked, “Where were you born?” and are expected to feel complimented when told “You speak good English.” These experiences cause some Asian Americans to feel like perpetual foreigners even when having grown up in the United States (Museus & Park, 2015). Ascription of intelligence is considered a positive stereotype. Although intended as a compliment, it is form of categorization that limits the individuality of the person. Prejudice in the form of ascription of intelligence would capture the belief that all Asians are possessed of superior math abilities. The experience of positive prejudice among Asian Americans can lead to increased tension with other racial groups such as Latinos and African American (Sue et al., 2007). This stereotype can cause Asian Americans to feel trapped and feel a need to perform in a manner that conform with societal beliefs and expectations (Nadal, Wong, Griffin, Davidoff, & Sriken, 2014). Denial of racial reality is best captured by Asian Americans being described as “the new Whites” or “model minorities” (Museus & Park, 2015; Sue et al., 2007).

Some of the more widely disseminated prejudical beliefs about Latinos are similar to those held about African Americans and these prejudicial beliefs are just as likely to translate to experiences of stereotype threat and acts of discriminatory behavior that target Latinos. Using a focus group methodology similar to that employed by Sue et al. (2007), Rivera, Forquer, and Rangel (2010) documented and categorized experiences of racism reported by representatives of the Latino community. Experiences of racism were represented within seven themes: ascriptions of intelligence; second-class citizens; pathologizing communication styles or cultural values; characteristics of speech; aliens in own land; assumptions of criminality; and invalidation of the Latino/a American experience. These racial stereotypes translate to discriminatory behavior and poorer health outcomes among Latinos. Latino children are consistently underrepresented in gifted and talented programs (Ford, Scott, Moore, & Amos, 2013). Latino males are at significantly greater risk of suffering disparate treatment at the hands of U.S. law enforcement officers (Sadler, Correll, Park, & Judd, 2012), with Latino males being more likely to be killed by police officers than white males (Edwards et al., 2019). Research indicates that detrimental impacts of racism on the physical and mental health of Latinos is even greater than those experienced by African Americans (Paradies et al., 2015).

Gender

Women are negatively impacted by modern sexism in a variety of contexts, including education, career progress, and physical safety (Catalyst, 2016; Center for the American Woman and Politics, 2018; Defense Advisory Committee on Women in the Services, 2018; Ginder, Kelly-Reid, & Mann, 2018; Herrero, Rodríguez, & Torres, 2017; Kuchynka et al., 2018). Women are significantly less likely to obtain high leadership roles, despite often surpassing men in the number of bachelors and advanced degrees earned, with current data revealing that women represent only 5% of CEOs, 24% of United States senators, 18% of state governors, 23% of United States congressional representatives, and 6.7% of military officers at the level of brigadier general or higher (Catalyst, 2016; Center for the American Woman and Politics, 2018; Defense Advisory Committee on Women in the Services, 2018). Women are also underrepresented in university Science, Technology, Engineering, and Mathematics (STEM) departments and programs. Kuchynka and colleagues (2017) found that female gender and feminine attributes were less likely correlated with STEM competence and stereotypes predicted lower STEM grade point averages and lower STEM major intentions. Clearly, sexism significantly impacts women's career trajectories and limits their educational possibilities.

Women are also disadvantaged due to the restrictive nature of traditional gender roles (Smith, Caputi, & Crittenden, 2012). In the context of heterosexual relationships, women have significantly greater responsibility for domestic duties than their partners do, despite being involved in paid outside occupations (Smith et al., 2012). This phenomenon is known in the literature as working the "second shift" (Hochschild & Machung, 1989). Women are more likely to experience depression and marital dissatisfaction when they hold an unequal share of domestic responsibilities (Coltrane, 2000; Stockard & Johnson, 1992). Sexism is also associated with higher levels of violence for women (Herrero et al., 2017). Individuals who endorse sexist beliefs are more likely to hold accepting attitudes toward interpersonal violence (IPV), and individuals who hold accepting attitudes toward IPV are more likely to engage in it.

Research has identified two types of modern sexism: hostile sexism and benevolent sexism (Glick & Fiske, 1996). Hostile sexism in the workplace is associated with experiences of depression, physical illness symptoms, absence from work, and low levels of job satisfaction for women (Fitzgerald, 1993). Benevolent sexism results in self-objectification and body shaming among women (Calogero & Jost, 2011) and can be associated with poorer cognitive performance (Dardenne, Dumont, & Bollier, 2007). Regardless of type of sexism, sexism limits women's power in society and preserves unearned advantage due solely to maleness.

Oppression among transgender persons is part of the sexism discussion (Nadal, Whitman, Davis, Erazo, & Davidoff, 2016). Although transgender individuals are included as members of the community of persons who hold non-mainstream sexual orientations and gender identities , studies examining sexism in transgender population are relatively few in number compared to studies examining other members of the LGBTQIA (i.e., lesbian, gay, bisexual, transgender, queer, intersex, and asexual) community. Transgender individuals faced with microaggressions experience anger, hopelessness, fatigue, and feelings of invalidation (Nadal et al., 2016). Some individuals do not recognize the validity of transgender individuals, and discrimination is associated with suicidality, symptoms of depression, substance abuse, and increased risk of violence and sexual assault (Schuster, Reisner, & Onorato, 2016). Transgender individuals encounter a unique form of adversity and require more empirical attention to more accurately capture their experiences with being mistreated.

Sexual Orientation

Sexual prejudice is recognized in the literature as negative attitudes and beliefs held about individuals due to their sexual orientation (Herek, 2000). More often than not studies of sexual prejudice have included some combination of individuals who identify as lesbian, gay, or bisexual (LGB). It has been found that LGB individuals exposed to microaggressions experience lower self-esteem, negative feelings pertaining to their sexuality, and challenges in establishing positive feelings about their sexuality (Nadal et al., 2016). LGB individuals are also more likely to develop psychological disorders, including depression and anxiety, than heterosexual individuals (Cochran & Mays, 2009; Cochran, Mays, Alegria, Ortega, & Takeuchi, 2007; Cochran, Sullivan, & Mays, 2003; Gilman et al., 2001; Sandfort, de Graaf, Bijl, & Schnabel, 2001). In their examination of the impact of stereotypes on the health and well-being of young adults who identified as gay, lesbian, or bisexual, Woodford, Howell, Silverschanz, and Yu (2012) determined that hearing the phrase "That's so gay" on their college campus was associated with reports of reduced appetite, increased headaches, and greater perceptions of being social ostracized among these young adults.

Gay and lesbian individuals are discriminated against in parenting and coaching roles due to their sexual identities (Massey, Merriwether, & Garcia, 2013; Sartore & Cunningham, 2009). Homosexual parents were classified as less accountable, capable, nurturing, emotionally stable, and sensitive than heterosexual parents (Massey et al., 2013). Gay and lesbian coaches are also impacted by prejudicial attitudes (Sartore & Cunningham, 2009). Parents with prejudicial attitudes are less likely to allow a homosexual coach to train their children, and athletes with prejudicial attitudes are less willing to participate in a sport that involves a homosexual coach (Sartore & Cunningham, 2009). Gay men who experience more discrimination reported higher nonprescription drug use, more doctor visits, and higher amounts of sick days used from work than bisexual men (Huebner & Davis, 2007). Bisexual individuals comprise a unique subgroup of sexual minorities in that they are often excluded by both homosexual and heterosexual communities (Balsam & Mohr, 2007; Mulick & Wright Jr., 2002). Bisexuals experience greater negative outcomes than both heterosexuals and homosexuals, such as more negative beliefs about their sexual identity, confusion about their sexual identity, experiences of harassment and violence, unhealthy drug and alcohol consumption and weight control procedures, anxiety, depression, and suicidality (Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002; Nadal et al., 2016; Robin et al., 2002; Sarno & Wright, 2013).

Religious/Spiritual Affiliation

Religious/spiritual affiliation or orientation represents another contexts in which prejudice and discrimination occur. Research examining the general relation between prejudice and religious/spiritual affiliation has produced largely inconclusive findings (Shaver, Troughton, Sibley, & Bulbulia, 2016). One consistent finding revealed by a meta-analytic review of religious racism is that religiously affiliated persons tend to hold more prejudicial attitudes and belifs about others and tend to be more judgmental of others (Hall, Matz, & Wood, 2010).

Due to the significance of national and international events that have occurred in recent times, individuals who identify as Muslim have received considerable research attention. Research suggests that Muslims have experienced less acceptance than any other religious, ethnic, or racial group with the exception of atheists (Edgell, Gerteis, & Hartmann, 2006). Muslim Americans are more likely than any ethnic group to be considered violent and untrustworthy (Sides & Gross, 2013) and there has been a 1700% increase in hate crimes against Muslims since the terrorist attacks in New York City (American Civil Liberties

Union, 2002; Council on American-Islamic Relations, 2005; Ibish, 2003). Muslim Americans are one of the few groups toward which people are willing to overtly express prejudice and restrict rights and access to resources (Kteily, Bruneau, Waytz, & Cotterill, 2015; Lajevardi & Oskooii, 2018). Findings from a study examining the psychological health of Arab and Muslim Americans following the September 11, 2001 terrorist attacks reveal that Arab and Muslim American experience prejudice and discrimination (77%), these experiences taking the form of discrimination in the workplace and loss of employment, incidents of name-calling and communication of negative attitudes and beliefs, and physical attacks and human rights violations. More than 60% of study participants endorsed symptoms of depression in response to their experiences of religious and racial prejudice and discrimination. These studies have demonstrated the ability of dominant in-groups to dehumanize persons who hold nondominant religious identities.

Disability

Within the United States, approximately 50 million people are characterized as living with a disability (Okoro, Hollis, Cyrus, & Griffin-Blake, 2018), that is, living with a physical or mental ciscumstance that impedes their ability to perform tasks that define a particular performance domain. Despite the domain-specific nature of disabilities, individuals who manifest diverse physical and mental abilities often bear the burden of being presumed to unable to meet most of life's day-to-day challenges (McCaughey & Strohmer, 2005). In addition to battling routine presumptions around their general competence and performance abilities, individuals with atypical intellectual, physical, and psychological abilities and needs are often the target of steroetypes that cast them as asexual (DeLoach, 1994), sexually deviant (Toomey, 1993), and psychologically unstable and posing a danger to others (McCaughey & Strohmer, 2005; Werner, 2015).

As is true in relation to other cultural identites, prejudices held in relation to disability status often translate to discriminatory behaviors. Research findings indicate that children and youths with atypical abilities and needs are often isolated from their peers in the school setting and are more likely to be suspended or expelled in response to rule infractions (Leone, Mayer, Malmgren, & Meisel, 2000). Adults with diverse abilities and needs are more likely to experience discrimination at work (Harpur, 2014). and more prone to psychological distress (Dagnan & Waring, 2004). Individuals with atypical abilities and needs also experience discrimination related to basic civil rights. One in seven individuals who are of voting age can be characterized as having atypical abilities and needs (Houtenville & Ruiz, 2012). Despite this fact, 73% of all polling locations used during the 2008 elections had potential impediments for individual with a physical disability (Schur & Adya, 2012). Individuals with intellectual disabilities experience even greater challenges to their basic civil rights (Schur, Adya, & Kruse, 2013). Individuals with disabilities are often ignored by mainstream media (Morris, 1991) or represented in manners consistent with negative stereotypes (Haller, 2010). Distorted portrayals of nondominant out-groups can negatively impact the performance of out-group members, challenge their own sense of identity (Ben-Zeev, Fein, & Inzlicht, 2005), and pose a significant threat to their psychological well-being (Dagnan & Waring, 2004).

Prejudice in the Context of Intersecting Cultural Identities

Recognizing the intersection of gender, race, sexual identity, socioeconomic status, national origin, age, religion, and disability status allows for a more thorough understanding of an individual's experience. Based on their review of the microaggressions literature, Nadal and colleagues (2015) determined that most studies address microaggressions occurring in relation to a single cultural identity rather than the multiple, intersecting cultural identities that all people hold. The intersectionality of gender and race has received some empirical attention. African

American males reportedly experience more microaggressions in the form of assumptions of criminality and second-class citizenship than African American females (Bennett, McIntosh, & Henson, 2017), while Latino women experience more workplace and school microaggressions than Latino men (Nadal, Mazzula, Rivera, & Fujii-Doe, 2014).

Nadal et al. (2015) used data from six qualitative studies to examine microaggressions occurring in relation to the intersection of gender, race, ethnicity, sexual identity, and religion. Focus group responses were characterized as capturing seven microaggression themes: exoticism of women of color; gender-based stereotypes for lesbian women and gay men; approval of LGBT identity by racial, ethnic, and religious groups; assumption of inferior status; invisibility and desexualization of Asian men; assumptions of inferiority or criminality of men of color; gender-based stereotypes of Muslim men and women; and women of color as spokespersons. The microaggression themes identified in the context of this study of intersecting cultural identities are largely consistent with the microaggressions identified in the context of studies addressing a single cultural identity (e.g., Asian American). Although researchers are already engaged in the creation of assessment tools that address prejudice at the level of more than one cultural identity (Balsam, Molina, Beadnell, Simoni, & Walters, 2011; Lewis & Neville, 2015), more research is needed to properly assess the impact of prejudice on intersectional lives.

Evaluating Modern Prejudice: Documenting Both the Occurrence and the Associated Harms

Evaluation of the impact of modern prejudice on nondominant out-groups requires the use of psychometrically sound assessment tools. Instruments used in the study of modern prejudice usually query prejudicial attitudes in relation to a singular cultural identity. Many of the early measures of modern prejudice addressed prejudicial attitudes, beliefs, and feelings held in relation to a specific racial identity or gender (Glick & Fiske, 1996). For example, research evaluating prejudicial attitudes toward African Americans generally addresses beliefs pertaining to discrimination as a historic occurrence rather than an current, ongoing circumstance, feelings of antagonism toward African Americans due to their persistent claims of discriminatory and unfair treatment, and feelings of resentment toward African Americans due to their receipt of special consideration in the form of employment quotas, for example. Measures of prejudice as experienced by African Americans assess the frequency of such experiences (e.g., the Perceived Racism Scale; McNeilly et al., 1996) and/or the impact of such experiences (e.g., the Index of Race-Related Stress; Utsey & Ponterotto, 1996). Currently, considerable research effort is being devoted to the assessment of prejudice occurring in relation to other cultural identities, including gender, disability status, religion, and sexual orientation (Lajevardi & Oskooii, 2018; Legge, Flanders, & Robinson, 2018; Nadal et al., 2012; Peters, Schwenk, Ahlstrom, & McIalwain, 2017). With increasing awareness of the fact that individuals hold multiple, intersecting cultural identities, we can anticipate the development of measures that evaluate prejudice at an increasing level of complexity.

Consistent with the notion of modern prejudice as reflecting the presence of prejudicial attitudes and feelings and the desire to not *appear* to hold such prejudices, researchers are examining the differential impacts of feeling motivated to express prejudice versus feeling motivated to not express prejudice. In developing and establishing the soundness and utility of the Motivation to Express Prejudice Scale, Forscher, Cox, Graetz, and Devine (2015) conducted seven studies that involved more than 6,000 participants. Findings from two of the studies revealed that, relative to participants who evidence low motivation to express prejudice, participants who evidenced high motivation to express prejudice were less supportive for programs aimed at increasing contact among persons of different races, were more supportive of political candidates who opposed same-sex marriage and who framed their message in the language of either antigay values or family values, and were less supportive of political candidates who championed same-sex marriage and who framed their message in the language of equality. Plant and Devine (1998), in a three-part study involving seven samples, demonstrated that high scores on the Motivation to Respond Without Prejudice Scale were associated with high stereotype endorsement, whether participants' reports were private or public.

Although recent years have been marked and marred by a resurgence of some of the most overtly ableist, antisemitic, Islamophobic, homophobic, racist, sexist, transphobic, and xenophobic behavior, the past two decades have witnessed a burgeoning of research effort aimed at recognizing and minimizing the impacts of covert prejudice or implicit bias. Implicit bias refers to a cognitive process in which associations are made between concepts without requiring active, conscious awareness of the associations that have been formed (Banaji & Greenwald, 1995). In studying implicit bias, researchers are employing reaction time tasks as a method of capturing prejudice at the level of unconscious processes (Forscher & Devine, 2016). One of the most respected measures that employs this methodology is the Implicit Association Test (IAT: Greenwald, McGhee, & Schwartz, 1998). The IAT is structured as a double discrimination task in which participants respond as quickly as possible to paired stimuli that are presented as words or pictures. Bias is assumed to be present when reaction time differences are observed in pairing target categories (e.g., African American versus Caucasian) with specific attributes (e.g., honest versus dishonest). For example, an implicit bias in favor of Caucasians would be assumed if the time taken to pair the category Caucasian with the attribute honest was less than the time taken to pair the category African American with the attribute honest and if the time taken to pair the category African American with the attribute dishonest was less than the time taken to pair the category Caucasian with the attribute dishonest.

Research suggests that performance on the IAT correlates positively with performance on measures of explicit bias. Based on results from a meta-analysis of 126 studies that included the IAT and one explicit prejudice measure, Hofmann, Gawronski, Gschwendner, Le, and Schmitt (2005) concluded that the association between levels of implicit bias revealed by the IAT and levels of explicit bias revealed by self-report measures is strengthened with increasing spontaneity of self-reports and increasing correspondence between measures. Findings from a more recent meta-analysis suggest that the relation of IAT performance to performance on measures of explicit bias is less strong than previously reported and call into question the utility of the IAT in predicting discriminatory behavior (Oswald, Mitchell, Blanton, Jaccard, & Tetlock, 2013).

The conceptualization of prejudice as a consequence of overlearned, and often erroneous, categorical associations that are automatically (and unconsciously) activated has led to the development of implicit bias trainings that aim to increase attendees' awareness of their biases, increase their knowledge of the impact of those biases on decision-making processes across a wide array of contexts, and increase the accuracy of evaluations made about members of nondominant out-groups (i.e., reduce bias-driven negative evaluations) and members of dominant in-groups (i.e., reduce bias-driven positive evaluations). Research findings indicate that interventions aimed at modifying implicit biases are effective in reducing implicit bias and increasing concern about discrimination (Devine, Forscher, Austin, & Cox, 2012) and increasing positive behavioral intentions (Lillis & Hayes, 2007).

Despite the effectiveness of interventions designed to reduce implicit bias, we forward two cautions. First, interventions undertaken with the aim of reducing implicit bias appear to assume that reductions in negative evaluations of members of nondominant out-groups will translate to reductions in discriminatory behavior. The falsity of this assumption is addressed eloquently by Dixon et al. (2012) in their response to critiques of their 2012 article "Beyond prejudice: Are negative evaluations the problem and is getting us to like one another more the solution?" as a rejection of the potential value of prejudice reduction:

> …First, we should not presume that the absence of negative intergroup feelings and conflict necessarily indicates the absence of discrimination and inequality. Second, we should not presume that their presence is necessarily an impediment to the reduction of discrimination and inequality. Third, by implication, we should not presume that nurturing warm feelings and harmonious relations necessarily creates a better society. Better for whom, in what ways, and at what costs? These are questions that have been marginalised in much of the prejudice literature, which has treated the reduction of negative evaluations as an unquestioned end in itself, quietly eclipsing more fundamental debates about how to implement sociopolitical change most effectively. (p. 452)

In their recent meta-analysis, Kurdi and colleagues (2019) examined the expanding research literature addressing the relation of the IAT to intergroup behavior. Based on their evaluation of more than 2200 implicit–criterion correlations, these researchers determined that measures of implicit cognitions predicted all types of behavior sampled across the 217 reports, with effect sizes ranging from small to moderate. Kurdi and colleagues acknowledge that the level of heterogeneity observed among the social groups, types of IATs, samples, and criterion variable employed across the research reports limits the strength of the reported findings. Of the 217 reports that involved more than 36,000 participants, only 13 studies that involved a combined sample of 54 participants were identified by the authors as permitting a reliable test of the relation of the IAT to behavior. When placed in the larger context of social action aimed at reducing discrimination, these findings can be interpreted as strengthening calls for caution regarding the usefulness of the IAT and similar measures of implicit cognition in predicting discriminatory behavior.

Second, our experiences with implicit bias trainings have generated concern about the emphasis placed on the universality of implicit biases. Trainers emphasize the universality of implicit biases but fail to acknowledge that members of dominant in-groups are far less likely to suffer harms as a consequence of prejudice and are uniquely empowered, by virtue of centuries of socially legitimized and institutionally sanctioned oppression of out-groups, to enact harms as a function of their prejudice. For a detailed discussion of a promising, new approach to implicit bias reduction that emphasizes high consistency between expressed values and actions taken in relation to those values and that is undergoing empirical evaluation, we direct the reader to chapter "Intersecting and Multiple Identities in Behavioral Health" of this book.

It can be concluded that although the number of measures of historic or explicit prejudice and modern or implicit prejudice is increasing and although different forms of prejudice are being tapped by these measures, much research is needed to evaluate the co-occurrence of explicit and implicit prejudice in relation to a single form of prejudice; to establish the co-occurrence of different forms of prejudice; to establish the degree to which explicit and implicit prejudice predict discriminatory behavior; and to identify the intrapersonal, interpersonal, and socioenvironmental factors that mediate the relation of explicit and implicit prejudice to discrimination.

Conclusion

Modern theories of prejudice can be viewed as promoting prejudice as a normative experience that can be assumed to contribute only to limited harms. As is true for all theories, modern theories of prejudice arise out of a sociopolitical agenda in which the cultural ideologies of dominant in-groups are legitimized and maintained, the fragility of dominant in-groups is prioritized, and in which members of dominant in-groups are held harmless around all the harms they perpetrate and all the harms they ignore in order to maintain dominance. Once again we find ourselves in a moment of placing more research emphasis on understanding the prejudicial attitudes and feelings of members of dominant in-groups, subtly endorsing the idea that the solution to institutionalized oppression of out-groups lies in increasing knowledge and insight regarding the cultural biases (presumably unrecognized but more likely actively unacknowledged) that advantage in-group members and disadvantage out-group members. The amelioration of aggression and violence against members of out-groups and the elimination of discriminatory practices that result in reduced access, participation, influence, and reward for out-group members require that prejudice and discrimination be addressed at the level of policy creation, policy implementation, and policy reinforcement. In addition to ensuring equality of access, opportunity, participation, influence, and reward, these policies should ensure that, when intergroup engagement occurs, in-group and out-group members are positioned to be maximally effective in achieving separate and shared objectives.

References

Abu-Ras, W., & Abu-Bader, S. H. (2009). Risk factors for depression and posttraumatic stress disorder (PTSD): The case of Arab and Muslim Americans post-9/11. *Journal of Immigrant and Refugee Studies, 7*(4), 393–418.

Adorno, T. W., Frenkel-Brunswik, E., Levinson, D., & Sanford, R. N. (1950). *The authoritarian personality* (p. 415). New York, NY: Harper & Brothers.

Alexander, M. (2010). *The new Jim Crow: Mass incarceration in the age of colorblindness*. New York, NY: The New Press.

Allport, G. W. (1954). *The nature of prejudice*. Cambridge, MA: Addison-Wesley.

Altemeyer, B. (1988). *Enemies of freedom: Understanding right-wing authoritarianism*. San Francisco, CA: Jossey-Bass.

Altemeyer, B. (1998). The other "authoritarian personality". *Advances in Experimental Social Psychology, 30*, 47–92.

American Civil Liberties Union. (2002). *International civil liberties report*. http://www.aclu.org/FilesPDFs/iclr2002.pdf

Balsam, K. F., & Mohr, J. J. (2007). Adaptation to sexual orientation stigma: A comparison of bisexual and lesbian/gay adults. *Journal of Counseling Psychology, 54*(3), 306–316.

Balsam, K. F., Molina, Y., Beadnell, B., Simoni, J., & Walters, K. (2011). Measuring multiple minority stress: The LGBT people of color microaggressions scale. *Cultural Diversity and Ethnic Minority Psychology, 17*(2), 163–174.

Banaji, M. R., & Greenwald, A. G. (1995). Implicit social cognition: Attitudes, self-esteem, and stereotypes. *Psychological Review, 102*(1), 4–27.

Bennett, L. M., McIntosh, E., & Henson, F. O. (2017). African American college students and racial microaggressions: Assumptions of criminality. *Journal of Psychology, 5*(2), 14–20.

Ben-Zeev, T., Fein, S., & Inzlicht, M. (2005). Arousal and stereotype threat. *Journal of Experimental Social Psychology, 41*(2), 174–181.

Böhm, R., Rusch, H., & Baron, J. (2018). The psychology of intergroup conflict: A review of theories and measures. *Journal of Economic Behavior and Organization*. https://doi.org/10.1016/j.jebo.2018.01.020

Borrell, L. N., Roux, A. V. D., Jacobs, D. R., Jr., Shea, S., Jackson, S. A., Shrager, S., & Blumenthal, R. S. (2010). Perceived racial/ethnic discrimination, smoking and alcohol consumption in the Multi-Ethnic Study of Atherosclerosis (MESA). *Preventive Medicine, 51*(3–4), 307–312.

Brondolo, E., Brady Ver Halen, N., Pencille, M., Beatty, D., Contrada, R. J., et al. (2009). Coping with racism: A selective review of the literature and a theoretical and methodological critique. *Journal of Behavioral Medicine, 32*(1), 64–88. https://doi.org/10.1007/s10865-008-9193-0

Calogero, R. M., & Jost, J. T. (2011). Self-subjugation among women: Exposure to sexist ideology, self-objectification, and the protective function of the need to avoid closure. *Journal of Personality and Social Psychology, 100*(2), 211–228.

Carter, R. T. (2007). Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress. *The Counseling Psychologist, 35*(1), 13–105.

Catalyst. (2016). *Quick Take: Women of color in the United States*. New York, NY: Author.

Center for the American Woman and Politics. (2018). *Fact sheet: Women in elective office 2018*. New Brunswick, NJ: Rutgers University.

Cochran, S. D., & Mays, V. M. (2009). Burden of psychiatric morbidity among lesbian, gay, and bisexual individuals in the California Quality of Life Survey. *Journal of Abnormal Psychology, 118*(3), 647–658.

Cochran, S. D., Mays, V. M., Alegria, M., Ortega, A. N., & Takeuchi, D. (2007). Mental health and substance use disorders among Latino and Asian American lesbian, gay, and bisexual adults. *Journal of Consulting and Clinical Psychology, 75*(5), 785–794.

Cochran, S. D., Sullivan, J. G., & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology, 71*(1), 53–61.

Coltrane, S. (2000). Research on household labor: Modeling and measuring the social embeddedness of routine family work. *Journal of Marriage and Family, 62*(4), 1208–1233.

Condit, C. M. (2007). How culture and science make race "genetic": Motives and strategies for discrete categorization of the continuous and heterogeneous. *Literature and Medicine, 26*(1), 240–268. *Project MUSE*. https://doi.org/10.1353/lm.2008.0000

Condit, C. M. (2008). Race and genetics from a modal materialist perspective. *Quarterly Journal of Speech, 94*(4), 383–406.

Council on American-Islamic Relations. (2005). *The status of Muslim Civil Rights in the United States: Unequal protection*. Washington, DC: Author.

Crandall, C. S., & Eshleman, A. (2003). A justification-suppression model of the expression and experience of prejudice. *Psychological Bulletin, 129*(3), 414.

Crandall, C. S., & Stangor, C. (2005). Conformity and prejudice. In J. F. Dovidio, P. Glick, & L. A. Rudman (Eds.), *On the nature of prejudice: Fifty years after Allport*. Malden, MA: Blackwell Publishing.

Dagnan, D., & Waring, M. (2004). Linking stigma to psychological distress: Testing a social–cognitive model of the experience of people with intellectual disabilities. *Clinical Psychology and Psychotherapy: An International Journal of Theory and Practice, 11*(4), 247–254.

Dardenne, B., Dumont, M., & Bollier, T. (2007). Insidious dangers of benevolent sexism: Consequences for women's performance. *Journal of Personality and Social Psychology, 93*(5), 764–779.

Davis, A. Y. (2016). *Freedom is a constant struggle: Ferguson, Palestine, and the foundations of a movement*. Chicago, IL: Haymarket Books.

Defense Advisory Committee on Women in the Services. (2018). *Defense Advisory Committee on Woman in the Service 2018 Annual Report*. (Report No. 8-1A20B83). Washington, DC: U.S. Department of Defense.

DeLoach, C. P. (1994). Attitudes toward disability: Impact on sexual development and forging of intimate relationships. *Journal of Applied Rehabilitation Counseling, 25*(1), 18–25.

DeSalle, R., & Ian Tattersall, I. (2018). *Troublesome science: The misuse of genetics and genomics in understanding race*. New York, NY: Columbia University Press.

Devine, P. G., Forscher, P. S., Austin, A. J., & Cox, W. T. L. (2012). Long-term reduction in implicit race bias: A prejudice habit-breaking intervention. *Journal of Experimental Social Psychology, 48*(6), 1267–1278.

Dixon, J., Levine, M., Reicher, S., & Durrheim, K. (2012). Beyond prejudice: Are negative evaluations the problem and is getting us to like one another more the solution? *Behavioral and Brain Sciences, 35*, 411–466. https://doi.org/10.1017/S0140525X11002214

Duckitt, J. H. (1992). Psychology and prejudice: A historical analysis and integrative framework. *American Psychologist, 47*(10), 1182.

Duckitt, J. (2015). Authoritarian personality. In J. D. Wright (Ed.), *International encyclopedia of the social & behavioral sciences 2*(2), 255–261. Oxford, EN: Elsevier.

Edgell, P., Gerteis, J., & Hartmann, D. (2006). Atheists as "other": Moral boundaries and cultural membership in American society. *American Sociological Review, 71*(2), 211–234.

Edwards, F., Lee, H., & Esposito, M. (2019). Risk of being killed by police use of force in the United States by age, race–ethnicity, and sex. *PNAS, 116*(34), 16793–16798

Fitzgerald, L. F. (1993). Sexual harassment: Violence against women in the workplace. *American Psychologist, 48*(10), 1070–1076.

Ford, D. Y., Scott, M. T., Moore, J. L., & Amos, S. O. (2013). Gifted education and culturally different students: Examining prejudice and discrimination via microaggressions. *Gifted Child Today, 36*(3), 205–208.

Forscher, P. S., Cox, W. T. L., Graetz, N., & Devine, P. G. (2015). The motivation to express prejudice. *Journal of Personality and Social Psychology, 109*(5), 791–812.

Forscher, P. S., & Devine, P. G. (2016). The role of intentions in conceptions of prejudice: An historical perspective. In T. D. Nelson (Ed.), *Handbook of prejudice, stereotyping, and discrimination* (2nd ed., pp. 241–254). New York, NY: Psychology Press.

Garth, T. R. (1925). A review of racial psychology. *Psychological Bulletin, 22*(6), 343–364.

Garth, T. R. (1930). A review of race psychology. *Psychological Bulletin, 27*(5), 329–356.

Gilman, S. E., Cochran, S. D., Mays, V. M., Hughes, M., Ostrow, D., & Kessler, R. C. (2001). Risk of psychiatric disorders among individuals reporting same-sex sexual partners in the National Comorbidity Survey. *American Journal of Public Health, 91*(6), 933–939.

Ginder, S. A., Kelly-Reid, J. E., & Mann, F. B. (2018). *Postsecondary Institutions and Cost of Attendance in 2017–2018; Degrees and Other Awards Conferred, 2016–2017; and 12-Month Enrollment, 2016–2017.* (Report No. NCES 2018060REV). Washington, DC: U.S. Department of Education.

Glick, P., & Fiske, S. T. (1996). The ambivalent sexism inventory: Differentiating hostile and benevolent sexism. *Journal of Personality and Social Psychology, 70*(3), 491–512.

Greenwald, A. G., & Banaji, M. R. (1995). Implicit social cognition: Attitudes, self-esteem, and stereotypes. *Psychological Review, 102*(1), 4–27.

Greenwald, A. G., McGhee, D. E., & Schwartz, J. L. (1998). Measuring individual differences in implicit cognition: The implicit association test. *Journal of Personality and Social Psychology, 74*(6), 1464–1480.

Hall, A. V., Hall, E. V., & Perry, J. L. (2016). Black and blue: Exploring racial bias and law enforcement in the killings of unarmed black male civilians. *American Psychologist, 71*(3), 175–186.

Hall, D. L., Matz, D. C., & Wood, W. (2010). Why don't we practice what we preach? A meta-analytic review of religious racism. *Personality and Social Psychology Review, 14*(1), 126–139.

Haller, B. A. (2010). *Representing disability in an ableist world: Essays on mass media*. Louisville, KY: The Advocado Press.

Hays, P. A. (2008). Addressing cultural complexities in practice: A framework for clinicians and counselors (2nd ed.). Washington DC: American Psychological Association.

Harpur, P. D. (2014). Combating prejudice in the workplace with contact theory: The lived experiences of professionals with disabilities. *Disability Studies Quarterly, 34*(1), 17.

Henry, F., & Tator, C. (1994). The ideology of racism: "Democratic racism." *Canadian Ethnic Studies, 26*(2), 1–14.

Herek, G. M. (2000). The psychology of sexual prejudice. *Current Directions in Psychological Science, 9*(1), 19–22.

Herrero, J., Rodríguez, F. J., & Torres, A. (2017). Acceptability of partner violence in 51 societies: The role of sexism and attitudes toward violence in social relationships. *Violence Against Women, 23*(3), 351–367.

Herrnstein, R. J., & Murray, C. (1994). *The bell curve: Intelligence and class structure in American life*. New York, NY: Free Press.

Hochschild, A., & Machung, A. (1989). *The second shift: Working parents and the revolution at home*. New York, NY: Viking.

Hofmann, W., Gawronski, B., Gschwendner, T., Le, H., & Schmitt, M. (2005). A meta-analysis on the correlation between the implicit association test and explicit self-report measures. *Personality and Social Psychology Bulletin, 31*(10), 1369–1385.

Houtenville, A. J., & Ruiz, T. (2012). *2012 annual disability statistics compendium*. Durham, NH: University of New Hampshire Institute on Disability.

Huebner, D. M., & Davis, M. C. (2007). Perceived antigay discrimination and physical health outcomes. *Health Psychology, 26*(5), 627–634.

Ibish, H., & ADC Research Institute., & American-Arab Anti-Discrimination Committee. (2003). *Report on hate crimes and discrimination against Arab Americans: The post September 11 backlash, September 11, 2001 – October 11, 2002*. Washington, DC: American-Arab Anti-Discrimination Committee.

Inter-American Commission on Human Rights. (2018). *African Americans, police use of force, and human rights in the United States*. Washington, D.C.: Organization of American States.

Jorm, A. F., Korten, A. E., Rodgers, B., Jacomb, P. A., & Christensen, H. (2002). Sexual orientation and mental health: Results from a community survey of young and middle–aged adults. *The British Journal of Psychiatry, 180*(5), 423–427.

Jost, J. T., & Hunyady, O. (2002). Antecedents and consequences of system-justifying ideologies. *Current Directions in Psychological Science, 14*(5), 260–265.

Keller, R. M., & Galgay, C. E. (2010). Microaggressive experiences of people with disabilities. In D. W. Sue (Ed.), *Microaggressions and marginality: Manifestation, dynamics, and impact* (pp. 241–268). Hoboken, NJ: Wiley.

Kendi, I. X. (2016). *Stamped from the beginning: The definitive history of racist ideas in America*. New York, NY: Nation Books.

Kendi, I. X. (2019). How to be an antiracist. New York, NY: One World.

Kteily, N., Bruneau, E., Waytz, A., & Cotterill, S. (2015). The ascent of man: Theoretical and empirical evidence for blatant dehumanization. *Journal of Personality and Social Psychology, 109*(5), 901–931.

Kurdi, B., Seitchik, A. E., Axt, J. R., Carroll, T. J., Karapetyan, A., Kaushik, N., ... Banaji, M. R. (2019). Relationship between the Implicit Association Test and intergroup behavior: A meta-analysis. *American Psychologist, 74*(5), 569–586.

Kuchynka, S.L., Salomon, K., Bosson, J.K., El-Hout, M., Kiebel, E., Cooperman, C., & Toomey, R. (2018). Hostile and benevolent sexism and college women's STEM outcomes. *Psychology of Women Quarterly, 42*(1), 72–87.

Lajevardi, N., & Oskooii, K. A. (2018). Old-fashioned racism, contemporary islamophobia, and the isolation of Muslim Americans in the age of Trump. *Journal of Race, Ethnicity and Politics, 3*(1), 112–152.

Lee, D. B., Kim, E. S., & Neblett, E. W., Jr. (2017). The link between discrimination and telomere length in African American adults. *Health Psychology, 36*(5), 458–467.

Legge, M. M., Flanders, C. E., & Robinson, M. (2018). Young bisexual people's experiences of microaggression: Implications for social work. *Social Work in Mental Health, 16*(2), 125–144.

Leone, P. E., Mayer, M. J., Malmgren, K., & Meisel, S. M. (2000). School violence and disruption: Rhetoric, reality, and reasonable balance. *Focus on Exceptional Children, 33*(1), 1–20.

Lewis, J. A., & Neville, H. A. (2015). Construction and initial validation of the Gendered Racial Microaggressions Scale for Black women. *Journal of Counseling Psychology, 62*(2), 289–302.

Lillis, J., & Hayes, S. C. (2007). Applying acceptance, mindfulness, and values to the reduction of prejudice. A pilot study. *Behavior Modification, 31*(4), 389–411.

Massey, S. G., Merriwether, A. M., & Garcia, J. R. (2013). Modern prejudice and same-sex parenting: Shifting judgments in positive and negative parenting situations. *Journal of GLBT Family Studies, 9*(2), 129–151.

McCaughey, T. J., & Strohmer, D. C. (2005). Prototypes as an indirect measure of attitudes toward disability groups. *Rehabilitation Counseling Bulletin, 48*(2), 89–99.

McNeilly, M. D., Anderson, N. B., Armstead, C. A., Clark, R., Corbett, M., Robinson, E. L., … Lepisto, E. M. (1996). The perceived racism scale: A multidimensional assessment of the experience of white racism among African Americans. *Ethnicity and Disease, 6*, 154–166.

Merriam-Webster. (2019) *Miraim-Webster.com dictoionary*. Retreived July 24, 2018 from http://www.merriam-webster.com/

Miller, K., & Vagins, D. J. (2018). *The simple truth about the gender pay gap: Fall 2018 edition*. Washington, DC: AAUW.

Morris, J. (1991). *Pride against prejudice: Transforming attitudes to disability*. London, UK: The Women's Press.

Mulick, P. S., & Wright, L. W., Jr. (2002). Examining the existence of biphobia in the heterosexual and homosexual populations. *Journal of Bisexuality, 2*(4), 45–64.

Museus, S. D., & Park, J. J. (2015). The continuing significance of racism in the lives of Asian American college students. *Journal of College Student Development, 56*(6), 551–569.

Nadal, K. L. (2011). The racial and ethnic microaggressions scale (REMS): Construction, reliability, and validity. *Journal of Counseling Psychology, 58*(4), 470–480.

Nadal, K. L., Davidoff, K. C., Davis, L. S., Wong, Y., Marshall, D., & McKenzie, V. (2015). A qualitative approach to intersectional microaggressions: Understanding influences of race, ethnicity, gender, sexuality, and religion. *Qualitative Psychology, 2*(2), 147–163.

Nadal, K. L., Griffin, K. E., Hamit, S., Leon, J., Tobio, M., & Rivera, D. P. (2012). Subtle and overt forms of Islamophobia: Microaggressions toward Muslim Americans. *Journal of Muslim Mental Health, 6*(2), 15–37.

Nadal, K. L., Issa, M., Griffin, K. E., Hamit, S., & Lyons, O. B. (2010). Religious microaggressions in the United States: Mental health implications for religious minority groups. In D. W. Sue (Ed.), *Microaggressions and marginality: Manifestation, dynamics, and impact* (pp. 287–310). Hoboken, NJ: Wiley.

Nadal, K. L., Mazzula, S. L., Rivera, D. P., & Fujii-Doe, W. (2014). Microaggressions and Latina/o Americans: An analysis of nativity, gender, and ethnicity. *Journal of Latina/o Psychology, 2*(2), 67–78.

Nadal, K. L., Whitman, C. N., Davis, L. S., Erazo, T., & Davidoff, K. C. (2016). Microaggressions toward lesbian, gay, bisexual, transgender, queer, and genderqueer people: A review of the literature. *The Journal of Sex Research, 53*(4–5), 488–508.

Nadal, K. L., Wong, Y., Griffin, K. E., Davidoff, K., & Sriken, J. (2014). The adverse impact of racial microaggressions on college students' self-esteem. *Journal of College Student Development, 55*(5), 461–474.

Nadler, J. T., & Clark, M. H. (2011). Stereotype threat: A meta-analysis comparing African Americans to Hispanic Americans. *Journal of Applied Social Psychology, 41*(4), 872–890.

National Council on Crime and Delinquency. (2007). *And justice for some: Differential treatment of youth of color in the justice system*. Oakland, CA: Author. Retrieved from http://www.nccdglobal.org/sites/default/files/publication_pdf/justicefor-some.pdf

Nguyen, H. H. D., & Ryan, A. M. (2008). Does stereotype threat affect test performance of minorities and women? A meta-analysis of experimental evidence. *Journal of Applied Psychology, 93*(6), 1314–1334.

Okoro, C. A., Hollis, N. D., Cyrus, A. C., & Griffin-Blake, S. (2018). Prevalence of disabilities and health care access by disability status and type among adults — United States, 2016. *Morbidity and Mortality Weekly Report, 67*, 882–887. https://doi.org/10.15585/mmwr.mm6732a3externalicon

Oswald, F. L., Mitchell, G., Blanton, H., Jaccard, J., & Tetlock, P. E. (2013). Predicting ethnic and racial discrimination: A meta-analysis of IAT criterion studies. *Journal of Personality and Social Psychology, 105*(2), 171–192.

Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., & Pieterse, A. (2015). Racism as a determinant of health: A systematic review and meta-analysis. *PLoS One, 10*(9), 1–48. https://doi.org/10.1371/journal.pone.0138511

Peters, H. J., Schwenk, H. N., Ahlstrom, Z. R., & McIalwain, L. N. (2017). Microaggressions: The experience of individuals with mental illness. *Counselling Psychology Quarterly, 30*(1), 86–112.

Pietrse, A. L., Todd, N. R., Neville, H. A., & Carter, R. T. (2012). Perceived racism and mental health among Black American adults: A meta-analytic review. *Journal of Counseling Psychology, 59*(1), 1–9.

Plant, E. A., & Devine, P. G. (1998). Internal and external motivation to respond without prejudice. *Journal of Personality and Social Psychology, 75*(3), 811–832.

Pratto, F., Sidanius, J., Stallworth, L. M., & Malle, F. (1994). Social dominance orientation: A personality variable predicting social and political attitudes. *Journal of Personality and Social Psychology, 67*(4), 741–763.

Paradies, Y. (2018). Racism and indigenous health. Retrieved July 2019 from https://oxfordre.com/publichealth/view/10.1093/acrefore/9780190632366.001.0001/acrefore-9780190632366-e-86

Rivera, D. P., Forquer, E. E., & Rangel, R. (2010). Microaggressions and the life experience of Latina/o Americans. In D. W. Sue (Ed.), *Microaggressions and marginality: Manifestation, dynamics, and impact* (pp. 59–83). Hoboken, NJ: Wiley.

Robin, L., Brener, N. D., Donahue, S. F., Hack, T., Hale, K., & Goodenow, C. (2002). Associations between health risk behaviors and opposite-, same-, and both-sex sexual partners in representative samples of Vermont and Massachusetts high school students. *Archives of Pediatrics and Adolescent Medicine, 156*(4), 349–355.

Sadler, M. S., Correll, J., Park, B., & Judd, C. M. (2012). The world is not black and white: Racial bias in the decision to shoot in a multiethnic context. *Journal of Social Issues, 68*(2), 286–313.

Salvatore, J., & Shelton, J. N. (2007). Cognitive costs of exposure to racial prejudice. *Psychological Science, 18*(9), 810–815.

Sandfort, T. G., de Graaf, R., Bijl, R. V., & Schnabel, P. (2001). Same-sex sexual behavior and psychiatric disorders: Findings from the Netherlands Mental Health Survey and Incidence Study (NEMESIS). *Archives of General Psychiatry, 58*(1), 85–91.

Sarno, E., & Wright, A. J. (2013). Homonegative microaggressions and identity in bisexual men and women. *Journal of Bisexuality, 13*(1), 63–81.

Sartore, M. L., & Cunningham, G. B. (2009). Gender, sexual prejudice and sport participation: Implications for sexual minorities. *Sex Roles, 60*(1–2), 100–113.

Sibley, C. G., & Duckitt, J. (2008). Personality and prejudice prejudice: A meta-analysis and theoretical review. *Personality and Social Psychology Review, 12*(3), 248–279.

Scarville, J., Button, S. B., Edwards, J. E., Lancaster, A. R., & Elig, T. W. (1999). *Armed forces equal opportunity survey*. Arlington, VA: Defense Manpower Data Center.

Schur, L., & Adya, M. (2012). Sidelined or mainstreamed? Political participation and attitudes of people with disabilities in the United States. *Social Science Quarterly, 94*(3), 811–839.

Schur, L., Adya, M., & Kruse, D. (2013). *Disability, voter turnout, and voting difficulties in the 2012 elections*. Washington, DC: U.S. Election Assistance Commission.

Schuster, M. A., Reisner, S. L., & Onorato, S. E. (2016). Beyond bathrooms—Meeting the health needs of transgender people. *New England Journal of Medicine, 375*(2), 101–103.

Shaver, J. H., Troughton, G., Sibley, C. G., & Bulbulia, J. A. (2016). Religion and the unmaking of prejudice toward Muslims: Evidence from a large national sample. *PLoS One, 11*(3). https://doi.org/10.1371/journal.pone.0150209

Sherif, M. (1966). *In common predicament: Social psychology of intergroup conflict and cooperation*. Boston, MA: Houghton Mifflin.

Sherif, M., Harvey, O. J., White, B. J., Hood, W. R., & Sherif, C. W. (1961). *Intergroup conflict and cooperation: The Robbers Cave experiment*. Middletown, PA: Wesleyan University Press.

Sherif, M., & Sherif, C. W. (1953). *Groups in harmony and tension: An integration of studies on intergroup relations*. New York, NY: Harper.

Sides, J., & Gross, K. (2013). Stereotypes of Muslims and support for the war on terror. *The Journal of Politics, 75*(3), 583–598.

Sims, M., Diez-Roux, A. V., Gebreab, S. Y., Brenner, A., Dubbert, P., Wyatt, S., … Taylor, H. (2016). Perceived discrimination is associated with health behaviours among African-Americans in the Jackson Heart Study. *Journal of Epidemiology and Community Health, 70*(2), 187–194.

Smith, P., Caputi, P., & Crittenden, N. (2012). How are women's glass ceiling beliefs related to career success? *Career Development International, 17*(5), 458–474.

Steele, C. M. (1997). A threat in the air: How stereotypes shape intellectual identity and performance. *American Psychologist, 52*(6), 613–629.

Steele, C. M., & Aronson, J. (1995). Stereotype threat and the intellectual test performance of African Americans. *Journal of Personality and Social Psychology, 69*(5), 797–811.

Stephan, W. S., & Stephan, C. W. (2000). An integrated threat theory of prejudice. In S. Oskamp (Ed.), *Reducing prejudice and discrimination* (pp. 23–46). Mahwah, NJ: Lawrence Erlbaum Associates.

Stockard, J., & Johnson, M. M. (1992). *Sex and gender in society* (2nd ed.). Englewood Cliffs, NJ: Prentice Hall.

Sue, D. W., & Capodilupo, C. M. (2008). Racial, gender, and sexual orientation microaggressions: Implications for counseling and psychotherapy. In D. W. Sue & D. Sue (Eds.), *Counseling the culturally diverse: Theory and practice* (5th ed., pp. 105–130). Hoboken, NJ: Wiley.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62*(4), 271–286.

Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. In W. G. Austin & S. Worchel (Eds.), *The social psychology of intergroup relations* (pp. 33–37). Monterey, CA: Brooks/Cole.

Tajfel, H., & Turner, J. C. (1986). The social identity theory of intergroup behavior. In S. Worchel & W. G. Austin (Eds.), *Psychology of intergroup relation* (pp. 7–24). Chicago, IL: Hall Publishers.

Thomas, R., Yee, L., Cooper, M., Krivkovich, A., Konar, H., Starikova, I., … Robinson, N. (2018). *Women in the workplace 2018*. New York, N.Y.: LeanIn.Org and McKinsey & Company.

Toomey, J. F. (1993). Final report of the Bawnmore personal development programme: Staff attitudes and sexuality programme development in an Irish service organization for people with mental handicap. *Research in Developmental Disabilities, 14*(2), 129–144.

Torres, L., Driscoll, M. W., & Burrow, A. L. (2010). Racial microaggressions and psychological functioning among highly achieving African-Americans: A mixed-methods approach. *Journal of Social and Clinical Psychology, 29*(10), 1074–1099.

Utsey, S. O., Giesbrecht, N., Hook, J., & Stanard, P. M. (2008). Cultural, sociofamilial, and psychological resources that inhibit psychological distress in African Americans exposed to stressful life events and race-related stress. *Journal of Counseling Psychology, 55*(1), 49–62.

Utsey, S. O., & Ponterotto, J. G. (1996). Development and validation of the Index of Race-Related Stress (IRRS). *Journal of Counseling Psychology, 43*(4), 490–501.

Walton, G. M., & Spencer, S. J. (2009). Latent ability: Grades and test scores systematically underestimate the intellectual ability of negatively stereotyped students. *Psychological Science, 20*(9), 1132–1139.

Washington, H. A. (2007). *Medical apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present*. New York, NY: Doubleday.

Werner, S. (2015). Public stigma in intellectual disability: Do direct versus indirect questions make a difference? *Journal of Intellectual Disability Research, 59*(10), 958–969.

Woodford, M. R., Howell, M. L., Silverschanz, P., & Yu, L. (2012). "That's so gay!": Examining the covariates of hearing this expression among gay, lesbian, and bisexual college students. *Journal of American College Health, 60*(6), 429–434.

Woodworth, R. S. (1916). The comparative psychology of races. *Psychological Bulletin, 13*(10), 388–397.

Zablotsky, B., Black, L. I., Maenner, M. J., Schieve, L. A., & Blumberg, S. J. (2015). *Estimated prevalence of autism and other developmental disabilities following questionnaire changes in the 2014 National Health Interview Survey.* (Report No. 87). Hyattsville, MD: National Center for Health Statistics.

Prejudice, Stigma, Privilege, and Oppression Regarding African Americans

Lindsey M. West

Abstract

This chapter includes current scientific information about African Americans' experience of oppression and prejudice. This chapter also critically examines the ways in which the profession of psychology has responded to the oppression and prejudice that African Americans experience. Further, the ways in which clinical psychologists ought to conceptualize and respond to the prejudice and oppression that African American (clients) experience will be explored. Moreover, an examination of the possible role of prejudice and oppression in our institutional structures such as the DSM and our professional organizations as it pertains to African Americans will be shared as it relates to its possible impact on the role of prejudice and oppression in the mental health status of African Americans. Finally, this chapter includes a discussion on African Americans in the profession of psychology and the ways in which prejudice and oppression can also impact the treating professional.

Keywords

Prejudice · Oppression · African Americans

Experiences of Oppression and Prejudice Among African Americans

President Barack Obama's remarkable win over John McCain on the evening of November 4, 2008, marked a historic moment in American history and African-American history. Undoubtedly, President Barack Obama had broken a once formidable "racial barrier" with his calls for hope and change. Though this broken "racial barrier" evoked jubilance among African Americans, it was also being used by some pundits as proof that we were becoming (or already are) a society where race no longer matters and racism is a thing of the past (CNN, 2008). Unfortunately, the experiences of many African Americans challenge this assertion. For example, within this millennium, alone, we have witnessed African-American children in Philadelphia being told that they would negatively "change the complexion" of a predominately White swim club (CNN, 2009) and we witnessed a prominent African-American Harvard professor arrested in his own home (CNN, 2009). Nationally representative polls confirm these feelings, with 88% of African Americans reporting that they experience racism and that 87% characterize racism as a "very serious" or "serious problem." In addition, 78% of African Americans perceive racism as being "widespread" in the United States (CNN, 2008; Pew Research Study, 2013).

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L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_4

Fast forward to 2013, the international, activist movement, better known as Black Lives Matter, was developed and propelled into action. The hashtags #BlackLivesMatter or #BLM created a swelling of the wounds of racism that poured out onto social media outlets. Now, BLM was not just a movement for social media protest. BLM's founders, Alicia Garza, Patrisse Cullors, and Opal Tometi called to action a series of nonviolent protests and street demonstrations in response to George Zimmerman's acquittal of the shooting of Trayvon Martin. Unfortunately, BLM's struggles for social justice and moments for healing were tested and continuously infected by the frequency of African-American deaths by police that seem to happen in succession. Given the depth of racism's wounds, BLM has even expanded its efforts in light of the political climate to include a policy for comprehensive police and criminal justice reform, economic investment in Black communities, voter rights, and other intersectional considerations for individuals who identify as Black and who also have other oppressed identities including identifying as Black and Muslim, Black and LGBT, Black and female, Black and trans, to name a few (Mother Jones Magazine, 2017). From experiences of racial slights (i.e., racial microaggressions) to tragedies of violence due to racism, it is clear that the United States has yet to achieve its *aspiration* of a postracial society and that racism continues to remain a problem.

Understanding Racism from a Psychological Perspective

Racism as a System

Experience of oppression among African Americans is often best known as, or operationalized as, racism. Of course, oppression can be a form of socioeconomic status, health disparities, educational achievement gaps, and inaccessibility to clean water or aid in the face of crisis; however, given the insidious nature of racism, these aforementioned examples may be symptoms or proxies to a larger, system-wide, institutional problem – the problem of racism.

In the psychological literature, racism has been conceptualized as "beliefs, attitudes, institutional arrangements, and acts that…denigrate individuals or groups because of phenotypic characteristics or ethnic group affiliation" (Clark, Anderson, Clark, & Williams, 1999, p. 805). Racism results from "the transformation of race prejudice and/or ethnocentrism through the exercise of power against a racial group defined as inferior, by individuals and institutions with the intentional and unintentional support of the entire culture" (Jones, 1997, p. 172). Racism extends beyond the construct of prejudice, which is defined as "positive or negative attitudes, judgments, or feelings about a person that is generalized from attitudes or beliefs held about the group to which the person belongs" (Jones, 1997, p. 10). Racism is differentiated into three important ways: (1) there is the underlying assumption that racialized group characteristics are biologically constructed, (2) there is an assumption of racial superiority, and (3) there is a rationalization and formalization of hierarchical domination of certain racial groups. Given this, racism has also been conceptualized, as a "system of dominance, power, and privilege based on racial group designation" (Harrell, 2000, p. 43). The system of racism is rooted in a history of oppression that is maintained by dominant groups and by those with societal privilege. In fact, it is such a complex system that it often manifests itself in different types of contexts (e.g., institutional, interpersonal/personally mediated, and internalized; Jones, 2000) and in different forms (e.g., overt or covert; Jones, 1997).

Jones (2000) proposes that the first level of this framework is institutionalized racism which refers to a structure that maintains barriers between disadvantaged groups and groups advantaged by unearned privilege. These barriers between advantaged and disadvantaged groups are evident in societal disparities with regard to access of goods, services, and opportunities. The next level of racism is personally mediated racism, which is defined as prejudice and discrimination. These personally mediated acts of racism are such acts, whether intentional or not, that reflect an individual's differential behavior (e.g., lack of respect, suspicion, devaluation, and purse clutching) toward particular groups of people (Jones, 2000). The last level of racism, as described by C. Jones, is internalized racism which refers to a belief and acceptance by individuals in marginalized races in the negative messages (e.g., messages of inferiority, messages of abnormality) that are perpetuated by others and, therefore, become condoned within the marginalized group. As a result, these messages can erode individuals' senses of self, leading to negative internalizations and beliefs about what it means to be Black in America.

Racism and the Individual

In the United States context, racial discrimination against Black individuals has undergone dramatic changes in the last 60 years. Because of the Civil Rights Act and the changing social mores, the once common overt acts of racial discrimination (e.g., actively preventing neighborhood integration, rights to vote) have dramatically declined (Jones, 1997). Nevertheless, racial discrimination continues to be a significant part of Black individuals' lives, although subtler in nature. These subtle forms of racial discrimination often occur in the form of slights from strangers or service providers, through job hiring practices, through disparities in health care, and through gaps in income (Sue et al., 2007).

Even though there has been a decline in overt racial discriminatory behavior, there has been a simultaneous increase in subtler racial discriminatory behavior (Sue et al., 2007). All these subtler forms of racial discrimination have been termed modern racism (McConahay, 1986), aversive racism (Dovidio, Gaertner, Kawakami, & Hodson, 2002), and symbolic racism (Sears, 1988). Symbolic racism (Sears, 1988) is a "pull yourself up by your bootstraps" mentality where White individuals continue to express anti-Black attitudes and strong endorsements of traditional US values and mores. Modern racism (McConahay, 1986) refers to the phenomenon where White individuals may not have considered themselves racist, but they were often found verbally expressing negative "facts" about Black individuals, for example, that Black individuals are demanding and attention-seeking individuals. Aversive racism (Gaertner & Dovidio, 1986) refers to an ambivalence among White individuals who held negative affective reactions toward individuals based on race, even while they consciously professed or desired to not be racist. All these conceptualizations emphasize the indirect and unintentional nature of this new racism that is rooted in ambivalent attitudes toward racial and ethnic minorities (Schneider, 2004).

More recently, these new forms of subtle racial discrimination have also been conceptualized as racial microaggressions. Sue and colleagues (Sue et al., 2007; Sue, Capodilupo, & Holder, 2008) have recently brought attention to the concept of racial microaggressions by examining the manifestation and effects of these daily hassles and daily slights on Black American individuals. However, Sue et al. (2007) were not the first to introduce the field to the topic of racial microaggressions. Pierce, Carew, Pierce-Gonzalez, and Willis (1978) had begun to conceptualize "racial microaggressions" many years before with the help of James Jones's legendary scholarship (1997) on concepts of micro-level manifestations of racial bias and racial discrimination. Historically, micro-level insults were prevalent in the United States in the 1980s when many White individuals perpetuated the belief that race relations were stably positive and that there was no longer a racial divide in this country.

Sue et al. (2007) define racial microaggressions as "brief, everyday exchanges that send denigrating messages to people of color because they belong to a racial minority group" (Sue et al., 2007, p. 273). Microaggressions are often unconsciously delivered in the form of "subtle snubs or dismissive looks, gestures, and tones" (p. 273). Sue et al. (2007) state that racial microaggressions can occur in three forms: as microassaults, as microinsults, and as microinvalidations. Microassaults are often conscious, often explicit, verbal or nonverbal racial derogations that are intended to hurt the targeted individual. Microinsults are often unconscious behavioral or verbal remarks that reflect a racial or cultural insensitivity to the targeted individual. Last, microinvalidations are often unconscious, behavioral/verbal comments that have the effect of excluding and invalidating the feelings and experiences of individuals from racial and ethnic minority groups. All these forms of racial microaggressions are experienced by Black Americans on a persistent basis (Sue et al., 2007).

Whether overt or subtle, evidence suggests significant psychological and physiological costs associated with persistent experiences of racism. Early psychological investigations on the effects of racism on health first proposed that Black individuals were more susceptible to psychological distress compared to White individuals (Breslau, Aguilar-Gaxiola, Kendler, Su, Williams, & Kessler, 2005). However, more recent data from the National Comorbidity study (NCS) suggest that Black individuals are not necessarily more susceptible to psychological distress; instead, differences relate to the fact that Black individuals who experience psychological symptoms tend to suffer longer and more severely than their White counterparts (Breslau, Kendler, Su, Gaxiola-Aguilar, & Kessler, 2006). Interestingly, based on the Kessler et al., (1994) sample of 8098 African Americans (gender and biological sex not reported), Diala, Muntaner, Walrath, Nickerson, LaVeist, & Leaf (2001) found that African Americans reported more positive attitudes toward seeking mental health services than Whites, suggesting that there is something beyond help seeking that is affecting these data. Since experiences of oppressive events have been previously linked to negative health and mental health outcomes, it is important to examine the factors that may influence these relationships (Clark et al., 1999; Fang & Myers, 2001; Krieger & Sidney, 1996; Slavin et al., 1991).

Experiences of racism have been characterized as a determinant of health (Paradies, 2006). In studies where racial stressors specific to Black individuals were examined using Black samples, experiences of racism were found to be negatively associated with Black individuals' cardiovascular health (Harrell, Hall, & Taliaferro, 2003), psychological well-being (Barnes & Lightsey, 2005; Williams & Williams-Morris, 2000), and self-esteem (Broman, 1997; Jackson et al., 1995; Utsey, Ponterotto, Reynolds, & Cancelli, 2000) and positively associated with hostility, somatic complaints (Steffen, McNeilly, Anderson, & Sherwood, 2003), anxiety, and depression (Landrine & Klonoff, 1996). With respect to health disparities, African Americans experience disproportionate rates of morbidity and mortality as compared to European Americans for cardiovascular disease, adverse birth outcomes, obesity, and diabetes (Giscombé & Lobel, 2005; Smedley, Stith, & Nelson, 2002; Sternthal, Slopen, & Williams, 2011; Williams, Mohammed, Leavell, & Collins, 2010). In addition, racism-related stress exposure has been found to impact stress appraisal, coping, oxidative stress, cortisol, C-reactive protein, lower resting heart rate variability, which is an indication of lower resilience and higher stress, and higher allostatic load (i.e., biological dysregulation; Woods-Giscombé & Gaylord, 2014; Braveman, Egerter, & Williams, 2011; Merritt, McCallum, & Fritsch, 2011; Lewis, Aiello, Leurgans, Kelly, & Barnes, 2010; Hill et al., 2017; Ong, Williams, Nwizu, & Gruenewald, 2017). Taken together, these findings raise the possibility that experiences of racism may be a unique stressor that impacts the ability of African Americans to function optimally.

Theoretical Models of Racism and Stress

Clark et al. (1999) articulated one of the first comprehensive, theoretical models of racism in Black Americans to better understand the distinction between perceived racial discrimination and racism-related stress and potential contributing factors in this relationship. They used Bronfenbrenner's (2000) bioecological model and Lazarus and Folkman's (1984) transactional model of stress and coping as a basis for their cultural-ecological perspective. As an expansion upon these models, Clark et al. (1999) asserted that experiences of racism serve as a stressor for Black Americans and can lead to negative psychological and physiological outcomes. Clark et al. (1999) acknowledged the role of perceived racism, which they define as the "subjective experience[s] of prejudice or discrimination" (p. 808). Perception of racism, however, is not enough to lead to stress; instead, perceived racism works in conjunction with situational appraisal, coping strategies, and personal factors. In fact, the authors proposed that such factors may moderate or mediate the relationship between PRD and racism-related stress. For example, a Black man who receives service only after White individuals who arrived after him are served may interpret this as an oversight, which will likely *not* contribute to a stress response. Interpreting the situation as racist also does not inevitably lead to psychological and physiological distress because the way in which he *relates* to his internal stress response would have an impact on a specific outcome. How he relates to the internal stress response would impact the decisions he makes about the situation (e.g., ignores it, talks to the manager, and leaves) and will influence his psychological and physiological outcomes.

Approximately 1 year later, Harrell (2000) proposed another ecological paradigm in her theoretical model for racism-related stress in order to better understand the complex pathways and experience of racism for people of color. Harrell expanded upon the Clark et al. (1999) model by illustrating a more nuanced review of the forms, the manifestations, the actual experiences of racism, and the ways in which racism's multiple dimensions affect stress in people of color. Though Harrell's model was conceptualized for all people of color, it will be discussed in terms of African-American individuals, specifically.

Harrell (2000), similar to Clark et al. (1999), was interested in understanding individuals' developmental context. Her conceptualization of a developmental context was related to an individual's interpersonal (e.g., direct or indirect interpersonal interactions), collective (e.g., racial disparities at systemic levels), cultural symbolic (e.g., images and media representations), and sociopolitical contexts (e.g., political practices) situated in a system of racism that occurs at individual, institutional, and cultural levels. Harrell (2000) also proposed a variety of external factors (e.g., environment and institutional structures) that impact physical and mental health outcomes. In order to more accurately address the experience of racism and its potential for stress, Harrell coined a multidimensional construct of racism-related stress defined as "race-related transactions between individuals or groups and their environment that emerge from the dynamics of racism, *and that are perceived to tax or exceed existing individual or collective resources or threaten well-being*" (p. 44, italics added).

The construct of racism-related stress allowed for Harrell (2000) to advocate for more in-depth study into the pathways to health for individuals experiencing racism. Given that the nature of the experience of racism is characterized by transactions between the individual and the environment, Harrell was particularly interested in the *internal* moderating factors that play a role in this experience. She notes that an individual's worldview and values are the key factors that provide him with a "sense of meaning…, a framework for decision making…, and an awareness…" (p. 51). Harrell argues that these are critical factors that provide individuals with "the racism-resistant armor needed to build positive well-being" (p. 51). Also, she clearly articulates that internal dilemmas and frameworks for decision-making contribute to an individual's well-being because this is the process in which the individual's internal stress response is the most vulnerable. This is the point at which an individual is determining whether she has perceived an experience of racism correctly or whether she has acquired the necessary proof. The way in which the individual relates to this internal stress response as a result of this uncertainty is critical to her well-being and critical to a reduction in her racism-related stress.

Sue et al. (2007), similar to Harrell (2000), also propose that we do not have a good understanding of why some Black individuals have fewer psychological consequences than others. Similar, to the previous model, Sue and colleagues believe that internal dilemmas and frameworks for decision-making are the factors that impact functional well-being and psychological consequences. To that end, it is likely that the Black individuals experiencing fewer psychological consequences are managing these internal factors in an adaptive way. To explore these internal phenomena, Sue and colleagues put forth a detailed model of the experience of perceiving racism in today's context. Sue et al. wanted to understand the race-related transactions between the individual and the environment. The primary aim of their model was not only to define these contemporary forms of covert racial discrimination, that is, racial microaggressions, but also to discuss the actual experience of perceiving a racial microaggression.

Sue et al. (2007) assert that perceiving racism is a process that begins with the targeted individual asking himself or herself some immediate questions. These questions are: "How can I prove that a microaggression has occurred?" and "If this were a microaggression, do I make the person aware of it?" These questions characterize what Sue and colleagues have termed a "Catch-22." For example, if a Black woman feels as if she is experiencing a racial microaggression from a store clerk who ignores her requests to have a dressing room made available to her, she may relate to this internal stress response by worrying about whether she is overreacting or even by convincing herself, "She must not have heard me or it must be because it is very busy." The result, in cases like the one provided, is that Black Americans often have difficulties relating to internal stress responses that result from potentially racist triggers, therefore, increasing their chances for becoming internally distressed.

In response to Sue et al.'s (2007) own call for future research that explores functioning during the experience of perceiving racial microaggressions, Sue and colleagues (2008) conducted a qualitative investigation to explore the phenomenon of racial microaggressions in the life experience of Black Americans. Specifically, the authors sought to understand the mechanisms involved in the dilemmas and decision-making responses in a sample of Black individuals. Even though there has been research on the frequency of experiences of racism, there has been significantly less research on the process and phenomenon of experiencing racism.

Sue et al. (2008) used a focus group data collection method with a sample of 13 self-identified Black or African-American college students (4 men and 9 women). Utilizing a consensual qualitative research (CQR) methodology for analysis, they extracted and generated a variety of domain themes. First, the researchers proposed that there is a process for how Black individuals handle the "Catch-22" of responding to racial microaggressions. They proposed that a racial incident leads to a perception, to a reaction, to an interpretation, and then to a consequence. Taken together, this process is quite complex.

First, the incident domain refers to the type of racial microaggression. At this stage, Black individuals assess the environment in which the verbal or nonverbal/behavioral incident took place. Second, the perception domain refers to the process of how the individual views the experience. At this stage, Black individuals perceive whether an event is racially motivated or not racially motivated. Individuals who are unable to respond with an immediate "yes" or a "no" may engage in a "questioning" process in order to discern if the incident was racially motivated. During this discerning process, the individual is not likely to simply respond with "yes," "no," or "maybe" to a potentially racist event; instead, the individual's reaction is much more complex.

Third, the reaction/mechanisms domain refers to the complex process of reacting to the racist event. These reactions and mechanisms suggest that there are differences in the ways in which Black individuals respond to racially motivated events. One mechanism is termed "healthy paranoia." Healthy paranoia refers to a necessary suspiciousness in response to the prevalence of racial microaggressions. Another possible mechanism is referred to as "sanity checks." Sanity checks refer to a reaction process where Black individuals look to other Black individuals, such as friends or family members for confirmation that the racial microaggression occurred. An additional mechanism is termed "empowerment."

The empowerment reaction refers to the process of locating the blame and fault in the aggressor instead of placing blame or shame on oneself. The last mechanism is "rescuing offender." This refers to when Black individuals decide to take care of the feelings (i.e., not wanting to make the aggressor feel badly) or consider the intentions (i.e., make excuses for the person's behavior) of the aggressor.

Even though there are many other possible mechanisms and reactions, it became clear in this study that these reactions influenced the ways in which the participants interpreted events. In fact, many of the mechanisms/reactions reported do seem adaptive in nature. However, the "rescuing offender" mechanism is clearly less adaptive. It is possible that individuals who react to racial microaggressions in this way are acting in ways that are not congruent with what is important to them. For example, if a Black individual purposely stands farther away from a White individual in an elevator in order to avoid the possibility that the White individual fears being near him, he is most likely utilizing a tremendous amount of thought and effort for a daily activity that should not require this much attention. This individual may be acting and thinking in ways that serve as constant interruptions and stressors in his life, creating a foreboding internal experience that prevents him from attending to the things in his life that may matter to him. Given this, the "rescuing offender" mechanism reveals that further research is much needed to explore the ways in which Black individuals can feel flexibility and choice for optimal functioning in various situations and contexts where an experience of racism may arise.

Other possible mechanisms and reactions may occur. An individual may react to racial microaggressions with feelings of anger, sadness, or frustration (Sue et al., 2007). These feelings often lead individuals to wonder about the aggressor's perception of them. They may wonder if the aggressor perceives them as a stereotype of a Black American (i.e., intellectually inferior, not trustworthy; Sue, Capodilupo, & Holder, 2008). These types of interpretations, as a result of the levels of racism acting upon the individual, may produce negative psychological consequences (the fourth and final stages in the proposed model). For example, some of the participants in the CQR study reported that they feel powerless, invisible, compliant, and representative of their racial group when they experience perceiving racial microaggressions. Given this, further research that explores these types of interpretations could reveal what may buffer against negative psychological consequences. Nadal, Griffin, Wong, Hamit, and Rasmus (2014) aimed to better understand the relationship between racial microaggressions and mental health consequences. Using Nadal's measure of racial microaggressions, the Racial and Ethnic Microaggressions Scale (REMS), the authors found particular relationships between microaggressions related to being treated like a second-class citizen, microaggressions in which they are invalidated, and microaggressions where they experienced exotification or assumptions of being similar to others in their group to be related to negative mental health symptoms, in particular depression and lack of positive affect (Nadal et al., 2014).

Individuals who often utilize adaptive mechanisms, such as healthy paranoia or sanity checks, may have particular experiences that may buffer potential negative consequences. But what if these individuals are alone during the time of the incident and do not have someone to turn to at that very moment for validation? How will they handle the uncertainty and ambiguity on their own? The immediate internal stress response elicited during these ambiguous events would likely benefit from a strategy that could be utilized "in the moment."

Even though these models define perceived racism as a recognition of a racist event, we know from Sue and colleagues' conceptualizations that the act of perceiving racism is more than just an endorsement of an event; instead, it is often an experience characterized by dilemmas and uncertainty. In the previous example, it is true that the Black man in the restaurant may not experience racism-related stress if he does not experience the poor service as a result of racism; but it is not necessarily true that the act of affirming an experience as racist would result in a noxious racism-related stress response that requires him to utilize a particular coping strategy in order to attempt to function. Perhaps he has developed a way to reduce racism-related stress associated with the initial internal stress response during the process of perceiving a racist event; for example, he may relate to the encounter with a response that feels congruent with what is personally important to him (e.g., deciding to ask the server the reason for why he has not been served or deciding to leave the restaurant and not patronize the establishment in the future).

Whether intentional or not, Clark et al.'s (1999) model describes the experience of racism as a simplistic, stage-like process. It is likely, however, that the experience is a much more complex process. It is likely that experiences of racism impact functional well-being, but we continue to know very little about why some African-American individuals experience fewer psychological consequences than others.

A Case for Racism in the Case Formulation/Conceptualization

As previously discussed, both Clark et al. (1999) and Harrell (2000) propose that it is important to understand the individual's developmental context (e.g., familial, socialization, environmental) so that the clinician can better understand the client's awareness of racism and perceptions of racism. In addition, according to Clark et al. (1999) and Harrell (2000), clinicians should assess the potential mediators and moderators (e.g., coping, worldviews) so that they can explore the factors that may also promote optimal functioning in the client or what may be hindering the client's functioning. Further, as proposed by Sue et al. (2007, 2008), clinicians should explore clients' unique "Catch-22's" and the ways in which they react to experiences of racism.

For African Americans, there are a number of barriers to engaging in the things that are meaningful in one's life, including experiencing racism in many contexts within daily life. It is understandable and important to acknowledge that it is natural for African Americans to want to avoid this pain. And, the avoidance of this pain can sometimes lead clients/patients down paths of avoiding things that are important and meaningful to them, which leads to more distress. We have all had clients/patients whose avoidance manifests itself through anxiety, depression, substance use, eating disorders, etc. When we as clinicians can understand the function of these symptoms in light of biological factors, developmental factors, and sociocultural factors, we are then positioning ourselves for initiating treatment using the best available research, our best clinical acumen, and our best understanding of the client's lived experience. Of course, a good conceptualization is also one that is revised along the way; however, why not begin treatment with an understanding of the possible role that racism and other forms of oppression may play in your client's life.

Avoidance in one's life as a result of experiences of racism may show up in various forms. For example, during a stressful encounter, it is extremely difficult for individuals to remember that they have choices in their lives and that they can experience empowerment in the face of restricted, judgmental thoughts such as, "I have no choice but to just allow my boss to say racist things to me because I will lose my job" or "I should be able to handle myself and not feel upset when my advisor doubts my abilities." For African Americans, in particular, reconnecting to values can be empowering such that making choices can feel natural, even in the face of racism.

In another example, an individual who experiences distress from his boss' racist jokes (e.g., "Dre, I bet you signed up to bring the fried chicken to the work potluck!") may choose to reconnect to his value of respect and may decide to approach his boss about the racist comments because simply accepting these comments would be living a life inconsistent with who he is and what he stands for. An African-American woman who perceives that she is being treated unfairly in school by her advisor because she is Black may be able to reconnect with what is meaningful to her about being a student and make a decision to continue to engage in her value of pursuing her education in the face of this discrimination. She may decide to report this to the dean and/or seek out a more helpful advisor, which is consistent with her value of pursuing education. She may also decide that social connectedness in the midst of discrimination is an important value and begin to develop safe spaces with colleagues or other students to garner social support and process these experiences. Her decision of acting in accordance with her values even in the face of these painful and unjust experiences may buffer some of the stress associated with racism.

Pushing away our emotions, as opposed to accepting them, may be another relevant component of the case conceptualization. We know that consistently attempting to control or suppress emotions provides an illusion of control, but in reality, it paradoxically heightens the intensity of our emotional experiences. Furthermore, from an acceptance-based behavioral framework (e.g., Roemer & Orsillo, 2009), an accepting relationship with emotional reactions to experiences of racism does not at all suggest approval of the existence of racism or racist experiences. The cultivation of an accepting relationship to, and a present moment awareness of, the overwhelming and distressing emotional responses that arise in the face of racism may lessen the intensity of our anxiety.

African Americans may be struck with the dilemma of figuring out the ways in which one can be strong and resilient, while simultaneously acknowledging emotions and turning toward these emotional experiences. As far as the conceptualization, it is also important to acknowledge that controlling emotional responses to racism can be effective to a certain extent, given its adaptive, survival quality that has contributed to the strength of African Americans for hundreds of years and through a variety of contexts.

In the service of connecting the conceptualization to goals and values, it is important to acknowledge the information that emotions have provided a client over his/her lifetime (Hayes, Strosahl, & Wilson, 2012; Roemer & Orsillo, 2009). One potentially effective strategy for responding to experiences of racism and for combating racism's effects on anxiety symptoms is the role of attending to and making choices based on our values (i.e., the things that are meaningful and matter to an individual). When individuals are able to identify and understand their values, they can be more aware of what matters to them during stressful moments, make choices consistent with their values, and act upon these choices. Value clarification is a potential avenue for helping African-American individuals experience choice and optimal functioning in the context of racism. Implementation of this construct in the context of racism would raise awareness and promote transparency about racism.

These value-oriented cues in response to racism can help clients navigate the world. They may have learned that racism is threatening or dangerous situation (e.g., signaling fear or anxiety), that their needs are not being met (e.g., through feelings and expressions of anger), or through sadness, which indicates that they are losing something that is important or valuable to them. Experiences of racism can elicit any and all of these emotional experiences, sometimes at the same time. There is a way that experiences of racism can threaten an individual's safety, can serve as barriers to accessing resources (e.g., employment, health care, education, respect/validation), and can deplete an individual's sense of self-worth and value. While it is natural to want to turn away from these emotional experiences, they provide important information that, when clear, can help clients respond in a meaningful way to these experiences of racism. One specific example can be found in the previously mentioned Black Lives Matter movement. In part, this movement arose as a meaningful response to the fear, anxiety, sadness, and anger felt by many African Americans in the wake of the multitude of unarmed Black men killed by law enforcement officers.

An additional aspect of the conceptualization as it relates to racism is the ways in which these levels of racism have permeated cultural and societal norms and, therefore, contributing to the client's understanding of being the product of an invalidating environment. Cultural and societal norms related to mental health stigma, in general, already tell us that feeling anxiety, sadness, or anger are signs of weakness or evidence of having lack of self-control. Therefore, for African

Americans who experience racism and emotional reactions to racism, there is an additional experience of invalidating messages that communicate one's over-reactivity and hypersensitivity, and therefore, perpetuating a myth that emotions are a sign of weakness (Sue et al., 2008).

The work here is in the practice of cultivating awareness of our human tendency to judge our emotional reactions. Specifically, treatment could aim to move the client toward a deliberate practice of self-compassion. Self-compassion in this context is described as the appreciation of difficult emotional responses to racism (e.g., anxiety, anger, and sadness) as being understandable, natural, and part of our human experience. For example, in the face of a racist experience, a Black woman can acknowledge that she is angry and appreciate that this anger is a natural and understandable response to an unjust situation rather than viewing her emotional response as being unreasonable or something to "get over." In this, it would be the self-judgment of internalization of invalidation that African Americans may experience in response to racism. Bringing self-compassion to both the emotional experiences and the judgment or self-criticism that may also arise.

Ruling in Racism, Diagnostic Impressions, and Differential Diagnoses

In 2015, researchers and clinicians out of Boston College created the hashtag #RacialTraumaIsReal (see https://www.bc.edu/content/dam/files/schools/lsoe_sites/isprc/jpg/infographic.jpg). In their infographic, they created a racism recovery plan for coping with racism. Their steps for coping with racism included connection, spiritual practices, self-care, and activism as possible daily maintenance strategies. In addition, they spelled out the ways in which one would manage triggers, warning signs, racism as trauma, and crisis planning. This step-by-step guide was developed due to the burgeoning evidence that experiences of racism are linked to poor mental and physical health outcomes.

Experiences of racism have been positively linked to mental health difficulties. In a meta-analysis of 66 studies ($N = 18{,}104$) exploring the link between racism and mental health, Pieterse and colleagues (2012) found a positive association between racism and anxiety, depression, and general distress. More specifically, racism has been linked to both anxiety disorders and anxious symptoms in Black samples (Barnes & Lightsey, 2005; Hill, Kobayashi, & Hughes, 2007; Rucker, West, & Roemer, 2009). For example, Donovan, Galban, Grace, Bennett, and Felicie (2012) explored the link between racism and anxiety in a sample of Black women and found that racial macroaggressions, or more overt experiences of racism, were significantly positively related to anxiety symptoms. Experiences of racism have also been found to be associated with symptoms that are similar to trauma-related symptoms, such as fear, hypervigilance, headaches, insomnia, body aches, memory difficulty, self-blame, confusion, shame, and guilt (Bryant-Davis & Ocampo, 2005; Carter, 2007; Helms, Nicolas, & Green, 2012). Soto and colleagues (2011) explored the link between racism and generalized anxiety disorder (GAD) in an ethnically diverse group of African Americans, Afro-Caribbeans, and non-Hispanic Whites and found that racism was positively associated with GAD in the African-American subgroup only. These findings are in line with previous research suggesting that Black Americans' experience of racism can differ based on ethnic background as well as immigration status (Hall & Carter, 2006; Yoo & Lee, 2008).

Given the research suggesting that experiences of racism are positively linked to both anxiety disorders and symptomology, the next step is to begin exploration to explore the underlying mechanisms in these relationships. One such underlying mechanism may be internalized racism. Internalized racism is defined as the acceptance, by the marginalized group, of negative and critical beliefs about one's worth (Cross, Parham, & Helms, 1991). Moreover, Williams and Williams-Morris (2000) assert that Black African-American individuals may internalize beliefs of racial inferiority communicated by the majority, otherwise known as internalized racism.

Many studies have found internalized racism to be linked to poor self-esteem and higher levels of psychological distress (e.g., Carter, 1991; Parham & Helms, 1985; Szymanski & Gupta, 2009). Specifically, Parham and Helms (1985) explored the relationship between internalized racism and self-esteem in a sample of Black African-American undergraduate students at four predominantly White universities. Results indicated that Black African-American students who endorsed devaluing themselves because of their race also reported lower self-esteem. In another study, Szymanski and Gupta (2009) explored the relationship between self-reported internalized oppression, self-esteem, and psychological distress in a sample of lesbian, gay, bisexual, and transgender individuals who racially identified as Black. Results indicated that internalized racism and internalized homophobia were each significant negative predictors of self-esteem and significant positive predictors of psychological distress.

Relatedly, research has shown that, in general, critical beliefs about oneself and negative self-focused thoughts are associated with the development and maintenance of anxiety symptoms in predominantly White samples (e.g., Hofmann, 2000; Rapee & Heimberg, 1997; Wells et al., 1995). Many theorists suggest that an overidentification with one's negative thoughts or emotions exacerbates the cycle of anxiety and contributes to anxious symptomology becoming overwhelming and intolerable (Hayes, Strosahl, & Wilson, 1999; Herbert & Cardaciotto, 2005; Rapee & Heimberg, 1997).

Ironically, the DSM diagnoses the person and not the system or context in which the person lives. Clearly, racism is a problem of the environment, and not a problem that lies within the person. Currently, our classification system does not recognize racism as a criterion or specifier, and this may be an important direction for future iterations.

Addressing Racism in Treatment Interventions

Addressing Racism in Clinical Care with Individuals, Groups, and Trainees

As Lee, Fuchs, Roemer, and Orsillo (2009) assert, clinicians can "empower clients to form understanding[s] of the ways systemic oppression has restricted them and [they can help clients] discover steps they can take to create changes despite those obstacles" (p. 219). Clinicians have the ability to foster and promote a dialog where the client can discuss how he or she can experience choice and freedom in situations that have historically caused him or her to have internal stress responses. Through understanding the various types of emotional and behavioral responses African American may have to racism, clinicians can listen for these types of responses, they can hypothesize with their clients about the role of racism, and most importantly, they can *validate* the client's experience of racism.

Validation and collaboration are critical throughout this process. Clinicians can validate clients' range of responses, and they can validate the ways in which it is difficult to know healthy and adaptive ways of responding to racism-related stressors optimally. Regardless of the client's presenting problem, therapists would benefit from understanding the six levels of validation (i.e., being present, accurate reflection, guessing unstated feelings/mindreading, consider past history and individual biology, consider present events and normalize, and radical genuineness) drawn from Dialectical Behavior Therapy (DBT; see Linehan, 2014).

Of course, as clinicians we want to solve the problem, but before doing so, our clients need to feel understood. Given the pervasiveness and insidiousness of racism, there may be very little we can do or suggest to our clients to do to solve the racism-related difficulties in their lives. At the same time, it is not necessarily our job to decide whether or not taking on racism is too formidable for our clients. Our clients can become agents in their lives and agents in the lives of others. The options for their advocacy and empowerment can be limitless. Out of our own fears or out of our own beliefs that this might be a Sisyphean task, our overprotection could lead our clients to foreclose on actions related to their purpose or their values. With that said, we always want to ensure that we have discussed safety concerns with our clients before they try anything that may make them susceptible to harm. At the same time, helping our clients address the racism that they are experiencing in their lives can be one of our most powerful interventions.

These same considerations are of critical importance in our one-on-one sessions, and they are of continued importance in other therapy (i.e., therapy groups, support spaces) modalities and in supervision and consultation with trainees and peers. Modeling, curiosity, understanding one's kernel of truth, identifying one's areas of privilege, and recognizing the role of implicit or unconscious bias are some of the critical multicultural supervision interventions to employ with supervisees and trainees. For the supervisor, awareness of self, awareness of one's identity as an authority (in relation to the supervisory hierarchy and not necessarily in relation to other identities), awareness of differences and similarities in the lived experiences of the trainees, recognition of possible values discrepancies, and, then finally, awareness of the interplay of the impact of these considerations as they play out in the trainees' psychotherapy sessions are all given thoughtful attention.

Once these multicultural discussions have been modeled in courses, didactics, and supervision, the trainees will likely have increased comfort and skill in addressing these multicultural considerations in session. Even though a novice therapist may want to jump into interventions, she or he must be cautious because many of our possible interventions are incongruent to the experiences of racism African-American clients may be facing. For example, a discussion about irrational thoughts or engaging in Socratic questioning that examines the evidence of one's thought about whether an encounter was racist could become *invalidating* quite quickly (Hays, 2009). Empathy and validation are paramount, and then depending on the readiness of the client, exploration of emotions related to experiences of racism (i.e., sadness, anger, anxiety) can then be explored. Again, without trying to question or even change the experiences of racism, interventions are aimed at helping the client experience optimal well-being in the face of these adversities.

There is burgeoning evidence that mindfulness and acceptance-based interventions are helpful for marginalized individuals (Fuchs et al., 2016) experiencing stigma and prejudice (Masuda, Hill, Morgan, & Cohen, 2012), gendered race-related stress (Watson, Black, & Hunter, 2016), health disparities (Woods-Giscombé & Gaylord, 2014), and anxiety and depression (Graham, Martinez, West, & Roemer, 2016; Graham, West, & Roemer, 2015; West, Graham, & Roemer, 2013). Clinical considerations for incorporating and adapting mindfulness and acceptance-based interventions for the patient in front of you require creativity, flexibility, and mindfulness on the part of the treating clinician (see Sobczak & West, 2013, for further reading).

Addressing Racism as a Professional

Although the stigma associated with seeing a therapist or having a mental health concern is not unique to African Americans, research has indicated that it has notable effects on African Americans' likelihood to seek treatment for mental health concerns (Alvidrez, Snowden, & Kaiser, 2008; Mishra, Lucksted, Giola, Barnet, & Baquet, 2009). Alvidrez et al. (2008) found that the African-American individuals in their study indicated that mental health stigma was the reason for not pursuing more educational information about mental health. In addition, participants in the study did not pursue mental health services despite knowing they needed them. In relation to discrimination and unfair treatment from therapists toward potential perceived clients of color, discrimination by race and class was found among therapists. In the article, *Not White, Not Rich, and Seeking Therapy* in *The Atlantic*, the authors found that 28% of White, middle-class therapy seekers were called back and offered an appointment, whereas 17% of Black, middle-class therapy seekers were called back and offered an appointment. Further, only 8% of working-class callers of either race were offered an appointment. The following algorithm was calculated in order to determine one's likelihood of being offered a psychotherapy appointment: "A Black, working-class man would have to call 80 therapists. A middle-class, White woman would only have to call five" (*The Atlantic*, July, 2016).

Clearly, there are many societal, systemic, interpersonal, and individual barriers to mental health treatment. The larger health-care system, the American Psychological Association, the American Psychiatric Association, and all of the other psychological and psychiatric organizations, all have a responsibility of bringing issues related to mental health education, mental health stigma, and mental health treatment to the population. The dissemination of this information in popular media, including social media, is critical to true public service and health-care advocacy.

However, before psychologists turn their attention outward to society, it is important to examine the societal microcosm that is reflected within our very own profession. No one, yes, no one is immune from the contagion of racism. We may all have our very own predispositions, sensitivities, antibodies, and remedies, but we must remember to look around at our own conference rooms, board rooms, and divisions and special interest groups and ask ourselves the question, "who does not have a seat at this table?" and "what are we going to do about it?" Our national organizations continue to have their divisions, special interest groups, journals, associations, and conferences. For the purposes of managing particular research and therapy specialties, clearly, this makes a great deal of sense. Safe spaces and affinity groups that focus on ethnic and minority psychology, women, LGBTQ+, and folks with disabilities are also of critical importance, in that they ensure that the people in our profession have a sense of belongingness within their career life. It is of critical importance that our profession begins to think intersectionally within our larger organizations and not just in our special interest groups.

Disseminating psychological and mental health issues to our academic communities of interest is already difficult enough. From citation index scores to h-indices, it is already challenging enough to have our colleagues see our work, never mind that community in which we are aiming to serve. But, before we put *all* of our efforts into disseminating our studies in popular media, we must start from within our social microcosm, think intersectionally from within, and ask ourselves the questions, "when was the last time I read a manuscript from the *Journal of Black Psychology* or *Culture and Ethnic Minority Psychology*?" or "when was the last time I attended a division (i.e., Division 45 within the American Psychological Association for Culture and Ethnic Minority Psychology), special interest group (i.e., African Americans in Behavior Therapy within the Association for Behavior and Cognitive Therapy) in order to be an ally or advocate, or association (i.e., Association for Black Psychologists)?" We may very well have more of the answers to understanding the science of prejudice, stigma, and privilege if we begin to examine ourselves and our own divisions and associations within our work.

Conclusion

This chapter examined the ways in which racism, as an oppressive experience, impacts our African-American clients. From a larger sociocultural viewpoint, racism, as one form of oppression, sets forth a whole host of potential exacerbating factors to one's health. From the aforementioned negative medical and mental health outcomes that are exacerbated by systems of racism, it is important for us, as clinicians, to consider and inquire about experiences of discrimination in general and racism in particular. Doing so, allows for us to better understand the sociocultural context and allows for our case conceptualizations to be more targeted in addressing the client's goals. At the same time, before we externalize racism as a societal issue that we as clinicians are not a part of, we must examine our own knowledge, attitudes, comforts, and skills. Clinicians and the organizations we belong to are not immune to individual, interpersonal, and systemic forms of racism, and it is important for all of us as individuals to pay attention to the ways in which we may be (unintentionally or even intentionally) participating in these personally mediated forms of racism with our clients and with our trainees. It is also of great importance that we take our individual and interpersonal knowledge to the larger institutional sphere so that we transmit our knowledge through our policy making, diagnostic considerations, and the literature we publish. We aim to help our clients live their lives in accordance with their values even in the face of adversity, so it is important for us to figure out ways to model this through validation of our clients and through advocating on their behalf when possible.

References

Alvidrez, J., Snowden, L. R., & Kaiser, D. M. (2008). The experience of stigma among black mental health consumers. *Journal of Health Care for the Poor and Underserved, 19*, 874–893.

Barnes, P., & Lightsey, O. (2005). Perceived racist discrimination, coping, stress, and life satisfaction. *Journal of Multicultural Counseling and Development, 33*, 48–71. https://doi.org/10.1002/j.2161-1912.2005.tb00004.x

Boston College. Retrieved 6 Aug from https://www.bc.edu/content/dam/files/schools/lsoe_sites/isprc/jpg/infographic.jpg

Braveman, P., Egerter, S., & Williams, D. R. (2011). The social determinants of health: Coming of age. *Annual Review of Public Health, 32*, 381–398.

Breslau, J., Aguilar-Gaxiola, S., Kendler, K. S., Su, M., Williams, D., & Kessler, R. C. (2006). Specifying race-ethnic differences in risk for psychiatric disorders in a USA national sample. *Psychological Medicine, 36*, 57–68.

Breslau, J., Kendler, K. S., Su, M., Gaxiola-Aguilar, S., & Kessler, R. C. (2005). Lifetime risk and persistence of psychiatric disorders across ethnic groups in the United States. *Psychological Medicine, 35*, 317–327.

Broman, C. L. (1997). Race-related factors and life satisfaction among African Americans. *Journal of Black Psychology, 23*, 36–49.

Bronfenbrenner, U., & Evans, G. W. (2000). Developmental science in the 21st century: Emerging questions, theoretical models, research designs and empirical findings. *Social Development, 9*, 115–125.

Bryant-Davis, T., & Ocampo, C. (2005). Racist-incident-based trauma. *The Counseling Psychologist, 33*(4), 479–500.

Carter, R. (1991). Racial identity attitudes and psychological functioning. *Journal of Multicultural Counseling and Development, 19*, 105–114. https://doi.org/10.1002/j.2161-1912.1991.tb00547.x

Carter, R. T. (2007). Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress. *The Counseling Psychologist, 35*(1), 13–105.

Clark, R., Anderson, N. B., Clark, V. R., & Williams, D. R. (1999). Racism as a stressor for African Americans: A biopsychosocial model. *American Psychologist, 54*, 805–816.

CNN. Retrieved 22 Mar from http://www.cnn.com/2009/US/07/22/gates.arrest.reaction/index.html?iref=newssearch

CNN. Retrieved 24 Mar from http://www.cnn.com/2009/US/07/09/philly.pool/index.html

CNN. Retrieved 26 Mar from http://www.youtube.com/watch?v=NTixCXmrezY

CNN/Essence Magazine/Opinion Research Corporation poll. Retrieved 26 Mar 2017 from http://www.cnn.com/2008/POLITICS/04/03/poll.black.president/index.html

Cross, W., Parham, T., & Helms, J. (1991). The stages of Black identity development: Nigrescence models. In R. Jones (Ed.), *Black psychology* (3rd ed., pp. 319–388). Berkeley, CA: Cobb & Henry Publishers.

Diala, C., Muntaner, C., Walrath, C., Nickerson, K. J., LaVeist, T. A., & Leaf, P. J. (2001). Racial/ethnic differences in attitudes toward seeking professional mental health services. *American Journal of Public Health, 91*, 455–464.

Donovan, R., Galban, D., Grace, R., Bennett, J., & Felicie, S. (2012). Impact of racial macro- and microaggressions in Black women's lives: A preliminary analysis. *Journal of Black Psychology, 39*, 185–196. https://doi.org/10.1177/0095798412443259

Dovidio, J. F., Gaertner, S. L., Kawakami, K., & Hodson, G. (2002). Why can't we all just get along? Interpersonal biases and interracial distrust. *Cultural Diversity and Ethnicity Minority Psychology, 8*, 88–102.

Fang, C. Y., & Myers, H. F. (2001). The effects of racial stressors and hostility on cardiovascular reactivity in African American and Caucasian men. *Health Psychology, 20*, 64–70.

Fuchs, C., West, L. M., Graham, J. R., Sullivan Kalill, K., Moran, L., Hayes-Skelton, S., … Roemer, L. (2016). Reactions to an acceptance-based behavior therapy for GAD: Giving voice to the experiences of clients from marginalized backgrounds. *Cognitive and Behavioral Practice, 23*, 473–484. https://doi.org/10.1016/j.cbpra.2015.09.004

Gaertner, S. L., & Dovidio, J. F. (1986). The aversive form of racism. In J. F. Dovidio & S. L. Gaertner (Eds.), *Prejudice, discrimination, and racism*. Orlando, FL: Academic.

Giscombé, C. L., & Lobel, M. (2005). Explaining disproportionately high rates of adverse birth outcomes among African Americans. The impact of stress, racism, and related factors in pregnancy. *Psychological Bulletin, 131*, 662–683.

Graham, J. R., Martinez, J., West, L. M., & Roemer, L. (2016). The mediating role of internalized racism in the relationship between racist experiences and anxiety symptoms in a Black American sample. *Cultural Diversity and Ethnic Minority Psychology, 22*(3), 369–376. https://doi.org/10.1037/cdp0000073

Graham, J. R., West, L. M., & Roemer, L. (2015). A preliminary exploration of the moderating role of valued living in the relationships between racist experiences and anxious and depressive symptoms. *Journal of Contextual Behavioral Science, 4*, 48–55. https://doi.org/10.1016/j.jcbs.2014.11.001

Hall, S., & Carter, R. (2006). The relationship between racial identity ethnic identity, and perceptions of racial discrimination in an Afro-Caribbean descent sample. *Journal of Black Psychology, 32*, 155–175. https://doi.org/10.1177/0095798406287071

Harrell, J. P., Hall, S., & Taliaferro, J. (2003). Physiological responses to racism and discrimination: An assessment of the evidence. *American Journal of Public Health, 93*, 243–248.

Harrell, S. P. (2000). A multidimensional conceptualization of racism-related stress: Implications for well-being of people of color. *American Journal of Orthopsychiatry, 70*, 42–54.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2012). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guilford Press.

Hays, P. (2009). Integrating evidence-based practice, Cognitive-Behavior Therapy, and Multicultural Therapy: Ten steps for culturally competent practice. *Professional Psychology: Research and Practice, 40*, 354–360.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York, NY: Guilford Press.

Helms, J. E., Nicolas, G., & Green, C. E. (2012). Racism and ethnoviolence as trauma: Enhancing professional and research training. *Traumatology, 18*, 65–74.

Herbert, J., & Cardaciotto, L. (2005). An acceptance and mindfulness-based perspective on social anxiety disorder. In S. Orsillo & L. Roemer (Eds.), *Acceptance and mindfulness-based approaches to anxiety: Conceptualization and treatment* (pp. 189–212). New York, NY: Springer.

Hill, L., Kobayashi, I., & Hughes, J. (2007). Perceived racism and ambulatory blood pressure in African American college students. *Journal of Black Psychology, 33*, 404–421. https://doi.org/10.1177/0095798407307042

Hill, L. B. K., Hoggard, L. S., Richmond, A. S., Gray, D. L. L., Williams, D. P., & Thayer, J. F. (2017). Examining the association between perceived discrimination and heart rate variability in African Americans. *Cultural Diversity and Ethnic Minority Psychology, 23*(1), 5–14.

Hofmann, S. (2000). Self-focused attention before and after treatment of social phobia. *Behaviour Research and Therapy, 38*, 717–725. https://doi.org/10.1016/S0005-7967(99)00105-9

Jackson, J. S., Brown, T. N., Williams, D. R., Torres, M., Sellers, S. L., & Brown, K. (1995). *Racism and the physical and mental health status of African Americans: A thirteen year national panel study*. Unpublished manuscript. Ann Arbor, MI: University of Michigan.

Jones, C. (2000). Levels of racism: A theoretic framework and a gardener's tale. *American Journal of Public Health, 90*, 1212–1215.

Jones, J. M. (1997). *Prejudice and racism* (2nd ed.). New York, NY: McGraw-Hill.

Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., … Kendler, K. S. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: Results from the National Comorbidity Survey. *Archives of General Psychiatry, 51*, 8–19.

Krieger, N., & Sidney, S. (1996). Racial discrimination and blood pressure: The CARDIA study of young black and white adults. *American Journal of Public Health, 86*(10), 1370–1378.

Landrine, H., & Klonoff, E. A. (1996). The schedule of racist events: A measure of racial discrimination and a study of its negative physical and mental health consequences. *Journal of Black Psychology, 22*, 144–168.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York, NY: Springer.

Lee, J. K., Fuchs, C., Roemer, L., & Orsillo, S. M. (2009). Cultural considerations inacceptance-based behavior therapy. In L. Roemer & S. M. Orsillo (Eds.), *Mindfulness and acceptance-based behavioral therapies in practice* (pp. 215–228). New York, NY: Guilford Press.

Lewis, T. T., Aiello, A. E., Leurgans, S., Kelly, J., & Barnes, L. L. (2010). Self-reported experiences of everyday discrimination are associated with elevated C-reactive protein levels in older African American adults. *Brain, Behavior, and Immunity, 24*, 438–443.

Linehan, M. (2014). *DBT skills training manual* (2nd ed.). New York, NY: The Guilford Press.

Masuda, A., Hill, M. L., Morgan, J., & Cohen, L. L. (2012). A psychological flexibility-based intervention for modulating the impact of stigma and prejudice: A descriptive review of empirical evidence. *Psychology, Society, & Education, 4*(2), 211–223.

McConahay, J. B. (1986). Modern racism, ambivalence, and the Modern Racism Scale. In J. F. Dovidio & S. L. Gaertner (Eds.), *Prejudice, discrimination, and racism* (pp. 91–125). Orlando, FL: Academic Press.

Merritt, M. M., McCallum, T. J., & Fritsch, T. (2011). How much striving is too much? John Henryism active coping predicts worse daily cortisol responses in African American but not White female dementia family caregivers. *American Journal of Geriatric Psychiatry, 19*, 451–460.

Mishra, S. I., Lucksted, A., Gioia, D., Barnet, B., & Baquet, C. R. (2009). Needs and preferences for receiving mental health information in an African American focus group sample. *Community Mental Health Journal, 45*(2), 117–126. https://doi.org/10.1007/s10597-008-9157-4

Mother Jones Magazine. Retrieved 22 Mar 2017 from http://www.motherjones.com/politics/2017/02/black-lives-matter-versus-trump

Nadal, K. L., Griffin, K. E., Wong, Y., Hamit, S., & Rasmus, M. (2014). Racial microaggressions and mental health: Counseling clients of color. *Journal of Counseling and Development, 92*(1), 57–66.

Ong, A. D., Williams, D. R., Nwizu, U., & Gruenewald, T. L. (2017). Everyday unfair treatment and multisystem biological dysregulation in African American adults. *Culture and Ethnic Minority Psychology, 23*(1), 15–26. https://doi.org/10.1037/cdp0000111

Paradies, Y. (2006). Defining, conceptualizing and characterizing racism in health research. *Critical Public Health, 16*, 143–157.

Parham, T., & Helms, J. (1985). Attitudes of racial identity and self-esteem of Black students: An exploratory investigation. *Journal of College Student Personnel, 26*, 143–147.

Pew Research Study. (2013). Retrieved 22 Mar 2017 from http://www.pewresearch.org/fact-tank/2013/06/28/for-african-americans-discrimination-is-not-dead/

Pierce, C., Carew, J., Pierce-Gonzalez, D., & Willis, D. (1978). An experiment in racism: TV commercials. In C. Pierce (Ed.), *Television and education* (pp. 62–88). Beverly Hills, CA: Sage.

Pieterse, A. L., & Carter, R. T. (2007). An examination of the relationship between general stress, racism-related stress, and psychological health among Black men. *Journal of Counseling Psychology, 54*, 101–109.

Rapee, R. M., & Heimberg, R. G. (1997). A cognitive-behavioral model of anxiety in social phobia. *Behaviour Research and Therapy, 35*, 741–756. https://doi.org/10.1016/S0005-7967(97)00022-3

Roemer, L., & Orsillo, S. M. (2009). *Mindfulness-and acceptance-based behavioral therapies in practice*. New York, NY: Guilford Press.

Rucker, L., West, L. M., & Roemer, L. (2009). Worry, racial stress, intolerance of uncertainty: A meditational model in a Black sample. *Behavior Therapy*. https://doi.org/10.1016/j.beth.2009.04.001

Schneider, S. J. (2004). *The psychology of stereotyping*. New York, NY: The Guilford Press.

Sears, D. O. (1988). Symbolic racism. In P. A. Katz & D. A. Taylor (Eds.), *Eliminating racism: Profiles in controversy* (pp. 53–84). New York, NY: Plenum.

Slavin, L. A., Rainer, K. L., McCreary, M. L., & Gowda, K. K. (1991). Toward a multicultural model of the stress process. *Journal of Counseling Development, 70*, 156–163.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academies Press.

Sobczak, L. R., & West, L. M. (2013). Clinical considerations in using mindfulness- and acceptance-based approaches with diverse populations: Addressing challenges in service-delivery in diverse community settings [Special series]. *Cognitive and Behavioral Practice, 20*, 13–22. https://doi.org/10.1016/j.cbpra.2011.08.005

Soto, J. A., Dawson-Andoh, N. A., & BeLue, R. (2011). The relationship between perceived racial discrimination and generalized anxiety disorder among African Americans, Afro Caribbeans and non-hispanic whites. *Journal of Anxiety Disorders, 25*, 258–265.

Steffen, P. R., McNeilly, M., Anderson, N., & Sherwood, A. (2003). Effects of perceived racism and anger inhibition on ambulatory blood pressure in African Americans. *Psychosomatic Medicine, 65*, 746–750.

Sternthal, M. J., Slopen, N., & Williams, D. R. (2011). Racial disparities in health: How much does stress really matter? *Du Bois Review: Social Science Research on Race, 8*, 95–113.

Sue, D. W., Capodilupo, C. M., & Holder, A. M. B. (2008). Racial microaggressions in the life experiences of Black Americans. *Professional Psychology: Research and Practice, 19*, 329–336.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., et al. (2007). Racial microaggressions in everyday life. *American Psychologist, 62*, 271–286.

Sue, D. W., Capodilupo, C. M., & Holder, A. M. B. (2008). Racial microaggressions in the life experiences of black Americans. *Professional Psychology: Research and Practice, 19*, 329–336.

Szymanski, D., & Gupta, A. (2009). Examining the relationship between multiple internalized oppression and African American lesbian, gay, bisexual, and questioning persons' self-esteem and psychological distress. *The Counseling Psychologist, 36*, 510–524. https://doi.org/10.1037/a0013317

The Atlantic. (2016). *Not white, not rich, and seeking therapy*. Retrieved 31 Mar from https://www.theatlantic.com/health/archive/2016/06/the-struggle-of-seeking-therapy-while-poor/484970/

Utsey, S. O., Ponterotto, J. G., Reynolds, A. L., & Cancelli, A. A. (2000). Racial discrimination, coping, life satisfaction, and self-esteem among African Americans. *Journal of Counseling and Development, 78*, 72–80.

Watson, N. N., Black, A. R., & Hunter, C. D. (2016). African American women's perceptions of mindfulness meditation training and gendered race-related stress. *Mindfulness, 7*, 1034–1043. https://doi.org/10.1007/s12671-016-0539-3

Wells, A., Clark, D., Salkovskis, P., Ludgate, J., Hackmann, A., & Gelder, M. (1995). Social phobia: The role of in-situation safety behaviors in maintaining anxiety and negative beliefs. *Behaviour Therapy, 26*, 153–161. https://doi.org/10.1016/S0005-7894(05)80088-7

West, L. M., Graham, J., & Roemer, L. (2013). Functioning in the face of racism: The potential buffering role of values clarification in a Black sample. *Journal of Contextual Behavioral Science, 2*, 1–8. https://doi.org/10.1016/j.jcbs.2013.03.003

Williams, D., & Williams-Morris, R. (2000). Racism and mental health: The African American experience. *Ethnicity & Health, 5*, 243–268. https://doi.org/10.1080/713667453

Williams, D. R., Mohammed, S. A., Leavell, J., & Collins, C. (2010). Race, socioeconomic status, and health: Complexities, ongoing challenges, and research opportunities. *Annals of the New York Academy of Sciences, 1186*, 69–101.

Yoo, H., & Lee, R. (2008). Does ethnic identity buffer or exacerbate the effects of frequent racial discrimination on situational well-being of Asian Americans? *Journal of Counseling Psychology, 55*(1), 63–74. https://doi.org/10.1037/0022-0167.55.1.63Woods-Giscombé, C. L., & Gaylord, S. A. (2014). The cultural relevance of mindfulness meditation as a health intervention for African Americans. *Journal of Holistic Nursing, 32*(3), 147–160. https://doi.org/10.1177/0898010113519010

Prejudice Regarding Latinx-Americans

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Abstract

Despite the growing immigrant and native-born Latinx population in the United States, the documentation of Latinx experiences of oppression, prejudice, and discrimination is limited in the field of clinical psychology. The lack of information on multiracial, sexual minorities, and older Latinx populations is most pronounced. This chapter focuses on the research that has been done to document the prevalence of self-perceived discrimination and the deleterious effect of microaggressions on the mental health of Latinx individuals. In addition, this chapter emphasizes the lack of Latinx representation in professional domains and the growing need for social justice training in clinical psychology graduate programs. Recommendations are provided for assessing and conceptualizing experiences of oppression, prejudice, and discrimination for Latinx populations. Furthermore, this chapter argues that other fields of psychology have developed models and guiding frameworks that can help clinical psychology become more responsive to the needs of Latinx students, faculty, and clients.

Keywords

Latinx/Latino/Hispanic · Clinical psychology · Racial/ethnic discrimination · Microaggressions · Mental health · Immigrant · Social justice · Advocacy · Multicultural

Regarding Latinx-Americans

The Latinx population currently makes up approximately 18% or 59.2 million of the US population, and projections estimate the population will double by 2060 (U.S. Census Bureau, 2018; Vespa, Armstrong, & Medina, 2018). A closer review of Latinx representation reveals that those of Mexican origin comprise the largest subgroup in the United States (63%) followed by Puerto Ricans (10%), Cubans (4%), Dominicans (3%), and Guatemalans (2%; U.S. Census Bureau, 2017a). Latinx individuals make up the largest ethnic minority group and Spanish has become the second most-spoken language in the country; 72% of Latinx speak Spanish at home (U.S. Census Bureau, 2017b). Despite the fact that the U.S.'s ethnic and racial composition grows more diverse, Latinx experiences of discrimination and prejudice are widespread. These experiences of individual and institutional

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L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_5

discrimination permeate the lives of Latinx people and impact several domains: employment, housing, medical care, and education (National Public Radio, Robert Wood Johnson Foundation, & Harvard T. H. Chan School of Public Health, 2017).

The current political climate of the United States has been characterized by a push for stricter immigration laws, the construction of a wall at the US–Mexico border, and rhetoric against Latinx immigrants. The focus of which has been the migrant caravans fleeing violence in Central America and the living conditions at immigration detention centers. Research has shown that Latinxs who live in states with more anti-immigration laws and policies report more experiences of perceived discrimination regardless of immigration status (Almeida, Biello, Pedraza, Wintner, & Viruell-Fuentes, 2016). For example, state laws such as Arizona's SB 1070, Alabama's HB 56, and Texas' SB 4 (also known as the "show me your papers" law) allowed local officials to act as federal immigration officers in their ability to hold a person if they were found to be undocumented even during traffic stops. These laws contributed to fears of police harassment, racial profiling, and deportation, even for those who were victims of crime. In addition, media representations of the Latinx community continue to perpetuate the myth of Latinx individuals as criminals or cheap labor (Négron-Muntaner, 2014). Collectively, these portrayals of Latinx people in the media have left many to be targets of oppression, racism, and prejudice. Researchers have documented the harmful psychological and physiological toll that perceived discrimination places on Latinx youth and adults (Cobb, Xie, Meca, & Schwartz, 2017; McClure et al., 2010; Sawyer, Major, Casad, Townsend, & Mendes, 2012). However, the experiences of discrimination and prejudice toward Latinxs have been far less researched in comparison to White–Black relations (Dovidio, Gluszek, John, Ditlmann, & Lagunes, 2010). In this chapter, we attend to the context of these experiences of oppression, prejudice, and discrimination. In addition, we will highlight the implications of experiences of oppression, prejudice, and discrimination on the mental health and well-being of Latinx individuals in the United States, both as consumers and as those working professionally in the field of psychology. We examine the role of our institutional structures on conceptualizing and responding to these issues for the Latinx population and take a critical view of the profession and its support of Latinx psychologists.

Latinx Experiences of Oppression, Prejudice, and Discrimination

There is limited research on the prevalence of oppression and prejudice that Latinxs encounter. Most research has focused primarily on prevalence rates of perceived ethnic discrimination. To our knowledge, there have been five published studies on Latinx experiences of discrimination using nationally representative surveys: the National Latino and Asian American Study (NLAAS; Pérez, Fortuna, & Alegría, 2008), the Hispanic Community Health Study/Study of Latinos Sociocultural Ancillary Study (HCHS/SOL; Arellano-Morales et al., 2015), the "Discrimination in America Survey" (National Public Radio et al., 2017), the National Latino Health Care Survey (NLHCS; Almeida et al., 2016), and the National Survey on Latinos (NSL; Pew Research Center, 2018). Together, these studies report 24% to 80% of US Latinx populations experience some form of ethnic/racial discrimination, but differ in terms of their measurement of discriminatory experiences. For example, the NLAAS and NLHCS reported on interpersonal experiences of discrimination that occur in daily interactions, while the NSL reported generally on any experience of unfair treatment and discrimination in the *past year*. In addition, the HCHS/SOL examined experiences of racism and discrimination over the *lifetime* for self-identified Cuban, Dominican, Mexican, and Puerto Rican adults. Lastly, the "Discrimination in America Survey" studied the prevalence of both institutional and individual forms of discrimination.

In the last two decades, studies on discrimination and the Latinx community have focused on whether prevalence rates differed by sociodemographic variables. Areas of research have focused on variables such as gender (e.g., Arellano-Morales et al., 2015; Nadal, Mazzula, Rivera, & Fujii-Doe, 2014; Otiniano Verissimo, Gee, Iguchi, Ford, & Friedman, 2013), socioeconomic status (e.g., Williams, Mohammed, Leavell, & Collins, 2010), acculturation status (e.g., Anderson & Finch, 2017), and Latinx subgroups (e.g., Lee & Ahn, 2012; Pérez et al., 2008). Relatedly, the experiences of individuals who occupy more than one socially disadvantaged status are more at risk for experiencing discrimination and prejudice (Cole, 2009). Research on intersectionality among Latinos and other socially disadvantaged statuses has primarily focused on the experiences of lesbian, gay, bisexual, transgender, questioning, intersex, and/or queer (LGBTQIQ) Latinxs (e.g., Cerezo, 2016; Díaz, Ayala, Bein, Henne, & Marin, 2001; Ibañez, Van Oss Marin, Flores, Millett, & Diaz, 2009; Kim & Fredriksen-Goldsen, 2017; Reisen, Brooks, Zea, Poppen, & Bianchi, 2013).

A growing, but still small, movement in the literature has begun to examine the concept of intersectionality to determine whether experiences of discrimination and prejudice differ for multiracial Latinx individuals (Chavez-Dueñas, Adames, & Organista, 2014; Chavez-Dueñas, Adames, Perez-chavez, & Salas, 2019; Golash-Boza & Darity, 2008). Still, our overall understanding of the frequency of prejudice and discrimination against multiracial Latinxs is limited at this time. One reason why information is lacking in this area is that researchers have traditionally treated ethnicity and race as one construct and have categorized all Latinx individuals into one homogenous group. Another reason why there is little information available on this population is due to the approach that the United States uses to classify Latinxs. For instance, in the 2010 US Census, 37% of Latinx identified themselves as Some Other Race, and most of the written responses for this category included "Latino," "Mexican," or other nationalities (Ennis, Ríos-Vargas, & Albert, 2011). Not surprisingly, most Latinx individuals identify with their nationality or family's country of origin rather than a pan-ethnic identity (Lopez, Gonzalez-Barrera, & López, 2017). Clearly, Latinx identity is not being captured adequately by our current census methods and requires a more multifaceted approach to conceptualizing identity.

Impact of Prejudice, Oppression, and Discrimination on the Mental Health of Latinxs

The impact of discrimination and oppression on the mental health of racial/ethnic minorities in the United States has been well documented (Gee, Ryan, Laflamme, & Holt, 2006; Lopez, LeBrón, Graham, & Grogan-Kaylor, 2016; Williams, Kanter, & Ching, 2018). Research has suggested that exposure to social stressors, such as overt discrimination and more subtle microaggressions, places an added burden on racial/ethnic minority individuals which contributes to elevated rates of mental illness (Held & Lee, 2017; Schwartz et al., 2015; Torres & Taknint, 2015; Williams et al., 2018). Specific to Latinx individuals, many unique environmental factors, such as immigration and lack of access to appropriate care in their native language, can increase exposure to prejudice and magnify its impact on mental health throughout their lifetime (Garcia & Lindgren, 2009; Gee et al., 2006; Torres & Taknint, 2015). When Latinx persons do access mental health services, the efficacy of treatment can also be impacted by stigma within the community and experiences of discrimination during mental health treatment itself. Nevertheless, researchers have also described factors that may mediate the relationship between experiences of discrimination/oppression and negative mental health consequences among Latinxs. Some of these factors include strong ethnic identity (Brittian et al., 2015; Pérez et al., 2008; Torres & Ong, 2010), self-efficacy (Umaña-Taylor, Tynes, Toomey, Williams, & Mitchell, 2015), and positive family dynamics (Ponting et al., 2018). In the following sections, we review the existing literature on the impact of prejudice and discrimination on Latinx mental health, the mechanisms of which have been largely understudied.

Early-Life Impact of Discrimination

The impact of discrimination among Latinxs can begin from a young age, even when they are not directly the target of discrimination. For example, Tran (2014) identified the role of family context in shaping the mental health of young children, such that parental experiences of discrimination and parental mental health were significant mediators of childhood mental health among Latinx youth, regardless of socioeconomic background. Latinx children also often experience additional unique cultural stressors, particularly if they are children of immigrant parents with limited English-language fluency. In a qualitative study exploring mental health stressors among Latinx immigrant families, Garcia and Lindgren (2009) identified fear of deportation as a unique stressor for families in which a parent was undocumented. Both adolescents and parents reported this stressor, although this was more a focus of discussion for parents. Per the researchers, "Mothers spoke of fears surrounding the threat of deportation, giving examples of friends who had been deported. Parents described attempts to keep children from knowing about deportation but indicated that this was difficult" (Garcia & Lindgren, 2009, p. 8). Given our current political climate, fear of deportation is on the rise and can significantly contribute to parenting stress (Berger Cardoso, Scott, Faulkner, & Barros Lane, 2018).

Another unique contributor of cultural stress within Latinx immigrant families occurs when there is a difference in the rate of acculturation among family members. In other words, youth often gain English-language skills and cultural understanding more quickly than their parents, which leads to a shift in family dynamics. The typical power differential in the family is, therefore, shifted from parents to children, such that parents rely on their children to translate for them in different situations. This power differential becomes most pronounced in adolescence and can lead to family stress, parents feeling less effective, and can contribute to adolescent substance use (Martinez, 2006) and increased depressive symptoms (Nair, White, Roosa, & Zeiders, 2013). Indeed, cultural stressors such as discrimination can exert negative effects on Latinx adolescents over time (Schwartz et al., 2015). Lopez et al. (2016) identify a link between experiences of discrimination and depressive symptoms among adolescents. They also identify differential impacts related to the source of discrimination, such that a stronger impact on mental health was observed when discrimination came from a teacher or a peer. Additionally, the researchers identified that co-ethnic discrimination (i.e., discrimination that comes from your own ethnic group on the basis of Spanish-language use, immigrant status, documentation status, and physical features) had the strongest negative impact on the mental health of Latinx youth. Lack of connectedness even with your own ethnic group can, therefore, have a detrimental effect on mental health of Latinx youth in addition to the other cultural stressors described above.

Latinx Adult Mental Health

For Latinx adults, unique factors associated with living in the United States appear to be linked to higher rates of psychiatric disorders. Research has highlighted that US-born Latinxs have higher lifetime rates of most mental health disorders when compared to foreign-born immigrant Latinxs (Alegría et al., 2008), consistent with the "immigrant paradox" observed in health-related outcome studies (Franzini, Ribble, & Keddie, 2001; Suárez-Orozco, Rhodes, & Milburn, 2009). The prevailing theory behind this observation is that there are factors about immigrants prior to immigration that are protective against mental health and other health conditions. However, Alegría et al. (2008) noted differences in the applicability of the paradox for mental health disorders across Latinx subgroups, noting that the immigrant paradox is only reliably observed for depression and anxiety disorders in Mexican immigrants. With regard to substance abuse, the paradox was observed across most of the Latinx subgroups, including Mexicans, Cubans, and other Latinxs from Central and South America. However, no evidence of the paradox was observed for Puerto Ricans, who are a unique group of Latinxs with US citizenship and considerable exposure to US culture. The researchers emphasize the importance of not assuming that there is a protective effect of nativity for all Latinx immigrants in the United States.

Among US-dwelling Latinxs, sociopolitical factors can also mitigate increasing risk for mental health disorders. For example, Alegría et al. (2008) noted that perceived level of neighborhood safety is associated with lower risk for substance use disorders, even when controlling for individual socioeconomic status. Research also suggests that neighborhood composition can impact mental health of Latinxs, with increased Latinx neighborhood concentration contributing to lower depressive symptoms among residents, but only for those who are English speaking (Shell, Peek, & Eschbach, 2013). Perceived discrimination and stress also moderated the relation between Latinx neighborhoods and mental health outcomes, such that this effect was more pronounced among those with higher levels of stress and experiences of discrimination. Additional factors such as strong ethnic identity and self-efficacy have also been proposed as moderating the effect of discrimination and stress on mental health outcomes (Pascoe & Smart Richman, 2009).

Impact of Macroaggressions and Microaggressions among Latinxs

Past research has found a significant relation between ethnic discrimination and increased traumatic stress symptoms among Latinxs (Flores, Tschann, Dimas, Pasch, & de Groat, 2010). Ethnic discrimination, particularly macroaggression (e.g., racial profiling, anti-immigrant sentiment), has been linked to traumatic stress symptoms, given the overt hostility of the aggressor and sense of lack of control from the victim (Flores et al., 2010).

Over the last two decades, interest has also grown in the concept of ethnic microaggressions, a term coined by Sue et al. (2007) to describe “brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color” (p. 1). While the impact of microaggressions on the mental health of racial/ethnic minorities continues to be explored, investigators have proposed that repeated exposure to microaggressions can induce emotional dysregulation and elicit trauma-like symptoms in some individuals. Borrowing from the research of Hatzenbuehler, Dovidio, Nolen-Hoeksema, and Phills (2009) on sexual minorities, Wong, Derthick, David, Saw, and Okazaki (2014) adapted a model delineating the ways in which microaggressions impact the mental health of racial/ethnic minorities.

The model highlights the direct relationship between microaggressions and emotional dysregulation (i.e., increased rumination, increased impulsivity), which then leads to increased risk for depression, anxiety, substance abuse, and other negative health outcomes. It also includes factors that are proposed to moderate this relationship, including coping strategies, social environment, and existing negative cognitions that predate microaggressions. In a recent study, Torres and Taknint (2015) tested a similar model to explore the impact of ethnic microaggressions on depression among Latinxs. Their model included moderating and mediational pathways to explain the link between ethnic microaggressions and depression among Latinxs. Their model was fully supported in a study, suggesting that microaggressions are associated with increased traumatic stress symptoms, which, in turn, relates to elevated depression. Additionally, the magnitude of traumatic stress symptoms was moderated by the individual’s level of ethnic identity/general self-efficacy. This research is promising, as it delineates a direct path through which microaggressions can impact emotional regulation (traumatic stress symptoms), and individual resources that could mitigate this response. It opens the door for further research targeting ways to reduce the impact of everyday discrimination, such as microaggressions, on the mental health of Latinx individuals during this stressful time in US history.

Gaps in the Literature

Despite a growing body of literature identifying the ways in which prejudice and discrimination impacts Latinx individuals in the United States across the lifespan, there are still several areas where further exploration is necessary. We believe that research exploring the impact of microaggressions among multiple identities found in Latinx subcultures would be beneficial. Such groups include LGBTQIQ Latinx and afro-Latinx individuals, whose intersecting identities are very rarely the focus of research. Because of their different minority identities, these individuals may be at greater risk for negative mental health outcomes related to discrimination. For example, a recent study found that lifetime experiences of discrimination and victimization were significant risk factors for mental health problems among LGB older adults (Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013). In addition, research suggests that individuals from multiracial heritage often experience isolation and exclusion from their families and communities (Nadal, Sriken, Davidoff, Wong, & McLean, 2013). Given that strong ethnic identity and self-efficacy can be protective, these factors may place multiracial individuals at particular risk for negative mental health outcomes in the face of discrimination. Researchers in this area should aim to explore the intersectionality present in our complex communities as we work to understand and mitigate the impact of discrimination among all cultural minorities.

We also emphasize the need to explore the experiences of prejudice, oppression, and discrimination among US older Latinx adults. Relatively little attention has been directed to the experiences of elderly Latinxs, except for the field of social work and sociology which has explored the impact of institutional racism and oppression on the functional impairment, chronic conditions, and the financial resources of this population (Angel, 2009; Angel, Angel, & Hill, 2015; Min, 2005). Clearly, the physical and economic consequences of experiences of immigration, acculturation, and barriers to care are pronounced in older Latinx adults, but more information is needed to identify the mental health impact of life-time experiences of prejudice and discrimination, especially among US-born Latinx elderly who report lower life satisfaction than their foreign-born counterparts (Calvo, Carr, & Matz-Costa, 2017).

Addressing Clients' Experiences of Prejudice, Discrimination, and Microaggressions

As the number of Latinxs grows in the United States, it is increasingly important for psychologists to know how to provide culturally competent services and to identify the institutional/individual forms of discrimination that Latinx clients face in their daily lives. As a field overall, there has been a movement for psychologists to promote equity and social justice as a way to tackle oppression, prejudice, and discrimination (Goodman et al., 2004; Rosenthal, 2016). For instance, the American Psychological Association's (APA, 2002) first set of multicultural guidelines promoted diversity and multiculturalism across all domains of the profession, including education, training, research, practice, and organizational change. A whole 10 years before this, Sue, Arredondo, and McDavis (1992) proposed a set of multicultural guidelines for the field of counseling psychology with a special emphasis on developing culturally skilled counselors who are aware of how oppression, racism, discrimination, and stereotyping affect their work with clients. Although multicultural guidelines exist, there is little information on *how* clinical psychologists ought to respond to oppression, prejudice, and discrimination experienced by clients. Additionally, the multicultural guidelines do not provide specific direction on the most pressing issues for many of our Latinx clients (i.e., prejudice against Spanish speakers and undocumented Latinx immigrants). Nonetheless, the multicultural guidelines provide a foundation for general practice recommendations. The purpose of this section is to provide additional recommendations for clinical psychologists addressing Latinx client experiences of prejudice and discrimination.

In the context of therapy, psychologists should be mindful of contextual factors that may influence a client's reported difficulties and objectives for treatment. Ideally, this should begin during the pretreatment assessment phase. We recommend that clinical psychologists specifically ask about client experiences of oppression, prejudice, and discrimination. As previously mentioned, evidence suggests that these experiences can deteriorate both physical and mental health (Garcini et al., 2018; Pascoe & Smart Richman, 2009). Although a psychologist could wait until a client brings up these issues in therapy, we recommend a proactive approach because it allows for an open discussion about these matters from onset. This also can communicate to the client that the psychologist acknowledges the existence of social disparities and that they are welcomed to be discussed in therapy. An open discussion of these experiences can provide valuable data and insight, which can later be used to generate a more accurate case conceptualization. For psychologists who utilize cognitive–behavioral approaches, these discussions may also clarify whether the presenting problem is primarily environmental, cognitive, or both, and help identify appropriate interventions for managing oppressive environments.

During the pretreatment assessment phase, we also recommend asking foreign-born Latinx clients about immigration experiences. The immigration process to the United States can be stressful and potentially traumatic, particularly for undocumented immigrants (DeLuca, McEwen, & Keim, 2010; Pumariega, Rothe, & Pumariega, 2005). For example, qualitative studies document the experiences of Latinx immigrants in transit to the United States who are threatened, kidnapped, and physically or sexually assaulted (DeLuca et al., 2010). For undocumented immigrants who cross the US-Mexican border by foot, there is also risk of dehydration, harsh weather conditions, and death. As before, we recommend specifically asking about these immigration experiences because they may go undetected, even when using standardized assessments that inquire about traumatic experiences (de Arellano et al., 2018).

In addition to asking about potentially stressful events like prejudice and discrimination, we recommend asking clients about their strengths. Exclusively using a deficit-focused model of assessment limits the range of information received from clients and ultimately reduces the amount of information considered in one's case formulation. Consequently, a deficit-focused model hinders our ability to identify resources and competencies that can be built upon when developing a treatment plan. Therefore, we recommend assessing strengths, skills, and personal accomplishments that help us understand the client as a whole and how they have managed experiences of prejudice and discrimination. There are many strategies to conduct strength-based assessments, including structured interviews, checklists, and targeted questions (for a review, see Tedeschi & Kilmer, 2005).

Throughout the duration of therapy, the psychologist can address racism and discrimination in various ways; however, tackling these issues can be difficult and uncomfortable, and specific guidelines on addressing these issues are lacking. Cardemil and Battle (2003) provide recommendations including avoiding assumptions that the client is like others from their racial and ethnic group, and openly discussing how power, privilege, and racism can affect the therapeutic process. Relatedly, psychologists should be aware of their own prejudices and biases and inadvertent use of microaggressions. For example, we recommend reviewing the updated Multicultural and Social Justice Counseling Competencies, which highlight the interaction of privileged and marginalized statuses belonging to both the counselor and their impact on the counseling relationship (Ratts, Singh, Nassar-Mcmillan, Butler, & McCullough, 2016). Additionally, the

Healing Ethno And Racial Trauma (HEART) framework assists psychologists in dually addressing the consequences of oppressive systems and psychological distress for Latinx individuals and communities (Chavez-Dueñas et al., 2019).

How the Field Has Responded to Latinx Experiences of Prejudice and Discrimination

Immigration policies under our current administration disproportionately impact Latinx families who represent 19.4 million of the foreign-born population and account for almost half (45%) of the immigrant population in the United States (U.S. Census Bureau, 2017c). As psychologists who serve those affected by the current anti-immigrant sentiment, forced separations at the border, forced deportations, and the resulting psychological trauma, we must become familiar with the policies in place that can impact the mental health of our Latinx clients. Indeed, updated APA multicultural guidelines in 2017 provided a much more specific guideline aimed at addressing the need for social justice and the recognition of experiences of oppression:

> Guideline 5. Psychologists aspire to recognize and understand historical and contemporary experiences with power, privilege, and oppression. As such, they seek to address institutional barriers and related inequities, disproportionalities, and disparities of law enforcement, administration of criminal justice, educational, mental health, and other systems as they seek to promote justice, human rights, and access to quality and equitable mental and behavioral health services. (APA, 2017)

What has the field of clinical psychology done to address these experiences of oppression and discrimination for Latinxs? Some might say too little, while others may believe we are doing now more than ever. The APA has taken an increasingly public stance on issues impacting Latinxs. For example, in 2017 after President Trump terminated the Development, Relief, and Education for Alien Minors (DREAM) Act, then APA President, Dr. Antonio Puente, wrote an op-ed piece in *USA Today* describing his personal experience as an undocumented immigrant from Cuba. Later in 2018, the APA sent a letter to President Trump urging for the end of forced detention and family separation at the US–Mexico border. More specifically, this letter identified the need for culturally competent psychological services in the family detention centers, especially by Spanish-speaking therapists with trauma-informed backgrounds and training in diversity. Other psychological associations, such as the National Latinx Psychological Association (NLPA) and APA's Society for Clinical Psychology, have also released statements condemning the separation of asylum-seeking families escaping violence in Central America. To fill the need for clinical guidelines where none exist, and in an effort to enhance the mental health of Latinxs, the NLPA developed the *Guidelines for Detention Center Personnel Working with Unaccompanied Asylum-Seeking Minors* (Torres Fernández, Chavez-Dueñas, & Consoli, 2015).

At the client-provider level, psychologists have an ethical responsibility to advocate for client needs, but when it comes to social justice issues and public advocacy, it is clear that clinical psychology falls behind the training provided by other fields (e.g., multicultural, counseling, and community psychology). In regard to doctoral training, the University of Tennessee Counseling Psychology Program developed the first scientist–practitioner–advocate (SPA) training model accredited by the APA (Mallinckrodt, Miles, & Levy, 2014). The SPA model calls for psychologists who can engage in social-action research, advocate at the policy level, and empower clients at the individual level. In order to respond more adequately to the experiences of oppression, prejudice, and discrimination of Latinxs, the field must make social justice an objective infused throughout the training of clinical psychologists, the research examining the experiences of Latinxs, and the provision of culturally competent services.

Given the growth of the Latinx population in the United States, the field of psychology has severely lacked the workforce necessary to meet the needs of this population. According to the

APA's Center for Workforce Studies, Latinxs make up only 6% (5,826) of the US psychology workforce, an increase of 107% since 2007 (APA, 2018c). In terms of service providers, a 2015 survey of licensed psychology health service providers revealed that Latinxs represented only 4.4% of licensed doctoral-level psychologists and 5.5% of respondents were able to provide services in Spanish (APA, 2016a). The shortage of culturally and linguistically competent psychologists is often cited as a barrier to mental health treatment for Latinx clients (Alegría, Alvarez, Ishikawa, DiMarzio, & McPeck, 2016; Bridges, Andrews, & Deen, 2012; Kim et al., 2011; Sentell, Shumway, & Snowden, 2007; Villalobos et al., 2016). Indeed, the inability to access a provider who speaks your language or who understands your culture is a social justice issue, one which places Latinxs with mental health problems at a greater risk for the negative sequelae that result from untreated mental illness. The diversification and expansion of the Latinx clinical psychology workforce is one avenue to increasing access to appropriate care.

Moreover, Latinxs represent only 10% of graduate students in Master's and Doctoral programs and 12% of psychology doctorates awarded (APA, 2016b, 2018b). These statistics do not specifically report on graduate students studying clinical psychology, and thus, numbers reported here may not reflect our actual representation in the field. In order to increase the number of culturally and linguistically competent clinical psychologists, the field must also ensure that Latinx, and non-Latinx students alike, receive specialized training to meet the needs of the Latinx community (e.g., William James College provides a Latinx mental health concentration for their Clinical Psychology PsyD program; APA, 2018a).

Impact on Professionals

Clinical psychologists and trainees who identify as Latinx are not immune to experiences of oppression, prejudice, and discrimination in professional contexts. Clinical psychologists and trainees often take on various roles in the same day, such as instructor, student, supervisor, and clinician. Although one might assume professionals, particularly those in psychology, do not discriminate or have negative biases about others, this is not the case. Unconscious and subtle attitudes are prevalent even among well-intentioned individuals and organizations (Dovidio et al., 2010). For instance, the APA Presidential Task Force on Enhancing Diversity reported that the APA was "unwelcoming" to ethnic minority psychologists, citing patronizing behavior, stigmatizing language, and stereotyping (Suinn et al., 2005). The purpose of this section is to provide a snapshot of what we know about Latinx clinical psychologists and trainee experiences with oppression, prejudice, and discrimination.

To our knowledge, there has been only one article that specifically focused on describing the Latinx clinical psychology trainee experience with oppression, prejudice, and discrimination. Noyola (2017) discussed personal experiences of microaggressions throughout the graduate school admission process and their time in a clinical psychology program. Similarly, other articles that discuss this topic are retrospective autobiographical life narratives of several US Latinx faculty/psychologists. Delgado-Romero, Unkefer, Capielo, and Crowell (2017) examined the narratives of 18 Latinx psychologists and conducted a thematic analysis that identified overarching themes. Under the theme of *cultural identities*, many narrative authors wrote about multiple experiences of oppression, racism, and discrimination across their academic careers (undergraduate, graduate, and faculty experiences). For instance, Miguel Gallardo (2014) reflected on being a faculty member of color and contemplated on how to change the admission process that he believed unfairly discriminated against students of color. Steven Lopez (1993) wrote about his interactions with colleagues who called him derogatory and racist names. Melba Vasquez (2001) discussed the impact affirmative action had on her ability to become a psychologist.

Through their thematic analysis, Delgado-Romero et al. (2017) also identified mentorship as a crosscutting theme. Specifically, many narratives discussed the importance of Latinx faculty who serve as advocates and mentors. Latinx faculty were seen as beacons of hope, support, and examples that Latinxs can succeed in academia. Many narrative authors also discussed the impact of not having Latinx mentors on their professional identity. For example, Bianca Guzman (2012) discussed leaving a position because there were no individuals who looked like her. The lack of Latinx representation is also apparent in leaders of professional organizations. For example, since the APA's inception in 1892, there have only been two Latinx presidents; in 2011, Melba Vasquez became the first Latina president of the APA, followed by Antonio Puente in 2017.

It is clear from there is still much to learn about the experiences of Latinx psychology professionals. What is needed are more studies that examine the experiences of injustice that Latinx psychology professionals experience. With the current literature available, it is difficult to assess the magnitude and severity of this issue, even though we know that these incidents occur to many of us – including all three Latinx authors of this chapter. Without documentation of the prevalence and consequences of these negative experiences, it is difficult to create large, organizational change. Thus, it is important for future studies to shed light on these incidents so we can continue to grow as a field.

Summary

As researchers, clinicians, and social justice advocates all working in the field of clinical psychology, it is imperative that we, and the institutions that represent us, do more to attend to the experiences of Latinx populations. Research on the specific mental health impact of oppression, prejudice, and discrimination on Latinx populations is lacking and warrants further investigation. Given the cultural and linguistic variability in this population, nuanced information can help inform our clinical practices and shape advocacy efforts at the individual and institutional levels. As Latinx populations are confronted with increasingly overt acts of discrimination and prejudice, enhancing access to mental health services and outlets for Latinx voices is critical to overcoming these experiences. *Sí, se puede* (Yes, we can)!

References

Alegría, M., Alvarez, K., Ishikawa, R. Z., DiMarzio, K., & McPeck, S. (2016). Removing obstacles to eliminating racial and ethnic disparities in behavioral health care. *Health Affairs, 35*(6), 991–999. https://doi.org/10.1377/hlthaff.2016.0029

Alegría, M., Canino, G., Shrout, P. E., Woo, M., Duan, N., Vila, D., … Meng, X.-L. (2008). Prevalence of mental illness in immigrant and non-immigrant U.S. Latino groups. *American Journal of Psychiatry, 165*(3), 359–369. https://doi.org/10.1176/appi.ajp.2007.07040704

Almeida, J., Biello, K. B., Pedraza, F., Wintner, S., & Viruell-Fuentes, E. (2016). The association between anti-immigrant policies and perceived discrimination among Latinos in the US: A multilevel analysis. *SSM - Population Health, 2*(October), 897–903. https://doi.org/10.1016/j.ssmph.2016.11.003

American Psychological Association. (2002). *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists American Psychological Association*. Retrieved from https://www.apa.org/about/policy/multicultural-guidelines-archived.pdf

American Psychological Association. (2016a). *2015 APA survey of psychology health service providers*. Washington, DC. Retrieved from https://www.apa.org/workforce/publications/15-health-service-providers/report.pdf

American Psychological Association. (2016b). *Graduate study in psychology 2017*. Washington, DC. Retrieved from www.apa.org/ed/graduate

American Psychological Association. (2017). *Multicultural guidelines: An ecological approach to context, identity, and intersectionality*. Retrieved from http://www.apa.org/about/policy/multicultural-guidelines.pdf

American Psychological Association. (2018a). Cultural and language programs. *Monitor on Psychology, 49*(6), 70. Retrieved from https://www.apa.org/monitor/2018/06/spanish-speaking-programs

American Psychological Association. (2018b). *Degrees in psychology* [Interactive data tool]. Retrieved from https://www.apa.org/workforce/data-tools/degrees-psychology

American Psychological Association. (2018c). *Demographics of the U.S. psychology workforce* [Interactive data tool]. Retrieved from https://www.apa.org/workforce/data-tools/demographics

Anderson, K. F., & Finch, J. K. (2017). The role of racial microaggressions, stress, and acculturation in understanding Latino health outcomes in the USA. *Race and Social Problems, 9*(3), 218–233. https://doi.org/10.1007/s12552-017-9212-2

Angel, R. J. (2009). Structural and cultural factors in successful aging among older Hispanics. *Family & Community Health, 32*(Supplement), S46–S57. https://doi.org/10.1016/j.neuroimage.2013.08.045

Angel, R. J., Angel, J. L., & Hill, T. D. (2015). Longer lives, sicker lives? Increased longevity and extended disability among Mexican-origin elders. *Journals of Gerontology Series B: Psychological Sciences & Social Sciences, 70*(4), 639–649. https://doi.org/10.1093/geronb/gbu158

Arellano-Morales, L., Roesch, S. C., Gallo, L. C., Emory, K. T., Molina, K. M., Gonzalez, P., … Brondolo, E. (2015). Prevalence and correlates of perceived ethnic discrimination in the Hispanic community health study/study of Latinos sociocultural ancillary study. *Journal of Latina/o Psychology, 3*(3), 160–176. https://doi.org/10.1037/lat0000040

Berger Cardoso, J., Scott, J. L., Faulkner, M., & Barros Lane, L. (2018). Parenting in the context of deportation risk. *Journal of Marriage and Family, 80*(2), 301–316. https://doi.org/10.1111/jomf.12463

Bridges, A. J., Andrews, A. R., & Deen, T. L. (2012). Mental health needs and service utilization by Hispanic immigrants residing in mid-southern United States. *Journal of Transcultural Nursing, 23*(4), 359–368. https://doi.org/10.1177/1043659612451259

Brittian, A. S., Kim, S. Y., Armenta, B. E., Lee, R. M., Umaña-Taylor, A. J., Schwartz, S. J., … Hudson, M. L. (2015). Do dimensions of ethnic identity mediate the association between perceived ethnic group discrimination and depressive symptoms? *Cultural Diversity and Ethnic Minority Psychology, 21*(1), 41–52. https://doi.org/10.1037/a0037531

Calvo, R., Carr, D. C., & Matz-Costa, C. (2017). Another paradox? The life satisfaction of older Hispanic immigrants in the United States. *Journal of Aging and Health, 29*(1), 3–24. https://doi.org/10.1177/0898264315624901

Cardemil, E. V., & Battle, C. L. (2003). Guess who's coming to therapy? Getting comfortable with conversations about race and ethnicity in psychotherapy. *Professional Psychology: Research and Practice, 34*(3), 278–286. https://doi.org/10.1037/0735-7028.34.3.278

Cerezo, A. (2016). The impact of discrimination on mental health symptomatology in sexual minority immigrant Latinas. *Psychology of Sexual Orientation and Gender Diversity, 3*(3), 283–292. https://doi.org/10.1037/sgd0000172

Chavez-Dueñas, N. Y., Adames, H. Y., & Organista, K. C. (2014). Skin-color prejudice and within-group racial discrimination: Historical and current impact on Latino/a populations. *Hispanic Journal of Behavioral Sciences, 36*(1), 3–26. https://doi.org/10.1177/0739986313511306

Chavez-Dueñas, N. Y., Adames, H. Y., Perez-chavez, J. G., & Salas, S. P. (2019). Healing ethno-racial trauma in Latinx immigrant communities: Cultivating hope, resistance, and action. *American Psychologist, 74*(1), 49–62. https://doi.org/10.1037/amp0000289

Cobb, C. L., Xie, D., Meca, A., & Schwartz, S. J. (2017). Acculturation, discrimination, and depression among unauthorized Latinos/as in the United States. *Cultural Diversity and Ethnic Minority Psychology, 23*(2), 258–268. https://doi.org/10.1037/cdp0000118

Cole, E. R. (2009). Intersectionality and research in psychology. *American Psychologist, 64*(3), 170–180. https://doi.org/10.1037/a0014564

de Arellano, M. A., Andrews, A. R., Reid-Quiñones, K., Vasquez, D., Doherty, L. S., Danielson, C. K., & Rheingold, A. (2018). Immigration trauma among Hispanic youth: Missed by trauma assessments and predictive of depression and PTSD symptoms. *Journal of Latina/o Psychology, 6*(3), 159–174. https://doi.org/10.1037/lat0000090

Delgado-Romero, E. A., Unkefer, E. N. S., Capielo, C., & Crowell, C. N. (2017). El que oye consejos, llega a viejo: Examining the published life narratives of U.S. Latino/a Psychologists. *Journal of Latina/o Psychology, 5*(3), 127–141. https://doi.org/10.1037/lat0000071

DeLuca, L. A., McEwen, M. M., & Keim, S. M. (2010). United States–Mexico border crossing: Experiences and risk perceptions of undocumented male immigrants. *Journal of Immigrant and Minority Health, 12*(1), 113–123. https://doi.org/10.1007/s10903-008-9197-4

Díaz, R. M., Ayala, G., Bein, E., Henne, J., & Marin, B. V. (2001). The impact of homophobia, poverty, and racism on the mental health of gay and bisexual Latino men: Findings from 3 US cities. *American Journal of Public Health, 91*(6), 927–932. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446470/pdf/11392936.pdf

Dovidio, J. F., Gluszek, A., John, M.-S., Ditlmann, R., & Lagunes, P. (2010). Understanding Bias toward Latinos: Discrimination, dimensions of difference, and experience of exclusion. *Journal of Social Issues, 66*(1), 59–78. https://doi.org/10.1111/j.1540-4560.2009.01633.x

Ennis, S. R., Ríos-Vargas, M., & Albert, N. G. (2011). *The Hispanic population: 2010. 2010 census briefs.* Retrieved from https://www.census.gov/content/dam/Census/library/publications/2011/dec/c2010br-04.pdf

Flores, E., Tschann, J. M., Dimas, J. M., Pasch, L. A., & de Groat, C. L. (2010). Perceived racial/ethnic discrimination, posttraumatic stress symptoms, and health risk behaviors among Mexican American adolescents. *Journal of Counseling Psychology, 57*(3), 264–273. https://doi.org/10.1037/a0020026

Franzini, L., Ribble, J. C., & Keddie, A. M. (2001). Understanding the Hispanic paradox. *Ethnicity & Disease, 11*(3), 496–518. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/11572416

Fredriksen-Goldsen, K. I., Kim, H. J., Barkan, S. E., Muraco, A., & Hoy-Ellis, C. P. (2013). Health disparities among lesbian, gay, and bisexual older adults: Results from a population-based study. *American Journal of Public Health, 103*(10), 1802–1809. https://doi.org/10.2105/AJPH.2012.301110

Gallardo, M. (2014). *Developing cultural humility: Embracing race, privilege and power*. Thousand Oaks, CA: SAGE Publications, Inc. https://doi.org/10.4135/9781483388076

Garcia, C., & Lindgren, S. (2009). "Life grows between the rocks": Latino adolescents' and parents' perspectives on mental health stressors. *Research in Nursing & Health, 32*(2), 148–162. https://doi.org/10.1002/nur.20317

Garcini, L. M., Chen, M. A., Brown, R. L., Galvan, T., Saucedo, L., Cardoso, J. A. B., & Fagundes, C. P. (2018). Kicks Hurt Less: Discrimination predicts distress beyond trauma among undocumented Mexican immigrants. *Psychology of Violence, 8*(6), 692–701. https://doi.org/10.1037/vio0000205

Gee, G. C., Ryan, A., Laflamme, D. J., & Holt, J. (2006). Self reported discrimination and mental health status among African descendants, Mexican Americans, and other Latinos in the New Hampshire REACH 2010 Initiative: The added dimension of immigration. *American Journal of Public Health, 96*(10), 1821–1828. https://doi.org/10.2105/AJPH.2005.080085

Golash-Boza, T., & Darity, W. (2008). Latino racial choices: The effects of skin colour and discrimination on Latinos' and Latinas' racial self-identifications. *Ethnic and Racial Studies, 31*(5), 899–934. https://doi.org/10.1080/01419870701568858

Goodman, L. A., Liang, B., Helms, J. E., Latta, R. E., Sparks, E., & Weintraub, S. R. (2004). Training counseling psychologists as social justice agents: Feminist and multicultural principles in action. *The Counseling Psychologist, 32*(6), 793–836. https://doi.org/10.1177/0011000004268802

Guzman, B. (2012). The educational journey of a Latina feminist community psychologist. *Journal of Community Psychology, 40*(1), 62–76. https://doi.org/10.1002/jcop.20503

Hatzenbuehler, M. L., Dovidio, J. F., Nolen-Hoeksema, S., & Phills, C. E. (2009). An implicit measure of anti-gay attitudes: Prospective associations with emotion regulation strategies and psychological distress. *Journal of Experimental Social Psychology, 45*(6), 1316–1320. https://doi.org/10.1016/j.jesp.2009.08.005

Held, M. L., & Lee, S. (2017). Discrimination and mental health among Latinos: Variation by place of origin. *Journal of Mental Health, 26*(5), 405–410. https://doi.org/10.1080/09638237.2016.1207220

Ibañez, G. E., Van Oss Marin, B., Flores, S. A., Millett, G., & Diaz, R. M. (2009). General and gay-related racism experienced by Latino gay men. *Cultural Diversity and Ethnic Minority Psychology, 15*(3), 215–222. https://doi.org/10.1037/a0014613

Kim, G., Aguado Loi, C. X., Chiriboga, D. A., Jang, Y., Parmelee, P., & Allen, R. S. (2011). Limited English proficiency as a barrier to mental health service use: A study of Latino and Asian immigrants with psychiatric disorders. *Journal of Psychiatric Research, 45*(1), 104–110. https://doi.org/10.1016/j.jpsychires.2010.04.031

Kim, H.-J., & Fredriksen-Goldsen, K. I. (2017). Disparities in mental health quality of life between Hispanic and non-Hispanic White LGB midlife and older adults and the influence of lifetime discrimination, social connectedness, socioeconomic status, and perceived stress. *Research on Aging, 39*(9), 991–1012. https://doi.org/10.1186/s40945-017-0033-9

Lee, D. L., & Ahn, S. (2012). Discrimination against Latina/os. *The Counseling Psychologist, 40*(1), 28–65. https://doi.org/10.1177/0011000011403326

Lopez, M. H., Gonzalez-Barrera, A., & López, G. (2017). *Hispanic identity fades as immigration connections fall away*. Pew Research Center*:* Hispanic Trends. Retrieved from http://www.pewhispanic.org/2017/12/20/hispanic-identity-fades-across-generations-as-immigrant-connections-fall-away/

Lopez, S. R. (1993). Building Bridges: The journey of one Chicano/Latino psychologist. In L. Huang (Ed.), *Career Development for ethnic minority psychologists: Choices and challenges* (pp. 27–34). Washington, DC: American Psychological Association.

Lopez, W. D., LeBrón, A. M. W., Graham, L. F., & Grogan-Kaylor, A. (2016). Discrimination and depressive symptoms among Latina/o adolescents of immigrant parents. *International Quarterly of Community Health Education, 36*(2), 131–140. https://doi.org/10.1177/0272684X16628723

Mallinckrodt, B., Miles, J. R., & Levy, J. J. (2014). The scientist-practitioner-advocate model: Addressing contemporary training needs for social justice advocacy. *Training and Education in Professional Psychology, 8*(4), 303–311. https://doi.org/10.1037/tep0000045

Martinez, C. R. (2006). Effects of differential family acculturation on Latino adolescent substance use. *Family Relations, 55*(3), 306–317. https://doi.org/10.1111/j.1741-3729.2006.00404.x

McClure, H. H., Snodgrass, J. J., Martinez, C. R., Eddy, J. M., Jiménez, R. A., & Isiordia, L. E. (2010). Discrimination, psychosocial stress, and health among Latin American immigrants in Oregon. *American Journal of Human Biology, 22*(3), 421–423. https://doi.org/10.1002/ajhb.21002

Min, J. W. (2005). Cultural competency: A key to effective future social work with racially and ethnically diverse elders. *Families in Society, 86*(3), 347–358. https://doi.org/10.1606/1044-3894.3432

Nadal, K. L., Mazzula, S. L., Rivera, D. P., & Fujii-Doe, W. (2014). Microaggressions and Latina/o Americans: An analysis of nativity, gender, and ethnicity. *Journal of Latina/o Psychology, 2*(2), 67–78. https://doi.org/10.1037/lat0000013

Nadal, K. L., Sriken, J., Davidoff, K. C., Wong, Y., & McLean, K. (2013). Microaggressions within families: Experiences of multiracial people.

Family Relations, 62(1), 190–201. https://doi.org/10.1111/j.1741-3729.2012.00752.x

Nair, R. L., White, R. M. B., Roosa, M. W., & Zeiders, K. H. (2013). Cultural stressors and mental health symptoms among Mexican Americans: A prospective study examining the impact of the family and Neighborhood context. *Journal of Youth and Adolescence, 42*(10), 1611–1623. https://doi.org/10.1007/s10964-012-9834-z

National Public Radio, Robert Wood Johnson Foundation, & Harvard T. H. Chan School of Public Health. (2017). *Discrimination in America: Experiences and Views of Latinos*. Retrieved from https://www.npr.org/documents/2017/oct/discrimination-latinos-final.pdf

Négron-Muntaner, F. (2014). *The Latino media gap: A report on the state of Latinos in U.S. media*. Retrieved from http://thecollectiveinitiative.org/images/archives/TheLatinoMediaGap.pdf

Noyola, N. (2017). It is time for academia to take a serious look in the mirror: Critical reflections from a gay, cisgender, immigrant Latino graduate student. *Latina/o Psychology Today, 4*(2), 19–22. Retrieved from https://www.nlpa.ws/latinx-psychology-today-bulletin

Otiniano Verissimo, A. D., Gee, G. C., Iguchi, M. Y., Ford, C. L., & Friedman, S. R. (2013). Discrimination, drugs, and alcohol among Latina/os in Brooklyn, New York: Differences by gender. *International Journal of Drug Policy, 24*(4), 367–373. https://doi.org/10.1016/j.drugpo.2013.01.010

Pascoe, E. A., & Smart Richman, L. (2009). Perceived discrimination and health: A meta-analytic review. *Psychological Bulletin, 135*(4), 531–554. https://doi.org/10.1037/a0016059

Pérez, D. J., Fortuna, L., & Alegría, M. (2008). Prevalence and correlates of everyday discrimination among U.S. Latinos. *Journal of Community Psychology, 36*(4), 421–433. https://doi.org/10.1002/jcop.20221

Pew Research Center. (2018). *More Latinos have serious concerns about their place in America under trump*. Retrieved from http://www.pewhispanic.org/2018/10/25/more-latinos-have-serious-concerns-about-their-place-in-america-under-trump/

Ponting, C., Lee, S. S., Escovar, E. L., Rapp, A. M., Camacho, A., Calderon, I., & Chavira, D. A. (2018). Family factors mediate discrimination related stress and externalizing symptoms in rural Latino adolescents. *Journal of Adolescence, 69*, 11–21. https://doi.org/10.1016/j.adolescence.2018.08.007

Pumariega, A. J., Rothe, E., & Pumariega, J. A. B. (2005). Mental health of immigrants and refugees. *Community Mental Health Journal, 41*(5), 581–597. https://doi.org/10.1007/s10597-005-6363-1

Ratts, M. J., Singh, A. A., Nassar-Mcmillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development, 44*(1), 28–48. https://doi.org/10.1002/jmcd.12035

Reisen, C. A., Brooks, K. D., Zea, M. C., Poppen, P. J., & Bianchi, F. T. (2013). Can additive measures add to an intersectional understanding? Experiences of gay and ethnic discrimination among HIV-positive Latino gay men. *Cultural Diversity and Ethnic Minority Psychology, 19*(2), 208–217. https://doi.org/10.1037/a0031906

Rosenthal, L. (2016). Incorporating intersectionality into psychology: An opportunity to promote social justice and equity. *American Psychologist, 71*(6), 474–485. https://doi.org/10.1037/a0040323

Sawyer, P. J., Major, B., Casad, B. J., Townsend, S. S. M., & Mendes, W. B. (2012). Discrimination and the stress response: Psychological and physiological consequences of anticipating prejudice in interethnic interactions. *American Journal of Public Health, 102*(5), 1020–1026. https://doi.org/10.2105/AJPH.2011.300620

Schwartz, S. J., Unger, J. B., Baezconde-Garbanati, L., Zamboanga, B. L., Lorenzo-Blanco, E. I., Des Rosiers, S. E., … Szapocznik, J. (2015). Trajectories of cultural stressors and effects on mental health and substance use among Hispanic immigrant adolescents. *Journal of Adolescent Health, 56*(4), 433–439. https://doi.org/10.1016/j.jadohealth.2014.12.011

Sentell, T., Shumway, M., & Snowden, L. (2007). Access to mental health treatment by English language proficiency and race/ethnicity. *Journal of General Internal Medicine, 22*(SUPPL. 2), 289–293. https://doi.org/10.1007/s11606-007-0345-7

Shell, A. M., Peek, M. K., & Eschbach, K. (2013). Neighborhood Hispanic composition and depressive symptoms among Mexican-descent residents of Texas City, Texas. *Social Science and Medicine, 99*, 56–63. https://doi.org/10.1016/j.socscimed.2013.10.006

Suárez-Orozco, C., Rhodes, J., & Milburn, M. (2009). Unraveling the immigrant paradox. *Youth & Society, 41*(2), 151–185. https://doi.org/10.1177/0044118x09333647

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development, 20*(2), 64–88. https://doi.org/10.1002/j.2161-1912.1992.tb00563.x

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62*(4), 271–286. https://doi.org/10.1037/0003-066X.62.4.271

Suinn, R. M., Abeles, N., Arredondo, P., Greene, B., Hedayat-Diba, Z., McDonald, J. D., … White, J. L. (2005). *APA presidential task force on enhancing diversity*. Retrieved from https://www.apa.org/pi/oema/resources/taskforce-report.pdf

Tedeschi, R. G., & Kilmer, R. P. (2005). Assessing strengths, resilience, and growth to guide clinical interventions. *Professional Psychology:*

Research and Practice, 36(3), 230–237. https://doi.org/10.1037/0735-7028.36.3.230

Torres Fernández, I., Chavez-Dueñas, N., & Consoli, A. J. (2015). *Guidelines for detention center personnel working with unaccompanied asylum-seeking minors*. Retrieved from https://www.nlpa.ws/assets/nlpa%20guidelines%20detention%20center%20personnel%20Jan%202015.pdf

Torres, L., & Ong, A. D. (2010). A daily diary investigation of Latino ethnic identity, discrimination, and depression. *Cultural Diversity and Ethnic Minority Psychology, 16*(4), 561–568. https://doi.org/10.1037/a0020652

Torres, L., & Taknint, J. T. (2015). Ethnic microaggressions, traumatic stress symptoms, and Latino depression: A moderated mediational model. *Journal of Counseling Psychology, 62*(3), 393–401. https://doi.org/10.1037/cou0000077

Tran, A. G. T. T. (2014). Family contexts: Parental experiences of discrimination and child mental health. *American Journal of Community Psychology, 53*(1–2), 37–46. https://doi.org/10.1007/s10464-013-9607-1

U.S. Census Bureau. (2017a). *Hispanic or Hispanic origin by specific origin, 2013–2017 American community survey 5-year estimates*. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF

U.S. Census Bureau. (2017b). *Language spoken at home by ability to speak English for the population 5 years and over (Hispanic or Latino), 2013–2017 American community survey 5-year estimates*. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_5YR_B16006&prodType=table

U.S. Census Bureau. (2017c). *Selected characteristics of the native and foreign-born populations, 2013–2017 American community survey 5-year estimates*. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_5YR_S0501&prodType=table

U.S. Census Bureau. (2018). *QuickFacts: UNITED STATES*. Retrieved from https://www.census.gov/quickfacts/fact/table/US/PST045218

Umaña-Taylor, A. J., Tynes, B. M., Toomey, R. B., Williams, D. R., & Mitchell, K. J. (2015). Latino adolescents' perceived discrimination in online and offline settings: An examination of cultural risk and protective factors. *Developmental Psychology, 51*(1), 87–100. https://doi.org/10.1037/a0038432

Vasquez, M. J. T. (2001). Reflections on unearned advantages, unearned disadvantages, and empowering experiences. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 64–77). Thousand Oaks, CA: Sage Publications.

Vespa, J., Armstrong, D. M., & Medina, L. (2018). Demographic turning points for the United States: Population projections for 2020 to 2060. *Current Population Reports*. Retrieved from www.census.gov/programs-surveys/popproj

Villalobos, B. T., Bridges, A. J., Anastasia, E. A., Ojeda, C. A., Rodriguez, J. H., & Gomez, D. (2016). Effects of language concordance and interpreter use on therapeutic alliance in Spanish-speaking integrated behavioral health care patients. *Psychological Services, 13*(1), 49–59. https://doi.org/10.1037/ser0000051

Williams, D. R., Mohammed, S. A., Leavell, J., & Collins, C. (2010). Race, socioeconomic status, and health: Complexities, ongoing challenges, and research opportunities. *Annals of the New York Academy of Sciences, 1186*(1), 69–101. https://doi.org/10.1111/j.1749-6632.2009.05339.x

Williams, M. T., Kanter, J. W., & Ching, T. H. W. (2018). Anxiety, stress, and trauma symptoms in African Americans: Negative affectivity does not explain the relationship between microaggressions and psychopathology. *Journal of Racial and Ethnic Health Disparities, 5*(5), 919–927. https://doi.org/10.1007/s40615-017-0440-3

Wong, G., Derthick, A. O., David, E. J. R. R., Saw, A., & Okazaki, S. (2014). The what, the why, and the how: A review of racial microaggressions research in psychology. *Race and Social Problems, 6*(2), 181–200. https://doi.org/10.1007/s12552-013-9107-9

The Invisibility of Asian Americans in the United States: Impact on Mental and Physical Health

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Abstract

Although Asian Americans are the fastest growing ethnic group in the United States, they are relatively invisible in behavioral health service delivery. Asian Americans generally have been overlooked in federal behavioral health policies. Underutilization of mental health services has also contributed to Asian Americans' invisibility. Therapist–client ethnic matching, increasing therapist cultural competence, cultural adaptations of interventions, and providing alternative services to traditional behavioral health interventions (e.g., movement-based interventions) have been approaches to making behavioral health services culturally relevant for Asian Americans. Future directions include the consideration of within-group variability among Asian Americans and of cultural influences that are proximal to treatment outcomes.

Keywords

Asian Americans · Health disparities · Cultural competence · Cultural adaptations · Alternative services

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Overview

Asian Americans have been an invisible group in the United States since their immigration to the United States. From immigration laws to present day media, Asian Americans' experiences, issues, and voices have consistently been ignored and minimized. It is a far-reaching problem that greatly impacts their mental health and well-being. We briefly review the history of Asian Americans and the rise of Asian-American stereotypes. We then discuss their effects on Asian Americans' physical and mental health, and how it affects providers. We also review examples of institutional racism and how Asian-American professionals can experience bias, racism, and invisibility in a field as progressive as clinical psychology. Finally, we discuss future directions and improvements the field can make to improve.

Asian Americans' History in the United States

Asian Americans' history in the United States has been wrought with difficulties and tribulations. "Asian American" is a broad categorical term that includes immigrants and their descendants from East Asia, Southeast Asia, and South Asia (U.S. Census Bureau, 2001, pg. B-14). But within these groups, there is a wide range of variability, such as circumstances of immigration,

© Springer Nature Switzerland AG 2020
L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_6

education, and culture. Early immigration of Asians in significant numbers to the United States began in the mid-nineteenth century, but Asians never made up more than about 5% of the total population (Barringer, Gardner, & Levin, 1995, *Table 2.1*). However, the amount of negative attention they received has been disproportionate. They have consistently been denied immigration opportunities, citizenship, and their civil rights. This has caused and exacerbated the continued invisibility and ignoring of Asian Americans' rights, issues, experiences, and needs.

Laws such as the 1882 Chinese Exclusion Act, the 1917 Immigration Act, and 1924 National Origins Act were enacted to prohibit immigration based on nationality. These laws were motivated by fears and stereotypes of the "yellow peril" (Walter, 2007). The *yellow peril* stereotype portrayed Asian Americans as economic competitive foreigners who were unable or unwilling to assimilate to U.S. norms, and thus a danger to American social and economic life (Kawai, 2005). Additionally, 120,000 Japanese Americans were incarcerated in U.S. internment camps during World War II, as Americans feared acts of sabotage against the United States. However, there was no evidence of Japanese Americans committing acts of sabotage against the United States before or during World War II (Nakanishi, 1988). Japanese Americans were not given a chance to defend themselves, and Italian and German Americans were also not sent to internment camps – why were only Japanese Americans singled out? Why was there also so little protest from non-Japanese Americans and Japanese Americans themselves? Perhaps, in addition to the yellow peril stereotype, Japanese culture's emphasis on harmony and conformity contributed to their silence.

Immigration restrictions against Asian Americans continued until the Immigration and Nationality Act of 1965, which undid decades of systematic racial prejudice and immigration bans for immigrants from all countries. Specifically, it repealed the 1917 Immigration Act, restricting "undesirables" from other countries and anyone from the Asiatic Barred Zone, and the National Origins Act of 1924, which extended the immigration ban to almost all of Asia, including Japan, which the previous law did not include.

This ushered in mass immigration from Asian countries, but there are always complications and ambiguities that arise. The current Asian-American population is still mostly first-generation immigrants (74.1%; Pew Research Center [PRC], 2012). Many of them experience problems assimilating, and there is a higher percentage of people of Asian descent in poverty compared to the general US public (PRC, 2012). Despite this, the perpetration of the "model minority" stereotype began to arise, lauding Asian Americans as success stories – minorities who succeed through hard work (Petersen, 1966).

Stereotypes and Attitudes About Asian Americans

Asian-American stereotypes have persisted since the 1960s, when the model minority stereotype was first introduced. These stereotypes typically revolve around educational stereotypes, but include personality and physical stereotypes as well. There are also gender stereotypes, such as viewing both men and women as more feminine and submissive.

Model Minority Stereotype

The most well-known and pervasive stereotype about Asian Americans is the model minority stereotype. The model minority stereotype lauds Asian Americans as success stories, minorities who have succeeded in the United States and achieved the American dream through education and hard work (Petersen, 1966). Indeed, there has been much attention and evidence that shows Asian Americans are succeeding and outperforming other racial/ethnic minority groups. For example, they have higher education achievement and are in more high-skill occupations than the overall U.S. population (PRC, 2012). They also have higher household incomes: $66,000 versus $49,800, for the overall U.S. population (PRC, 2012).

However, despite these stellar statistics, the model minority stereotype and evidence supporting it ignore the insidious message it holds: promoting color blindness via allowing the denial of the existence of institutional racism and that American society allows success and the achievement of the American Dream for all races and ethnicities (Kawai, 2005). Because Asian Americans are viewed as successful, they are seen as not needing social programs designed to help other minority groups (Ho & Jackson, 2001). Their voices are ignored when they ask for help, with people in leadership positions citing the above statistics. The statistics supporting the stereotype are misleading as they aggregate all Asian-American groups' data and ignore individual and group differences (Ngo & Lee, 2007). These deceptive statistics harm all minority groups and continue to silence Asian Americans when they speak up, as people do not believe Asian Americans have struggles. For example, Ho and Jackson (2001) primed White students to think about Asian Americans before answering questions about African Americans. They found that their model minority identity causes White Americans to have more negative attitudes about other minority groups who are not "successful." Negative attitudes toward Asian Americans also increase when their status is viewed as threatening to one's group (e.g., job competition, school competition; Maddux, Galinsky, & Cuddy, 2008). This can create tensions between minority groups.

Perpetual Foreigner and Yellow Peril Stereotypes

The perpetual foreigner and yellow peril stereotypes were some of the first stereotypes of Asian Americans. The perpetual foreigner stereotype postulates that Asian Americans are always foreigners who cannot assimilate and mesh with the dominant culture (i.e., American culture; Lee, Wong, & Alvarez, 2009). Thus, they are always viewed as "different" and not as Americans. A blatant example of the perpetual foreigner stereotype is the internment of Japanese Americans during WWII. Even though two-thirds of the interned Japanese Americans were US citizens, they were still viewed as foreigners. The yellow peril stereotype depicts Asian Americans as foreigners who are a threat to the economy and social culture of the United States (Fong, 2002, pg. 189). White Americans feared that people of Asian descent (called "oriental" or "yellow race") would take over the United States and outnumber and overpower them (Kawai, 2005). Yellow peril propaganda portrays Asian Americans as less than human (e.g., *The Mongolian Octopus*) – as something to be defeated.

While there is little evidence that the yellow peril stereotype still remains in the twenty-first century, the perpetual foreigner stereotype is still present and has great impact on Asian Americans' identity and mental health. Kim, Wang, Deng, Alvarez, and Li (2011) found that the perpetual foreigner stereotype impacts Chinese American girls' perceptions of chronic daily discrimination and Chinese American boys' experiences of discrimination. This in turn increases their risk of depressive symptoms. Huynh, Devos, and Smalarz (2011) also found similar results: Asian-American students who were aware of the perpetual foreigner stereotype also endorsed lower hope and life satisfaction.

Personality and Physical Stereotypes

Personality stereotypes of Asian Americans often portray them as competent, but cold (Fiske, 2012; Lin, Kwan, Cheung, & Fiske, 2005). This mixed stereotype is explained by the Stereotype Content Model (SCM), which states that stereotypes are captured through two dimensions: competence and warmth. The various combinations of differing levels of competence and warmth produce four distinct stereotypes: (1) admiration (high warmth, high competence), (2) paternalistic stereotypes (high warmth, low competence), (3) envious stereotypes (low warmth, high competence), and (4) contemptuous prejudice (low warmth, low competence; Fiske, Cuddy, Glick, &

Xu, 2002). The authors argue that Asians, viewed as the model minority, are seen as extremely competent and hardworking, but not sociable (Fiske et al., 2002). In other words, they are viewed with admiration and respect, but also with resentment and envy. Physical stereotypes of Asian Americans generally revolve around looking feminine (Wilkins, Chan, & Kaiser, 2011). Other physical stereotypes of Asian Americans include being short, unattractive (for men), having slanted eyes, and exotic (for women; Sue, Bucceri, Lin, Nadal, & Torino, 2009; Wong, Owen, Tran, Collins, & Higgins, 2012).

Stereotypes, Oppression, and Prejudice, and Their Effects on Asian American Health

Mental Health

In mental health, Asian Americans are again viewed as the model minority. Indeed, they have lower psychopathology prevalence rates and mental health services usage rates (Abe-Kim et al., 2007; Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). However, again these statistics are misleading. Upon closer inspection, psychopathology prevalence and mental health services usage rates differ between generation groups (i.e., immigrant generation vs. children of immigrants [second generation] vs. third generation). Second generation Asian Americans have higher psychopathology rates than immigrant Asian Americans (25.7% vs. 15.9%, respectively; Hong, Walton, Tamaki, & Sabin, 2014). Later generations also utilize mental health services at rates similar to the general US population (2nd: 3.51%, 3rd: 10.10%; Abe-Kim et al., 2007). Similar to other populations, the most common mental health disorders are anxiety and depression (10.2% and 9.5%, respectively; Hong et al., 2014).

There is a multitude of research indicating the impact of stereotypes, discrimination, acculturation, and other factors on Asian Americans' mental health. One of the most prevalent factors is the model minority stereotype. Despite the fact that Asian Americans perform well academically, they struggle psychologically and socially (Chae, Lee, Lincon, & Ihara, 2012). Asian-American students have reported being bullied for their model minority status, citing that they are viewed as "too smart" or "work too hard" (Qin, Way, & Rana, 2008). In other words, Asian-American students are resented and isolated by their peers (Qin et al., 2008). Given the conflicting message of the model minority stereotype, it is possible that the stereotype can contribute to feelings of depression and anxiety.

Indeed, many reasons Asian Americans give for their feelings of depression, anxiety, and stress revolve around the model minority stereotype, such as feeling like they are not able to meet the standards the stereotype creates (Gupta, Szymanski, & Leong, 2011; Lee et al., 2009). Lee, Juon, et al. (2009) found that the model minority stereotype was one of the strongest sources of stress, as Asian cultures prize academic success more so than other ethnic groups. Asian American youths may feel extra pressure to meet expectations and may feel great distress when they cannot (Lee, Juon, et al., 2009).

Similarly, Gupta et al. (2011) found that Asian Americans who endorsed positive Asian stereotypes (i.e., model minority) had higher levels of psychological distress. This again suggests that they may not feel like they are meeting expectations and thus experience stress. Participants who had internalized these stereotypes also were less willing to seek mental health services (Gupta et al., 2011). Perhaps, they feel the shame of not "living up" to the stereotype and are afraid that their therapist will judge them as well.

Furthermore, other stereotypes, such as the perpetual foreigner stereotype and stereotypes of physical attributes, have also shown to play a role in Asian Americans' mental health. The perpetual foreigner stereotype has been associated with increased distress or increased risk of depressive symptoms (Huynh, 2012; Wong et al., 2012). Even innocuous questions, such as "Where are you really from?" and "What are you?," were shown to be associated with higher levels of anxiety, anger, and stress (Huynh, 2012). Stereotypes of Asian Americans' physical attributes often reinforce the perpetual foreigner stereotype, as they revolve around them looking different, exotic, or "alien." These also affect Asian Americans' mental health, as they experience distress over their features (Kaw, 1993; Wong et al., 2012). Men who endorsed stereotypes about Asian-American men's sexual and romantic fallibility experienced more depressive symptoms than those who did not (Wong et al., 2012). Women who endorsed stereotypes about their faces looking "plain" or "dull," or did not think their body is up to Western standards, also experienced more distress than those who do not (Kaw, 1993).

Physical Health

At first glance, Asian Americans appear healthier than the average American. Asian American women have the highest life expectancy (85.8 years old) compared to all other groups in the United States (Office of Minority Health [OMH], 2017). Asian Americans also have lower obesity rates (11.7%) compared to other groups: Caucasian American (34.5%), African American (48.1%), and Hispanic American (42.5%, Centers for Diseases and Control [CDC], 2017a).

However, the model minority stereotype may generalize to Asian Americans' physical health. Indeed, experiences with discrimination have been associated with multiple chronic conditions, such as heart disease, respiratory illness, and pain (Gee, Spencer, Chen, & Takeuchi, 2007), increased BMI and obesity (Gee, Ro, Gavin, & Takeuchi, 2008), and poor sleep (Ong, Cerrada, Lee, & Williams, 2017). One can also imagine that individuals who endorse the model minority stereotype may assume that, similar to their work and school ethic, Asian Americans are competent and diligent in taking care of themselves. Ibaraki, Hall, and Sabin (2014) found that college students assumed Asian Americans were the least likely to suffer from any illness (i.e., diabetes, heart disease, cancer), despite evidence that they are disproportionately affected by specific diseases. For example, Asian Americans are one of only two ethnic groups where cancer is the leading cause of death (Heron, 2016). Why are they dying of cancer when they have lower cancer rates than other ethnicities (CDC, 2017b)? An explanation is their low cancer screening rates, as Asian Americans are routinely underscreened (CDC, 2012). This begs the question – why are Asian Americans underscreened? Are physicians are not recommending screening due to the model minority stereotype and believing their Asian-American patients are healthier (Ibaraki et al., 2014)? Asian Americans themselves may also be contributing to their own underscreening: because of Asian cultures' values of respect for authority (Hirschman & Wong, 1986), they may not ask their doctors for screening recommendations.

In conclusion, stereotypes and discrimination have a negative effect on Asian Americans' mental and physical health. Model minority stereotypes make mental and physical health problems invisible. More efforts to dispel laypersons', and especially physicians', belief in the model minority stereotype is needed. In the meantime, Asian Americans may need to start advocating for themselves and speak up to providers and other members of the community to combat the negative effects of stereotypes.

Effects of Stereotypes, Oppression, and Prejudice on Providers Toward Asian Americans

Unfortunately, but not surprising given how little emphasis society gives Asian Americans, the literature on clinical psychologists' and other providers' stereotypes and attitudes toward them is extremely limited. Approximately three decades ago, Frederick Leong contended that "the personal characteristics of most counselors and therapists are in sharp contrast to those of Asian Americans" (Leong, 1986, pg. 197). His words ring true to this day – the demographics of current psychology workforce is primarily White (83.6%), with ethnic minority psychologists accounting for less than 20% of the workforce (American Psychological Association [APA], 2015). Out of this 20%, Asian-American psychologists only make up 4.3% of the workforce (APA, 2015). Thus, because the majority of the active psychology workforce is White, many counselors and therapists will have different cultural and personal backgrounds than Asian American clients.

Current forms of racism and stereotypes that target Asian Americans tend to be subtle and covert, manifesting as microaggressions. Microaggressions are "brief, everyday exchanges that send denigrating messages to people of color because they belong to a racial minority group" (Sue et al., 2007, pg. 273). Examples include "Where are you from,?" "You speak English so well," and "I don't see color" (see Sue et al., 2007, pg. 276–277, for examples). Clinical psychologists, while not likely to engage in blatant forms of racism such as refusing to see a client based on their race or ethnicity, may engage in microaggressions. It should be noted that microaggressions are a somewhat controversial topic, with a recent critique by Lilienfeld (2017) doubting microaggression research and its existence in the real world. However, microaggressions have been demonstrated to have subsequent health effects, including negative affect, somatic symptoms, and sleep disturbance (Ong et al., 2017; Ong, Burrow, Fuller-Rowell, Ja, & Sue, 2013).

As clinical psychologists, we have a duty and obligation to provide the best therapy we can to our clients. Addressing microaggressions may be important in the clinical context. Clinical psychologists are in a position of power because they can diagnose disorders and control treatment (Hall & Malony, 1983). Additionally, the majority of clinical psychologists are White, which may add onto the imbalance of the power dynamic. Clinical psychologists must be mindful of their client's relationship with their culture and the host culture. For example, if a psychologist has an Asian American client who has trouble-making eye contact, the psychologist may quickly diagnose the client with social anxiety disorder. But, the psychologist is not considering the client's Asian culture, where eye contact with authority figures may not be the norm. Here, the psychologist has a skill deficit in the functional understanding of the client's behavior (i.e., it is culturally shaped). By not understanding that, it may mask the true disorder the client is suffering from.

Clinical psychologists may believe that they are unbiased and just, but by ignoring or invalidating microaggressions clients experience, it can harm the therapeutic relationship and hamper effective therapy. For example, if an Asian American client expresses frustration over being continuously asked "Where are you from?" or "Where are you really from?" and the psychologist minimizes it by wondering if the person was just curious, it may invalidate the client's feelings over the situation. The client may feel like she/he does not belong in the United States (i.e., perpetual foreigner stereotype), but by not acknowledging this experience, it can frustrate the client and incite feelings of resentment toward the therapist. Thus, we must be aware and even more careful of how we identify, validate, and address microaggressions in the clients' life and in therapy. If we do not, then we are putting Asian American clients at risk for premature termination from therapy (Kim, Park, La, Chang, & Zane, 2016).

We present a case example to illustrate our point below:

> Molly, an 18-year-old US-born Chinese American college freshman, is seeking treatment for anxiety and depression. She reports that she is having trouble adjusting to school and feels like she does not belong. She expresses frustrations over people assuming she is an international student, commenting on her English, and expecting her to know the answers in her Calculus class. She is also frustrated by the dismissive nature her friends and family have when she expresses her feelings about these things. They tell her to not be so sensitive. Molly states that she tries to not let these things get to her, but sometimes she feels stuck and paranoid, which worries her.

In this case, we have a clear example of microaggressions (i.e., perpetual foreigner stereotype) and invalidation of Molly's feelings and emotions over her experiences. It is obvious she is bothered by the foreigner assumptions and is frustrated by the minimization of her feelings. As her therapist, how would you respond? In conceptualizing Molly's case, one can see that, perhaps, her Chinese-American identity is not as strong for her. She is a very assimilated individual and from her reactions to people assuming she is a foreigner, she may not identify strongly as Chinese, but more American. Despite this, it seems like Molly places great emphasis on her relationships (as per values found in Chinese culture). While she does express frustrations toward her friends and family, she "tries not to let things get to her," indicating she accepts and follows their advice.

In responding to Molly's case, it is vital that you as her therapist acknowledge and validate her experiences with microaggressions and her feelings about them. By doing so, she may see you as more credible and your therapeutic alliance may strengthen. Of course, a rupture in your therapeutic relationship may happen if she does not agree with you. Accept her feelings and ask direct questions on why she does not agree. By showing humility and that you are willing to listen (i.e., validating) to her, the rupture may be repaired. From there, as Molly has expressed discomfort over her feelings and is feeling "stuck," helping her process and interpret her thoughts and emotions to the microaggressions would be most helpful. You and Molly could also figure out responses or coping mechanisms to future microaggressions.

Conceptualizing and Responding to Prejudice and Oppression Toward Asian Americans

Case Conceptualization

The first step to effective treatment, regardless of theoretical orientation, is to have a good case conceptualization. For Asian American clients, a good case conceptualization is even more important, as having one the client agrees with ascribes credibility to the psychologist (Sue & Zane, 1987). To develop an accurate case conceptualization, psychologists must be able to address therapy issues that include cultural contexts (Hansen, Pepitone-Arreola-Rockwell, & Greene, 2000). For Asian Americans, this means, in addition to understanding and explaining their situation and presenting issues, also being aware of cultural values and behavior, culture-specific syndromes (e.g., somatic expression and emotional suppression), and their cultural history in the United States. Asian Americans' history in the United States is especially important because much of their experiences deal with being invisible. As the model minority, people do not believe or care about Asian Americans' experiences and issues. Thus, conceptualizations of Asian-American clients should address the invisibility they face, either by discussing it explicitly in session or by inferring it from clients' experiences.

Of course, despite the general characteristics we have reviewed, each Asian American client is unique. One client may have a strong Asian American identity, while another may not. One cannot and should not assume that a specific client adheres to all the customs, values, attitudes, and beliefs of their culture. However, one *can* assume that almost every Asian American client will at least be somewhat familiar with their culture's customs, values, attitudes, and beliefs. For example, one Chinese American client may believe strongly in *saving face* in front of strangers, while another does not; yet, both are likely to be aware of *saving face* and the fact that it is valued in Chinese culture. Thus, psychologists should not automatically assume that their Asian American client is completely aligned with their culture, but should also not assume that their client is a blank slate. Instead, when assessing their clients' needs, it is necessary to assess both personal beliefs, their cultures' and communities' beliefs, and the interaction between them. We provide a clinical vignette below:

> Joshua is a 25-year-old Japanese-American man with the presenting problem of not being able to focus at work. He states that he feels overworked and unhappy with his boss and coworkers, and that he does not fit in. His emotions are starting to affect his work performance, and he is worried he may lose his job.

In this vignette, it is obvious that there is a mismatch between Joshua's interests and his immediate community's (i.e., work place) interests. How would we, as psychologists, assess his needs? First, we can ask why he feels overworked and unhappy with his boss and coworkers. Some questions to ask: do they expect too much out of him? If so, why? Are there other reasons, such as values or beliefs? We can then ask questions about his community and their interaction: Why does he feel like he does not fit in? Does he think there is a cultural divide? If there is a cultural divide, what is happening (values are different, microaggressions)? If there is not a cultural divide, then what kind of divide is there (age, gender, SES, etc.)? By asking direct questions, it can encourage Joshua to talk more and feel comfortable speaking his true feelings.

Responding to Oppression, Prejudice, and Discrimination Asian Americans Experience

As clinical psychologists, how do we respond to Asian Americans' experiences of racism and discrimination? First, ensure that your client views their experience as an act of racism and discrimination. As stated earlier, an accurate case conceptualization is crucial in developing credibility and rapport with Asian clients. Perhaps, asking a direct question, such as "That sounds like an unpleasant experience. Why do you think this person acted this way toward you?," will provide insight on how your clients see their experience.

If your client does view their experience as an act of racism and discrimination, be aware of your own experience and feelings in the moment as your client is sharing their story with you, as racism and discrimination can be difficult to hear (Hays, 2001, pg. 34). For example, you have a Chinese American client who shares he was called a racial slur by a White man and you yourself are a White man. You may feel yourself getting defensive and wanting to explain that not all White men are like that. Or as an Asian American female therapist, you experience resistance from your Asian American male client, which may cause you to feel resentment toward him. These are valid feelings, but are not conductive to effective therapy. Instead, use them as indications of what you are feeling.

Next, validate the experiences with racism, prejudice, and discrimination your client has and help them cope with it. This will help clinical psychologists earn or achieve credibility for two reasons: (a) many Asian Americans may feel that they are invisible in the United States and are, thus, not taken seriously or thought about and (b) gaining credibility from clients is crucial in keeping them in therapy, particularly for Asian American clients (Sue & Zane, 1987).

In terms of helping your client cope with experiences of racism and discrimination (usually microaggressions), it may be difficult for them to process and interpret their reactions, as microaggressions are quick and subtle. They may feel confusion, regret, guilt, anger, or shame for either addressing or not addressing the microaggression. As psychologists, helping our clients process their cognitions and emotions surrounding their experience during session would be most beneficial (Nadal, Griffin, Wong, Hamit, & Rasmus, 2014). The psychologist him/herself could serve as a stimulus for the client, such as a reminder of the person who committed the microaggresion, and address thoughts and feelings in session as they analyze the clients' response to the microaggression. By doing so, Asian American clients may feel acknowledged and understood. We present a few examples on how to process their thoughts and feelings in session below:

1. Have the client describe their thoughts and emotions about the event, and validate them. It may also be helpful to brainstorm responses for future experiences with racism and discrimination.
2. Do a role-play with the client about the event, with the psychologist acting as the perpetrator. The client can "redo" their experience and respond how they wished they responded.

Institutional Racism

There have been many forms of institutional racism against Asian Americans throughout their history in the United States. In the beginning, it was the laws that limited and prohibited Asian immigration. Then, it was the mass incarceration of Japanese Americans. Although institutional racism is not as overt now, it still exists and harms. Current forms of institutional racism are more subtle and are found in schools, academia, and the work force.

Undergraduate Admissions and Graduate School

Recent reports of Asian American students being discriminated against by college admissions have made national news. In 2014, a federal lawsuit was filed against Harvard University, claiming that Ivy League schools were using implicit race quotas, despite the fact that doing so is illegal (U.S. Supreme Court, 1978). Indeed, although Asian Americans are applying to colleges in increasingly larger numbers (National Center of Education Statistics, 2015), the ratio of their admissions to prestigious universities has remained the same. There is also evidence that students with an Asian background need to achieve an extra 50 points on the SAT relative to Whites to offset their Asian background (Espenshade, Chung, & Walling, 2004).

When looking at graduate school doctoral program admissions, there is also some suggestion of bias. Milkman, Akinola, and Chugh (2015) contacted 6500 professors at US universities from various disciplines via fictional prospective students seeking out research opportunities to help them apply for graduate school. These students all sent the same email, but were randomized on gender and race (White, Black, Hispanic, Chinese, and Indian). The authors found that in general, ethnic minority students were ignored more often than White male students. Asian American students received the least responses from professors compared to all other ethnicities (Milkman et al., 2015). In other words, they were ignored the most, reflecting the invisibility of Asian Americans.

Academia and the Work Force

Evidence for institutional racism against Asian Americans is inconclusive. Statistics of hiring faculty of color indicate that from 1993 to 2013, the number of Asian-American faculty across all disciplines in the United States grew by 171%, from 4.7% to 8.6% full-time faculty members (Finkelstein, Conley, & Schuster, 2016). This suggests that they do not experience bias in hiring. There also does not seem to be bias in research productivity and salary, with Asian American faculty having greater research output (Bellas & Toutkoushian, 1999) and higher mean salaries than other racial/ethnic groups, including White faculty (Webber & Canché, 2015).

However, they face a “bamboo ceiling,” similar to the “glass ceiling” women face, in terms of advancing to top administrative positions. Asian Americans may not be promoted to top positions due to their race, similar to women not advancing to top positions due to their gender. In 2009, the percentage of Asian Americans in senior administration positions only increased about 1–3.4% (Digest of Education Statistics, 2011, pg. 380). In 2001, Asian Americans only made up about 1% of all presidencies, and since then, has increased only to 2% in 2016 (American Council of Education, 2017).

What is keeping them from achieving leadership positions? Perhaps in addition to language and accent discrimination, the perpetual foreigner stereotype, and perceptions of low social skills (i.e., competent but cold), Asian Americans are viewed as lacking leadership skills (Burris, Ayman, Che, & Min, 2013; Xin, 2004). Indeed, Xin (2004) found that Asian American managers do not use tactics that impress their supervisors that improve their relationship and help them achieve higher positions. They self-disclose less, are less self-focused, and use less supervisor-focused management tactics (e.g., building a relationship with their supervisor; Xin, 2004).

Instead, they focus more on job-focused tactics (e.g., working hard and producing results), which did not impress supervisors as they may expect Asian Americans to work hard. By not self-promoting and socializing, Asian Americans are overlooked by their managers for promotions. Burris et al. (2013) also found that both Caucasian and Asian American employees view Asian American managers as competent, but less social (competent but cold stereotype).

Field of Psychology

Although there has been recent progress in addressing culture in the field of behavioral health, institutional racism is often found in the way Asian Americans are diagnosed and treated. One of the biggest changes in the way we diagnose disorders is found in the transition from the DSM-4 (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition) to the DSM-5. The DSM-5 is much more inclusive of different expressions of psychopathology in non-Western cultures. Many disorder diagnostic criteria now include a “Culture-Related Diagnostic Issues” section, indicating different symptoms a client of color may exhibit or at least a reminder to keep the clients’ culture and experiences in mind. In treatment, over 20 years, a plethora of research has been conducted on creating and testing culturally adapted treatments for its effectiveness – enough for 12 meta-analyses to be conducted (see Hall, Ibaraki, Huang, Marti, & Stice, 2016, for the most recent list of all meta-analyses published). Obviously, this increase of research demonstrates the acknowledgment of the necessity to provide culturally adapted therapy.

Despite these advances, there is still more that needs to be done. First, it remains unclear whether the current diagnoses adequately capture the behavioral health of Asian Americans. Asian Americans’ low prevalence rates are still an open-ended question; it is not clear whether they truly experience lower rates of mental health disorders or whether we are simply unable to determine it due to current definitions and conceptualizations of mental health (Sue, Cheng, Saad, & Chu, 2012). As stated earlier, psychopathology prevalence rates differ between generation groups and sub-Asian groups (e.g., Chinese, Korean, and Vietnamese Americans), and prevalence rates also change depending on how the diagnosis is defined (Sue et al., 2012). Future epidemiology studies need to update current mental health definitions to be culturally specific. They also need to standardize mental health definitions to include culture and take these differences into account. Finally, future studies also need to stop aggregating Asian American groups together.

A second issue is the behavioral health service underutilization in Asian Americans. Asian American mental health services usage rates continue to be low. This may be due to barriers, such as language, stigma, insurance, and transportation (Sue et al., 2012). It can also be argued that because service usage rates are low, the need for services among Asian Americans is low. However, even among Asian Americans with a DSM-IV diagnosis, service usage rates are lower compared to non-Asian Americans with a diagnosis. Wang et al. (2005) found that only 34.1% of Asian Americans with a diagnosis sought any mental health service vs. 41.4% of all others with a diagnosis. Other studies have found similar results: Abe-Kim et al. (2007) found that 34.1% with a diagnosis sought services, and Le Meyer, Zane, Cho, and Takeuchi (2009) found that only 28% sought services.

One way to increase service usage rates is to have more Asian American psychologists. This could potentially lessen both the language and stigma barrier. Although many Asian American psychologists may not be comfortable conducting therapy in the client’s language, just by being able to understand and converse may increase credibility and establish rapport. Asian Americans also may feel pressured to hide their mental health issues because of the model minority stereotype and stigma of mental health in Asian culture. Having a greater number of Asian American psychologists could lower the stigma by normalizing mental health issues. Certainly, ethnic matching between therapist and client increases ethnic minorities’ treatment stay and adherence (Ibaraki & Hall, 2014).

Third, despite the increase of culturally adapted therapies, the quality of these adaptations varies as they can be time consuming and difficult to do. Many times, researchers do the bare minimum of language and ethnic-matching therapists and clients and call it a cultural adaptation. This is not enough. Matching alone does not predict positive outcomes for ethnic minority clients (Maramba & Hall, 2002). The therapy also needs to be modified to include cultural beliefs, values, and attitudes, and the therapist delivering the therapy needs to be culturally competent (i.e., aware of their own biases and aware of the history, experiences, and cultural values and beliefs Asian cultures encompass).

Asian American Professionals, Stereotypes, and Discrimination in the Field

Asian American professionals may experience discrimination and prejudice from both their clients and colleagues. Indeed, to illustrate the many experiences a psychologist can have, Arthur Nezu (2010), a Japanese American, wrote about various stereotypes and comments his clients have made. He writes he has been seen as "calm and collected," "wise and highly educated," and "a good teacher" (Nezu, 2010, pg. 173). However, clients have also commented on how "nonmythical" he is (i.e., not adopting more alternative therapies) and how he seems emotionally closed at times. All these descriptions of Dr. Nezu map onto various stereotypes of Asian Americans – model minority, perpetual foreigner, and competent but cold.

Research on discrimination from colleagues is more limited. Clinical psychology as a field is progressive; it is not likely that most psychologists will be overtly racist. Instead, discrimination and stereotypes may manifest themselves subtly again, such as unconscious biases and microaggressions.

Although in general it does not appear that Asian American professionals are having trouble getting hired as faculty (Finkelstein et al., 2016), there is evidence that employers are less likely to respond to resumes where the applicants' name does not sound "White" (Kang, DeCelles, Tilcsik, & Jun, 2016). However, when Asian applicants changed their names to a more "American-sounding" name, the number of callbacks they receive increased (Kang et al., 2016). Perhaps, when faced with a "non-White" name, the employers think of the perpetual foreigner stereotype. Asian American professionals may be "whitening" up their resumes by leaving out, changing, or shortening their Asian-sounding names to appear more American.

Asian Americans are also not advancing to top administrative and leadership positions, such as deans of departments and university presidents (ACE, 2017; DES, 2011). Perhaps, other stereotypes, such as being competent but cold, are in play. These stereotypes conflict with traits that are often associated with good leadership, such as confidence, compassion, collaboration, and fearlessness (Farrell, 2011). The methods Asian Americans use to promote themselves, such as focusing on working hard and producing results, but not on establishing and maintaining relationships with colleagues and superiors, are not be enough to be considered for leadership positions (Xin, 2004). These behaviors may not inspire others to believe in them and to want to follow them. Of course, these behaviors are in line with Asian cultural values such as humility and conformity. However, mainstream American culture values self-promotion. Asian Americans, even if not comfortable with it, may need to self-promote and advocate for themselves. Otherwise, they may not be noticed and may not advance in their careers.

Future Directions and Improvements

Clinical Practice

As clinical psychologists, we have the moral obligation to provide the best and most ethical care for our clients. To begin, we need to make therapy as accessible as possible to clients. Some examples: providing free or low-cost therapy, hiring diverse clinicians and other mental health professionals who speak the same language as their Asian American clients, and educating Asian Americans on the importance of mental health and therapy. The next step is to adapt therapies and interventions to fit with Asian American clients' values and beliefs. Both Bernal and Sáez-Santiago (2006) and Hwang (2006) present frameworks and suggestions on culturally adapting a therapy. For an example of a successful cultural adaption, Hinton et al. (2004) adapted cognitive–behavioral theory for Vietnamese refugees with trauma. This is a slow and never-ending process, but the first step is to improve our cultural competency, changing and improving the way we think and conceptualize Asian Americans' experiences and problems in the context of Asian American history and culture.

Most crucially, when we work with Asian Americans and conceptualize their issues, we need to address the invisibility they experience. A recurring theme is Asian Americans being overlooked, not considered (e.g., promotion, friend, significant other), their feelings and history invalidated, and their voices and culture whitewashed. When Donald Trump assumed a Korean American student was an immigrant, people joked about carrying their birth certificates around, but not realizing that these innocuous questions are harmful (Khalid, 2015). In the media, directors continue to cast White characters to play Asian characters: Emma Stone in "Aloha," Scarlett Johanson in "Ghost in the Shell," and Matt Damon in "The Great Wall." When confronted, they refuse to apologize and defend their choices. Audaciously, the director of *Ghost in the Shell* stated that it is not a Japanese story, despite remaking it from a Japanese manga (Berman, 2017). These are just a few examples of the silencing and isolation of Asian Americans and their voices.

Even within the group, Asian Americans can feel invisible to each other. There are many instances of intergenerational conflict between Asian American children and their parents. For example, daughters report feeling torn between pursuing a career in a field they are interested in vs. what their family wants them to do, such as a STEM career or getting married (Robinson, 1994). Many children also report feeling stuck in the middle between their Asian culture and their American culture and not feeling that they belong in either group (Kim, Brenner, Liang, & Asay, 2003). When they speak out or try to make their voices heard, both worlds and cultures may ignore them, as they do not see them as "belonging" in either group. Thus, it is imperative as clinical psychologists that we make Asian Americans feel heard in therapy since they may not feel heard in other aspects of their lives.

Academia and the Work Force

Although evidence for discrimination and bias against Asian American students is mixed, there are still ways we can address institutional racism and systematic barriers. The high rates of Asian American students applying, entering, and graduating colleges are misleading. Much of these data are aggregated, lumping various Asian subgroups together. In doing so, it masks the significant variations of students in different subgroups' education attainment. Many South Asian students have lower rates of attaining a Bachelor's degree than East Asian students (PRC, 2015). Through arguing affirmative action is not needed or emphasizing color blindness, we are not addressing group differences and are doing a disservice to marginalized Asian American students. We are making these students even more invisible.

Asian American students also face difficulties in finding mentors as they progress through their academic journey. Universities need to hire faculty for psychology programs from different Asian backgrounds. This will encourage more Asian American students, both undergraduate and graduate, to apply for psychology programs, seek out mentorship, and progress and excel in academia. However, the hiring process is long and arduous and we cannot hire Asian American faculty if there are no Asian American graduate students. Therefore, in the meantime, White faculty must be willing to accept and mentor Asian American students to create a pipeline.

Finally, Asian American professionals are not being promoted to leadership roles. Asian American psychologists and therapists are not administrators, directors, or presidents of organizations. Asian American faculty are also not advancing to top administrative positions, such as university presidents and department heads. We need to start putting Asian Americans in leadership positions. Until we do so, urgent issues that Asian Americans face, such as discrimination and mental health, will never be the priority until those in power see it as a priority. Although Asian Americans do have non-Asian allies, the ones most concerned about Asian American issues are Asian Americans themselves. Efforts must be made to put Asian Americans in leadership positions and power, where they can make Asian American issues a priority. On the flip side, Asian Americans themselves must start taking the initiative to seek out leadership roles. This may be difficult since Asian culture highly emphasizes group harmony, conformity, and not "rocking the boat." But, as evident in our current society, no one will care about Asian American issues unless Asian Americans themselves do. We must start advocating for ourselves. We cannot rely on others.

Summary

Asian Americans have faced extensive societal and institutional discrimination and racism for as long as they have been in the United States. They have endured long-standing stereotypes that continue to impact generations despite evidence showing that these stereotypes are not true, such as the model minority stereotype. These stereotypes and the discrimination Asian Americans face have profound effects on their mental and physical health. Unfortunately, when they do seek help for their mental health, they may experience bias from providers. Providers may invalidate Asian Americans' thoughts, feelings, and experiences of discrimination and oppression. To be better clinical psychologists, we must be aware of our own biases and become more culturally competent. We also need to do more in encouraging and mentoring Asian American psychologist students, putting Asian-American professionals in positions of power, and advocating for ourselves. Unless we do this, the needs and issues of Asian Americans will never be a priority.

References

Abe-Kim, J., Takeuchi, D. T., Hong, S., Zane, N., Sue, S., Spencer, M. S., … Alegría, M. (2007). Use of mental health-related services among immigrant and US-Born Asian Americans: Results from the National Latino and Asian American Study. *American Journal of Public Health, 97*, 91–98. https://doi.org/10.2105/AJPH.2006.098541

American Council of Education. (2017). *College presidents, by race/ethnicity*. Retrieved from http://www.aceacps.org/minority-presidents-dashboard/

American Psychological Association. (2015). *2005–13: Demographics of the U.S. psychology workforce*. Retrieved from https://www.apa.org/workforce/publications/13-demographics/index.aspx

Barringer, H. Gardner, R. W., & Levin, M. J. (1995). [Table 2.1: Immigration to the United States from Asia, 1820–1990]. *Asians and Pacific Islanders in the United States*. Retrieved from https://www.russellsage.org/sites/default/files/Barringer_Tables%20%Figures.pdf

Bellas, M. L., & Toutkoushian, R. K. (1999). Faculty time allocations and research productivity: Gender, race, and family effects. *The Review of Higher Education, 22*(4), 367–384.

Berman, E. (2017). *A comprehensive guide to the Ghost in the Shell controversy*. Retrieved from http://time.com/4714367/ghost-in-the-shell-controversy-scarlett-johansson/

Bernal, G., & Sáez-Santiago, E. (2006). Culturally centered psychosocial interventions. *Journal of Community Psychology, 34*(2), 121–132.

Burris, K., Ayman, R., Che, Y., & Min, H. (2013). Asian Americans' and Caucasians' implicit leadership theories: Asian stereotypes, transformational, and authentic leadership. *Asian American Journal of Psychology, 4*(4), 258–266.

Centers for Disease Control and Prevention. (2017a). *Adult obesity facts*. Retrieved from https://www.cdc.gov/obesity/data/adult.html

Centers for Disease Control and Prevention. (2017b). *Cancer rates by race/ethnicity and sex*. Retrieved from https://www.cdc.gov/cancer/dcpc/data/race.htm

Centers for Disease Control and Prevention. (2012). *Study finds racial and ethnic disparities in US cancer screening rates*. Retrieved from https://www.cdc.gov/media/releases/2012/p0126_cancer_screening.html

Chae, D. H., Lee, S., Lincon, K. D., & Ihara, E. S. (2012). Discrimination, family relationships, and major depression among Asian Americans. *Journal of Immigrant Minority Health, 14*, 361–370. https://doi.org/10.1007/s10903-011-9548-4

Digest of Education Statistics. (2011). *Table 260. Employees in degree-granting institutions, by race/ethnicity, sex, employment status, control and level of institution, and primary occupation: Fall 2009*. Retrieved from https://nces.ed.gov/pubs2012/2012001_3a.pdf

Espenshade, T. J., Chung, C. Y., & Walling, J. L. (2004). Admission preferences for minority students, athletes, and legacies at elite universities. *Social Science Quarterly, 85*(5), 1422–1445.

Farrell, R. (2011). *23 traits of good leaders*. Retrieved from http://www.cnn.com/2011/LIVING/08/03/good.leader.traits.cb/index.html

Finkelstein, M. J., Conley, V. M., & Schuster, J. H. (2016). *Taking the measure of faculty diversity*. Retrieved from https://www.tiaainstitute.org/sites/default/files/presentations/2017-02/taking_the_measure_of_faculty_diversity.pdf

Fiske, S. T. (2012). Warmth and competence: Stereotype content issues for clinicians and researchers. *Canadian Psychology/Psychologie Canadienne, 53*(1), 14–20. https://doi.org/10.1037/a0026054

Fiske, S. T., Cuddy, A. J. C., Glick, P., & Xu, J. (2002). A model of (often mixed) stereotype content: Competence and warmth respectively follow from perceived status and competition. *Journal of Personality and Social Psychology, 82*(6), 878–902. https://doi.org/10.1037//0022-3514.82.6.878

Fong, T. P. (2002). *The contemporary Asian American experience: Beyond the model minority* (2nd ed.). Upper Saddle River, NJ: Prentice Hall.

Gee, G. C., Spencer, M. S., Chen, J., & Takeuchi, D. (2007). A nationwide study of discrimination and chronic health conditions among Asian Americans. *American Journal of Public Health, 97*, 1275–1282. https://doi.org/10.2105/AJPH.2006.091827

Gee, G. C., Ro, A., Gavin, A., & Takeuchi, D. T. (2008). Disentangling the effects of racial and weight discrimination on body mass index and obesity among Asian Americans. *American Journal of Public Health, 98*, 493–500. https://doi.org/10.2105/AJPH.2007.114025

Gupta, A., Szymanski, D. M., & Leong, F. T. L. (2011). The "Model Minority Myth": Internalized racialism of positive stereotypes as correlates of psychological distress, and attitudes toward help-seeking. *Asian American Journal of Psychology, 2*(2), 101–114. https://doi.org/10.1037/a0024183

Hall, G. C. N., Ibaraki, A. Y., Huang, E. R., Marti, C. N., & Stice, E. (2016). A meta-analysis of cultural adaptations of psychological interventions. *Behavior Therapy, 47*, 993. https://doi.org/10.1016/j.beth.2016.09.005

Hall, G. C. N., & Malony, H. N. (1983). Cultural control in psychotherapy with minority clients. *Psychotherapy: Theory, Research & Practice, 20*(2), 131–142. https://doi.org/10.1037/h0088484

Hansen, N. D., Pepitone-Arreola-Rockwell, F., & Greene, A. F. (2000). Multicultural competence: Criteria and case examples. *Professional Psychology: Research and Practice, 31*(6), 652–660. https://doi.org/10.1037//0735-702831.6.652

Hays, P. A. (2001). *Addressing cultural complexities in practice: A framework for clinicians and counselors*. Washington, DC: American Psychological Association.

Heron, M. (2016). Deaths: Leading causes for 2014. *National Vital Statistics Reports, 65*(5), 1–96. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_05.pdf

Hinton, D. E., Pham, T., Tran, M., Safren, S. A., Otto, M. W., & Pollack, M. H. (2004). CBT for Vietnamese refugees with treatment-resistant PTSD and panic attacks: A pilot study. *Journal of Trauma Stress, 17*(5), 429–433. https://doi.org/10.1023/B:JOTS.0000048956.03529.fa

Hirschman, C., & Wong, M. G. (1986). The extraordinary educational attainment of Asian Americans: A search for historical evidence and explanations. *Social Forces, 65*(1), 1–27.

Ho, C., & Jackson, J. W. (2001). Attitudes toward Asian Americans: Theory and measurement. *Journal of Applied Social Psychology, 31*(8), 1553–1581.

Hong, S., Walton, E., Tamaki, E., & Sabin, J. A. (2014). Lifetime prevalence of mental disorders among Asian Americans: Nativity, gender, and sociodemographic correlates. *Asian American Journal of Psychology, 5*(4), 353–363. https://doi.org/10.1037/a0035680

Huynh, V. W. (2012). Ethnic microaggressions and the depressive and somatic symptoms of Latino and Asian American adolescents. *Journal of Youth Adolescence, 41*, 831–846. https://doi.org/10.1007/s10964-012-9756-9

Huynh, Q. L., Devos, T., & Smalarz, L. (2011). Perpetual foreigner in one's own land: Potential implications for identity and psychological adjustment. *Journal of Social and Clinical Psychology, 30*(2), 133–162. https://doi.org/10.1521/jscp.2011.30.2.133

Hwang, W. C. (2006). The psychotherapy adaptation and modification framework. *American Psychologist, 61*(7), 702–715.

Ibaraki, A. Y., & Hall, G. C. N. (2014). The components of cultural match in psychotherapy. *Journal of Social and Clinical Psychology, 33*, 936–953.

Ibaraki, A. Y., Hall, G. C. N., & Sabin, J. A. (2014). Asian American cancer disparities: The potential effects of model minority health stereotypes. *Asian American Journal of Psychology, 5*(1), 75–81. https://doi.org/10.1037/a0036114

Kang, S. K., DeCelles, K. A., Tilcsik, A., & Jun, S. (2016). Whitened resumes: Race and self-presentation in the labor market. *Administrative Science Quarterly, 61*(3), 469–502. https://doi.org/10.1177/0001839216639577

Kaw, E. (1993). Medicalization of racial features: Asian American women and cosmetic surgery. *Medical Anthropology Quarterly, 7*(1), 74–89.

Kawai, Y. (2005). Stereotyping Asian Americans: The dialectic of the model minority and the yellow peril. *Howard Journal of Communications, 16*(2), 109–130. https://doi.org/10.1080/10646170590948974

Khalid, A. (2015). *South Korea? Trump's "Where are you from" moment*. Retrieved from http://www.npr.org/sections/itsallpolitics/2015/10/15/448718726/south-korea-trumps-where-are-you-from-moment

Kim, J. E., Park, S. S., La, A., Chang, J., & Zane, N. (2016). Counseling services for Asian, Latino/a, and White American students: Initial severity, session attendance, and outcome. *Cultural Diversity and Ethnic Minority Psychology, 22*(3), 299–310.

Kim, B. S. K., Brenner, B. R., Liang, C. T. H., & Asay, P. A. (2003). A qualitative study of adaptation experiences of 1.5-generation Asian Americans. *Cultural Diversity and Ethnic Minority Psychology, 9*(2), 156–170. https://doi.org/10.1037/1099-9809.9.2.156

Kim, S. Y., Wang, Y., Deng, S., Alvarez, R., & Li, J. (2011). Accent, perpetual foreigner stereotype, and perceived discrimination as indirect links between English proficiency and depressive symptoms in Chinese American adolescents. *Developmental Psychology, 47*(1), 289–301. https://doi.org/10.1037/a0020712

Lee, S., Wong, N. W. A., & Alvarez, A. (2009). The model minority and perpetual foreigner: Stereotypes of Asian Americans. In N. Tewari & A. N. Alvarez (Eds.), *Asian American Psychology: Current Perspectives* (pp. 69–84). New York: Routledge/Taylor & Francis Group.

Lee, S., Juon, H. S., Martinez, G., Hsu, C. E., Robinson, S., Bawa, J., & Ma, G. X. (2009). Model minority at risk: Expressed needs of mental health by Asian American young adults. *Journal of Community Health, 34*, 144–152. https://doi.org/10.1007/s10900-008-9137-1

Leong, F. T. L. (1986). Counseling and psychotherapy with Asian-Americans: Review of the literature. *Journal of Counseling Psychology, 33*(2), 196–206.

Le Meyer, O., Zane, N., Cho, Y. I., & Takeuchi, D. T. (2009). Use of specialty mental health services by Asian Americans with psychiatric disorders. *Journal of Consulting and Clinical Psychology, 77*(5), 1000–1005. https://doi.org/10.1037/a0017065

Lilienfeld, S. (2017). Microaggressions: Strong claims, inadequate evidence. *Perspectives on Psychological Science, 12*(1), 138–169. https://doi.org/10.1177/1745691616659391

Lin, M. H., Kwan, V. S. Y., Cheung, A., & Fiske, S. T. (2005). Stereotype content model explains prejudice for an envied outgroup: Scale of anti-Asian American stereotypes. *Personality and Social Psychology Bulletin, 31*(1), 34–37. https://doi.org/10.1177/0146167204271320

Maddux, W. M., Galinsky, A. D., & Cuddy, A. J. C. (2008). When being a model minority is good and bad: Realistic threat explains negativity toward Asian Americans. *Personality and Social Psychology Bulletin, 34*(1), 74–89. https://doi.org/10.1177/0146167207309195

Maramba, G. G., & Hall, G. C. (2002). Meta-analyses of ethnic match as a predictor of dropout, utilization, and level of functioning. *Cultural Diversity and Ethnic Minority Psychology, 8*, 290–297. https://doi.org/10.1037/1099-9809.8.3.290

Milkman, K. L., Akinola, M., & Chugh, D. (2015). What happens before? A field experiment exploring how pay and representation differentially shape bias on the pathway into organizations. *Journal of Applied Psychology, 100*(6), 1678–1712.

Nadal, K. L., Griffin, K. E., Wong, Y., Hamit, S., & Rasmus, M. (2014). The impact of racial microaggressions on mental health: Counseling implications for clients of color. *Journal of Counseling & Development, 92*, 57–66. https://doi.org/10.1002/j.1556-6676.2014.00130.x

Nakanishi, D. T. (1988). Seeking convergence in race relations research: Japanese-Americans and the resurrection of the internment. In P. A. Katz & D. A. Taylor (Eds.), *Eliminating Racism. Perspectives in Social Psychology (A Series of Texts and Monographs)* (pp. 159–180). Boston, MA: Springer.

National Center of Education Statistics. (2015). *Table 306.10. Total fall enrollment in degree-granting postsecondary institutions, by level of enrollment, sex, attendance status, and race/ethnicity of student: Selected years, 1976 through 2014.* Retrieved from https://nces.ed.gov/programs/digest/d15/tables/dt15_306.10.asp?current=yes

Nezu, A. M. (2010). Cultural influences on the process of conducting psychotherapy: Personal reflections of an ethnic minority psychologist. *Psychotherapy Theory, Research, Practice, Training, 47*(2), 169–176. https://doi.org/10.1037/a0019756

Ngo, B., & Lee, S. J. (2007). Complicating the image of model minority success: A review of Southeast Asian American education. *Review of Educational Research, 77*(4), 415–453.

Office of Minority Health. (2017). *Profile: Asian Americans.* Retrieved from https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=63

Ong, A. D., Burrow, A. L., Fuller-Rowell, T. E., Ja, N. M., & Sue, D. W. (2013). Racial microaggressions and daily well-being among Asian Americans. *Journal of Counseling Psychology, 60*(2), 188–199. https://doi.org/10.1037/a0031736

Ong, A. D., Cerrada, C., Lee, R. A., & Williams, D. R. (2017). Stigma consciousness, racial microaggressions, and sleep disturbance among Asian Americans. *Asian American Journal of Psychology, 8*(1), 72–81. https://doi.org/10.1037/aap0000062

Petersen, W. (1966). Success story, Japanese American style. *New York Times Magazine*, pp. 20–21, 33, 36, 38, 40–41, 43.

Pew Research Center. (2012). *The Rise of Asian Americans.* Retrieved from http://www.pewsocialtrends.org/2012/06/19/the-rise-of-asian-americans/.

Pew Research Center. (2015). *Fact sheets on Asians in the U. S.* Retrieved from http://www.pewresearch.org/topics/asian-americans/

Qin, D. B., Way, N., & Rana, M. (2008). The "model minority" and their discontent: Examining peer discrimination and harassment of Chinese American immigrant youth. *New Directions for Child and Adolescent Development, 2008*(121), 27–42. https://doi.org/10.1002/cd.221

Robinson, S. (1994, January 23). Asian-American women struggling to move past cultural expectations. *The New York Times*. Retrieved from http://www.nytimes.com/1994/01/23/us/asian-american-women-struggling-to-move-past-cultural-expectations.html

Substance Abuse and Mental Health Services Administration. (2012). *Results from the 2010 National Survey on Drug Use and Health: Mental health findings* (NSDUH Series H-42, HHS Publication No. (SMA) 11-4667). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Sue, D. W., Bucceri, J., Lin, A. I., Nadal, K. L., & Torino, G. C. (2009). Racial microaggressions and the Asian American experience. *Asian American Journal of Psychology, S*(1), 88–101. https://doi.org/10.1037/1948-1985.S.1.88

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62*(4), 271–286. https://doi.org/10.1037/0003-066X.62.4.271

Sue, S., Cheng, J. K. Y., Saad, C. S., & Chu, J. P. (2012). Asian American mental health: A call to action. *American Psychologist, 67*(7), 532–544. https://doi.org/10.1037/a0028900

Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *The American Psychologist, 42*(1), 37–45.

U. S. Census Bureau. (2001). *Census 2000 summary file 1 technical documentation*. Retrieved from https://www.census.gov/prod/cen2000/doc/sf1.pdf.

U. S. Supreme Court. (1978). *Regents of University of California v. Bakke, 438 U.S. 265*. Retrieved from https://supreme.justia.com/cases/federal/us/438/265/case.html

Walter, Y. (2007). Asian Americans and American immigration and naturalization policy. *American Studies Journal, 49*. Retrieved from http://www.asjournal.org/49-2007/asian-americans-and-american-immigration-and-naturalization-policy/

Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 629–640.

Webber, K. L., & Canché, M. G. (2015). Not equal for all: Gender and race differences in salary for doctoral degree recipients. *Research in Higher Education, 56*(7), 645–672.

Wilkins, C. L., Chan, J. F., & Kaiser, C. R. (2011). Racial stereotypes and interracial attraction: Phenotypic prototypicality and perceived attractiveness of Asians. *Cultural Diversity and Ethnic Minority Psychology, 17*(4), 427–431. https://doi.org/10.1037/a0024733

Wong, Y. J., Owen, J., Tran, K. K., Collins, D. L., & Higgins, C. E. (2012). Asian American male college students' perceptions of people's stereotypes about Asian American men. *Psychology of Men & Masculinity, 13*(1), 75–88. https://doi.org/10.1037/a0022800

Xin, K. R. (2004). Asian American managers: An impression gap? An investigation of impression management and supervisor-subordinate relationships. *The Journal of Applied Behavioral Science, 40*(2), 160–181. https://doi.org/10.1177/0021886304263853

Prejudice, Stigma, and Oppression on the Behavioral Health of Native Hawaiians and Pacific Islanders

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Abstract

In this chapter, we provide an historical and demographic overview of Native Hawaiians and Pacific Islanders in the USA, their exposure to oppression and prejudice, and their most prevalent behavioral health problems compared to other ethnic groups. We review the psychosocial perspectives offered to explain the role of oppression, stigmatization, and prejudices in their behavioral health problems and highlight their resiliency and protective family factors. We also provide a review of the extant literature examining the effects of historical trauma, oppression, and discrimination on a range of behavioral health problems among Native Hawaiians and Pacific Islanders to include depression, psychological distress, physiological stress indices, general mental health, suicidality, and substance use. A conceptual model of the pathways from oppression and discrimination to behavioral health problems is offered. Finally, we discuss culturally responsive approaches to providing behavioral health services to Native Hawaiians and Pacific Islanders that focus on issues related to prejudice, stigma, and oppression.

Keywords

Pacific Islanders · Prejudice · Stigma · Oppression · Native Hawaiians

Pacific Islanders are the indigenous peoples of the regions of the Pacific known as Polynesia (e.g., Hawai‘i, Tonga, Sāmoa, and Aotearoa New Zealand), Melanesia (e.g., Fiji and Vanuatu), and Micronesia (e.g., the Marshall Islands, the Federated States of Micronesia, Guam, and Palau) (Fischer, 2002). Since arriving in the Pacific over 4000 years ago, the ancestors of Pacific Islanders have been living and thriving on the over 25,000 islands and atolls linked by the Pacific Ocean that, together, comprises 180 million square kilometers and includes more than 1500 languages. They developed unique cultures and sophisticated forms of government and resource management systems that were conducive to an island ecosystem. They traversed the Pacific on double-hulled canoes visiting other Pacific Island groups for centuries before Europeans set sail across the Atlantic (Low, 2013). When Capt. James Cook, the British explorer, and his expedition came across the islands of the Pacific and their peoples between

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© Springer Nature Switzerland AG 2020
L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_7

1769 and 1779, they were impressed by, if not envious of, the physical, emotional, and social well-being of many of these Pacific Island nations (Beaglehole, 1967).

In this chapter, we first provide a post-Western contact, historical overview of Native Hawaiians and Pacific Islanders because their history is often overlooked in US history courses and thus unfamiliar to most people in the USA, especially as it relates to the emphasis of this book – prejudice, stigma, and oppression. We then describe their emerging demographics and exposure to stigmatization and discrimination in the USA. We then follow with a review of the behavioral health status of Native Hawaiians and Pacific Islanders and the psychological perspectives and scant studies pertaining to the effects of prejudice, stigma, and oppression on behavioral health outcomes. We then discuss the provision of culturally responsive, behavioral health services to Native Hawaiians and Pacific Islanders. Finally, we conclude with a summary and recommendations for future research with Native Hawaiians and Pacific Islanders.

Despite our collective discussion of Native Hawaiians and Pacific Islanders in this chapter, we want to emphasize that they represent a diverse group of peoples with different languages, customs, acculturation statuses (e.g., indigenous, immigrant, and migrant), and aspirations. Although the US Office of Management and Budget (OMB) aggregates them into a single ethnic/racial category called Native Hawaiians and Other Pacific Islanders, we eliminate the word "Other" in this chapter to avoid minimizing the importance of any one of the diverse Pacific Islander groups living in the USA.

History of Exploitation, Oppression, and Displacement in the Pacific

Following Cook's Pacific expedition in the late 1700s, an influx of European (e.g., British, Germans, Spanish, and French) and American foreigners followed with the intent of Christianizing the natives, exploiting their resources, and developing commerce (e.g., whaling and plantations). These foreigners also introduced infectious diseases (e.g., gonorrhea, measles, influenza, and Hansen's disease) against which the aboriginal populations had no natural immunity to ward off, thereby decimating many of their populations to near extinction throughout the 1800s (Bushnell, 1993). In Hawai'i, as an example, Native Hawaiians went from a population of roughly 650,000 in 1778 to barely 35,000 by 1898, which is over a 95% decline in the matter of a century (Goo, 2015; Stannard, 1989). Many Pacific Island nations succumbed to Western control by countries, such as the USA, France, Germany, and England, as either colonized or occupied territories. They asserted their Western values, norms, and notions of governance, land ownership, and commerce on the aboriginal populations, which were counter to their traditional worldviews and practices that emphasized communal cooperation, living in balance with others and nature, and strict resource management. Thus, Western imposition led to population decline, cultural suppression, social marginalization, and economic deprivation for many Pacific Islanders (Spickard, Rondilla, & Hippolite Wright, 2002). A Hawaiian saying from this time period exemplifies the sentiment of Pacific populations in regard to their experience with Western foreigners: *Lawe li'ili'i ka make a ka Hawai'i, lawe nui ka make a ka haole;* translating as *Death by Hawaiians takes a few at a time; death by foreigners takes many* (Pukui, 1983).

In the late 1800s and early 1900s, there was an increase in military conflicts in the Pacific, which brought further marginalization, displacement, and hardship for the aboriginal populations (Davis, 2015). Spain and Imperial Japan had taken possession of many Pacific Islands in the South and Western Pacific, which led to US intervention. The Spanish–American War of 1898 between the USA and Spain over the latter's territories in the Pacific, and Imperial Japan's occupation of many Micronesian Islands during World War II, led to the USA eventually acquiring control over much of the Western and Northern Pacific. The Pacific Campaign of World War II was fought literally in the "backyard" of many

Pacific Islander communities with Imperial Japan's occupation of their islands (e.g., Guam, Saipan, Kiribati, and Nauru). The USA entered World War II after Imperial Japan bombed the U.S. Naval Base at Pearl Harbor on the island of O‘ahu in the Hawaiian archipelago on December 7, 1941. Between 1946 and 1962, the USA conducted nuclear testing in places such as the Bikini Atoll in the Marshall Islands, which destroyed and contaminated the surrounding islands and waters, thereby displacing many Pacific Islanders in the area and placing them at an increased risk for various cancers that persist to the present day (Yamada & Akiyama, 2014). Throughout the Pacific, Pacific Islanders were forced to abandon their subsistence and communal lifestyle and practices of traditional land stewardship (Palafox, 2011).

With US militarization in the Pacific came oppression and discrimination directed toward Pacific Islanders by these foreign settlers in their homeland, as exemplified by the Massie Affair from Hawai‘i (Stannard, 2005). By the 1930s, a white oligarchy had formed with the militarization of Hawai‘i, which included high-ranking senior Naval officers and their families. In September 1931, five local men – three Native Hawaiian and two Japanese men – were wrongfully arrested and accused of gang raping Thalia Massie, the daughter of a wealthy and politically connected family and wife of Lieutenant Thomas Massie, a US Naval officer. The case pitted the Native Hawaiian and Asian local community against the elite White “haole” (foreigner) community. Thalia Massie falsely accused these five local men of the crime. The Massie trial made national news in the USA, with Massie represented by one of the most prominent lawyers of the time, Clarence Darrow. Thalia's mother, Grace Hubbard Fortescue, arranged for two of the five men to be kidnapped by US Navy personnel to beat a confession out of them after the initial trial ended in a hung jury, which resulted in one of them, Joseph Kahahawai, a Native Hawaiian, being murdered. The Massie Affair exposed the deep-rooted racism that existed in the islands, primarily toward Native Hawaiians at the time, which mirrored what was happening to African-Americans in the Southern United States.

Throughout the Pacific, a century of wars, exploitation, and turmoil by foreign powers altered the island homes and way of life for Pacific Islanders and placed them at a political, social, and economic disadvantage in their own homelands. Many of the types of commerce Westerners were engaged in (e.g., whaling and plantation farming) brought more foreigners, mainly of East Asian descent (e.g., Chinese, Japanese, and Filipino), into their island communities as hired labor, which further marginalized Pacific Islanders. Compulsory acculturation strategies and stigmatization of Pacific Islander worldviews and practices (i.e., banning of native language and dances) by Christian missionaries and Western-imposed laws and lifestyles had significant adverse physical and mental health consequences for contemporary Pacific Islanders. For example, the highest rates of obesity, diabetes (Hawley & McGarvey, 2015), and suicide (Else, Andrade, & Nahulu, 2007) in the world are found in Pacific Islander communities, which are in sharp contrast to the health status observed by Cook and members of his expedition prior to Western intrusion. Consequently, these adverse conditions, to include the loss of atolls and islands to sea level rising due to global warming, led to a Pacific Islander diaspora to countries such as the USA, New Zealand, and Australia in search of educational and economic opportunities (Ahlgren, Yamada, & Wong, 2014; Spickard et al., 2002). However, they continue to face discrimination, stigmatization, acculturative stressors, and economic deprivation in these countries.

Emerging Presence of Native Hawaiians and Pacific Islanders in the United States

Native Hawaiians are the Indigenous People of the Hawaiian Islands, territories now occupied by the USA as the 50th state in the union and collectively called Hawai‘i. Hawai‘i was a sovereign nation under the Kingdom of Hawai‘i from the time the islands were united under one government by King Kamehameha I in 1810 to the illegal US-supported overthrow of Queen Liliuʻokalani in 1893 (Dougherty, 1992). Interestingly, those who conspired to overthrow the monarch were descendants of the early missionaries to Hawaiʻi who had become part of the wealthy elite. Two American presidents recognized the overthrow of the Hawaiian monarchy as illegal: Grover Cleveland in 1893 based on the findings of the Blount Report and Bill Clinton in 1993 with the Apology Resolution (U.S. Public Law 103–150). Under international law, Hawaiʻi is considered to be occupied by the USA since Native Hawaiians never relinquished their claims to their inherent sovereignty over their national lands to the USA (Sai, 2015) "either through the Kingdom of Hawaiʻi or through a plebiscite or referendum," as stated in U.S. Public Law 103–150.

Despite the tenuous acquisition of Hawaiʻi by the USA, Native Hawaiians do not share a similar political status as an indigenous population like that of American Indians and Alaska Natives with the US government. They do not have federal recognition or a mechanism to exercise their sovereignty and are not eligible for support from Indian Health Services. Although it was never enacted, there has been an attempt to introduce federal legislation for the recognition of a Native Hawaiian governing entity with the Native Hawaiian Government Reorganization Act of 2009. However, three federal policies have been enacted to improve the living (i.e., Hawaiian Homes Commission Act), educational (i.e., Native Hawaiian Education Reauthorization Act), and physical and mental health (i.e., Native Hawaiian Health Care Improvement Act) conditions of Native Hawaiians. They have also been included in the other federal legislation as part of American Indian and Alaska Native policies (e.g., the Native American Programs Act and the Native American Languages Act). In 1978, the State of Hawaiʻi also established the Office of Hawaiian Affairs (OHA) to manage assets set aside for the betterment of Native Hawaiians (Article XII of the Hawai'i State Constitution). These legislations were established to address past injustices and their negative consequences on Native Hawaiians. Nonetheless, many Native Hawaiians have been actively protesting the US occupation of their islands and seeking restoration of their government since 1893 up to the present (Goodyear-Kaʻopua, Hussey, & Wright, 2014; Silva, 2004). They are also actively revitalizing their cultural values and practices (e.g., native language) and asserting their aspirations, but often face discrimination and opposition from the settler society in these endeavors (Goodyear-Kaʻopua et al., 2014).

The circumstance that brought other Pacific Islanders under US influence varies. For most Pacific Islanders, educational and economic opportunities were the primary reason for emigration to Hawaiʻi and the continental US. After World War II, Samoans emigrated from American Sāmoa, an incorporated territory of the USA since 1900, and Sāmoa (formally known as the Independent State of Sāmoa) for agricultural and factory work. It was a similar case for Tongans who came from the Kingdom of Tonga in Polynesia. Guam, from which Guamanians/Chamorro people come from, has been a territory of the USA after Spain ceded control to the USA in 1898. After international condemnation regarding USA's geopolitical involvement in Micronesia (Riklon, Alik, Hixon, & Neal, 2010) in the late 1980s, the USA and three Micronesian nations – the Federated States of Micronesia, the Republics of Marshall Islands and Palau – signed the Compact of Free Association (COFA) treaties (U.S. Public Law 180–188). These treaties gave the USA exclusive military access to the region in exchange for the responsibility to build their health and education infrastructures and provide COFA citizens entry into the USA without visas. However, the US government has failed to live up to their obligations under COFA, and despite the fact that COFA migrants are required to pay taxes, the USA has revoked Medicaid coverage for many of these Pacific Islanders (Yamada & Akiyama, 2014). This barrier is especially devastating as Micronesians have a high burden of infectious and chronic diseases and thus healthcare has been a reason many of them moved to Hawaiʻi and the continental US (MacNaughton

& Jones, 2013). At the same time, military occupation and damage from radiation continue to disrupt Micronesia's traditional economies, cultures, and subsistence diets, leading to Western-diet-related chronic diseases (Palafox, 2011).

Today, Native Hawaiians and Pacific Islanders make up roughly 1.2 million of the total US population, with Native Hawaiians making up a majority (43%) of all Pacific Islanders followed by Samoans (15%) and Guamanians/Chamorros (12%; Hixson, Hepler, & Kim, 2012). About half of all Native Hawaiians and Pacific Islanders in the USA report mixed-ethnic ancestry. Native Hawaiians have the highest percentage of individuals reporting mixed-ethnic ancestry, with 30% reporting Hawaiian-only ancestry. Despite the large ethnic admixture among Native Hawaiians, it is estimated that over 90% of them strongly identify with their Native Hawaiian ancestry, regardless of their degree of Hawaiian ancestry (Kaholokula, Nacapoy, & Dang, 2009). Native Hawaiians and Pacific Islanders are any individuals having origin in any of the original inhabitants of the Pacific Islands from which they claim ancestry.

The fastest-growing Pacific Islander groups in the USA come from the Federated States of Micronesia (e.g., Chuukese and Kosrae), the Republic of the Marshall Islands (Marshallese), and the Republic of Palau (Hixson et al., 2012). A majority of Pacific Islanders in the USA reside in Hawai‘i (355,816), California (286,145), and Washington State (70,322), but they can be found in all US states and in high concentrations in places like Springdale, Arkansas. Arkansas has the second largest Marshallese population outside of Hawai‘i, many of whom emigrated to Arkansas for economic opportunities (McElfish, Hallgren, & Yamada, 2015). For many Pacific Islanders in the USA, whose religious faiths for the most part are Protestant, Mormon, and Catholic, churches serve as the focal point and major source of support for them to deal with the acculturative stressors they experience and to maintain a sense of community (Aitaoto, Braun, Dang, & So'a, 2007).

Shifting Forms of Stigmatization and Discrimination

Although initially characterized by Capt. Cook and his men as “humane,” “friendly,” and “hospitable,” Native Hawaiians and Pacific Islanders were eventually stigmatized by negative stereotypes held by Western foreigners. They were labeled as “savages,” “heathens,” and “wretched creatures,” often by Christian missionaries seeking to convert the natives to Christianity (McCubbin & Marsella, 2009). These early Christian missionaries perhaps wanted the natives to be perceived, true or not, as “savages” in need of salvation to justify their existence and presence in the Pacific. Overtime, other negative categorizations were assigned to Native Hawaiians and Pacific Islanders that continues today, such as being labeled as “lazy,” “unintelligent,” “violent,” and “unmotivated.” Ironically, there also exist positive stereotypes assigned to them, such as in the case of Native Hawaiians. They are known to show much *aloha* (affection, love, hospitality, and respect) toward others. In fact, the concept of “aloha spirit” is widely promoted in Hawai‘i where it is a slogan used to attract tourist and codified in state law to promote civil behavior. Of course, what appears to be a positive stereotype may actually be another form of oppression designed to subtly placate the natives by encouraging passive indigenous values while suppressing those that may empower them.

Needless to say, the overt and covert racial discrimination experienced by Native Hawaiians and Pacific Islanders have had profound adverse effects on their self-identity and psychological well-being. For many Native Hawaiians living in the early to mid-1900s, their Hawaiian phenotype and language were often the target of discrimination, as they became a minority in their own homeland with the influx of European American and Asian settlers to Hawai‘i. The speaking and teaching of Hawaiian language was outlawed in government and the school systems by the US-supported provisional government after the overthrow in 1893 (Act 57, sec. 30 of the 1896 Laws of the Republic of Hawai‘i; Kahumoku, 2003). This suppression of the Hawaiian language (as well as many cultural practices) carried on under US control. Native Hawaiian youth were physically disciplined (e.g., struck on their knuckles with a ruler) by their schoolteachers for speaking their native language in the classroom. As a result, many Native Hawaiian parents raised their children with English as their first, and often the only language, with the hopes that they would easily assimilate into the American-dominated mainstream. This led to an entire generation of Native Hawaiians not acquiring fluency in their native language, which almost led to the disappearance of the language. Ironically, these schoolteachers who enforced these discriminatory policies against Native Hawaiians were often of Asian ancestry and descendants of immigrants to Hawaiʻi, who themselves were also the target of discrimination by Whites.

A suppressed version of Hawaiian history from the colonizer's perspective was also being taught in the school systems that cast a positive light on America and its presence in Hawaiʻi while patronizing or demonizing the lifestyle and practices of Native Hawaiian ancestors. Native Hawaiians were made to feel ashamed of their Hawaiian ancestry because facts about their history and culture were distorted in order to justify the US occupiers' agenda of manifest destiny. Many Native Hawaiians who also had Asian or White ancestry would try to pass themselves off as these other ethnic groups and conceal their Hawaiian ancestry in order to avoid being discriminated against. Private and certain public (e.g., English standard schools) schools were established to separate the social elite, often White students, from the Indigenous and Asian immigrant students. This educational segregation has had lasting effects on the educational system in Hawaiʻi and the socioeconomic status of many contemporary Native Hawaiians and Pacific Islanders (Benham & Heck, 1998; Okamura, 2008).

For Native Hawaiians, a turning point in this history of oppression was the Hawaiian Renaissance of the 1970s when there was a resurgence of pride in being Native Hawaiian and a pushback against nearly a century of cultural, psychological, and physical oppression and marginalization. From the Hawaiian Renaissance emerged cultural and political movements that eventually led to the revitalization of the Hawaiian language and other indigenous practices (e.g., hula, traditional Hawaiian dancing, and chanting); the protection of cultural and natural resources (e.g., stopping the Navy's bombing practices on the island of Kahoʻolawe); the return of traditional voyaging canoes and navigation that confirmed the technological and scientific sophistication of Hawaiian ancestors; and the creation of Hawaiian studies and language centers at the University of Hawaiʻi and other educational opportunities for Native Hawaiians (Goodyear-Kaʻopua et al., 2014). As Tengan (2008) asserts, in describing the significance of the Hawaiian Renaissance, "despite the fact that Hawaiian control over land, government, and resources has not materialized, there has been a paradigmatic shift in thinking since the 1960s on the reality of sovereignty and decolonization for Hawaiians" (p. 57).

Some argue that explicit or overt racism has declined over the past 50 years in the USA and morphed into more of a subtle or implicit racism that thrives because of its incorporation into our systems and policies (e.g., Levy, 2016). Others argue that explicit racism has reemerged stronger than ever in the USA (e.g., Perrin, 2018). Perhaps, both the institutional racism that maintains the status quo of inequities and the renewed attacks on ethnic minorities as their numbers and influence grow in the USA are operating simultaneously. Whether it is overtly or covertly experienced, many Native Hawaiians and Pacific Islanders deal with some form of racial discrimination on a regular basis. For example, it is estimated that 48% of Native Hawaiians are discriminated against "often" to "most of the time" while 52% experience discrimination "sometimes" over a 12-month period (Kaholokula, 2014).

As contemporary Native Hawaiians and Pacific Islanders assert their unique cultural worldviews and indigenous prerogatives, and revitalize their cultural practices and institutions, they often find themselves being challenged by the larger dominant society. Native

Hawaiians, for example, seeking to protect their sacred lands from further desecration currently find themselves in opposition with certain policymakers, university leaders, and some in the astronomy community over the proposed development of a Thirty Meter Telescope (TMT) on the top of Mauna Kea, one of the world's tallest mountains on the island of Hawai'i. If developed, the TMT would be a formidable structure standing about 217 feet in diameter and 180 feet in height. Some believe the TMT would provide an unprecedented view of the universe, allowing for more scientific advances, while also boosting Hawai'i's economy. However, TMT opponents, mainly Native Hawaiians, are concerned about the long-term environmental damage this structure could cause and, most importantly, the disrespect to Mauna Kea's status as a *wao akua* (sacred site) and *piko* (portal to the ancestors) for Native Hawaiians. It is important to note that there already exist several observatories on top of Mauna Kea, although they are considerably smaller in scale than the TMT. Individuals and organizations representing the interests of Native Hawaiians seeking to protect Mauna Kea and those seeking to develop TMT are currently engaged in a legal battle over this contentious issue. Many other indigenous communities, such as Māori of New Zealand and American Indians/Alaska Natives on the continental US, have come out in strong support of Native Hawaiians in their opposition to the TMT development.

The strife over the development of TMT on Mauna Kea is only of many that Native Hawaiians have had to contend with over the last several decades to protect their indigenous values, practices, lands, and aspirations in Hawai'i. It is a struggle that other Pacific Islanders will likely face as they to seek to reverse the effects of US colonialism and occupation on their island homes. The chronic and persistent stressors from cultural loss, economic deprivation, and discrimination are likely the underlying causes of the poorer behavioral health status of Native Hawaiians and Pacific Islanders when compared to other ethnic groups in the USA.

Behavioral Health Status of Native Hawaiians and Pacific Islanders

Native Hawaiians and Pacific Islanders have among the highest prevalence of behavioral health problems compared to other US ethnic groups to include depression, anxiety, suicide, substance use, interpersonal violence, and accidents. It is often difficult to ascertain specific behavioral health data among Native Hawaiians and Pacific Islanders because they are usually aggregated with Asian populations in many epidemiological studies and public health reports because of concerns regarding small sample size (Panapasa, Crabbe, & Kaholokula, 2011). We present studies that disaggregated Native Hawaiians and Pacific Islanders from Asian samples to highlight the most prevalent behavioral health inequities.

Studies indicate that depression is higher in Native Hawaiians and Pacific Islanders compared to other ethnic groups and the general population. Adult Native Hawaiians living in Hawai'i have a higher prevalence of current depression (13%) compared to Filipinos (9%), Whites (9%), Japanese (6%), Chinese (5%), and the overall state's population (8%; (Salvail & Smith, 2007). Across the USA, Native Hawaiians and Pacific Islanders are more likely to report experiencing serious psychological distress in the past 30 days (4%) when compared to Asians (2%) and the general US population (3%) (Galinsky, Zelaya, Barnes, & Simile, 2017). According to the 2009 Youth Risk Behavior Survey (YRBS), Native Hawaiian and Pacific Islander high school students reported feeling sad or hopeless more frequently over a 12-month period (33%) than did their American Indian/Alaska Native (31%), Asian (24%), Black (28%), and White (24%) counterparts across the USA. The prevalence of severe or moderately severe depression is higher in Native Hawaiians and Pacific Islanders of ages 65 and older (4.8%) compared to Asians (1.5%) and the overall population of Hawai'i (2.7%) (Aczon-Armstrong, Inouye, & Reyes-Salvail, 2013). Depression in Native Hawaiians and Pacific Islanders is strongly associated with anxiety, aggression (Makini Jr. et al., 1996), substance use (Kaholokula, Grandinetti, Crabbe, Chang, & Kenui, 1999), and suicide (Yuen, Nahulu, Hishinuma, & Miyamoto, 2000).

Lowry, Eaton, Brener, and Kann (2011) examined pooled behavioral health data from several years (2001, 2003, 2005, and 2007) of the YRBS. They found that Native Hawaiians and Pacific Islander high school students ($n = 56{,}773$) had higher rates of substance use, sexual activity, carrying a weapon, engaging in a physical altercation, and suicidal ideations and attempts than students of other ethnic groups, which were the same when stratified by gender. As an example, the substance use among Native Hawaiians and Pacific Islander students was 44% for alcohol, 32% for heavy drinking, and 23% for marijuana use. A study by Sasaki and Kameoka (2009) showed that Native Hawaiian adolescents were at least two times more likely to engage in lifetime sexual intercourse, recent sexual intercourse, and sexual initiation before the age of 13 years compared to White adolescents. Substance use in Native Hawaiian youth is associated with many other behavioral health issues, such as depression, anxiety, suicidality, conduct disorders, unsafe sex with multiple partners, and experiencing violence (Edwards, Giroux, & Okamoto, 2010).

Klest, Freyd, and Foynes (2013) found that Native Hawaiians were exposed to greater trauma related to accidents and abuse and reported more symptoms of trauma (e.g., depression, anxiety, PTSD, and sleep disturbances) over the life course than Japanese, Filipinos, and Caucasians in Hawai‘i, which did not differ by gender as it did with other ethnic groups. Goebert et al.’s (2000) study of 4164 adolescents found that Native Hawaiian adolescents experienced greater family adversity than non-Hawaiian adolescents, and that family adversity was associated with substance use by a family member, which strongly influenced adolescent use. Examples of family adversity that were greater in Native Hawaiians included family disruption (e.g., death or separation of family member), family criminality (e.g., arrest of a family member), and poor family health (e.g., a family member with a severe illness or injury).

Ye and Reyes-Salvail (2014) examined adverse childhood experiences (e.g., physical, verbal, sexual abuse, domestic violence) among Hawai‘i adults using data from the 2010 Behavioral Risk Factor Surveillance System (BRFSS). Seventy-five percent of Native Hawaiian adults reported one or more adverse childhood experiences compared to 64% of Whites, 52% of Filipinos, 45% of Japanese, 40% of Chinese, and 69% of others. The gap between Native Hawaiian adults and their ethnic counterparts widened with increasing number of adverse childhood experiences reported. The largest difference between Native Hawaiians and other ethnic groups was in the adverse childhood experiences of living with a family member with substance abuse (39%), having a family member in prison (13%), witnessing interpersonal violence (31%), and experiencing physical (25%) and verbal abuse (47%).

Most concerning are the extremely high suicide rates among Native Hawaiians and Pacific Islanders. Among Native Hawaiians of 15–44 years of age, suicide rates per 100,000 range from 52.8 to 72.4 compared with 22 to 47.2 for Caucasians, 21.5 to 49 for Japanese, and 27.4 to 37.5 for Filipinos, rendering the overall suicide rate among Native Hawaiians to be the highest in the USA (Else et al., 2007). There is very little information regarding suicidality among other Pacific Islander groups in Hawai‘i and the continental US. However, the suicide rates reported in the US-Affiliated Pacific Islands are among the highest in the world. In some Micronesian communities, such as in Chuuk, completed suicide rates are at 194 per 100,000 for ages 15–24 (Booth, 1999). Elsewhere in the US-Affiliated Pacific Islands, the rates are as high as 59 per 100,000 in Guam and 99 per 100,000 across all of Micronesia (Else et al., 2007). For the most part, the suicide rates are higher for Pacific Islander males than females, with the exception of Sāmoa.

The Behavioral Health Consequences of Prejudice, Stigma, and Oppression

Psychosocial Perspectives

Several psychosocial perspectives have been advanced to explain the disproportionate rates of behavioral health problems observed among Native Hawaiians that directly link these problems to issues of cultural loss and conflict, acculturative stressors, stigma, and oppression (Kaholokula, 2007; Kaholokula et al., 2009). In a 1983 report prepared by the Native Hawaiian Education Assessment Project (NHEAP), it was determined that "Modern Hawaiians seem to suffer from a new kind of depression, a being 'beaten down', but not by rain, rather, by a sense of enormous personal loss.…caused by two centuries of rapid change away from Hawaiian culture…" (p. 212).

Hammond (1988) presented the *cultural loss/stress hypothesis*, which was used as the conceptual framework for the NHEAP report, to explain the concerning educational outcomes and associated behavioral problems observed in Native Hawaiian youth. Based on the ecological systems theory by Bronfenbrenner (1979), this hypothesis describes a causal mechanism that starts with an unbalanced cultural contact between Native Hawaiians and Westerners, in favor of the latter, which resulted in cultural conflicts (macro system level) leading to Hawaiian cultural loss (exo system level) and to negative social outcomes (meso system level). The negative social outcomes then lead to increased family and community stressors (micro system) and to individual risk for physical and mental health problems (individual development). As long as an individual or group is preoccupied in dealing with significant physical and mental health issues, the other parts of this system in this causal mechanism, such as the meso- and micro systems, remain problematic and unchanged – a perpetual cycle of adversity.

Rezentes (1996), a Native Hawaiian psychologist, described the psychological distress and range of interrelated behavioral health problems caused by oppression and cultural disruptions as the *kaumaha syndrome*. Kaumaha is the Hawaiian word for heavy, but figuratively means sad or depressed. The symptoms of the kaumaha syndrome include sadness, sense of hopelessness, anger, and hostility. Rezentes asserts that contemporary Native Hawaiians share a "collective sadness and moral outrage" from centuries of oppression and cultural discord with Westerners and the 1893 overthrow of the ruling monarch. He states:

> Hawaiians were coerced into submitting to foreign institutions, laws, and cultures and forced to either give up or be punished for practicing their traditional culture. Some Hawaiians have internalized their oppressors' messages. They have become trapped in vicious cycles of poor health practices, abuse of ʻohana [family] members, neglect or prostitution of traditional Hawaiian culture, and the abandonment of their spirituality.' (p. 37)

Crabbe (1999), another Native Hawaiian psychologist, speculated that many contemporary Native Hawaiians suffer from a form of depression that he refers to as *hōʻinoʻino* or broken-spirit. Hōʻinoʻino in Hawaiian literally means to abuse or injure. Crabbe writes, "This type of depressed 'broken-spirit' may be the psychological repercussion from years of cultural conflict with Westerners, acculturative discord, and progressive cultural regress" (p. 125).

The type of depression that NHEAP (1983), Rezentes (1996), and Crabbe (1999) described are consistent with the theory of learned helplessness postulated by Seligman (1974). Miller, Rosellini, and Seligman (1985) described it as the actions of "passive people who have negative cognitive sets about the effects of their own actions, who become depressed upon the loss of an important source of gratification" (p. 182–183). It is a reactive type of depression caused by environmental events (e.g., oppression) influencing internal events (e.g., negative thoughts about self-worth or efficacy). Learned helplessness is associated with behavioral health problems, such as depression (Smallheer, Vollman, & Dietrich, 2018), posttraumatic stress disorder (PTSD) (Hammack, Cooper, & Lezak, 2012), substance abuse (Thornton et al., 2003), and risky sexual behaviors (Pittiglio, 2017). Learned helplessness as a form of depression may be an adaptive response to subjugation and exploitation among conquered peoples (Gilbert, 2000; Sloman, 2000).

Many behavioral health professionals working with Indigenous populations promote the concept of *historical trauma* to describe the type of psychological wounding experienced by Indigenous communities because of past and present transgressions. These transgressions include interpersonal violence, forced displacement from ancestral lands, cultural and language loss, compulsory acculturation strategies (e.g., forced removal of children to boarding schools), and overt and covert discrimination (Sotero, 2006). Historical trauma can be transmitted from one generation to the next (e.g., cross-generational cycle of trauma) and relived by many Indigenous persons in both narrative forms (e.g., stories passed down) and through their lived experiences of stigmatization (e.g., drunk or lazy native) and other prejudices and violence directed toward them by others. Thus, it is a chronic race-based type of trauma with serious psychological consequences, such as depression, anxiety, anger, shame, grief, and social isolation (Mohatt, Thompson, Thai, & Tebes, 2014).

Resilience, Family Support, and Behavioral Health

These notions of depression as an adaptive response to oppression and the idea that Native Hawaiians and Pacific Islanders are simply “helpless” and “traumatized” fail to take into account their resilience and ability to flourish, despite these adversities. They also fail to recognize that a majority of them do not suffer from a significant behavioral health issue. They are revitalizing their traditional values and practices (e.g., native language; traditional diets, forms of physical activities, and resource management; and ocean voyaging traditions) and utilizing these cultural assets to support their aspirations and for health promotion (Aitaoto et al., 2007; Look, Kaholokula, Carvhalo, Seto, & de Silva, 2012). Over 90% of Native Hawaiians strongly identify with their Native Hawaiian heritage and culture (Kaholokula, 2017), and 80% strongly believe it is important to maintain their unique cultural values and practices for psychological well-being (Kamehameha Schools, 2014). Since Christianization and the loss of their traditional leadership structures, churches have served as the focal point and major source of support for many Pacific Islanders living in the USA. Their religious or spiritual faith is a source of strength and support in dealing with the acculturative stressors they experience and in organizing Pacific Islander communities (Aitaoto et al., 2007). Native Hawaiian and Pacific Islanders have formed civic, sports clubs, and other nonprofit organizations to engage, support, and celebrate their communities.

Native Hawaiians and Pacific Islanders share similar cultural values and notions of well-being. Familial and social relations are interdependent in nature, with families encompassing a vast extended social network that goes beyond the immediate family to include their community, clan, and village, whether in their islands of origin or in the continental US. As mentioned earlier, they hold a high reverence for the church, but they also have a strong connection to their lands, practice reciprocity, and adhere to authority and protocols (Braun, Kim, Ka‘opua, Mokuau, & Browne, 2015). Samoans, for example, practice *fa‘asāmoa,* or to behave Sāmoan, which requires fidelity to family, ancestral lands, and the church (Aitaoto et al., 2007). Native Hawaiians practice *mālama ‘āina* or land stewardship and resource sustainability that is genealogically linked and an ancestral responsibility (Kaholokula, 2017). The ability of Native Hawaiians and Pacific Islanders to adhere to these cultural values and practices central to their identity and social relations is intimately tied to their physical and emotional well-being.

Studies show that strong positive family relations are protective against behavioral health problems in Native Hawaiian and Pacific Islander youths. Among 155 Native Hawaiian adolescents living in poverty, DeBaryshe, Yuen, Nakamura, and Stern (2006) found that those who believe in the importance of respecting family members and whose parents provide a supportive environment (versus creating a harsh environment) were less likely to exhibit behavioral problems. Carlton et al. (2006) examined the effects of resilience and family adversity indicators on internalizing (i.e., depression and anxiety) and externalizing (i.e., aggression) symptoms over 2 years among 1832 Native Hawaiian (64%) and non-Native Hawaiian (36%) adolescents. They examined a range of individual, family, and community-level resilience indicators (e.g., academic achievement, family support, and extracurricular activities) and family adversity (e.g., family discord). Although Native Hawaiian adolescents were found to experience more family adversity (i.e., low socioeconomic status and higher family discord, stress, psychopathology, and poor health), they reported higher levels of family support (i.e., emotional support) compared to non-Native Hawaiian adolescents. For both groups of adolescents, they found that the resiliency factors of greater family support and physical fitness were strongly associated with less internalized symptoms, whereas the resiliency factors of greater academic achievement and family support were strongly associated with less externalizing symptoms. However, physical fitness had a greater effect on externalizing symptoms for Native Hawaiian adolescents than their non-Hawaiian counterparts, but academic achievement had a greater effect on internalizing symptoms for non-Hawaiian than for Native Hawaiian adolescents.

The Effects of Oppression and Discrimination on Behavioral Health Indicators

Lending support to the psychological theories previously reviewed, scientific studies are slowly mounting showing the deleterious effects of oppression, as manifested in the experience of historical trauma, racism, and cultural discord, on behavioral health indices in Native Hawaiians and Pacific Islanders, albeit most focused on Native Hawaiians. They range from psychophysiological to epidemiological studies, aimed at elucidating the relationship between various indices of oppression on suicidality, psychological distress, substance use, and physiological measures of distress.

Yuen et al. (2000) examined the effects of Hawaiian cultural identification, socioeconomic status, and psychiatric symptoms on suicidality in 3094 Native Hawaiian high school students. They found that Native Hawaiian adolescents had higher rates of suicide attempts (13%) compared to non-Hawaiian adolescents (10%). The higher rates among Native Hawaiian adolescents were associated with greater Hawaiian cultural identification (odds ratio [OR] = 1.99), depression (OR = 1.07), substance abuse (OR = 1.39), and grade levels. The finding that a stronger Hawaiian cultural identity was associated with more suicide attempts among Native Hawaiian adolescents, independent of the psychiatric measures, was counter to what the researchers expected. One plausible hypothesis they offered to explain this finding was that Native Hawaiian youth with a stronger cultural identity were mostly at odds with the dominant Western culture in Hawaiʻi and thus they were experiencing higher levels of cultural conflicts and acculturative stress, which in turn placed them at a greater risk for suicide.

Subsequent studies among adult Native Hawaiians have lent support to the notion that Hawaiian cultural identity may be a marker for the cultural discord and acculturative stress they are experiencing as measured by perceptions of oppression. Kaholokula et al. (2012) examined the effects of perceived ethnic oppression on physiological stress indices in 146 adult Native Hawaiians. The physiological stress indices measured were salivary cortisol levels (i.e., a hormone of the hypothalamic–pituitary–adrenal [HPA] axis) and systolic and diastolic blood pressure (as an indicator of sympathetic-adrenal-medullary activity). Ethnic oppression was measured using a modified version of the Oppression Questionnaire (OQ), which measured two aspects of oppression: (1) felt oppression (i.e., the respondent's subjective experience of feeling oppressed and (2) attributed oppression (i.e., oppression attributed to an oppressive social group by the respondent) (Victoroff, 2005). First, they found that a stronger Hawaiian cultural identity had a significant positive correlation with both attributed (r = 0.17) and felt oppression (r = 0.21), lending support to Yuen et al.'s (2000) hypothesis regarding their aforementioned findings. They further found a significant negative correlation between attributed oppression and diurnal cortisol levels ($r = -0.21$), which persisted after adjusting for the effects of sociodemographic (e.g., age, sex, and education level), biological (e.g., body mass index and blood pressure), and psychosocial factors (e.g., cultural identity and psychological stress). They also found a significant positive correlation between felt oppression and systolic blood pressure (r = 0.22). However, this correlation was attenuated after adjusting for body mass index (BMI), a measure of obesity. McCubbin and Antonio (2012) have found an association between overt discrimination and overweight/obesity (BMI ≥ 25) status in Native Hawaiian adults.

The negative correlation between perceived oppression and cortisol levels found by Kaholokula et al. (2012) may be indicative of oppression as a chronic stressor versus an acute stressor in which cortisol is expected to increase to prepare the body for "fight or flight" (Fries, Hesse, Hellhammer, & Hellhammer, 2005). A lower, flattened, or blunted cortisol output occurs after a prolonged period of HPA axis hyperactivity (i.e., long period of elevated cortisol levels) due to chronic stress (Susman, 2007). A similar cortisol activity is found in persons with PTSD (Heim, Ehlert, Hanker, & Hellhammer, 1998), burnout (Pruessner, Hellhammer, & Kirschbaum, 1999), and atypical depression (Gold & Chrousos, 2002). Lower cortisol levels have also been found to be associated with depression linked to learned helplessness (Croes, Merz, & Netter, 1993).

Hermosura, Haynes, and Kaholokula (2018) reported the findings from a psychophysiological laboratory experiment examining the possible role that racism may play in the risk for cardiovascular disease (CVD) among Native Hawaiians. They examined the cardiovascular reactivity and recovery responses of 35 Native Hawaiian college students to subtle and blatant racist stimuli (i.e., vignettes depicting subtle or blatant racism toward a Native Hawaiian individual) and their subjective levels of distress to these stimuli. These participants were previously categorized into either a high- or a low-perceived racism group based on their self-report on a racism measure. During participants' exposure to the blatant and subtle racist stressors, frequent blood pressure and heart rate measurements were collected. The investigators found that systolic blood pressure recovery following exposure to both types of stressors was significant for both groups. Overall, participants reported greater subjective distress following blatant stressor exposure compared to subtle stressor exposure. Albeit nonsignificant, interesting trends in the high-perceived racism group were observed. Specifically, participants had greater reactivity to the subtle stressor exposure compared to the blatant stressor, incomplete heart rate recovery after exposure to both stressors, and partial systolic and diastolic blood pressure recovery following exposure to the subtle stressor compared to the participants in the low-perceived racism group. Researchers suggested that interventions aimed at increasing the self-awareness of the physiological reactions to racial stressors and using effective coping strategies by individuals who report greater experience of racism may reduce their risk for CVD development.

Pokhrel and Herzog (2014) examined the effects of historical trauma and perceived discrimination on substance use (i.e., past 30 days of cigarette, alcohol, and marijuana use) in 128 Native Hawaiian college students using structural equation modeling (SEM). They measured two aspects of historical trauma using a self-report instrument originally developed for American Indians: One aspect was the historical traumatic events experienced by the students and relatives and the other aspect related to historical loss (e.g., thoughts about lost land and culture) and their emotional reactions to the thoughts of historical loss (e.g., depressed, sad, or angry) (Whitbeck, Adams, Hoyt, & Chen, 2004). Perceived ethnic discrimination was measured based on the experience of day-to-day unfair treatment because of their ethnicity (Williams, Yan, Jackson, & Anderson, 1997). Interestingly, they found a direct negative path from historical trauma to substance use (−0.21; $p < 0.05$), but a direct positive path from historical trauma to perceived discrimination (0.49; $p < 0.001$) and then from perceived discrimination to substance use (0.32: $p < 0.01$), with age, sex, and income as covariates. These findings suggest that the effects of historical trauma on substance use risk in Native Hawaiians appear to operate through their experience of discrimination.

Antonio et al. (2016) examined the relationship between the experience of discrimination and depression symptoms in 104 Native Hawaiians who were residents of a Hawaiian homestead community. The discrimination measure used in this study was the Everyday Discrimination Scale, the same used by Pokhrel and Herzog (2014). The depression measure was the 10-item version of the Center for Epidemiologic Studies Depression (CES-D) Scale (Hertzog, Alistine, Usala, Hultsch, & Dixon, 1990). They found a significant positive correlation between perceived discrimination and symptoms of depression ($r = 0.32$), which persisted after adjusting for differences in sociodemographics and degree of both Native Hawaiian and American cultural identity, separately. Unlike previous studies, Hawaiian cultural identity did not have a significant correlation with perceived discrimination, which could be due to the small sample size (i.e., not enough statistical power to detect a significant correlation) or due to characteristics unique to Hawaiian homestead communities. Under the Hawaiian Homes Commission Act, lands in Hawai‘i were set aside in public trust for homesteading by Native Hawaiians to enable them to return to their lands to promote self-sufficiency and the preservation of their cultural values and traditions. Only Native Hawaiians with 50% blood quantum and greater are eligible for Hawaiian homestead, which currently includes about 9450 individuals who hold Hawaiian Home Land lessees.

Kaholokula et al. (2017) examined the potential mediating effects of 14 coping strategies on the relationship between perceived racism and psychological distress among 145 Native Hawaiians using structural equation modeling. The same sample and oppression measure was used as in Kaholokula et al.'s (2012) study. Coping strategies were measured with the Brief Coping Orientation to Problems Experienced (COPE) (Carver, 1997) and psychological distress was a composite measure based on the 10-item version of the CES-D Scale (Hertzog et al., 1990) and the 10-item Perceived Stress Scale (Cohen, Kamarck, & Mermelstein, 1983). They found that two types of coping strategies – venting and behavioral disengagement – were independently significant mediators. Controlling for the effects of age, gender, educational level, and marital status, perceived racism had significant positive paths to both venting ($\beta = 0.23$) and behavioral disengagement ($\beta = 0.25$) coping strategies and, in turn, these coping strategies had significant positive paths to psychological distress ($\beta = 0.17$ and 0.31, respectively). Thus, perceived racism had a significant indirect effect on psychological distress, mediated through these two coping strategies.

As described by Kaholokula et al. (2017), venting is a form of anger expression while behavioral disengagement might be an indicator of learned helplessness (i.e., a person giving up or withdrawing from any effort to deal with a stressor). Understandably, anger expression is a prevalent coping strategy when dealing with the experience of racism for many racial and ethnic minority groups in the USA. Anger expression has also been found to mediate the relationship between perceived racism and psychological distress in African-Americans (Nyborg & Curry, 2003; Pittman, 2011) and general health in Aboriginal youth of Australia (Priest, Paradies, Stewart, & Luke, 2011). Brown, Phillips, Abdullah, Vinson, and Robertson (2011) used the Brief COPE to examine what coping strategies African-Americans used in response to racism-specific stressors and found that venting and religion were the most common coping strategies. However, anger expression and behavioral disengagement as a means of coping with racist stressors may only serve to maintain or "relive" the emotional distress (anger or helplessness); thus, exacerbating the adverse effects of racism on a person's psychological well-being.

Ta, Chao, and Kaholokula (2010) conducted a qualitative study to explore the conceptualization of depression among 30 Native Hawaiian women who were either college students or residents of a Hawaiian homestead community. Based on semi-structured interviews, they found that a majority of the women (63.3%) identified strongly with their Native Hawaiian heritage and reported that family traditions and educational environments that incorporated Native Hawaiian language and cultural practices were integral in shaping their Native Hawaiian identity. Ta et al. found that the predominant themes among these women involved a link between depression and issues of cultural loss and identity, loss of lands and nation, and diminished social status resulting from US occupation and other traumatic life events. A quote from one of the women in response to a question about the common causes of depression exemplifies this point, in which she stated, "Bringing someone down…oppression, I think is another one. In a Hawaiian perspective in Native Hawaiian men and women, we still feel through colonization and the overthrow of the kingdom and stuff like that."

Inada et al. (2018) were perhaps the first and the only group to formally study the issue of racism among Micronesians, the most recent Pacific Islander group to come to Hawai‘i and the continental US. Anecdotal reports of racial discrimination toward Micronesians have been documented (Yamada, 2011), including an article published in a Hawai‘i-based news outlet titled, "No Aloha for Micronesians" (Blair, 2011). In the article, they noted "that the Micronesian is defined by exclusion – that the group has become Hawaii's newest underclass, with all the negative connotations that come with the term." To explore this issue of racial discrimination on the health status of the Chuukese community in Hawai‘i, Inada et al. conducted in-depth interviews with 12 Chuukese and eight healthcare providers who serve this community. Chuukese come from the islands of Chuuk, a state within the Federated States of Micronesia. Interviews revealed that Chuukese experienced high levels of interpersonal racial discrimination and oppression as a collective group both in the larger society and in the healthcare system. The Chuukese participants noted that these experiences adversely impacted their emotional well-being and their ability to access essential healthcare, housing, employment, and education services. They also expressed that these issues "hurt their heart" to know their children were witnessing and experiencing these prejudices against them. They reported that the strategies they employ to deal with these experiences include turning to their religious faith and the larger Chuukese community for emotional support. Healthcare providers commented on the need for a change in society's attitude toward Micronesians and viewed racial discrimination as a disease of society and healthcare as a human rights issue.

Hagiwara (2016) conducted a study to examine the effects of both interpersonal experiences of racial discrimination and oppression as a collective group experience with 71 Chuukese migrants. Modified versions of the Experience of Discrimination measure (Krieger, Smith, Naishadham, Hartman, & Barbeau, 2005) and the Oppression Questionnaire (Victoroff, 2005) were used, which had a significant positive correlation ($r = 0.41$) in this study. Physical and mental health status were measured based on items from the BRFSS. It was found that self-reported poor physical and mental health status were significantly associated with higher oppression and racial discrimination scores. After controlling for demographics, access to healthcare, and tobacco use, oppression and racial discrimination, analyzed separately, were significantly associated with mental health status (OR = 1.25 and 1.03, respectively). When both measures were examined together, only oppression remained significantly associated with mental health status (OR = 1.20). These findings highlight the importance of considering racial discrimination, in particular oppression and social justice issues, when addressing health inequities in this community.

To summarize our review, most of the studies to date that have examined the effects of oppression and discrimination on behavioral health variables focused primarily on Native Hawaiians.

Aside from Hagiwara's (2016) study with Chuukese, the effects of oppression on behavioral health outcomes have yet to be empirically examined among other Pacific Islander groups. Notwithstanding, the studies reviewed here, collectively, indicate that a greater sense of historical trauma, oppression, racist experiences, and cultural discord are associated with higher levels of depression symptoms, psychological distress, suicidality, and substance use among Native Hawaiians and Pacific Islanders. The psychophysiological studies done by Kaholokula et al. (2012) and Hermosura et al. (2018) demonstrate how the experience of oppression and racial discrimination gets "under a person's skin" through activation of their physiological stress responses (e.g., elevated blood pressure, heart rate, and cortisol dysregulation), both during and long after exposure to a racist event.

Although in this chapter, we focus on Native Hawaiians and Pacific Islanders residing in the USA and its territories, studies of Māori, the Indigenous Polynesian population of New Zealand, also find that perceived racial discrimination and socially assigned Māori ethnicity are associated with both poorer physical and mental health status (Harris et al., 2006; Harris, Cormack, & Stanley, 2013). Among Native Hawaiians, perceived oppression is also associated with hypertension risk (Kaholokula, Iwane, & Nacapoy, 2010). Nevertheless, more rigorous studies among other Pacific Islander groups are needed that examine the deleterious effects of oppression and stigma on behavioral health problems, especially on co-occurring behavioral health problems. The few epidemiological studies conducted show that Native Hawaiians and Pacific Islanders may suffer from multiple, interrelated behavioral health issues (e.g., Lowry et al., 2011). It is also important to examine these relationships among distinct Pacific Islander groups because of likely differences in the frequency and intensity of oppressive experiences, the type (i.e., institutional versus interpersonal) and nature of these experiences (e.g., overt versus covert), the contexts in which these experiences occur (e.g., workplace versus public places), and the coping strategies and cultural assets used to deal with these experiences across specific Pacific Islander groups. As Kaholokula et al.'s (2017) study found, certain coping strategies, such as anger expression and behavioral disengagement, may actually exacerbate the negative effects of oppression and racism experienced by Native Hawaiians and Pacific Islanders.

Pathway from Oppression to Behavioral Health Outcomes

No doubt, there is a tremendous sense of cultural loss and suppression, feelings of marginalization and oppression, and associated psychological distress that ranges from outrage to depression among many Native Hawaiians and Pacific Islanders. The psychosocial theories reviewed and the notion of cultural trauma provide an explanation for how experiences of oppression and discrimination are associated with behavioral health problems and their transgenerational and cumulative effects. And, the empirical studies reviewed lend support to the notion that historical trauma, oppression, and discrimination are adversely associated with a range of behavioral health problems in these populations. Although not reviewed here, studies are emerging to suggest that mental health factors associated with racism may precede chronic disease development (Kaholokula, 2016).

Integrating conceptual models from both Paradies et al. (2013) and Walters and Simoni (2002), Fig. 1 illustrates a hypothesized pathway from oppression and racism to behavioral health outcomes consistent with the extant literature and specific to Indigenous populations. The figure shows that the interpretation of an environmental event as oppressive or racist can lead to elevated psychological and physiological distress. Whether or not this distress eventually leads to serious behavioral health problems depends on the coping strategy employed to deal with these stressors and the presence of other chronic environmental stressors due to economic deprivation and lack of needed resources and services to effectively manage these multiple sources of stress. The psychological stress or distress

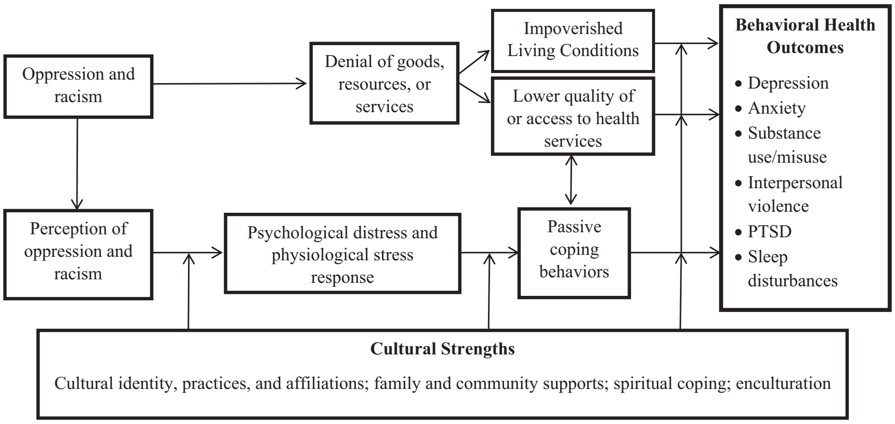

Fig. 1 Modified from Paradies et al. (2013) and Walters and Simoni (2002) to illustrate the pathways from oppression and racism to behavioral health outcomes with cultural strengths serving to moderate (i.e., buffer against) the effects of this pathway

resulting from oppressive or racist experiences can include subclinical depression and anxiety, emotional unrest, anger, resentment, hypervigilance, suspicion, and mistrust. If not addressed effectively, they can lead to major behavioral health issues. For a discussion on the psychological processes (e.g., relational schemas) involved in the relationship between racism and psychological distress, we refer the reader to Brondolo, Ng, Pierre, and Lane (2016).

Also included in Fig. 1 are the cultural strengths of Native Hawaiians and Pacific Islanders that can serve to buffer them against the adverse effects of oppression and racism. For many Native Hawaiians and Pacific Islanders, like those of other Indigenous populations, the preservation and practice of cultural traditions (e.g., native language, values, and practices), protecting and accessing sacred places and ancestral lands, a strong cultural and secure identity, and cultural participation and affiliations are important to their quality of life and psychological well-being (Kaholokula, 2017). However, their cultural values, practices, and aspirations are often at odds with those of the dominant society leading to cultural conflicts and marginalization. Barriers to accessing or expressing these cultural strengths only serve to remind, if not relive, past transgressions and trauma, which is an example of the contemporary effects of historical trauma.

Culturally Responsive Behavioral Health Services

Culturally responsive behavioral health services require providers to be mindful of their own cultural worldviews, identities, and biases and how they may affect the care they provide to persons of diverse cultural backgrounds. At the same time, it also requires providers to be sensitive to the cultural worldviews, identities, and aspirations of clients from diverse cultural backgrounds. In the act of being mindful of these cultural factors and interactions, it further requires providers to avoid stereotyping and overgeneralizing these cultural factors by not assuming that all persons with the same ethnocultural background are similar in other aspects as well. Recall that there is much cultural diversity among Native Hawaiians and Pacific Islanders, such as in languages, worldviews, acculturation status (e.g., native versus migrant), enculturation and acculturation strategies (e.g., assimilation versus integration), and sociopolitical aspirations (e.g., political self-determination). They may also have their own explanatory models and preferred healing modalities for their behavioral health issues.

In this final section, we focus on issues related to providing culturally responsive behavioral health services to Native Hawaiian and Pacific

Islander clients. There is a dearth of information on behavioral health assessment and treatment issues in these populations. The information that is available is often aggregated with Asian populations, making it difficult to discern what is relevant to Pacific Islander populations. Thus, we draw from our collective and extensive clinical experience working with Native Hawaiians and Pacific Islanders and discuss these issues in three broad areas: (1) Provider Issues, (2) Client Issues, and (3) Therapeutic Issues.

Provider Issues

It is important for providers to have the knowledge and skills necessary to be culturally responsive to the behavioral health needs of Native Hawaiians and Pacific Islanders. Much attention has been given, and standards proposed, to developing "cultural competence" among mental health providers, but there is limited evidence of training in this regard showing better client experience and outcomes (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007). In fact, cultural competency training may lead to a complacency that may be more of a disservice to clients and perpetuate stereotypes. A cultural safety paradigm, rather than a cultural competence paradigm, may be more appropriate in addressing behavioral health issues among Native Hawaiians and Pacific Islanders because it relies on a sociohistoric lens to understanding the biases and injustices the clients experience (Doutrich, Arcus, Dekker, Spuck, & Pollock-Robinson, 2012).

The concept and practice of cultural safety originated from the field of nursing in New Zealand to address the bicultural divide between Māori (the Indigenous population) and non-Māori (Doutrich et al., 2012). It emphasizes the examination of repression, social domination, and the differential social class and power between indigenous populations and the Western-dominated society. The cultural safety framework not only focuses on increasing a provider's knowledge of different cultural practices and traditions, but also emphasizes the importance of understanding the inherent power imbalances, the existence of institutional discrimination, and the effects of colonization on a client's health concerns. Providers are encouraged to examine their own conscious and unconscious racial/ethnic biases and how they may affect the therapeutic relationship with their clients. Implicit and explicit bias among behavioral health providers, as with other healthcare providers, has the potential to do real harm to clients by adversely influencing provider–patient interactions, treatment decisions, and thus treatment outcomes. Recent systematic reviews of various studies highlight differences in the treatment of minority and non-minority patients based on whether or not the healthcare provider holds an implicit bias toward certain ethnic minorities, albeit these studies have been mostly conducted with medical professionals (Dehon et al., 2017; FitzGerald & Hurst, 2017; Hall et al., 2015).

Guidelines and training curricula for cultural safety are still being examined and refined, but they offer a promising approach to improve the cultural responsiveness of healthcare providers (Gibbs, 2005). Ensuring cultural safety in the provision of behavioral health services can pose some challenges because it is based on the client's perceptions regarding whether the services are culturally safe or not. The client's perceptions can be influenced by the characteristics and behaviors of the provider and whether he or she is perceived by the client as being placed at a cultural risk (Wepa, 2005). Thus, cultural safety approaches emphasize the importance of self-reflection by the provider, such as being aware of their position of power in relation to the client's experience with oppression and discrimination and his or her cultural values and beliefs.

Part of providing culturally safe care is the examination of a provider's implicit bias. Implicit bias is defined as an "attitude, thought, or feeling that often exists outside of our conscious awareness" (Hall et al., 2015, pg. e60). Implicit biases may contradict one's explicit values and beliefs and are usually created because of societal messaging (Sabin, Nosek, Greenwald, & Rivara, 2009). Implicit racial biases have been implicated as a contributor to health disparities as observed in the differential diagnoses and treatment and in levels and quality of care provided to different racial and ethnic groups (FitzGerald & Hurst, 2017). The implicit biases of a provider can lead to condescending or paternalistic treatment of patients that negatively impact provider–patient relationship and treatment recommendations offered (Hall et al., 2015).

The most widely used and robust test of implicit biases is the Implicit Association Test (IAT; Greenwald & Banaji, 2017). The IAT is a response-latency measure that examines the relative speed with which a person is able to pair two different concepts with an attribute. A concept that is more quickly associated with an attribute is considered to be stronger than another concept associated with the same attribute. Many IATs have been developed to examine implicit biases toward African-Americans and Hispanics but, to our knowledge, there are no IATs that have been created to examine implicit biases toward Pacific Islander groups in relation to other ethnic groups in the USA. An IAT relevant for Māori in the New Zealand context is available (Harris et al., 2016; Harris et al., 2018). Efforts are underway to develop an IAT to examine implicit biases toward Native Hawaiians and Micronesians compared to Caucasians and Japanese-Americans, the two dominant ethnic groups in Hawaiʻi.

Client Issues

It is important to keep in mind that the experience of oppression and discrimination may or may not directly affect a Native Hawaiian or Pacific Islander client's behavioral health problem. However, it is likely to be an underlying and ever-present stressor associated with other socio-environmental (e.g., economic deprivation and unsafe living conditions) and interpersonal stressors (e.g., family and work-related challenges). As Perry, Harp, and Oser (2013) point out, a person can face multiple disadvantages based on their race, social status, and even gender that reduces his or her capacity for avoiding stress or defusing its effects.

In working with Native Hawaiians and Pacific Islanders where oppression and discrimination are believed to be affecting a client's behavioral health, several factors need to be understood and taken into account. These factors include, but are not limited to, the following:

- Client's and family's ethno-cultural heritage and identity.
- Client's level of acculturative stress and adjustment.
- Degree of cultural or other loss and traumatic experience.
- Family, financial, and work stressors.
- Family dynamics, problems, and strengths.
- Physical health and medication history.
- Client's understanding of his or her presenting problem, help-seeking behavior, and treatment expectations.
- Client's previous interactions with the healthcare system.

The cultural identity (e.g., degree of pride and practice of Hawaiian cultural values and practices) of Native Hawaiians and Pacific Islanders in relation to their affiliation and engagement with American mainstream culture can vary. For example, studies among Native Hawaiians show that 70–77% report highly identifying with both their Hawaiian culture and that of the American mainstream; 17–23% highly identify with only their Hawaiian culture; 1–2% highly identify with only the American mainstream culture; and 4–6% identify with neither their Hawaiian culture nor that of the American mainstream (Kaholokula et al., 2009). Native Hawaiians, more so than other Pacific Islanders, have a diverse racial/ethnic ancestry due to a high degree of intermarriage stemming back to the 1800s. As mentioned earlier, many of them are of mixed Native Hawaiian, Asian, and European ancestries. Yet, a vast majority of Native Hawaiians strongly identify with their Hawaiian heritage and culture, despite their degree of Hawaiian ancestry. Overall, identity is really a construct to be defined by the individual or group collectively and should not be imposed upon them by the therapist, healthcare system, or institution.

For Native Hawaiians, skin color as an indicator of blood quantum has been a difficult issue for many. For most other Indigenous groups, any trace of Indigenous genealogy or genotype allows one to claim status within that group without much explanation or hindrance. Unfortunately, legislation introduced by the U.S. Congress in 1921 in regard to ownership of Hawaiian Homelands defined Native Hawaiians as those "with at least one-half blood quantum of individuals inhabiting the Hawaiian Islands prior to 1778" for that purpose. Although not the definition for other federal programs or endorsed by most Native Hawaiians, it has had adverse social and psychological affects for some Native Hawaiians when they do not possess the typical phenotype associated with being Native Hawaiian. It has also created an indiscriminate divide within the community that is not based on acculturation status or cultural identity, but based on unsubstantiated biological constructs imposed by the dominant culture (Kauanui, 2008).

Because of differences in socioeconomic conditions and cultural aspirations, Native Hawaiian and Pacific Islander clients can vary in how oppression and discrimination affect their behavioral health problems. A subset of Native Hawaiians and Pacific Islanders experience anxiety and depression as a result of disenfranchisement. Many are unemployed or employed in multiple low-paying jobs, struggling to afford housing and healthcare, and are food insecure. These clients typically need some form of state assistance, such as food stamps, welfare, or housing assistance. However, they teeter on the edge of eligibility for these services, leading to another source of stress as they struggle to comply with this system in an effort to maintain services. This group of Native Hawaiians and Pacific Islanders often have a high degree of trauma exposure and report having suicidal thoughts. Therapy and a mental illness diagnosis itself carry a particular stigma, often resulting in a delay in seeking services. As a result, symptoms are typically more severe at the time of presentation and complicated by multiple co-occurring behavioral health problems.

Another subset of Native Hawaiians and Pacific Islanders represent an emerging type of client seeking services, especially among Native Hawaiians. Having benefitted from higher levels of education and advancing into good paying jobs or professions, their sources of stress are typically the result of a more internal conflict. Attainment of higher education typically requires an adoption of Western values with regard to individual achievement. There may be criticism from others around them and external judgment that the individual is a "sell-out" or now feels superior to others. Internally, the clients often feel an increased sense of *kuleana* or responsibility to promote the Native Hawaiian or Pacific Islander agenda in the workplace or other settings where others are not always responsive or sensitive to these issues, leading to interpersonal conflicts. Having more affluence, such clients often feel they need to "fight" to create more opportunities for others from their ethnic group, educate non-Pacific Islanders on issues important to Pacific Islanders, or counsel other non-Pacific Islanders on their offensive behaviors toward Pacific Islanders. This strong sense of responsibility often causes overwhelming stress that affects their mood and sense of self-efficacy.

Pacific Islanders from Micronesia, such as Marshallese and Chuukese, face tremendous hardships to accessing a range of health services to include the needed behavioral health services. Some of the barriers include language and health literacy issues (i.e., lack of interpreters or providers who speak their language), discrimination in the healthcare system (both overt and covert), and cultural safety issues regarding providers (e.g., providers' lack of understanding of the geopolitical history between Micronesia and the USA). Compared to Pacific Islanders from Polynesia, those from Micronesia tend to be more reticent to seek health services (Choi, 2008). Exacerbating these issues are their poor socioeconomic circumstances coupled with barriers to accessing appropriate healthcare coverage.

As stated earlier, originally the COFA migrants were eligible for Federal Medicaid, a program to help ensure access to healthcare for individuals with limited incomes. However, due to changes in this policy, the majority of COFA migrants do not qualify for this program due to their migrant status. This means those who are not considered aged, blind, or disabled, or who do not obtain coverage through their employers, must purchase a plan through the Affordable Care Act, plans which were tailored for individuals who are 130% above the federal poverty line. In many cases, this situation results in individuals either remaining uninsured or enrolling in a plan but not being able to afford the co-pays attached to receiving health services and medications. This forces many Micronesians to not seek care or to withhold picking up their medications until they are experiencing intolerable pain or illness.

Pacific Islanders from Micronesia face daily discrimination and negative stereotypes not only within the healthcare system and from the dominant society, but also from other Pacific Islanders with well-established roots in the USA. A point of contention is the perceived competition among Pacific Islander communities for limited and scarce resources allocated for socially disadvantaged groups. This spawns a fear that COFA migrants are using up resources that would otherwise go to other Pacific Islanders, including employment, social, and housing services. In addition to the acculturative and economic stressors faced by COFA migrants, these types of discrimination toward COFA migrants by other Pacific Islanders are a serious issue because there is the potential of a higher exposure and conflict because they are likely to live in the same neighborhoods, work in similar job settings, and attend the same schools.

Therapeutic Issues

Prior to Western contact, Native Hawaiians and Pacific Islanders had developed their own health-related concepts, diagnostic classification systems, and healing modalities to address illnesses of both a physical and an emotional/spiritual nature. For example, the causes of illnesses according to Native Hawaiian healing traditions were broadly conceptualized as being either *maʻi kino* (body sickness), *maʻi ma loko* (illness within), or *maʻi mai waho* (illness from outside; Pukui, Haertig, & Lee, 1979). Maʻi kino were illnesses due to physical causes, whereas maiʻi ma loko and maʻi mai waho were the result of interpersonal transgressions or spiritual and supernatural forces. Various treatment modalities existed based on the specific diagnosis, which included *lāʻau lapaʻau* (medicinal plants and herbs), *lāʻau kāhea* (calling medicine), and *pule* (prayers), to name a few examples. Many of these healing practices were considered *huna,* or not for general public viewing or knowledge, and under the purview of the *Kāhuna* who were the experts and keepers of their specific healing tradition. Many of the Indigenous healing practices in the Pacific were either outlawed or discounted by Western settlers during the 1800s and early 1900s, which led many to practice in secrecy for some time.

Hawaiian healing practices, as an example, have since been revitalized by contemporary healers and recognized under both Hawaiʻi State and U.S. Federal law as important to the health and well-being of Native Hawaiians (Donlin, 2010). The United Nations Declaration on the Rights of Indigenous Peoples also calls for the recognition of Indigenous healing practices and their role in improving the health and well-being of Indigenous Peoples (United Nations, 2008). Although these traditional healing practices are often preferred over Western approaches among many Indigenous Pacific Islanders, they have grown in popularity among nonindigenous peoples. Unfortunately, with their rise in popularity come the exploitation and commercialization of such practices mostly by outsiders who are not properly trained or sanctioned based on accepted cultural protocols and traditions.

Although there have been attempts to integrate traditional Hawaiian healing practices into Western clinical settings and to form a credentialing body to govern their practices, it is a contentious issue among many Indigenous healers. Many believe that no financial compensation should be received for their services, and that the person seeking healing needs to find their way to the healer; thus, referrals from Western practitioners are not acceptable in many cases. These preferred practices are beginning to change with the younger generation of Indigenous healers who seek to make these practices a viable profession or livelihood and, as a result, are making them more accessible and legitimizing their use as a healthcare option. However, for the most part, many traditional healing practices are not easily accessible by the general public. Only a small number of community health centers and Native Hawaiian Health Care Systems in Hawaiʻi offer traditional Hawaiian healing services, two being the Waiʻanae Coast Comprehensive Health Center on the Island of Oʻahu and Hui No Ke Ola Pono – Native Hawaiian Health Care System on the island of Maui.

In Hawaiʻi, and relevant to behavioral health, the traditional Native Hawaiian practice of *hoʻoponopono* has long been used as a form of family, community, and group therapy for addressing interpersonal conflicts. Hoʻoponopono literally means "to make right" and is often conceptualized as a therapeutic approach for reconciliation or forgiveness or as an interpersonal problem-solving process (Ito, 1985). It has been applied and/or recommended for use in clinical (Mokuau, 2002), organizational (Patten Jr, 1994), school (Brinson & Fisher, 1999), and criminal justice settings (Hosmanek, 2005). It is used to address issues of substance use and abuse (Mokuau, 2002), interpersonal violence (Smith, 2002), and historical trauma (Paglinawan & Paglinawan, 2012). There are many how-to books written on hoʻoponopono and workshops offered to teach this healing method and in becoming a *haku* (facilitator/convener), which can vary in their approach from each other and from its original intended applications. Despite variations in how hoʻoponopono is practiced, most involve several key features: (1) prayers or ceremonies for opening and closing the reconciliation process, (2) stating the specific problem or *hihia* (entanglement) and its offense to all parties involved, and (3) working to disentangle the hihia to include admission of problem, atonement (*mihi*) for its negative effects, and forgiveness (*kala*).

Although Indigenous healing practices are now in greater demand and positively regarded, there remains an absence of research into their treatment efficacy for illnesses, whether of a physical or psychological nature. Many of these traditional healing practices are now being applied to a wide range of contemporary physical (e.g., diabetes) and mental health (e.g., depression) issues. Aside from their potential treatment efficacy, some argue that traditional healing practices could be used to incentivize Native Hawaiians and Pacific Islanders to seek Western-based medical care or to enhance the effectiveness of Western medical treatments by addressing the spiritual aspect of a problem – an aspect often believed to be lacking in Western treatments. Whatever the case may be, Indigenous healing practices can play an important role in addressing the health inequities experienced by Native Hawaiians and Pacific Islanders.

Despite the resurgence of Indigenous healing practices, Native Hawaiians and Pacific Islanders seeking behavioral health services are most likely to have access to Western treatment modalities based on biomedical (e.g., psychopharmacological treatments) and psychological (e.g., cognitive-behavioral therapy) models of care. And, like Indigenous healing modalities, there has been an absence of research into common behavioral health interventions for Native Hawaiians and Pacific Islanders found efficacious in other populations, such as cognitive-behavioral therapy (CBT) or interpersonal therapy (IT). Nevertheless, CBT and other "evidence-based" psychological therapies are often recommended for use with Native Hawaiians and Pacific Islanders, despite the fact that they have not been rigorously examined in these populations. They often need to be modified, so they are culturally responsive (e.g., emphasizing Pacific values and use of common Pacific Islander analogies) to Native Hawaiians and Pacific Islanders.

Native Hawaiians and Pacific Islanders report a preference for traditional healing practices and spiritual−/religious-based interventions when available (Aitaoto et al., 2007; Kaholokula, Saito, Mau, Latimer, & Seto, 2008). When considering Western-based treatments, there is the assumption that psychological therapies are preferred over psychopharmacological therapies. Research with other ethnic minority populations, including other Indigenous populations, suggests that clients prefer psychological therapies over medication use for certain behavioral health issues, such as depression. Depression is often seen as resulting not from biological factors but from external factors and thus some people are more responsive to counseling and prayer (Givens, Houston, Van Voorhees, Ford, & Cooper, 2007).

To illustrate the key components of CBT modified to be culturally responsive to Native Hawaiian and Pacific Islander clients, and the other points we previously made, we briefly present the case of a Native Hawaiian client named, Ikaika. Ikaika is a 25-year-old male who was referred to a community provider after a change in his insurance coverage. Ikaika reported that he began having severe panic attacks 6 years earlier that resulted in paranoid and intrusive thoughts. He was treated at another clinic for a period of time and was placed on heavy antipsychotics that resulted in what he described as a "zombie-like" state. He eventually stopped these medications because of the side effects and terminated care there, switching his care over to a private practitioner who diagnosed him with obsessive compulsive disorder (OCD) and started him on a tricyclic antidepressant. At the time of intake, he reported that his OCD symptoms are well controlled with medication. However, he came in complaining of a recent increase in anxiety symptoms with a new job pending. He denied any current suicidal or homicidal ideation, but did report a brief period of suicidal ideation 1 year ago. At that time, he wrapped something around his neck but immediately took it off. Ikaika reported he grew up in a family in which yelling and conflict were an everyday occurrence. He reported that his current support system is relatively good.

The first few sessions focused on the assessment and building trust. Assessment included a discussion of his values, both in his family of origin and currently as an adult. It is important for the therapist to have a good understanding of the client's values, as these will often become the motivating factors that promote growth and healing. Moving into the therapeutic portion of treatment, the focus shifted to discussion of his cultural identity and why the beliefs of others resulted in extreme emotional reactions. Additionally, the therapy focused on behavior change and willingness to take medications. Throughout therapy, Ikaika was asked to identify his locus of control for issues that arose and focus his efforts only when it was perceived that he could affect the outcome.

Very early on, it became clear that the cultural identification and related issues were the most problematic issues. At his second session, he came in to the visit upset at his treatment by clinic staff. While he could have been written off as another "angry Hawaiian," he explained that after his intake appointment, he was given an After Visit Summary (AVS) by clinic staff and, when he read through it, he found they had assigned his ethnicity as "White," instead of asking for his self-report. As we discussed this interaction, he reported a long history of cultural identity issues. Ikaika is phenotypically white, but is part-Hawaiian and identifies strongly as a Native Hawaiian. He was raised mostly on the continental US but returned to live in Hawai'i as an adult. He explained that he gets very upset when people question his "Hawaiianess," no matter if this is an outright or perceived judgment.

Through this assessment and treatment process, Ikaika was able to strengthen his own cultural identity through a series of activities that increased his cultural knowledge and foundation. After making the decision to stay in Hawai'i, he is now focusing on activities that help him establish roots here and a connection to his ancestral lands. This vignette illustrates that trusted relationships, connection to the community, and consideration of spirituality are essential components to interfacing with Native Hawaiian and Pacific Islander clients.

Conclusion

Native Hawaiians and Pacific Islanders share a disturbing history of oppression, stigmatization, and prejudices against them as a result of exploitation, colonization, and occupation of their island homes by Western powers. In the USA and its territories, they continue to face oppression, stigmatization, and prejudices in both subtle and blatant forms. They face discrimination in housing, education, employment, and in the healthcare system. Thus, they are at a greater risk for behavioral health problems, such as depression, substance use, suicide, interpersonal violence, adverse childhood experiences, and high-risk sexual behaviors. The psychological stress caused by such mistreatments and the experience of deprivation are hypothesized to adversely impact their psychological well-being. Although the number and scale of the extant studies are limited, they clearly link perceptions of oppression and discrimination to depression (Antonio et al., 2016), psychological distress (Kaholokula et al., 2017), general mental health status (Hagiwara, 2016), and substance use (Pokhrel & Herzog, 2014) as well as physiological indices of stress (Hermosura et al., 2018; Kaholokula et al., 2012) among Native Hawaiians and Pacific Islanders.

Whether or not issues of oppression and discrimination are directly associated with the behavioral health problems of Native Hawaiians and Pacific Islanders, most certainly their lower assigned social status and poorer socioeconomic conditions are due to past and present-day oppression and discrimination that places them at risk as well as present challenges to their treatment. The provision of behavioral health services to Native Hawaiians and Pacific Islanders needs to consider the effects of oppression, stigmatization, and racism in the etiology, progression, and/or treatment of their behavioral health concerns in the context of their sociocultural and socioeconomic circumstances. These services also need to consider the role of the provider and healthcare system in inadvertently perpetuating stereotypes and institutional discriminatory practices. Traditional explanatory models of illnesses and Indigenous healing practices offer the promise of acceptable and effective behavioral health treatment approaches. Notwithstanding, more studies are needed among specific Pacific Islander groups beyond Native Hawaiians to elucidate the effects of oppression, stigmatization, and prejudices across a range of behavioral health problems to include co-occurring problems (e.g., depression and substance abuse) and on the acceptance and effectiveness of different therapeutic modalities to include the use of traditional healing and psychopharmacology.

References

Aczon-Armstrong, M., Inouye, J., & Reyes-Salvail, F. (2013). Depression and chronic illness: Asian/Pacific Islander adults in Hawaii. *Issues in Mental Health Nursing, 34*(3), 169–179. https://doi.org/10.3109/01612840.2012.738356

Ahlgren, I., Yamada, S., & Wong, A. (2014). Rising oceans, climate change, food aid, and human rights in the Marshall Islands. *Health and Human Rights, 16*(1), 69–80.

Aitaoto, N., Braun, K. L., Dang, K. L., & So‘a, T. (2007). Cultural considerations in developing church-based programs to reduce cancer health disparities among Samoans. *Ethnicity & Health, 12*(4), 381–400. https://doi.org/10.1080/13557850701300707

Antonio, M. C., Ahn, H. J., Ing, C. T., Dillard, A., Cassel, K., Kekauoha, B. P., & Kaholokula, J. K. (2016). Self-reported experiences of discrimination and depression in native Hawaiians. *Hawaii Journal of Medicine and Public Health, 75*(9), 266–272.

Beaglehole, J. (Ed.). (1967). *The journals of captain James Cook on his voyage of discovery¸ Vol. III The voyage of the resolution and the discovery, 1776–80*. London, UK: Cambridge University.

Benham, M. K. P. A., & Heck, R. H. (1998). *Culture and educational policy in Hawaii: The silencing of native voices*. New York, NY: Taylor & Francis.

Bhui, K., Warfa, N., Edonya, P., McKenzie, K., & Bhugra, D. (2007). Cultural competence in mental health care: A review of model evaluations. *BMC Health Services Research, 7*, 15. https://doi.org/10.1186/1472-6963-7-15

Blair, C. (2011). *No Aloha for Micronesians in Hawaii*. Retrieved from http://www.civilbeat.org/2011/06/no-aloha-for-micronesians-in-hawaii/

Booth, H. (1999). Pacific Island suicide in comparative perspective. *Journal of Biosocial Science, 31*(4), 433–448.

Braun, K. L., Kim, B. J., Ka‘opua, L. S., Mokuau, N., & Browne, C. V. (2015). Native Hawaiian and Pacific islander elders: What gerontologists should know. *Gerontologist, 55*(6), 912–919. https://doi.org/10.1093/geront/gnu072

Brinson, J., & Fisher, T. A. (1999). The ho‘oponopono group: A conflict resolution model for school counselors. *Journal for Specialists in Group Work, 24*(4), 369–382.

Brondolo, E., Ng, W., Pierre, K. L. J., & Lane, R. (2016). Racism and mental health: Examining the link between racism and depression from a social cognitive perspective. In A. N. Alvarez, C. T. H. Liang, & H. A. Neville (Eds.), *The cost of racism for people of color: Contextualizing experiences of discrimination* (pp. 109–132). Washington, DC: American Psychological Association.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Harvard University Press.

Brown, T., Phillips, C., Abdullah, T., Vinson, E., & Robertson, J. (2011). Dispositional versus situational coping: Are the coping strategies African Americans use different for general versus racism-related stressors? *Journal of Black Psychology, 37*, 311–325.

Bushnell, O. (1993). *The gift of civilization: Germs and genocide in Hawai'i*. Honolulu, Hawaii: University of Hawai'i Press.

Carlton, B. S., Goebert, D. A., Miyamoto, R. H., Andrade, N. N., Hishinuma, E. S., Makini, G. K., Jr., … Nishimura, S. T. (2006). Resilience, family adversity and well-being among Hawaiian and non-Hawaiian adolescents. *The International Journal of Social Psychiatry, 52*(4), 291–308. https://doi.org/10.1177/0020764006065136

Carver, C. S. (1997). You want to measure coping but your protocol's too long: Consider the brief COPE. *International Journal of Behavioral Medicine, 4*(1), 92–100. https://doi.org/10.1207/s15327558ijbm0401_6

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior, 24*(4), 385–396.

Choi, J. Y. (2008). Seeking health care: Marshallese migrants in Hawai'i. *Ethnicity and Health, 13*(1), 73–92.

Crabbe, K. (1999). Conceptions of depression: A Hawaiian perspective. *Pacific Health Dialog, 61*(1), 122–126.

Croes, S., Merz, P., & Netter, P. (1993). Cortisol reaction in success and failure condition in endogenous depressed patients and controls. *Psychoneuroendocrinology, 18*(1), 23–35.

Davis, S. (2015). *The empires' edge: Militarization, resistance, and transcending hegemony in the Pacific*. Athens, Greece: The University of Georgia Press.

DeBaryshe, B. D., Yuen, S., Nakamura, L. N., & Stern, I. R. (2006). The role of family obligations and parenting practices in explaining the Well-being of native Hawaiian adolescents living in poverty. *Hūlili: Multidisciplinary Research on Hawaiian Well-Being, 3*(1), 103–125.

Dehon, E., Weiss, N., Jones, J., Faulconer, W., Hinton, E., & Sterling, S. (2017). A systematic review of the impact of physician implicit racial bias on clinical decision making. *Academic Emergency Medicine, 24*(8), 895–904. https://doi.org/10.1111/acem.13214

Donlin, A. L. (2010). When all the Kāhuna are gone: Evaluating Hawai'i's traditional Hawaiian Healers' law. *Asia-Pacific Law & Policy Journal, 12*(1), 210–248.

Dougherty, M. (1992). *To steal a kingdom*. Waimanalo, Hawaii: Island Style Press.

Doutrich, D., Arcus, K., Dekker, L., Spuck, J., & Pollock-Robinson, C. (2012). Cultural safety in New Zealand and the United States: Looking at a way forward together. *Journal of Transcultural Nursing, 23*(2), 143–150. https://doi.org/10.1177/1043659611433873

Edwards, C., Giroux, D., & Okamoto, S. K. (2010). A review of the literature on Native Hawaiian youth and drug use: Implications for research and practice. *Journal of Ethnicity in Substance Abuse, 9*(3), 153–172. https://doi.org/10.1080/15332640.2010.500580

Else, I. R., Andrade, N. N., & Nahulu, L. B. (2007). Suicide and suicidal-related behaviors among indigenous Pacific Islanders in the United States. *Death Studies, 31*(5), 479–501. https://doi.org/10.1080/07481180701244595

Fischer, S. R. (2002). *A history of the Pacific Islands*. New York, NY: Palgrave.

FitzGerald, C., & Hurst, S. (2017). Implicit bias in healthcare professionals: A systematic review. *BMC Medical Ethics, 18*(1), 19. https://doi.org/10.1186/s12910-017-0179-8

Fries, E., Hesse, J., Hellhammer, J., & Hellhammer, D. H. (2005). A new view on hypocortisolism. *Psychoneuroendocrinology, 30*(10), 1010–1016. https://doi.org/10.1016/j.psyneuen.2005.04.006

Galinsky, A. M., Zelaya, C. E., Barnes, P. M., & Simile, C. (2017). Selected health conditions among Native Hawaiian and Pacific Islander adults: United States, 2014. *NCHS Data Brief*, (277), 1–8.

Gibbs, K. A. (2005). Teaching student nurses to be culturally safe: Can it be done? *Journal of Transcultural Nursing, 16*(4), 356–360. https://doi.org/10.1177/1043659605278944

Gilbert, P. (2000). Varieties of submissive behavior as forms of social defense: Their evolution and role in depression. In L. Sloman & P. Gilbert (Eds.), *Subordination and defeat: An evolutionary approach to mood disorders and their therapy* (pp. 3–45). Englewood Cliffs, NJ: Lawrence Erlbaum.

Givens, J. L., Houston, T. K., Van Voorhees, B. W., Ford, D. E., & Cooper, L. A. (2007). Ethnicity and preferences for depression treatment. *General Hospital Psychiatry, 29*, 182–191.

Goebert, D., Nahulu, L., Hishinuma, E., Bell, C., Yuen, N., Carlton, B., … Johnson, R. (2000). Cumulative effect of family environment on psychiatric symptomatology among multiethnic adolescents. *The Journal of Adolescent Health, 27*(1), 34–42.

Gold, P. W., & Chrousos, G. P. (2002). Organization of the stress system and its dysregulation in melancholic and atypical depression: High vs low CRH/NE states. *Molecular Psychiatry, 7*(3), 254–275. https://doi.org/10.1038/sj.mp.4001032

Goo, S. (2015, April 6). *After 200 years, native Hawaiians make a come back*. Retrieved from http://www.pewresearch.org/fact-tank/2015/04/06/native-hawaiian-population/

Goodyear-Kaʻopua, N., Hussey, I., & Wright, E. K. A. (2014). *A nation rising: Hawaiian movements for life, land, and sovereignty*. Durham, NC: Duke University Press.

Greenwald, A. G., & Banaji, M. R. (2017). The implicit revolution: Reconceiving the relationship between conscious and unconscious. *American Psychologist, 72*(9), 861–871.

Hagiwara, M. K. I. (2016). *Racial discrimination, health, and healthcare in Hawaii's Chuukese community*. Honolulu, Hawaii: (Dr.PH), University of Hawaii at Manoa.

Hall, W. J., Chapman, M. V., Lee, K. M., Merino, Y. M., Thomas, T. W., Payne, B. K., … Coyne-Beasley, T. (2015). Implicit racial/ethnic Bias among health care professionals and its influence on health care outcomes: A systematic review. *American Journal of Public Health, 105*(12), e60–e76. https://doi.org/10.2105/AJPH.2015.302903

Hammack, S. E., Cooper, M. A., & Lezak, K. R. (2012). Overlapping neurobiology of learned helplessness and conditioned defeat: Implications for PTSD and mood disorders. *Neuropharmacology, 62*(2), 565–575. https://doi.org/10.1016/j.neuropharm.2011.02.024

Hammond, O. W. (1988). Needs assessment and policy development: Native Hawaiians and Native Americans. *American Psychologists, 43*(5), 383–387.

Harris, R., Tobias, M., Jeffreys, M., Waldegrave, K., Karlsen, S., & Nazroo, J. (2006). Effects of self-reported racial discrimination and deprivation on Maori health and inequalities in New Zealand: Cross-sectional study. *Lancet, 367*(9527), 2005–2009. https://doi.org/10.1016/S0140-6736(06)68890-9

Harris, R. B., Cormack, D. M., & Stanley, J. (2013). The relationship between socially-assigned ethnicity, health and experience of racial discrimination for Maori: Analysis of the 2006/07 New Zealand Health Survey. *BMC Public Health, 13*, 844. https://doi.org/10.1186/1471-2458-13-844

Harris, R., Cormack, D., Curtis, E., Jones, R., Stanley, J., Lacey, C. (2016). Development and testing of study tools and methods to examine ethnic bias and clinical decision-making among medical students in New Zealand: The Bias and Decision-Making in Medicine (BDMM) study. *BMC Med Educ*, 16:173.

Harris, R. B., Stanley, J., Cormack, D. M. (2018). Racism and health in New Zealand: Prevalence over time and associations between recent experience of racism and health and wellbeing measures using national survey data. PLoS One, 13:e0196476.

Hawley, N. L., & McGarvey, S. T. (2015). Obesity and diabetes in Pacific Islanders: The current burden and the need for urgent action. *Current Diabetes Reports, 15*(5), 29. https://doi.org/10.1007/s11892-015-0594-5

Heim, C., Ehlert, U., Hanker, J. P., & Hellhammer, D. H. (1998). Abuse-related posttraumatic stress disorder and alterations of the hypothalamic-pituitary-adrenal axis in women with chronic pelvic pain. *Psychosomatic Medicine, 60*(3), 309–318.

Hermosura, A. H., Haynes, S. N., & Kaholokula, J. K. (2018). A preliminary study of the relationship between perceived racism and cardiovascular reactivity and recovery in Native Hawaiians. *Journal of Racial and Ethnic Health Disparities., 5*(5), 1142–1154. https://doi.org/10.1007/s40615-018-0463-4

Hertzog, C., Alistine, J. V., Usala, P. D., Hultsch, D. F., & Dixon, R. P. A. (1990). Measurement properties of the center for epidemiological studies depression scale (CES-D) in older populations. *Psychological Assessment, 2*, 64–72.

Hixson, L., Hepler, B., & Kim, M. (2012). *The native Hawaiian and other Pacific Islander population: 2010*. U.S. Department of Commerce, Economics and Statistics Administration Retrieved from https://www.census.gov/prod/cen2010/briefs/c2010br-12.pdf

Hosmanek, A. J. (2005). Cutting the cord: Hoʻoponopono and Hawaiian restorative justice in the criminal law context. *Pepperdine Dispute Resolution Law Journal, 5*(2), 359–376.

Inada, M. K., Braun, K. L., Mwarike, P., Cassel, K., Comptom, R., Yamada, S., & Sentell, T. L. (2018). Experiences of racial discrimination and other barriers to healthcare for Hawai'i's Chuukese community: Perspectives from community members and the providers that serve them. *Social Medicine*.

Ito, K. L. (1985). Hoʻoponopono, "to make right": Hawaiian conflict resolution and metaphor in the construction of a family therapy. *Culture, Medicine and Psychiatry, 9*(2), 201–217.

Kaholokula, J. K. (2017). Mauli ola: Pathways to optimal Kanaka ʻŌiwi health. In M. Look & W. K. Mesiona-Lee (Eds.), *Mauli Ola: Hawaiʻinuiākea Monograph* (Vol. 5, pp. 2–22). Honolulu, Hawaii: University of Hawai'i Press.

Kaholokula, J. K. (2016). Racism and physical health disparities. In A. N. Alvarez, C. T. H. Liang, & H. A. Neville (Eds.), *Contextualizing the cost of racism for people of color: Theory, research and practice* (pp. 163–188). Washington, DC: American Psychological Association.

Kaholokula, J. K. (2014). Achieving social and health equity in Hawaiʻi. In J. N. Goodyear-Kaʻopua & A. Yamashiro (Eds.), *The value of Hawaiʻi 2: Ancestral roots, oceanic visions* (pp. 254–264). Honolulu, Hawaii: University of Hawaiʻi Press.

Kaholokula, J. K. (2007). Colonialism, acculturation and depression among Kānaka Maoli of Hawaiʻi. In P. Culbertson, M. N. Agee, & C. Makasiale (Eds.), *Penina Uliuli: Confronting challenges in mental health for Pacific peoples*. Honolulu, Hawaii: University of Hawai'i Press.

Kaholokula, J. K., Antonio, M. C., Ing, C. K., Hermosura, A., Hall, K. E., Knight, R., & Wills, T. A. (2017). The effects of perceived racism on psychological distress mediated by venting and disengagement coping in Native Hawaiians. *BMC Psychol, 5*(1), 2. https://doi.org/10.1186/s40359-017-0171-6

Kaholokula, J. K., Grandinetti, A., Crabbe, K. M., Chang, H. K., & Kenui, C. K. (1999). Depressive symptoms and cigarette smoking among Native Hawaiians. *Asia-Pacific Journal of Public Health, 11*(2), 60–64. https://doi.org/10.1177/101053959901100202

Kaholokula, J. K., Grandinetti, A., Keller, S., Nacapoy, A. H., Kingi, T. K., & Mau, M. K. (2012). Association between perceived racism and physiological stress indices in Native Hawaiians. *Journal of Behavioral Medicine, 35*(1), 27–37. https://doi.org/10.1007/s10865-011-9330-z

Kaholokula, J. K., Iwane, M. K., & Nacapoy, A. H. (2010). Effects of perceived racism and acculturation on hypertension in Native Hawaiians. *Hawaii Medical Journal, 69*(5 Suppl 2), 11–15.

Kaholokula, J. K., Nacapoy, A. H., & Dang, K. L. (2009). Social justice as a public health imperative for Kānaka Maoli. *AlterNative: An International Journal of Indigenous Peoples, 5*(2), 117–137.

Kaholokula, J. K., Saito, E., Mau, M., Latimer, R., & Seto, T. (2008). Pacific Islanders' perspectives on heart failure management. *Patient Education and Counseling, 70*(2), 281–291.

Kahumoku, W. (2003). A tragic indigenous moʻolelo: The decline of Kanaka Maoli linguistic identity. *ʻŌiwi^3: A Native Hawaiian Journal: Huli Au*, 160–167.

Kamehameha Schools. (2014). *Ka Huakaʻi 2014 Native Hawaiian educational assessment*. Retrieved from Honolulu, HI: http://www.ksbe.edu/_assets/spi/pdfs/kh/Ka_Huakai_2014.pdf

Kauanui, J. K. (2008). *Hawaiian blood: Colonialism and the politics of sovereignty and indigeneity*. Durham, NC: Duke University Press.

Klest, B., Freyd, J. J., & Foynes, M. M. (2013). Trauma exposure and posttraumatic symptoms in Hawaii: Gender, ethnicity, and social context. *Psychological Trauma, 5*(5), 409–416. https://doi.org/10.1037/a0029336

Krieger, N., Smith, K., Naishadham, D., Hartman, C., & Barbeau, E. M. (2005). Experiences of discrimination: Validity and reliability of a self-report measure for population health research on racism and health. *Social Science & Medicine, 61*(7), 1576–1596. https://doi.org/10.1016/j.socscimed.2005.03.006

Levy, N. (2016). Am I a racist? Implicit bias and the ascription of racism. *The Philosophical Quarterly, 67*(268), 534–551. https://doi.org/10.1093/pq/pqw070

Look, M. A., Kaholokula, J. K., Carvhalo, A., Seto, T., & de Silva, M. (2012). Developing a culturally based cardiac rehabilitation program: The HELA study. *Progress in Community Health Partnerships: Research, Education, and Action, 6*(1), 103–110. https://doi.org/10.1353/cpr.2012.0012

Low, S. H. (2013). *Hawaiki rising: Hokule'a, Nainoa Thompson, and the Hawaiian renaissance* (1st ed.). Waipahu, Hawaii: Island Heritage Pub.

Lowry, R., Eaton, D. K., Brener, N. D., & Kann, L. (2011). Prevalence of health-risk behaviors among Asian American and Pacific Islander high school students in the U.S., 2001–2007. *Public Health Reports, 126*(1), 39–49. https://doi.org/10.1177/003335491112600108

MacNaughton, N. S., & Jones, M. L. (2013). Health concerns of Micronesian peoples. *Journal of Transcultural Nursing, 24*(3), 305–312.

Makini, G. K., Jr., Andrade, N. N., Nahulu, L. B., Yuen, N., Yate, A., McDermott, J. F., Jr., … Waldron, J. A. (1996). Psychiatric symptoms of Hawaiian adolescents. *Cultural Diversity and Mental Health, 2*(3), 183–191.

McCubbin, L. D., & Antonio, M. (2012). Discrimination and obesity among Native Hawaiians. *Hawaii Journal of Medicine and Public Health, 71*(12), 346–352.

McCubbin, L. D., & Marsella, A. (2009). Native Hawaiians and psychology: The cultural and historical context of indigenous ways of knowing. *Cultural Diversity & Ethnic Minority Psychology, 15*(4), 374–387. https://doi.org/10.1037/a0016774

McElfish, P. A., Hallgren, E., & Yamada, S. (2015). Effect of US health policies on health care access for Marshallese migrants. *American Journal of Public Health, 105*(4), 637–643. https://doi.org/10.2105/AJPH.2014.302452

Miller, W. R., Rosellini, R. A., & Seligman, M. E. P. (1985). Learned helplessness and depression. In J. C. Coyne (Ed.), *Essential papers on depression* (pp. 181–219). New York, NY: New York University Press.

Mohatt, N. V., Thompson, A. B., Thai, N. D., & Tebes, J. K. (2014). Historical trauma as public narrative: A conceptual review of how history impacts present-day health. *Social Science & Medicine, 106*, 128–136. https://doi.org/10.1016/j.socscimed.2014.01.043

Mokuau, N. (2002). Culturally based interventions for substance use and child abuse among native Hawaiians. *Public Health Reports, 117*(Suppl 1), S82–S87.

Native Hawaiian Educational Assessment Project. (1983). *Native Hawaiian educational assessment project*. Retrieved from Honolulu, HI: http://www.ksbe.edu/_assets/spi/pdfs/kh/NHEA_1983.pdf

Nyborg, V. M., & Curry, J. F. (2003). The impact of perceived racism: Psychological symptoms among African American boys. *Journal of Clinical Child and Adolescent Psychology, 32*(2), 258–266. https://doi.org/10.1207/S15374424JCCP3202_11

Okamura, J. (2008). *Ethnicity and inequality in Hawai'i*. Philadelphia, PA: Temple University Press.

Paglinawan, R. K., & Paglinawan, L. K. K. (2012). Living Hawaiian rituals: Lua, hoʻoponopono, and social work. *Hūlili: Multidisciplinary Research on Hawaiian Well-Being, 8*, 11–28.

Palafox, N. (2011). The health and wellbeing of the Pacific indigenous peoples. *Hawaii Med J*, 70:3.

Panapasa, S. V., Crabbe, K. M., & Kaholokula, J. K. (2011). Efficacy of federal data: Revised OMB standard for Native Hawaiians and Other Pacific Islanders examined. *AAPI Nexus Journal: Policy, Practice, and Community, 9*(1,2), 212–220.

Paradies, Y., Priest, N., Ben, J., Truong, M., Gupta, A., Pieterse, A., … Gee, G. (2013). Racism as a determinant of health: A protocol for conducting a systematic review and meta-analysis. *Systematic Reviews, 2*, 85. https://doi.org/10.1186/2046-4053-2-85

Patten, T. H., Jr. (1994). Hoʻoponopono: A cross cultural model for organizational development and change. *International Journal of Organizational Analysis, 2*(3), 252–263.

Perrin, P. B. (2018). Academic medicine's responses to national race-related events and its role in civil rights. *Health Equity, 2*(1), 5–6. https://doi.org/10.1089/heq.2017.0052

Perry, B. L., Harp, K. L., & Oser, C. B. (2013). Racial and gender discrimination in the stress process: Implications for African American Women's Health and Well-being. *Sociological Perspectives, 56*(1), 25–48.

Pittiglio, L. (2017). Learned helplessness and sexual risk taking in adolescent and young adult African American females. *AIDS Patient Care and STDs, 31*(8), 356–361. https://doi.org/10.1089/apc.2017.0052

Pittman, C. T. (2011). Getting mad but ending up sad: The mental health consequences for African Americans using anger to cope with racism. *Journal of Black Studies, 42*(7), 1106–1124.

Pokhrel, P., & Herzog, T. A. (2014). Historical trauma and substance use among Native Hawaiian college students. *American Journal of Health Behavior, 38*(3), 420–429. https://doi.org/10.5993/AJHB.38.3.11

Priest, N., Paradies, Y., Stewart, P., & Luke, J. (2011). Racism and health among urban Aboriginal young people. *BMC Public Health, 11*, 568. https://doi.org/10.1186/1471-2458-11-568

Pruessner, J. C., Hellhammer, D. H., & Kirschbaum, C. (1999). Burnout, perceived stress, and cortisol responses to awakening. *Psychosomatic Medicine, 61*(2), 197–204.

Pukui, M. K. (1983). *Olelo no'eau: Hawaiian proverbs & poetical sayings*. Honolulu, Hawaii: Bishop Museum Press.

Pukui, M. K., Haertig, E. W., & Lee, C. A. (1979). *Nānā I Ke Kumu: Look to the source* (Vol. II). Honolulu, Hawaii: Hui Hānai.

Rezentes, W. C. (1996). *Ka lama kukui–Hawaiian psychology: An introduction*. Honolulu, Hawaii: A'ali'i Books.

Riklon, S., Alik, W., Hixon, A., & Neal, A. (2010). The "Compact impact" in Hawai'i: Focus on health care. *Hawai'i Medical Journal, 7*, 7–11.

Sabin, J. A., Nosek, B. A., Greenwald, A. G., & Rivara, F. P. (2009). Physicians' implicit and explicit attitudes about race by MD race, ethnicity, and gender. *Journal of Health Care for the Poor and Underserved, 20*(3), 896–913.

Sai, D. K. (2015). *Ua mau ke ea = Sovereignty endures: an overview of the political and legal history of the Hawaiian Islands* (3rd ed.). Honolulu, Hawai'i: Pu'a Foundation.

Salvail, F. R., & Smith, J. M. (2007). *Prevalence of anxiety and depression among Hawaii's adults derived from HBRFSS 2006.* Retrieved from Honolulu, HI: https://health.hawaii.gov/brfss/files/2013/11/PrevalenceOfAnxietyAndDepression.pdf

Sasaki, P. Y., & Kameoka, V. A. (2009). Ethnic variations in prevalence of high-risk sexual behaviors among Asian and Pacific Islander adolescents in Hawaii. *American Journal of Public Health, 99*(10), 1886–1892. https://doi.org/10.2105/AJPH.2008.133785

Seligman, M. E. P. (1974). Depression and learned helplessness. In R. J. Friedman & M. M. Katz (Eds.), *The psychology of depression: Contemporary theory and research* (pp. 83–109). Oxford, UK: Wiley.

Silva, N. K. (2004). *Aloha betrayed: Native Hawaiian resistance to American colonialism*. Durham, NC: Duke University Press.

Sloman, L. (2000). How the involuntary defeat strategy relates to depression. In L. Sloman & P. Gilbert (Eds.), *Subordination and defeat: An evolutionary approach to mood disorders and their therapy* (pp. 47–67). Englewood Cliffs, NJ: Lawrence Erlbaum.

Smallheer, B. A., Vollman, M., & Dietrich, M. S. (2018). Learned helplessness and depressive symptoms following myocardial infarction. *Clinical Nursing Research, 27*(5), 597–616. https://doi.org/10.1177/1054773816689752

Smith, B. V. (2002). Battering, forgiveness, and redemption. *American University Journal of Gender, Social Policy the Law, 11*(2), 921–962.

Sotero, M. (2006). A conceptual model of historical trauma: Implications for public health practice and research. *Journal of Health Disparities Research and Practice, 1*(1), 93–108.

Spickard, P. R., Rondilla, J. L., & Hippolite Wright, D. (2002). *Pacific diaspora: Island peoples in the United States and across the Pacific*. Honolulu, Hawaii: University of Hawai'i Press.

Stannard, D. E. (1989). *Before the horror: The population of Hawai'i on the eve of Western contact*. Honolulu, Hawaii: Social Science Research Institute, University of Hawaii.

Stannard, D. E. (2005). *Honor killing: How the infamous "Massie Affair" transformed Hawaii*. New York, NY: Viking.

Susman, E. J. (2007). Toward a psychobiologic understanding of youth health disparities. *The Journal of Adolescent Health, 41*(1), 1–2. https://doi.org/10.1016/j.jadohealth.2007.04.002

Ta, V., Chao, P., & Kaholokula, J. (2010). Cultural identity and conceptualization of depression among Native Hawaiian women. *AAPI Nexus Journal: Policy, Practice, and Community, 8*(2), 63–85.

Tengan, T. (2008). *Native men remade: Gender and nation in contemporary Hawai'i*. Durham, NC: Duke University Press.

Thornton, C. C., Patkar, A. A., Murray, H. W., Mannelli, P., Gottheil, E., Vergare, M. J., & Weinstein, S. P. (2003). High- and low-structure treatments for substance dependence: Role of learned helplessness. *The American Journal of Drug and Alcohol Abuse, 29*(3), 567–584.

United Nations. (2008). *United Nations declaration on the rights of indigenous peoples*. Retrieved from

United Nations: http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf

Victoroff, J. (2005). *Introduction to the oppression questionnaire (OQ)*. Retrieved from http://www.humiliationstudies.org/documents/VictoroffOppressionQuestionnaire.pdf

Walters, K. L., & Simoni, J. M. (2002). Reconceptualizing native women's health: An "indigenist" stress-coping model. *American Journal of Public Health, 92*(4), 520–524.

Wepa, D. (2005). *Cultural safety in Aotearoa New Zealand*. Auckland, NZ: Pearson Education.

Whitbeck, L. B., Adams, G. W., Hoyt, D. R., & Chen, X. (2004). Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology, 33*(3–4), 119–130.

Williams, D. R., Yan, Y., Jackson, J. S., & Anderson, N. B. (1997). Racial differences in physical and mental health: Socio-economic status, stress and discrimination. *Journal of Health Psychology, 2*(3), 335–351. https://doi.org/10.1177/135910539700200305

Yamada, S. (2011). Discrimination in Hawaii and the health of Micronesians. *Hawaii Journal of Public Health, 3*(1), 55–57.

Yamada, S., & Akiyama, M. J. (2014). "For the good of mankind": The legacy of nuclear testing in Micronesia. *Social Medicine, 8*(2), 83–92.

Ye, D., & Reyes-Salvail, F. (2014). Adverse childhood experiences among Hawai'i adults: Findings from the 2010 Behavioral Risk Factor Survey. *Hawaii Journal of Medicine and Public Health, 73*(6), 181–190.

Yuen, N. Y., Nahulu, L. B., Hishinuma, E. S., & Miyamoto, R. H. (2000). Cultural identification and attempted suicide in Native Hawaiian adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*(3), 360–367. https://doi.org/10.1097/00004583-200003000-00019

Disability: An Integral Aspect of Being Human

Shula Wilson

Abstract

Disability is a concern to all of us, as no one is immune to the loss of ability.

For most disabled people, their actual physical impairment is the least of their problems. A great deal of their frustration, hurt and pain results from the attitudes and reactions of other people, including health professionals. This chapter is about demystifying disability and introducing a model aimed at achieving an autonomy based on the primary mother–baby relationship and the awareness of human mortality. This requires therapists to be aware of their own internal process, including attraction and repulsion that disability might evoke.

Through a range of case studies, we will be looking at the felt experience of disabled people and how this psychodynamic model could be constructively utilised in bringing to the surface the desires, hopes and frustrations of disabled people living in an environment ridden with fears and prejudices. Each disabled person is a unique individual; no two people experience disability in the same way, as no two people experience life in the same way.

Keywords

Disability · Psychotherapy · Fear · Mortality · Hope

Since the 1980s, disability action groups such as Disabled People International (DPI) and British Council of Organisations of Disabled People (BCOD) have been gaining strength through demanding and facilitating the movement away from the medical–individual model of disability, towards a social model of disability (Marks, 1999, pp. 3–4). Disabled activists and their supporters had some successes in raising awareness of disability issues and effecting legislation aiming at improving inclusion. Yet, most models rarely see disability as an integral part of the human condition and are attempting to define and locate what is seen as 'the problem'. Social models such as Oliver 1996 in the UK and Zola 1988 in the USA (Zola, 1988) see the 'problem' as society's unwillingness to include and accommodate disabled people. The question to be asked is: What is the 'unwillingness' about, and why non-disabled people find it difficult to relate to people with disability as equals?

This chapter offers practitioners ways of thinking and acting towards enabling equality and autonomy in a world that is not yet designed for disabled people.

A disabled baby is born into exile. She is often the odd one out within her own family and the wider community. But unlike people in exile who

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L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_8

have memories and legends of a homeland, people who have been born disabled have no other place to dream about or long for.

Anne McDonald was born with cerebral palsy; she was placed in a hospital at the age of three, where she remained until her eighteenth birthday. She spent 15 years locked away under a hospital regime that might have led to her death. In the preface to the book 'Annie's Coming Out' (Crossley & McDonald, 1984), she writes:

> To be imprisoned inside one's own body is dreadful. To be confined to an institution for the profoundly retarded does not crush you in the same way; it just removes all hope.
> I went to St Nicholas Hospital when I was three. The hospital was the state garbage bin. Very young children were taken into a permanent care, regardless of their intelligence. If they were disfigured, distorted or disturbed then the world should not have to see or acknowledge them. You knew that you have failed to measure up to the standard expected of babies. You were expected to die.
> Never seeing normal children, we were not sure what they were like. Where did we fall short? In your ugly body it was totally impossible that there could be a mind. Vital signs showed that your title was 'human'; but this did not entitle you to live like normal children. You were totally outside the boundary which delineated the human race. (Crossley & McDonald, 1984)

There are no better words than Anne McDonald's summary of the experience at the receiving end of social rejection and segregation mechanism. The method was to de-humanise those who are different and therefore fail to measure up. The unconscious aim of de-humanisation was to enable society to rid itself of guilt and to have a moral justification and permission for following the survival instinct to discard the 'rejects' by institutionalising them away from human environment and eventually away from life.

Rosemary Crossley, the teacher, who together with Anne MacDonald wrote 'Annie's Coming Out', quotes relatives' reactions when they first met with Anne: 'Well, if it was a puppy you'd knock it on the head, wouldn't you?' one of them said. Another who was senile, kept repeating loudly like a cracked record, 'If it was my child I'd kill it and you could not blame me' (1984, pp. 82–83).

The wish to annihilate the deformed, bad object is expressed here in two ways: the more 'civilised' person de-humanises the disabled person by likening her to a puppy, before imagining the killing. The senile person, who had lost the thin veneer of civilisation, was able to envisage killing a human being, but still had some fear of being blamed and punished for it. The apparent helplessness of disabled people acts as a reminder of death awaiting us all. Thus, our wish to deny our vulnerability by eliminating reminders of it can lead to acts of aggression from locking people away to mass killing as the Nazis did and justified as an act of self-preservation (Asch, 1988; Hubbard, 1997). The growing popularity of the Paralympics (Luci Katchpole, The Guardian 20.07.16) is a positive step forward towards including and respecting disabled people. But does it also mean that, in order to be included and respected and thus escape the threat of annihilation, a disabled person has to be a world champion in some athletic endeavour?

It seems that current attitude to disability is still in the early developmental stage of the paranoid schizoid position (Klein, 1946) which means splitting all perceptions and experiences into good or bad. (Schizoids are out of contact with reality delusions or hallucinations—paranoid irrationally untrusting.) Paranoid-schizoid position is Klein's terminology to describe the early primitive stage of child development. So, if we look at social attitude, it means that, in order to be accepted as 'good', a disabled person may feel the need to excel and compensate for the loss of ability which often is seen as bad, by developing and performing extreme other ability (Dixson & Gibbson, 2014). This leaves the majority of disabled people who are not at the high end of extreme achievements feel rejected and threatened by the glorification of the few. (ibid).

Most disabled people are, and want to be, accepted as ordinary human beings (Begum, 1996; Brown, 1954, Keith, 2001; Morris, 1996; Murphy, 1990; Oliver, 1996; Shakespeare, et al. 1996; Williams, 1994). Yet, the sad reality is that more often than not they are not treated as equals. One of the reasons is that 'Modifying attitudes toward people with disability is dependent to a large extent, on people's ability to come to terms with their own inevitable death' ('Death and Reactions toward Disability' Hirschberger & Mikulincer, 2005, p. 255). Therefore, therapists need to become aware of their own death anxiety and ask themselves: 'What do I feel in the presence of disabled people?' If the answer is 'They are like anybody else, there is no important difference', then one needs to check whether it is genuine acceptance of equals or it is a denial of disability by pretending it is not there. 'Rescue fantasy' which may be defined as the wish to be seen by self and others as the saviour is another pitfall to be aware of when working with disabled people, as it leads to therapist/rescuer holding to power, thus disempowering the client. A therapist may defend himself against the fear and distress triggered by disability by creating a clear division in which the therapist climbs onto a pedestal labelled 'Excellent Carer', which creates a distance between him and the patient. In the process, he may become too active and taking over the responsibility of the patient, which will create dependency and leave the patient holding the feeling of incompetence and powerlessness (Holland, 1995, p. 161).

Psychotherapy with people who are in physical as well as emotional distress can be a difficult and lonely experience as there are very few psychotherapists interested in physical disability (Wilson, 2003, p. 59). Unlike doctors or nurses who may be able to discharge their anxieties through action-oriented tasks, psychotherapists' task is to stay with distress and anxiety to enable clients to gain a better understanding of their predicament and thereby restore or achieve autonomy. Therapists working with people who are also under medical care may be, consciously or unconsciously, tempted to alleviate difficult emotions by busying themselves with medical issues. Therapists who find themselves in close proximity to what seems like overwhelming human suffering sometimes develop distancing defence mechanisms which aim either to objectify the other, for example, by devising pseudo-scientific, rigid assessment procedures or to infantilise through patronising attitudes. Whatever the distancing method, the usual outcome would be in my experience lack of respect for the clients who are related to as if they were either objects or babies. Working with disabled people adds a sense of urgency to the wish to help, which can cause considerable frustration as the therapists recognise their limitations.

So how do we do it? In the coming pages the implementation of professional ethics and practice when working with disabled people will be explored, starting with the first contact.

The duty counsellor's phone rang, on the other end of the line a woman asked: 'Do you do counselling for disabled people? I need to arrange therapy for my daughter'. Without waiting for a reply, she carried on talking about the family's recent move from Switzerland back to England and her daughter's rare and complicated medical condition (dysautonomia cardiaca, which is dysfunction of the autonomic nervous system. There are many symptoms which include affecting the heart, bladder, sweat glands and blood vessels). The duty counsellor asked how old the daughter was in order to ascertain whether she was still under parental guardianship. Lynn was 29 years old, so the counsellor explained that the first step in the referral procedure was for the prospective client to contact the service in person.

The next day, Lynn phoned the agency to ask for an appointment, but when it came to arranging the time and venue, she handed the phone over to her mother. When Lynn arrived for her first appointment, she was in a wheelchair and her mother was pushing her. The therapist opened the door for Lynn to enter, whereupon the mother expectantly asked the therapist: 'Do you want me to come in?' Rather than responding to the mother, the therapist turned to Lynn and said: 'Lynn, this is your therapy time, you can decide how you want to use it.' Before Lynn had time to reply, her mother spoke about Lynn's medical condition and its manifestation, to which the therapist said: 'I believe Lynn will tell me as much as she wants me to know'. Lynn then said: 'I will stay on my own'. She got out of the wheelchair and wheeled it into the consulting room. The wheelchair was never again brought to therapy.

Once in the room, Lynn said: 'Sometimes I feel very upset, but I can't be upset at home, my parents don't like it. My mother is very worried about me; she would not allow me to dye my hair like my cousin does. She says it is too dangerous; it may hurt my eyes'. After a deep sigh, Lynn added: 'What's the point of it all, if I can't do anything I like?

The Wish to Help

When the therapist first saw Lynn, she felt a desire to take care of Lynn and make her better, to take away this awful condition that stunted her growth and left her so fragile and vulnerable. The therapist's inability to make a physical change caused frustration and a sense of helplessness. Resisting the wish to rescue and becoming aware and acknowledging her own frustration and helplessness not only prevented mismanagement of the relationship but also gave the therapist a glimpse into the client's ongoing experience and created a common ground for understanding the predicament of the client. The therapist, like other care workers, will experience an internal struggle between the omnipotent wish 'to make a difference' by appearing strong and able and the awareness that acknowledging one's own limitations and frustrations is a prerequisite for empathy and understanding (Rycroft, 1968). When the therapist is able to let go of the omnipotent fantasy of being the 'saviour', she arrives at a more realistic perception. She becomes aware that her task is not to change or to improve the client's physical condition, but to participate in a mutual process in which the client will be helped to develop her or his autonomy. By letting go of the omnipotent fantasy of control, therapists may find themselves confronted not only by the client's helplessness and vulnerability but also by their own. The fear and discomfort caused by close proximity to the fragility of human existence which I believe are the main reasons behind the fact that many therapists refrain from working with disabled people.

Third-Party Involvement

Because disabled people are sometimes perceived as incomplete, there is a tendency to fill in the missing parts by bringing in elements external to the therapeutic dyad. These elements are referred to as 'third party' (Smith, 1991).

Let us look again at the sequence of the initial contact with Lynn. The first call was made by the mother who took charge presumably because she did not believe that her daughter was capable of doing so. She also informed the duty counsellor that the medical condition was the reason why she needs counselling. At this point, confusion may arise as to who was actually seeking help. It is not unusual that a referral is made by a relative who may unconsciously BE seeking counselling for himself or herself but is not yet ready to admit to it. Challenging the mother on her possible motive would not have been productive and could have resulted in unnecessary tension and heightened defences. Instead, the therapist who had been trained and prepared for dealing with confused and worried relatives just explained the referral procedure which, in order to promote the client's autonomy, usually requires the prospective client to contact the service directly.

Another approach could have been to offer family therapy, in which the family would be treated as a unit. The reason for not offering family therapy in the first instance when the original request is for individual therapy is that the disabled person often needs help in addressing issues such as impaired autonomy and a blurred sense of self. For many disabled people, natural separation from parental figures is often delayed due to the complexity of the practical and emotional issues involved (Wilson, 2003). Their need to experience a private space of their own is often better addressed initially through individual therapy. Then, when appropriate, family therapy could be suggested as a follow-up.

When Lynn eventually did contact the service herself, she was not ready to take charge, and she quickly handed the phone and the control back to mother. This was the first manifestation of her ongoing inner conflict between autonomy and dependency. When Lynn and her mother arrived at the counselling centre, her mother, still in control, tried to push both Lynn and herself, physically and symbolically, into the first session. This was a difficult moment for the therapist who was meeting mother and daughter for the first time and was unsure of the dynamics between them.

It is clear that mutual dependency plays a major role in this mother–daughter–therapist triad. When the mother asked ‘Do you want me to come in?’, the therapist felt as if she was walking on a tight rope, with Lynn’s autonomy as the client at one end, and the mother’s position as the principal carer at the other. However, as Lynn was identified both by her mother and by herself as the client, it was clear that initially a dyad rather than a triad needed to be established.

The options open to her were:

- To let mother in and approach the therapeutic work from a systemic, family perspective.
- To say to mother something like ‘I am sorry, but only Lynn can come into the room’.
- To put Lynn in charge of the decision.

Let us look at the advantages and disadvantages of each option.

Firstly, having both Lynn and her mother in the room would have given the therapist an opportunity to observe the mother–daughter dynamic, which might have offered some understanding of Lynn’s everyday life. By agreeing to the mother’s request, the therapist would have promoted a positive relationship with her, Lynn’s main carer and obtained information about Lynn that might have lessened the anxiety of working with an unknown client. As for the mother, she would have received a degree of ‘counselling by proxy’. Any therapist who chooses to include the mother needs to think long and hard about how and why a request for individual therapy has been turned into family work. Going along with the mother’s desire to be present would have meant that Lynn’s need to gain control and develop her autonomy would have been pushed to the side.

Secondly, the therapist’s clear assertion that only Lynn could enter the room could have made Lynn feel that at long last she has an ally, a professional who was on her side rather than on her mother’s. It would also have made clear to the mother and Lynn that the therapeutic frame was strong, non-negotiable and therefore reliable. On the other hand, if the therapist had made the decision for Lynn, she might have perpetuated Lynn’s dependency by exchanging a controlling mother for a controlling therapist.

Thirdly, in the end, the therapist decided to take a calculated risk and give the decision-making power to Lynn. The risk was related to the fact that this was the first meeting and Lynn would be the therapist’s sole source of information. Furthermore, she did not know how Lynn would respond to the power and trust invested in her, and how it would affect the relationship with her mother.

When the therapist told Lynn that this is her therapy time, and she can decide how to use it, the mother, obviously feeling somewhat excluded, reacted immediately, by giving instructions about Lynn’s medical condition. She used her knowledge of and involvement with Lynn to assert her own importance. The therapist in keeping with the decision to foster autonomy in Lynn turned to mother and said, ‘I believe Lynn will tell me as much as she wants me to know’. This comment served to establish the basis of the therapeutic relationship.

From then on, only Lynn and the therapist would take part in the therapeutic relationship; there would be no third party to cause confusion. Lynn was an adult and that is how she would be related to in the therapy. The therapy would focus on Lynn and not on her medical condition. The therapist can tolerate not knowing all the details of it.

Marion Milner compared the function of the therapeutic frame to the part that is played by the frame of a picture in art: ‘The frame marks off the different kind of reality that is within it from that which is outside it; but a temporal spatial frame also marks off the special kind of reality of a psychotherapeutic session. And it is the existence of this frame that makes possible the full development of that creative illusion that makes therapy possible’ (Milner, 1952, p. 183).

Hence, the therapist’s efforts were directed at establishing Lynn’s status as an adult and offered Lynn a space in which she could exercise her autonomy. Her response 'I will stay on my own' indicated that she was willing to try to let go of her dependency on her mother. Her getting out of the wheelchair may be interpreted as 'I need the support of the wheelchair at times, but I want to be the one who controls it'. Lynn's first comment in the session, 'Sometimes I feel very upset', was possibly triggered by the difficulty of having to choose between mother and therapist, a little like a child having to let go of mother on the first day of school.

Despite the separation pain, Lynn desperately wanted to be like any other young woman, which she indicated by her expressed wish to be allowed to dye her hair as her cousin had done. She asked for help because her attempt at becoming an autonomous adult had been thwarted by parental anxiety and over care. Although she knew that at times her condition could threaten her life, it is important to note that the first issue she raised was not to do with her disability or medical condition but with her difficulty in the relationship with her parents, particularly her mother's anxiety.

Why did the therapist dismiss Mrs. Dale's offer of medical information? Should she have asked for Lynn's medical records, so that she would learn more about her new client?

Let us look at the possible benefits and disadvantages of obtaining medical information.

A positive aspect of medical information is that the therapist's fantasies about a client's condition, its cause and its prognosis can be minimised in the light of scientific facts. For example, a client with a severe skin disorder may trigger an image of leprosy and fear of contamination. The factual information whether or not it is contaminating will affect the therapeutic relationship. With some conditions, such as epilepsy, therapists need to know how to act when the client has seizure. In general, once the therapist has been told by the client about her or his medical condition and is then able to relate to the client's subjective experience, he or she may seek further information and understand that condition through further reading. Information on the condition as such is different from information about the client.

On the other hand, when the therapist is informed about the client's medical condition before meeting the client, it is highly likely that the therapist's perception of the client's concerns will be distorted. Also, as mentioned above, having a description of the medical condition could trigger unconscious fears of contamination, pain and death, which may cause the therapist, especially if this is her or his first disabled client, to defend against these fears by emotional withdrawal, relating to the client as a 'case' rather than as a fellow human being.

Any information about the client that has been obtained through someone other than the client means introducing a third-party element into the relationship and might divert the therapist's attention away from the client's concern towards those who supply the information. Clients who realise that the therapist is using other sources of information about them may find it difficult to develop trust in that therapist, who could be perceived as going behind their back. Although it is difficult at times, therapists have to trust that their client will tell them as much as they need to know. The information is not always straightforward and may sometimes come in disguises, as happens in the following vignette.

Nine-year-old Gill's speech and gait were affected by cerebral palsy, and lately, she had several mild convulsive fits. Gill had been in therapy for nearly 2 years. One day, she took a piece of card from her box, balanced it carefully on my head and said: 'stay still, relax'. She added: 'it will take only twenty minutes'. She then proceeded to put toys, pencils and more pieces of card on my head all the while issuing instructions. I was somewhat puzzled….

What is it all about, what was she trying tell me? However, after a while, it all fell into place. Through this game, Gill was telling me what had happened to her in the hospital when the neurologist was testing her, trying to find the cause of her fits. In this 'role play', Gill was the doctor and I became the patient. She was trying to communicate her feeling of puzzlement, of wonder at what was going on. Taking on the role of the medical person was an attempt to understand the aspects of her experience that had not made sense to her at the time.

If Gill's mother had told me about this procedure beforehand, I would not have gone through the wondering, not-knowing phase, and Gill would have been denied the opportunity to share with me her puzzlement and struggle with the unknown. Role-play with children, like acting out with adults, is a form of 'communication by impact', which allows the therapist a glimpse into the client's world. The role reversal helped Gill to work through the experiences of being subjected to the medical procedures and of being just as out of control during the tests as she was during her fits. Because of her age, Gill did not have access to the information on the tests and therefore needed her therapist to share her fears and the experience of UN-knowing.

A psychotherapist working in an environment such as a hospital could be tempted to fall in with the medical team, as this may feel safer and more comfortable than maintaining a separate position. But, the client who perceives the therapist as part of the team, as 'yet another medic' may not be able to view the therapist as an ally and lose the opportunity for a relationship that is influenced by no perspectives other their own.

Let us look again at Lynn's first words to her therapist: 'Sometimes I feel very upset, but I can't be upset at home, my parents don't like it. My mother is very worried about me; she would not allow me to dye my hair, like my cousin does. She says it is too dangerous; it may hurt my eyes'. On the surface, Lynn is sharing with her therapist an aspect of her relationship at home, but in order to improve our understanding of her communication, we need to ask why she chose this particular story. In this narrative, Lynn paints a picture of caring parents, whose concern about her medical condition renders them unable to relate to her as a young woman; they can only see her illness. Perhaps one of the reasons for her unconscious choice of this narrative as her first communication was to tell her therapist that there were enough people worrying about her medical condition and she did not need the therapist to become one of them. What she needed was an ally who would not succumb to the anxiety provoked by her physical condition and can relate to her as the person she is. In time, as trust developed, Lynn came to speak to the therapist about her experience of and feelings about her condition.

Autonomy and External Information

In the patient–carer (doctor, parent, therapist) relationship, the patient, due to his or her medical condition, has to hand over responsibility to the carer. Such a relationship is reminiscent of the early mother and baby relationship, when the mother has absolute responsibility for the care of her baby. A competent mother who is not too anxious might also derive a great deal of satisfaction from the absolute power over another human being, and when a patient is in need of total care, the same could be said about the competent carer. It is healthy and positive for the carer to derive satisfaction from the demanding task of providing such care. However, the challenge is how to let go of this power imbalance when the patient's need for total care subsides.

The intensity required while providing total care can lead carers to treat their patient as annexes of themselves rather than as separate entities (Holland, 1995, p. 82). Disabled people who experience long periods of total care have to learn to tolerate a state of fusion with their carers and, some admitted to me, may even long for it. The regressive experience of giving up responsibility can lead to a 'Peter Pan syndrome', whereby patients who have lost trust in their own body may try to avoid adult responsibility in order to remain in the regressive state of total care (Sinason, 1992).

When a client shows a tendency towards 'Peter Pan syndrome', the therapist's role is to identify and acknowledge the fear and exhaustion experienced by the client. The client's need to retreat from the harsh reality of life should be respected by the therapist, while facilitating the process towards restoring the client's autonomy. The first step in this process is to establish the separateness of each individual by defining the boundaries between self and others (Blos, 1967). One way of doing this is to insist that any information about an individual belongs to that individual and can be shared with others only at that individual's discretion. Therapists who follow this rule build up a relationship based on respect. Unless prior information is essential to the management of the therapy, the therapist should refrain from seeking or accepting it before seeing the client. This will also help to prevent contamination of the therapist's perception of the client (Bion, 1962). The drawback of expecting clients to be the sole source of information is that they have to repeat their story yet again. However, most people I have worked with are grateful for the opportunity to do so, especially if they can do it in their own pace. People do not often come across a listener who is genuinely trying to understand their unique experience, rather than trying to compare it to that of others in order to diagnose and categorise.

Home Visits

The voice on the answer phone said: 'This is Terry, social worker from team B. My client, Mrs Coyer, needs counselling, she is in her early 70s, very fragile and frightened'. The therapist returned the call and explains to Terry that Mrs. Coyer has to call the Counselling Centre herself to make an initial appointment. Terry was surprised: 'Can't you just tell me when you intend to go and see her and I'll arrange it'. The therapist realised that there was a discrepancy between the concept of counselling held by Terry, the well-meaning social worker, and the counselling she was there to provide. In the discussion that followed, Terry explained that Mrs. Coyer lives in a first floor flat without a lift and she had difficulty negotiating the stairs. She was also a little paranoid and very suspicious of strange people. Therefore, it would be best if he went with the therapist to see Mrs. Coyer in her own home, as she knew and trusted him.

Should the therapist have gone along with Terry's idea? Visiting the client's home would have been an opportunity to ascertain the extent of her physical limitation and emotional distress as well as offering a glimpse into her lifestyle and other pertinent factors. It would also have pleased the social worker. However, the therapist explained that the time and place of the meeting had to be negotiated between the therapist and Mrs. Coyer in accordance with the counselling service policy, in which home visits were a rare exception.

Terry reluctantly agreed to give Mrs. Coyer the counselling phone number, but warned that this would not work. Nevertheless, Mrs. Coyer did call and a few days later came to see the therapist in the consultation room. She had also managed to arrange her own transport.

In the first session, Mrs. Coyer talked about certain doctors who did not listen properly to her description of her complaint, misdiagnosing her and administering unnecessary treatment that caused her problem with balancing. In effect, she was expressing mistrust in the professionals' ability to understand her needs and to respond to them appropriately. She perceived her disability as a result of the professionals' incompetence. Listening to all this, the therapist asked herself: 'What is this all about?' and 'what is the client saying about the therapy?'

The therapist began to formulate an interpretation based on the concept of mother–child relationship:

- The social worker and the therapist represented the parental couple getting together in order to take care of the client/child.
- The social worker represented an overprotective parental figure who offered help without considering or encouraging the client's real ability.
- There was a split within the 'parental couple'. The client received a different message from each party: The social worker's message: 'You are weak, unable to go out; you need me to look after you', while the therapist's message was 'You are an adult and I will relate to you as such, unless you ask to be treated differently'.

The therapist's belief in Mrs. Coyer's ability encouraged the latter to exercise her autonomy.

However, the conflict between the social worker and the therapist made the client uneasy. Doctors, social workers and therapists were all professionals who were there to help her. Yet, in her experience, they did not always know what they were doing and they could actually cause harm. Her first comment was an unconscious plea to the therapist to listen to her and not to misdiagnose her as the doctor and social worker had done. Another interpretation is that the therapist had 'misdiagnosed' the client's ability and made a heavy demand on her by relating to her as an autonomous adult. The therapeutic relationship that followed this initial interchange indicates that the therapist's 'diagnosis' was right; Mrs. Coyer kept her regular counselling appointments for 2 years and arranged her own transport without the social worker's help.

'Why don't you see people in their own home?' This question has been put to me many times, mostly by social workers and other health and care professionals and rarely by clients seeking the service. The issue of home visit is a delicate one and requires sensitive judgement. For some of those who seek professional help, it is very difficult or even impossible to leave their home to meet at a neutral place, so home visits are the only way to receive necessary services, including psychotherapy. These people, however, represent only a small minority of those who are reluctant to leave their home. The majority, for a variety of reasons, are initially unwilling to make the effort to go out, but are well able to do so, although some support might be needed. The difficult task for a professional helper is to differentiate between these two groups.

There is an innate conflict between autonomy and dependency (Blos, 1967). The wish to help and be needed, which often underlies people's decision to choose a vocation within the 'caring professions', can at times promote dependency when the declared aim is to facilitate autonomy and self-reliance.

Another aspect of a home visit is the lack of neutrality. The home is the client's private space. The client may initially be keen for the therapist to enter and share their space, but, as in most relationships, there are likely to be times when the client needs to express his or her anger. For example, when a therapist takes a break, some clients would communicate their sense of abandonment and rejection, by missing a session before or after the break. Clients who find the therapist's absence very painful may not even call to cancel, as they need the therapist to experience anxiety and frustration. This is impossible when therapy takes place at the client's home, as the only options are to call and cancel the session, to be out or not answer the door. None of these delivers the same emotional message as letting the therapist wait, not knowing whether the client will come. Other factors that can erode the privacy and neutrality of the therapeutic space include other people sharing the home, neighbours, unexpected callers or telephone calls.

Therapy in the client's own home is a compromise. The home contains a range of memories and experiences that may need to be addressed from a distance. Whenever possible, the therapist should aim to offer clients uncompromising therapy. However, if a client is unable to get to the consulting room, the therapist may make an exception. But this should be considered very carefully as home visits can create confusion and undermine the therapeutic relationship.

Clients Who Need to Be Escorted

Ian, a successful journalist in his mid-thirties, became paralysed as a result of a train collision. His wheelchair was not motorised and he needed a carer to escort him to and from the therapy sessions. This arrangement put into question Ian's body boundaries. Had the wheelchair become an integral part of Ian, forming a single unit? And what about the carer? Has he or she been integrated into the entity called Ian? In general, if the wheelchair and the carer are there to replace the dysfunctioning limbs, does this mean that they are perceived as part of Ian's body? There is no absolute answer because each individual relates differently to his or her wheelchair and carer. At one end of the scale are those who view the wheelchair as part of their body self; at the other end are those who hate their wheelchair because it symbolises their dependency, and in the middle are those who see it just as a mechanical device facilitating movement.

The therapist could become another element in this complex interplay of testing and re-identifying boundaries. When a client in a wheelchair is escorted, the therapist needs to consider two additional issues: How to relate to the wheelchair and how to relate to the escort.

The Wheel Chair

As a matter of course, it is the therapist's responsibility to arrange the consulting room furniture. The chairs should be close enough not to cause a sense of isolation, but sufficiently far apart to avoid the sense of suffocation that can result from a too close proximity. However, clients in a wheelchair have the relative freedom to choose where to position themselves in the room, which can leave the therapist with a dilemma. Should they be left free to choose any position, or should they be guided to a position that the therapist believes to be conducive to therapy? What should the therapist do if the client positions himself or herself too near or too far away?

The question whether to reposition the client is a delicate matter because a wheelchair is not just another piece of equipment as discussed above; for some people, it becomes a part of their identity, even part of their body. Therefore the experience of being moved around in a wheelchair is comparable to a non-disabled person's experience of being pushed about.

One day, Ian was wheeled by his escort into the consulting room and was positioned so that the therapist could not close the door. The therapist said: 'I will have to move you forward a bit so that I can close the door'. Ian did not respond immediately. Later on in the session, he talked about old friends who were trying to keep in touch with him. He was unsure of their motive. Did they enjoy his company or did they wish to see him out of pity and charity?

Ian was not only sharing doubts about his friendships, he was also telling the therapist that the experience of being wheeled by her had harmed his fragile sense of equality as a fellow human being.

The Escort

When a client comes with an escort, the therapist has to consider carefully how to relate to the escort. Lynn's mother was an example of a 'pushy' escort, and it was clear to the therapist that the therapeutic space had to be protected from invasion. It was different when Ian and his escort were late for therapy 1 day after a very difficult journey in a winter storm. The therapist's impulse as the host was to offer the escort a warm welcome and a cup of tea. This friendly human gesture might have made the therapist feel good about herself and comforted the escort, but how would it have affected the client?

Therapists who work with escorted clients have to re-examine the therapeutic construct and consider the escort as a third party. Unless the escort is the client's partner and both come for couple or family therapy, the therapist should keep the interaction with the escort to the very minimum. But because the escort is a fellow human being and not an inanimate object, it may be difficult sometimes to ignore his or her needs. Ian's therapist had to remind herself that the purpose of the journey was Ian's session, and therefore she should leave the escort to take care of himself. Looking after the escort's needs would have taken away one of the fundamental elements unique to the therapeutic relationship: that, for the duration of the session, the client has the therapist entirely for himself/herself. Even with careful consideration and thoughtful action, the fact that an escort is involved in the relationship has a direct impact on the therapy and has to be integrated into the therapist's thinking and interventions (Wilson, 2003).

Sexuality and Disability

A difficult task for therapists is to identify and monitor how differences in appearance and physical functioning affect the way they relate to disabled people. How do they feel about the sexuality of their disabled clients? The aspects that are rarely addressed in psychotherapy training and literature are disability and sexuality; perhaps the avoidance is linked to its power to invoke guilt and fear, stemming from archaic psychical and cultural roots. Whenever we feel guilty, we defend against it by pushing it away from our conscious mind, we try to avoid and deny the disturbing issue (Rycroft, 1968). As one doctor reports, 'I have done many consultations about youngsters with disability for private physicians, and I have never had one say: "You know, the problem with this youngster and his family is that he never asks anything about sex". It is not thought of as a problem to deal with' (Bullard & Knight, 1981, p. 82). This illustrates the all-too-familiar situation when professionals, families and disabled people are colluding in the effort to ignore or deny the possibility that a disabled person is also a sexual being. To avoid this pitfall, therapists need to deal with their own unresolved issues regarding sexuality and body self, before addressing the client's sexual, physical and emotional differences. The question to be investigated is: Why is it that disabled people are frequently seen as either over-sexed as in perversion or as lacking any sexual drive or interest? What could be the reason for perceiving disabled people as occupying only the extremes of the human sexuality scale, pushing them outside the main sexual playing fields?

Acquired Disability

At about the time of his fortieth birthday, Fred was diagnosed as having multiple sclerosis (MS). At first, Fred was told that his type of MS was non-progressive, which meant that apart from some temporary discomforts, he would be able to rely on his bodily functioning for many years to come. Unfortunately, this prognosis was wrong, and within 4 years, his condition deteriorated and he was losing muscle control in various parts of his body and was hardly able to walk.

During his first therapy session, Fred talked about his medical condition, the confusing prognosis and his family's difficulty with accepting the fact that he was disabled. Then, he stopped and fell into a silence, his face contorted with pain and discomfort. Long minutes passed before he blurted out: 'I need to digress, it is about sex, I am impotent, I can't have sex'. He paused, tensed, waiting for a response. This is a tender moment and the therapist's reaction at this point would go a long way towards shaping the nature of the therapeutic relationship. The therapist tried to organise her thoughts. The statement 'I am impotent, I can't have sex' followed a detailed description of Fred's perception of the unreliable and disappointing systems that were supposed to support him. Fred felt that he had been let down by his body, the medical profession and his own family. While the therapist had been listening to Fred's narrative, she had thought to herself: 'This man's existence is strewn with complicated survival problems, fears of the future and on-going frustrations. Yet, he talks about his inability to perform sexually as the main cause for his distress. What could this be about? Perhaps Fred is unconsciously concerned about my motive for seeing him, and is testing my capacity to accept an impotent man?' The therapist, still somewhat puzzled, just said: 'Perhaps you want to say a bit more about it'. In her intervention, she was trying to address Fred's discomfort when he raised the sexual issue; she wanted to establish that there are no taboo subjects. She was also hoping to ascertain, whether the word 'impotent' was being applied to his disability, his sexuality or both.

Fred responded: 'My wife does not let me touch her; she turns her back to me whenever I try to get near her. Her father thinks I am making it all up. I am a very good accountant but I have lost my business'. Fred was not just talking about his inability to perform sexually, he was talking about his inability to perform as the man he wanted to be. Fred was talking about his losses, about the lack of intimacy between him and his wife and about his father-in-law's lack of trust in him. In this short comment, past, present, disability, relationship and sexual identity were all interwoven into the broad canvas of his life.

When faced with such complexity, a therapist might be tempted to simplify matters by focusing on the link between the client's sexual incapacity and the physical effect of MS. Such an approach would allow clear and simple reasoning. However, this would be a narrow and reductionist approach. Any therapist, who listened carefully to Fred's response, would recognise that other forces, some preceding the onset of disability, were affecting and shaping his felt experience.

Becoming disabled in midlife meant that Fred had to struggle with unexpected losses such as the deteriorating functioning of his body, the erosion of his status as the breadwinner and his shattered hopes for the future. His main concern was his ability to remain active as a man, husband and father. It became clear during therapy that other losses and disappointments had been projected into the current sexual and relational difficulties.

Fred's midlife experience of disability brought to the surface the loss of love, intimacy and status. What is, if any, the sexual significance of the time in life at which a person becomes disabled? In order to address this question, we shall consider the experience of a person who was impaired since birth.

Congenital Disability

Dan who was 23 years old told his therapist that although the girl he loved said she loved him too, she was relating to him in a sisterly manner, avoiding any possibility of sexual intimacy. It was confusing and did not make sense. Before seeking psychotherapeutic help, Dan told his GP about his problem and had been referred to the local hospital for sex therapy. This experience left him both disappointed and humiliated. He said furiously, 'What do they think I am, a machine? It is not what to do that I need to learn, it is why it does not work for me, why Laura does not fancy me'. The 'Me' in Dan's comment needed attention; he did not need a sex manual; he needed an understanding of his unique predicament.

Despite the fact that his legs and one arm had been deformed and partially paralysed since birth, Dan lived with his parents and went to mainstream schools. He had just been awarded with a degree in business studies and was looking for work. Dan had not been institutionalised. He was familiar with the non-disabled world, well informed and aware of his sexuality. He was able to form close emotional relationships with women. Yet, this had always remained platonic, leaving him sexually frustrated and confused. He could not understand what was blocking the development of sexual intimacy, why the woman he loved was treating him like an asexual being? Why did she tell him all about her relationships with other men, didn't she recognise the pain she was causing?

Several months into therapy, Dan became aware that he was angry with his body, and he despised the look of this body, which he felt had let him down. This realisation allowed him to understand that as long as he treats his body with contempt, others including his girlfriend would tend to avoid contact with it. At about this time, his orthopaedic consultant suggested a risky and complicated experimental surgery that offered some hope of improving his stature. After deliberating at length, Dan decided to go ahead with it.

What led him to such a decision? Perhaps one of the main determinants was that he did not feel like a whole person. He felt like a eunuch. He had internalised the message that his body was not loveable as it is. As a newborn, his mother who was depressed had been unable to show him the full acceptance and love that he had needed to develop a positive self-image. Dan's needs had not been met; he had not been made to feel perfect and loved but different, imperfect and difficult to love because of his deformed body. This is what is defined as mirroring, which is the need to be seen and reflected with love in the mother's eyes (Kohut, 1978; Winnicott, 1965). It seemed that his decision to have the operation was in part an expression of self-hatred in the way of mutilation or castration by proxy. It could be interpreted, as 'This is a bad body, no one wants this body as it is. My mother never liked it, my girlfriend does not like it, I hate it, and therefore it has to go under the knife.' Although this seems aggressive or even violent, it was also invested with the hope, however slim, that a new, reformed and loveable body would emerge from the pain and suffering.

What are the differences and similarities between Fred and Dan? Both of them experienced the loss of the wished-for body (Merleau-Ponty, 1962), the object of love and desire. Regardless of their age and the stage in their life when they became disabled, they perceive their 'body in the world' as poorly functioning and unlovable. Underlying this was the familiar tension between the wish for the perfect body and the inevitable imperfection of the human body. Although this is a universal conflict, the presence of impairment can exacerbate it by pointing out the gap not only between the body as it is and the wished-for body but also between disabled and non-disabled bodies. Those whose body is furthest from the desired wished-for body may find themselves marginalised or even excluded.

Physical and mental impairment or ugliness has been used since time immemorial to signify badness, evil or moral deviance, thus effectively casting the impaired individual out of the community. In his study of English cultural history, Keith Thomas (1971) found that as late as the eighteenth century, doctors and midwives in England believed that deformed children might well result from indecent sexual acts and that the morally deviant state of mind of the coupling parties helped to give the embryo its distinctive shape. Unlike non-disabled children who try to deny that their existence is due to their parents' lovemaking, children born with an impairment feel connected to that sexual act (Sinason, 1992, p. 267). Society's negative and often denigrating reaction to disability contributes to the child perception that he or she must be the result of bad intercourse.

What Is 'Normal'?

The wish to distinguish between what is 'normal' and therefore acceptable and what is not normal and therefore perverse plays an important role, both in the way we relate to disability and in the way we relate to sexuality. The concepts of narcissism and body image are tied together in the development of self-identity as the composite of psychological self and body self. The person with a congenital disability knows no other body, and his or her developing ego, identity and body image is subject to the same parenting needs as any other child. Greenacre (1958) put forward the idea that self-image, which is intimately related to body image, is the core on which one's sense of identity is built. She writes, 'The individual is in need of at least one other person, similar to himself, to look at and to speak to in order to feel safe in his own identity' (ibid, p. 625). Greenacre considers that the face and the genitals are the most important body parts involved in this process. Lussier (1980, p. 183) takes Greenacre's idea a step further and suggests that 'The mother as well as the child needs a similar person, a similar body in order to be led to achieve the necessary fusion with the child'. According to Lussier, the mother's unconscious interpretation of the dissimilarity can be seen as a castration threat or as a threat of ego disintegration through the loss of a body part. The anxiety caused by the physical dissimilarity can lead the mother to withdraw psychologically from her baby in order to protect herself from loss of identity. In addition to her unconscious concern about her own ego integrity comes the near conscious narcissistic blow for not producing a perfect child. The child will not reflect for the mother and the mother will not reflect for the child. The primary identification will be impaired. In order to be able to reach her disabled child, the mother needs an amazing degree of ego integrity, emotional security and harmony with her own body self (Greenacre, 1958). The child will relate to his body in the same way his mother relates to it (Winnicotte, 1965). Lussier concluded that the problem is not the actual physical difference, but the ability of the parents to adapt and to deal with their own issues such as guilt, shame and pity. Emotional support for parents of disabled children should be regarded as an essential provision to ensure healthy and trouble-free upbringing.

Al was paralysed from birth. He had very limited movement and could not speak. His limitations prevented him from experiencing and expressing the physical manifestations of the psychosexual stages, as he was unable to control or manipulate most parts of his body. At the age of 22, he received a computerised voice synthesiser, and for the first time in his life, he was able to express himself in words. For the first 2 weeks, the computer emitted an avalanche of ‘dirty talk’. Al’s vocabulary consisted mainly of words with sexual connotations. The members of staff at his institution were horrified; they thought that the synthesiser had unleashed a monster. They found it hard to understand how this helpless and quiet person, who had never uttered a word before, was now producing a barrage of verbal abuse. It took some time for them to appreciate that he was trying to ‘catch up’ on his developmental process and that he was using his newly acquired means of expression and communication to demonstrate his sexual interest and to learn what effect it has on others. Although his body was deformed and paralysed, his mind was full of sex. Despite institutionalisation in a sexually repressive environment and the fact that his physical restrictions had prevented him from progressing through all the psychosexual phases, he appeared to have a lively interest in sexual matters.

The libido of disabled young people does not seem to be in any significant way different from that of a non-disabled young person. However, their physical restrictions may limit and sometimes prevent progress through the psychosexual stages of the developmental process (oral, anal, phallic and genital) as traditionally understood.

How can the oral stage be completed when the satisfaction of sucking is not possible due to rigid facial muscles?

How can the body be discovered and experienced when the child does not have control over his own hands and cannot touch himself, herself or others?

Could it still be said that the only way to reach sexual maturity is by possessing a fully formed and functioning body?

Maria, a bright young woman of 22 with cerebral palsy, was watching a sex education film. At one point, the people in the film were discussing the issue of masturbation. A few minutes later, Maria turned around and said: ‘What is masturbation, what are they talking about?’ I thought, ‘how is it that a woman as bright as Maria did not know what masturbation was; what is the reason for her ignorance? Could it be that her disability impaired her sexuality to such an extent as to prevent natural curiosity and interest in sexual matters?’ Yet, this explanation did not fit with the facts that Maria had chosen to go and watch a film that was advertised as dealing with sex education and that she was interested and curious enough to ask what masturbation was. Such ignorance is not a rare occurrence.

At the age of 29, Neal told his therapist that until very recently he was not aware that apart from voice and external appearance, there were other meaningful differences between the male and the female body. At the age of 29, Neal made a discovery usually made by the age of two. Maria and Neal, like many disabled people, had not had the opportunity to discover their own body or that of others. This was due not only to their physical limitations but also to being closely watched by the adults who looked after them. Literally and metaphorically, they lost touch with their body and may have internalised a message that the body has to be kept hidden. In order to defend against the pain of believing that the body they possessed is undesirable or shameful, some people developed an equalising psychic construct which ‘hides’ all body features from their awareness, male, female, disabled and non-disabled alike. It took Neal more than 20 years and a long spell of therapy to familiarise himself with his own body. Only when he no longer needed to hide his body could he begin to appreciate differences in the bodies of others. So, perhaps such a state of ignorance is caused by the social and environmental context in which the young person’s sexuality is encouraged or discouraged.

In Maria’s case, she had been born to an Italian Catholic family and later was sent to a Special Needs School. Both family and school had avoided addressing the question of sexuality. Nonetheless, it was apparent that this young woman developed, albeit later than her peer group, a healthy interest in sex and relationships. Both Neal and Maria had had restricted access to information and sexual exploration with other young people, not only due to their disability but also because their respective families and schools perceived them as asexual, thus denying them sex information and education. Should therapists act as the providers of missing sex education?

The argument in favour of this additional role is that some clients are isolated and unable to access information. It could be quite tempting for the therapist to become 'the bearer of vital information' and by doing so becoming the 'good object' well separated from the badness attached to the social and educational shortcomings. During internal debates and supervision discussions, therapists need to be reminded that their primary task is to help their clients to become aware of what is lacking, so that when ready, they will be able to engage in seeking and finding the missing aspects of their sexual knowledge and/or experience. Although it is not within the therapist role to provide such information, in some circumstances, it may be appropriate to alert other professionals to the gaps that had been revealed.

Disabled women are perceived as having lost not only some of their ability but also a great deal, if not all, of their womanhood. An anecdote quoted in T. Shakespeare et al. (1996, p. 66) illustrates this point: 'This head waiter that I knew well, I could speak Italian and we got on reasonably well, and he came up to me and said: "You can't, can you...?" I said, "Can't what …?" I knew what he meant, I thought, I'll drag this out a bit, and he said: "Well, you can't have sex, can you?", and I said, "Why ever not?," and he said, "Well, you can't walk...", and I said, "You walk while you are having sex? I haven't seen that in the Kama Sutra!"' A Freudian interpretation of this would be that the legs are often seen as a phallic symbol. This unconscious fantasy may have led the waiter to his erroneous conclusion; the phallus represents sexuality, and legs symbolise the phallus; therefore, dysfunctioning legs means dysfunctioning sexuality. The positive and humorous response of the woman in this anecdote could well be linked to her being a woman and not a man. Being viewed as a castrated male, a woman starts at a lower rank than a man, so she is both more accustomed to be seen as less able to function compared to other members of society and thus developed ways of dealing with patronising and misinformed attitudes.

If we accept Freud's idea that a male body is perfect, then any change is a loss rather than gain. Gerschick and Miller (1995) investigated the clash between hegemonic masculinity, a theory informed by feminism which asserts that people will act in a way that reinforces male privilege by supporting conformity to an idealised version of masculinity such as self-reliance, courage, aggression or career orientation, even when it may not be in their best interest. A study by Connell (1995) defines the social perception of disability as weakness. They interviewed 10 disabled men and found that the better adjusted were those who rejected the social concept of masculinity, which they saw as problematic. In doing so, they had created alternative gender practice. These were often linked to membership of the disability rights movement. One way of interpreting this finding is that in order to reject the socially accepted masculine identity, another identity had to be found. This took the form of 'coming-out' as a disabled person. By adopting the disability movement as a social milieu or even an alternative family, the disabled person was able to create the dimension of 'that which resembles me'. Most disabled children grow up in an environment that offers them no resemblances and thus provides no role model. However, in subsequent years, it may become possible to identify with other disabled people. Once the identity of a disabled person has been established as positive or even desirable, the mode of sexuality can be adjusted to their own physical reality, without the need to look up or be compared to the able bodied, mainstream sexual identity.

Acquired Disability

People with acquired disability once lived in mainstream society. Their psychosexual development, body image and sexual experience were part of the varied and colourful tapestry that makes up the human experience. The reaction of each person who subsequently becomes disabled is different and unique. However, some common experiences are shared by most newly disabled people. The most significant of which is losing the body that one had grown to know and to identify with and acquire a body that is different and new.

For most people, becoming disabled is a traumatic event whose magnitude the psyche is struggling to process (Schore, 2016). People's reactions range from giving in to the helplessness and impotency while regressing to an infantile state of dependency to denying the emotional or even the physical effects of the event and pretending that nothing has really changed. With regard to sex, one could argue that people with an acquired disability have enough obstacles to overcome in their everyday lives and their libidinal energy would be better channelled into the struggle to survive in a difficult and often excluding environment. Sexuality may not be uppermost on their mind. Indeed, some disabled people may be completely unconcerned with sexual matters, in the same way as some non-disabled people opt for celibacy. But not all of them: 'To be totally honest, sex is one thing that torments my mind more than any other aspect of paralysis. In fact, for me, it has taken over my life as a constant obsession. (Spinal Injuries Association Newsletter, 1982, p. 16).

The physical aspect of sexual activity for people who acquired disability in adult life requires considerable maturity and the internal flexibility needed to adopt to a new way of being. Part of the problem lies in people's tendency to compare their current ability to perform and derive sexual pleasures, with their ability prior to the onset of disability. Some people may well give up, but others learn how to turn their own disability, or their partner's into an advantage. Bob was paralysed due to an accident, and Bernie, his partner, is a non-disabled woman. According to Bernie, 'One of the advantages for me of Bob not being able to physically do some things is that he's gotten into the habit of asking for what he wants. It's great when he says, "I'd really like to make love" or "I'd like to hug you" because I know that's what he wants, and I can decide whether that's what I want or not'. As for Bob, 'One thing I do know is that I am a much better lover now than I ever was before. There are a lot of reasons for that, but one of the biggest is that I am more relaxed. I don't have a list of do's and do not's, a timetable or a proper sequence of moves to follow, or the need to 'give' my partner an orgasm every time we make love. Sex isn't just orgasm for me; it's pleasuring, playing, laughing and sharing' (Bullard & Knight, 1981, p. 65).

When therapists work with disabled people, it is essential for them to familiarise themselves with testaments carrying a positive message so that they could hold out hope for their clients, from a position of knowing that it is possible for disabled people to be happily sexually active.

As Bob and Bernie demonstrate, when disability is taken just as another fact of one's life, there can be positive aspects even in the delicate matter of sexual relations. The experience of disability may bring the realisation that sexual activity need not involve genital sensation and does not depend on sexual gymnastics but on the couple's capacity to weave their changing personal needs into the complex net of the total relationship.

Conclusion

The reactions of others to one's disability can at times be more painful than the experience of disability itself. The perception of disabled people as asexual can cause suffering and confusion. Hugh, who was paralysed by a brain tumour, said: 'I once had a wife who was my lover, now I have a wife who is my nurse, but where is my lover? I know I have lost her, and I miss her so much, but I cannot tell her'. Hugh's wife's emotional withdrawal is a common defence against the disturbing fears triggered by disability. Psychotherapists who choose to work with disabled people have to brace themselves for the powerful and wide ranging internal reactions they may experience: incompetence, frustration, rage, despair and protectiveness, just a few examples. Becoming aware of those reactions and working through their own process is essential and will provide many clues to the experience of the client, often uncomfortable and sometimes unbearable. Courage and support are needed to help the client to live fulfilling meaningful life beyond mere survival.

The therapeutic private space where intimate issues can be talked about and receive serious attention is a small step towards redressing the balance and enabling disabled people to hold on to their hopes and desires as whole and equal human beings.

References

Asch, A. (1988). *Shared dreams*. Philadelphia, PA: Temple University Press.

Begum, N. (1996). Doctor, doctor…disabled women experience of general practitioners. In J. Morris (Ed.), *Encounters with strangers*. London, UK: Women's Press.

Bion, W. R. (1962). A theory of thinking. In *Second thoughts*. London, UK: Karnac.

Blos, P. (1967). The second individuation process. *Psychodynamic Study of the Child, 22*, 162–186.

Brown, C. (1954). *My left foot*. London, UK: Minerva.

Bullard, D., & Knight, S. (Eds.). (1981). *Sexuality and physical disability*. St. Louis, MO: C.V. Mosby.

Connell, R. W. (1995). *Masculinities*. Cambridge, UK: Polity Press.

Crossley, R., & McDonald, A. (1984). *Annie's coming out*. Melbourne, Australia: Penguin.

Dixson, K., & Gibbson, T. (2014). *The impact of 2012 Olympic and Paralympic*. Basingstoke, UK: Palgrave.

Gerschick, T., & Miller, A. (1995). Coming to terms. In D. Sabo & D. Gordon (Eds.), *Men's health and illness*. London, UK: Sage.

Greenacre, P. (1958). Early physical determination in the development of the sense of identity. *Journal of the American Psychoanalytic Association, 6*, 612–627.

Hirschberger, G., & Mikulincer, M. (2005). Fear and compassion: A terror management analysis of emotional reaction to physical disability. *Rehabilitation Psychology, 50*(3), 246–257.

Holland, J. W. (1995). *A doctor's dilemma*. London, UK: Free Association Books.

Hubbard, R. (1997). Abortion and disability. In J. Davis (Ed.), *The disability study reading* (p. 57). London, UK: Routledge.

Keith, L. (2001). *Take up they bad and walk*. London, UK: The Women Press.

Klein, M. (1946). *Notes on some schizoid mechanisms: Envy and Gratit other works*. New York, NY: Delacote Press.

Kohut, H. (1978). Forms and transformation of narcissism. In P. Orienstein (Ed.), *The search for the self* (Vol. 1). New York, NY: International University Press.

Lussier, A. (1980). The physical handicap and the body ego. *International Journal of Psychoanalysis, 61*, 179–185.

Marks, D. (1999). *Disability*. London, UK: Routledge.

Merleau-Ponty, M. (1962). *Phenomenology of perception*. London, UK: Routledge.

Morris. (1996). *Encounters with strangers*. London, UK: Women's Press.

Murphy, R. (1990). *The body silent*. New York, NY: W. W. Norton.

Oliver, M. (1996). *Understanding disability from theory to practice*. London, UK: Macmillan.

Rycroft, C. (1968). *A critical dictionary of psychoanalysis*. London, UK: Penguin Books.

Schore, A. N. (2016). The right brain implicit self. In *Unrepressed unconscious, implicit memory and clinical work*. London, UK: Karnac.

Shakespeare, T., et al. (1996). *The sexual politics of disability*. London, UK: Cassell.

Sinason, V. (1992). *Mental handicap and the human condition*. London, UK: Free Association Books.

Smith, D. L. (1991). *Hidden conversations*. London, UK: Routledge.

Thomas, K. (1971). *Religion and the decline of magic*. London, UK: Penguin.

Williams, D. (1994). *Somebody somewhere*. London, UK: Bantam.

Wilson, S. (2003). *Disability, counselling and psychotherapy*. Basingstoke, UK: Palgrave.

Winnicott, D. W. (1965). *The family and the individual development*. London, UK: Tavistock.

Zola, R. (1988). *Hand book of disability studies*. London, UK: Sage.

Psychology's Prejudice Against the Military

Jacob T. Shoenleben and Larry C. James

Abstract

Military psychologists have been at the forefront of innovation in clinical practice, training, and research within the clinical field since the early 1900s. Yet since the 9–11 attacks, military psychologists have been attacked and vilified as the leaders in the abuses at the detention facilities at both Guantanamo Bay, Cuba, and Abu Ghraib, Iraq, without evidence to support these attacks. To date, no military psychologists have been sanctioned by the American Psychological Association for unethical conduct at any time post 9–11. Moreover, in spite of a lack of evidence documenting that military psychologists have committed ethical violations at these facilities, the American Psychological Association's governing body in 2015 (the Council of Representatives) voted to ban military psychologists from serving at the Joint Task Force in Guantanamo Bay, Cuba. Why? What motivated the leaders of the American Psychological Association to pursue such antimilitary legislation if there was no evidence to support a decision to ban military psychologists for serving in any country or location? This chapter will examine the history of prejudice, bias, and disdain against the military by civilian psychologists. The authors will trace historical roots of this bias and provide the reader with case examples of the prejudice against military psychologists.

Keywords

Military · Prejudice

In the summer to fall of 2003, the now infamous abuses at the Abu Ghraib prison happened under the occupation by U.S. Army military police and interrogators (James, 2008). Later, in the spring of 2004, leaked photos of naked dog piles, humiliation, and shocking abuses were shown on major news networks around the country. James (2008), in his book entitled Fixing Hell: An Army Psychologist Confronts Abu Ghraib, describes not only the abuses at Abu Ghrib but also the prejudiced attacks against military psychologists even before any investigations had begun into the causes of the abuses. Perhaps as a result of the abuses at Guantanamo in 2002, some members of the American Psychological Association may have wrongly concluded that military psychologists were at the center of these abuses. Or could it be that most civilian psychologists hold an inherent prejudice against the military and, in particular, military psychologists?

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© Springer Nature Switzerland AG 2020
L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_9

Prejudice is defined as “unfavorable affective reasons to or evaluations of groups and their members,” while stereotypes are “generalized beliefs about groups and their members” (Paige, 2007, p. 475). As such, discrimination is a behavioral bias, while prejudice is an emotional bias and stereotypes are a cognitive bias. To date, much of the research and literature related to the above topics have focused on ethnic and racial minorities (Jones & Dovidio, 2013; Sue, 2010). However, it has been suggested that veterans and military service members, as a result of the language, norms, and specific beliefs inherent within the military, constitute a subculture (Meyer, 2015; Reger, Etherage, Reger, & Gahm, 2008; Strom, Leskela, Gavian, Possis, & Seigel, 2012). As such, in concordance with the multicultural guidelines established by the American Psychological Association, clinicians, trainees, and other providers must be aware of, and consult the literature, to provide comprehensive multicultural treatment to this unique subculture (APA, 2017).

Throughout this chapter, we will explore the prejudicial treatment of military members and veterans throughout recent history with a cultural focus on modern bias against the military. It should be noted that the term service member will be used throughout the chapter to refer to active duty, reserve, and retired/veteran military members as at any point throughout an individual’s military career, they may experience the prejudices described in this literature.

The aim of this chapter is not to only document historical and subjective experiences of prejudice against service members; rather, the identified objective of this chapter is to explore the nature of prejudice, a sensitive subject in many arenas, as applied to the military, its members and veterans, and any progress made to ameliorate the identified deficiencies. A review of the literature regarding prejudice and stereotypes will inform empirical and theoretical work discussed in this chapter while allowing a critical understanding of the status quo and a progressive agenda to foster future work and research to be applied to this seemingly ignored aspect of cultural sensitivity, that is, prejudice against the military.

While there have been obvious instances of discrimination, racism, prejudice, and stereotypes surrounding the military and its treatment of members since the Declaration of Independence, our review of the literature begins with Vietnam War 1955–1975 and focuses on the prejudice experienced by service members returning home after their tour or tours of duty. For example, the American Psychological Association banned military clinical psychology internship programs from advertising in any of the APA publications. The ban was out of protest over the military barring gays and lesbians from military service. The misguided belief among APA members was that somehow military psychologists directed this ban rather than the President of the United States under an executive order.

While a complete history of the Vietnam War is outside the scope of this chapter, however, the reader is referred to an excellent Vietnam War documentary (Burns, 2007); the Vietnam War is regarded as an “unnecessary” war not only by many today but also by many throughout the war and shortly thereafter, which undoubtedly influenced service members’ reception at their homes.

Glover (1984) described themes of mistrust and posttraumatic stress disorder in Vietnam veterans. Within this research, the author notes the confounding experiences that service members witness throughout their time in theater, suggesting that the Vietnam War had been referred to as a “no-win war,” citing ineffective military strategy, problematic terms of engagement, and hostility by the Vietnamese as problematic events that the service members experienced while serving, which likely resulted in conflicting views of the war, its necessity, and eventual outcome (Glover, 1984).

Glover (1984, p. 446) also noted mainstream society’s negative response to the war, documenting that “the attitude of the public towards the returning veteran has ranged from indifference and lack of recognition to hostile condemnation.”

If one is unsure of the sociopolitical divide surrounding the Vietnam War, speak with several Vietnam veterans and you will likely find two views surrounding a shared major political event despite being a part of the same generational cohort. Flores (2014), in his review of sources of Vietnam veteran pro- and antiwar political attitudes, suggested that broader cultural debates be included when examining political outcomes. As such, it is vital to understanding the prejudice against service members and the military that a look toward modern concepts of prejudice and stereotypes be critically examined to determine what societal factors are at play leading to overt or covert emotional or cognitive bias. General Colin Powell also added that most Americans don't have an understanding of the fact that the military at the enlisted ranks are men and women who come from the American lower SES. He went on to assert that these young soldiers view the military as a place to grow (Powell, 1995). Moreover, under the United States Constitution, the military does not decide whether to fight—civilian politicians do, even the terms of engagement. But the military personnel are usually the persons whom the Americans blame and vilify for "going to war."

Before discussing the outcomes of the sociopolitical climate and its influence on prejudice and stereotypes regarding the military and service members, it is imperative to work from an empirical perspective. As such, a review of the literature will be documented below in order to provide the foundation for which theoretical and future empirical research will be explored at the conclusion of this chapter. In reviewing the literature related to prejudice and stereotypes against the military and service members, there is a stark contrast between the empirical research available for other selected areas of cultural sensitivity and the military. This may in fact reflect society's overlooking, minimization, or perceived competence in the area of prejudice against the selected demographic.

This is particularly problematic, given the large portion of the United States' population that identifies as veteran or service members. In fact, there are an estimated 23.4 million veterans and 2.2 million active duty service members in the United States (SAMHSA, 2017). Additionally, one should note that many of these individuals would also experience prejudice for other reasons; for example, they are black or female or gay and thus experience additional prejudice. Given this large population, why is there not more research in these areas? While a complete review of the many possible or plausible factors leading to this paucity of empirical research is outside the scope of this chapter, societal beliefs regarding the treatment of veterans and service members may be the most obvious factor.

It is fairly apparent that veterans and service members from modern conflicts, such as those involved in Operation Enduring Freedom (from 2003 to present), Operation Iraqi Freedom (from 2003 to 2009), and Operation New Dawn (2010 to 2011), do not receive the lack of recognition, and more importantly hostility, that Vietnam veterans and service members experienced upon their return home. However, is the warm reception at the airports or surplus of viral videos of homecomings disguising prejudices and stereotypes underlying the American society that rear their ugly head after the essential "honeymoon" of returning from deployment had dissipated?

For example, Redding (2001), in an American Psychologist article, posited that most psychologists are politically liberal and possess not only an antiwar belief system but an antimilitary sentiment as well. Is there a sociopolitical façade within the United States masking varying levels of prejudice against the military and service members? The research published by Greenberg Quinlan Rosner Research hawk and Public Opinion Strategies and the Pew Research Center will inform the following documentation of society's view of the military and service members with complimentary research conducted by various authors while serving as palpable evidence of the paucity of research in the area of attitudes and perceptions of the military and service members (Greenberg Quinlan, Rosner, Research, and Public Opinion Strategies, 2012; Pew Research Center, 2011).

One of the most notable and encouraging findings from the Pew Research Center's survey of 1853 veterans and 2003 adult respondents was in the area of respect and admiration for service members (Pew Research Center, 2011).

Unfortunately, it is also in this same area, and more specifically within the public's view and understanding of the military and service members, that we find our first evidence at a plausible prejudicial approach to service members, whether overt or covert.

Overall, Americans hold the military in high regard and have a respect for service members and their family's sacrifices, with 90% of Americans reporting to have felt proud of the troops in Afghanistan and Iraq (Pew Research Center, 2011). Furthermore, modern-era service members have identified the American populace as more supportive and respectful of them as compared to Vietnam-era veterans, stating that 47% and 24% see the public as having "a lot more respect" or "a little more respect" for the military now than when they served, although results differ significantly by era of service (Pew Research Center, 2011). Not surprising given the above documented public reception of Vietnam-era service members, 81% of these individuals state that modern-era service members are respected more than when they served (Pew Research Center, 2011). This era of service members is followed by 74% of service members who entered the military prior to 9/11 and 46% of all Korean War and World War II (WWII)-era veterans in believing that modern-era service members receive more respect than they did regarding their service (Pew Research Center, 2011).

Despite the respect that the American public has toward the military, it is clear, in the eyes of both service members and the populace, that the general public has little understanding of the military and the burden it imposes on service members. While seven in ten veterans say that the public has an incomplete appreciation of the rewards and benefits of military service, about eight in ten say that the public does not understand the problems, such as the physical, social, or psychological difficulties faced by those in the military or their families (Pew Research Center, 2011). This is particularly problematic as, in the eyes of service members, the general public does not understand the rewards and benefits of military service, nor does the public understand the problems faced by those in the military.

The Pew report (2011) goes on to say that the U.S. military is one of the most diverse organizations in the United States, and very few Americans are mindful of this. Most Americans are not mindful of the fact that according to the Pew Research Center, the U.S. military is one of America's most diverse organizations. For example, 40% of the military are persons of color. Seventeen percent are African American, 12% are Hispanic, 7% are Asian, and the remainder indicates others. As one examines these data, it can be asserted that few, if any, major corporations possess such a diverse workforce.

The opportunities for women, minorities, and persons from lower SES are outstanding, according to Pew.

Furthermore, of the post-9/11 service members who knew and served with someone who was seriously injured, 46% say that the public understands their problems "not well at all." The public appears generally aware of their lack of understanding, with 71% of respondents stating that most Americans have little or no understanding of the problems faced by those in the military (Pew Research Center, 2011). Moreover, while the general public appears to acknowledge their lack of understanding, even reporting that 83% of the service members and their families have had to make sacrifices compared to only 43% saying so about the American public, seven in ten agree that "it's just part of being in the military" (Pew Research Center, 2011).

Finally, despite this respect, the American public (47%) is much more ambivalent regarding encouraging youth to join the military than both post-9/11 (82%) and pre-9/11 (74%) veterans (Pew Research Center, 2011). This begs the question why, if the military is such a respected profession, the public does not encourage the youth to join. Is it as simple as saying that a service member is dangerous? Or are there much more insidious factors involved in this uncertainty?

Perhaps stigma, prejudice, and stereotypes related to service member behavior upon reentry to civilian life, mental health concerns, or work life after the military has some bearing on behavioral, emotional, and cognitive bias against the military? While it is common in media reports and layperson conversations to identify reentry into civilian life as a significant barrier to returning to life after the military for veterans of all eras, the Pew Research Center (2011) found that over 70% of veterans noted their readjustment as "very" or "somewhat" easy. However, when one considers the modern-era veterans, that is, post-9/11, 44% note that they had difficulty readjusting to civilian life compared to 25% of pre-9/11 veterans (Pew Research Center, 2011). In light of these differences, there may be prejudice.

Additionally, if one considers the higher rate of serious injuries in the post-9/11 era despite a lower death rate, one can imagine the difficulty with which service members are returning to civilian life. Service members are returning with acquired disabilities due to traumatic brain injuries and likely find difficulty with readjusting to life with a new disability in a world built upon ableism. Conceivably, there is a difference in attitudes and stereotypes within the public regarding visible as opposed to invisible disabilities in service members.

The research supports the public viewing invisible disabilities as more common in service members than what has traditionally been found. MacLean and Kleykamp (2014), in their study of attitudes toward United States veterans returning from Iraq, found people to hold a negative stereotype about how service members behave upon their return home.

However, the researchers also found a conflicting approach to service members in that public perception may be colored by what is termed symbolic capital, defined as "the resources available to an individual on the basis of honor, prestige or recognition, and functions as an authoritative embodiment of cultural value; yet, when a service members behaves negatively, to an amount that exceeds their symbolic capital, stereotypes predominate" (MacLean & Kleykamp, 2014 p. 134). A survey of 801 adults throughout the United States aimed at taking an in-depth look at the country's perceptions of Iraq and Afghanistan veterans demonstrated that while the public viewed the service members in high regard, similar to that of the Pew Research Center's (2011) study, these service members are disproportionately viewed as associated with stress, depression, and anger (Greenberg Quinlan, Rosner, Research, and Public Opinion Strategies, 2012).

Furthermore, work conducted by Schreger and Kimble (2017) found a moderate effect size for an association task between veterans and instability, demonstrating an implicit bias, which the authors believes may partially mediate the reintegration difficulties that service members experience. While an all-encompassing examination of the stigma, prejudice, and discrimination that individuals diagnosed with a mental health disorder experience is out of the scope of this work, it can reasonably be presumed, given the research presented above, that such approaches and treatment affect the service member population. But in what ways?

An alarming statistic found in the Pew Research Center's, 2011 study is the difference in unemployment rates among post-9/11 service members. Service members in this era experience an unemployment rate of 11.5%, which is greater than that of the unemployment rate of all other eras of veterans combined (8.7%) and for nonveterans (9.4%) (Pew Research Center, 2011). This single statistic communicates that there may be factors negatively affecting service member's reentry into civilian life. Is it covert prejudice, overt stigma, or blatant stereotypes of service members that dominate the mainstream sociopolitical culture as factors?

Perhaps the answer lies in the views of the necessity for the current conflicts as it is plausible that the public view of the worthiness of the conflicts reflects the unconscious affective treatment of service members. While it is not necessarily surprising that those who have had a role in the military (i.e., pre- and post-9/11 veterans) view the conflicts in Afghanistan and Iraq as worthwhile endeavors, the public does not seem to be as certain. The American public views the conflicts at levels eight and nine percentage points lower than that of post-9/11 veterans, suggesting a view that the wars are not worthwhile in the eyes of the public (Pew Research Center, 2011).

Furthermore, 57% of the surveyed population says that the war in Iraq has not been worth engaging in, while 52% says the same about the Afghanistan conflict (Pew Research Center, 2011). Given this information, it appears clear that the American public has grown tired of the conflicts in the Middle East, and survey data support this inclination, stating that the public is paying less attention to the conflicts now than previously (Pew Research Center, 2011). Furthering the distance between the public and the military/service members, the survey data suggest that approximately half of the public says that these conflicts have had negligible impact on their lives (Pew Research Center, 2011).

While there is not a landslide difference in the views of whether the wars are worthwhile between service members and the public, the little impact on the public's lives, per the public, is somewhat alarming. Here, the general public is saying they are proud of the military and its service members; however, the individuals who have clearly sacrificed (in the eyes of not only the service members but the public as well) are being told that their efforts, losses, and resulting difficulties have had little impact on the lives of individuals back home. This is particularly disturbing as 93% of pre-9/11 service members and 88% of post-9/11 service members noted serving their country as the top motivating factor for joining the military (Pew Research Center, 2011).

Is the public's more recent indifference toward the war and the minor impact of engaging in such conflicts on day-to-day living a covert message being communicated to service members through interaction with the public after airport welcome receptions and the hometown parades? Conceivably, this covert, insidious attitude could be fueled by political influence and fear.

It is no surprise, during time war, that the public is not always supportive or proud of what the military and service members making the challenging decisions have to do. This is reflected in the research conducted by the Pew Research Center (2011), stating approximately that one third of Americans feel ashamed of the conduct of the military in the Afghanistan and Iraq conflicts. Perhaps it is party affiliation or cohort may be swaying the public's opinion of the conduct of the military. And is it this dissatisfaction with the military as an entity that results in the clandestine prejudice that appears palpable to service members upon their return stateside?

Obviously, it is impossible and wildly unacceptable to make determinations regarding causal factors without further in-depth research; however, adults between the ages of 18 and 29 are more likely than older adults to have mixed or negative feelings regarding the military's conduct (Pew Research Center, 2011).

College graduates are most likely to say that they have felt ashamed of something that the military has engaged in during these conflicts, while Democrats and Independents are more likely than Republicans to say the same (Pew Research Center, 2011).

These sentiments may have been at play during the APA Convention in Toronto in 2015. It was at this Convention that APA's governing body, the Council of Representatives, voted to ban military psychologists from serving at the Joint Task Force Detention facility at Guantanamo Bay Cuba. In spite of the fact that there was no evidence that any military psychologist had been found guilty of any wrongdoing at all, the Council of Representatives voted to ban military psychologists from deploying to this location. Why? The vote or decision was not based on fact. Moreover, no military psychologist has ever had his or her license suspended for unethical behaviors. As James (2008) described in his book Fixing Hell, there appears to be an underlying resentment, disdain, and/or prejudice against military psychologists. Clearly, efforts to "ban" military psychologists were motivated not by facts but by prejudice.

As such, one must consider the sociopolitical climate, a climate that has shifted its focus toward acceptance and openness of differing ethnicities, religions, sexes, relationships, etc., that is so outwardly spoken, and rightfully so, regarding minority justice, how doing so may marginalize service members who, while holding other minority identities that are openly supported, also experience microaggressions, prejudice, and stereotypes given their connection with the military.

While there is no research regarding this subject matter, viewing the military as a subculture necessitates a similar openness of the language,

cultural views, and traditions inherent in military culture with the same respect and openness that other cultures are afforded.

Thus far, the chapter has focused on the relatively few research studies considering the military and its service members as a unique subculture that experiences prejudice, stigma, stereotypes, and even discrimination. What little available research there is, as so often is the case, leaves one with many more questions than answers. In the following paragraphs, a theoretical approach to understanding these factors will be undertaken with careful consideration that more research is needed in these areas.

This section is not to be taken as empirically supported truths; rather, directions future research may explore. Does the sociopolitical climate of the United States play a negative role in the attitudes of the public in viewing the military and service members? Does the stark contrast between public respect of the military and its little understanding of what being involved in the military and its operations is result in either overt or covert prejudice? Is it plausible that the volume of media coverage of military shortcomings and the ever-present political unrest communicate, in subtle ways, covert attitudes of the general public?

Does the fact that the conflict has lasted many years without clear "wins" and the perception that the conflicts have little impact on day-to-day life of the public negate the experiences that service members who joined the military to serve their country must live with daily? These are questions that cannot be answered at this time; rather, they may help to guide the following theoretical framework.

Case Examples of How the American Psychological Association Is Prejudiced Against the Military

In the aftermath of the 9–11 attacks, the United States captured the orchestrators of the 9–11 terrorist attacks at the Pentagon and the Twin Towers in New York City. The terrorists were captured then imprisoned at the Joint Task Force Detention Center at Guantanamo Bay, Cuba.

At the height of the post 9–11 frenzy to kill or capture terrorists who plotted to kill Americans, the United States held approximately 660 to 700 prisoners at the Guantanamo Detention facility.

James (2008) and others (ACLU, 2018; Amnesty International, 2017) documented the abuses at the prison. In spite of the fact that there were no military psychologists involved in any prisoner abuses at Guantanamo, the American Psychological Association's membership voted in 2008 that military psychologists could not be involved in interrogations at any unlawful detention facility in the entire world (APA Membership Petition Resolution, 2008). An unlawful detention facility is any prison facility outside of the United States that, according to U.S. law, violates United Nations agreements. This action was the first step in a process of any health care membership organization attempting to regulate where its members could and could not work.

Moreover, the shamefulness of resolution was that the learned PhD scholars who had voted for this ban could not provide any evidence that military psychologists had either violated the APA ethics code or participated in any criminal activity.

As James (2008) described in his book entitled "Fixing Hell," many of the American Psychological Association members lacked any first-hand understanding of the role that military psychologists provided in a national security venue. James (2008) asserted that it seemed that these psychologists relied on the stereotype that military psychologists were "baby killers" or "war mongers." The author went on to argue that many in the APA membership have a disdain for and/or a distrust of any psychologist who either wears a military uniform or is employed as a police psychologist. The assumptions are that the military psychologist must be dirty or evil.

There is more evidence of this. A psychologist who Colonel James has never met filed multiple and redundant ethics charges against him in Hawaii, Guam, Ohio, Louisiana and at the American Psychological Association. In the complaints, Colonel James was charged with doing harm to prisoners and failing to prevent prisoner abuse. When the state psychology boards dismissed the cases, this psychologist filed civil lawsuits in both Louisiana and Ohio.

In the civil lawsuits, these same individuals filed the lawsuits against the psychology licensing boards in both Louisianan and Ohio in an effort to have the court force an additional investigation of Colonel James even though there was no evidence that he had done anything wrong according to the Ohio and Louisiana psychology license boards.

The effort was an attempt to get a civil judge to force additional investigations of Colonel James even though his accusers could not present any evidence that he had acted either unethically or criminally. The civil lawsuits were dismissed by the courts in both states. Although there were no financial costs to James because the complaints were reviewed and dismissed, there were the lingering emotional and stress toll that these drawn out ethics complaints had on him and his family.

The assumption by James' accusers was that just because he served at Guantanamo and later at Abu Ghrib means that he must be guilty of wrongful acts (see Harvard Center for Constitutional Rights give https://hrp.law.harvard.edu/u-s-health-professionals-and-torture/accountability-for-torture-begins-at-home/).

In 2015, the American Psychological Association, in an effort to have an objective investigation into all of these allegations, sanctioned what is now known as the "Hoffman Report" (2015), which was conducted by David Hoffman, an attorney at the Sidley law firm in Chicago, Il. Many hoped that Hoffman would be able to ascertain and grasp both the complexities of the military culture, the military organization, and their chain of command and how military psychologists must follow all ethical, moral, and lawful orders.

In the Hoffman Report (2015, pp. 520–522), either Hoffman did not understand the military structure, culture, and rules that govern the military or he was prejudiced against the military or one could have had the impression that the investigation was incomplete. For example, on pages 520 to 522 of the Hoffman report, he described the ethics investigation filed against Colonel James at the American Psychological Association. But Hoffman failed to mention that there had been four other ethics investigations filed against Colonel James (as well as civil lawsuits filed against psychology licensing boards regarding Colonel James service at Detention facilities). Why did Hoffman withhold this information? Was this a naïve omission, or was it a deliberate attempt to mislead the readers? Or perhaps this omission was a function of Hoffman's stereotypes about the military? In any event, stereotyping and discrimination against the military appeared to have played a role in his lack of military knowledge.

This was interpreted by the Department of Defense—that even military psychologists who were providing routine psychological care to detainees were "banned" and could not be stationed at these facilities. The unintended result of this was that, as of this writing, the United States is not in compliance with the United Nations treaty that asserts that captures must provide comprehensive medical and mental health care to its captives.

In an effort to "undo" this act of international negligence, military psychologists attempted to have a resolution passed that would allow military psychologists to provide treatment to detainees at the August 2018 Convention. The measure was voted down by a large margin by the APA's Council of Representatives. Critics of this resolution feared that it would open the door to military psychologists torturing detainees again (Jindial, 2018). Even though no one can produce evidence that military psychologists are guilty of any wrongdoings, the prejudice and attacks toward them have continued.

For example, in February of 2014, the American Psychological Association released a letter to explain why there was "no cause for action" against Dr. John Leso. Dr. Leso was a major in the U.S. Army and stationed at the Guantanamo Detention facility in 2002. An ethics investigation was filed against him at the American Psychological Association, and the investigation has gone down in history as the longest and costliest in the history of the APA ethics committee. The gist of the allegations was that

Dr. Leso did harm to the detainees and/or failed to prevent harm to them. The investigation spanned 7 years, and the committee reviewed over 2000 pages of documents. There was no evidence that Major Leso had done anything wrong at all. Regardless of the factual evidence, many psychologists still held the belief that military psychologists were torturers (Eidelson, 2013; Rosenthal, 2015). The final outcome from the APA Ethics Committee was that Dr. Leso had done nothing wrong upon the completion of the seven-year investigation.

Roughly a year later, in August of 2015 (item #23B), the American Psychological Association Council of Representatives voted to ban military psychologists from military detention facilities around the world (APA, August, 2015). The problem with this resolution was that this resolution "banned" all military psychologists from military detention facilities.

Also, in 2015, the American Psychological Association voted to accept a report that was a result of an investigation into the acts of military psychologists and APA staff. Coined the Hoffman report, it concluded that military psychologists and some APA staff "curried favor" with each other in an effort to support the military and the CIA in their national security endeavors. The author of the report reached conclusions that were later contradicted by a Society of Military Psychology investigation (2015). For example, in the executive summary of the report on pages i and ii,

The Society of Military Psychology Task Force found that the Hoffman Report's conclusions are based on

1. An inaccurate understanding of DoD interrogation policies in place when the PENS Task Force met in June 2005,
2. An inadequate understanding of how military interrogations are conducted,
3. A misconception of military culture,
4. A deep bias against military psychology and Military psychologists, and that
5. While acknowledging that U.S. personnel were involved in Torture and abusive treatment of detainees following the events of September 11, 2001, TF19 did not find a basis for an apology by Division 19 for actions of the division or for the actions of division 19 members with regard to interrogation support.

The Hoffman Report, including its appendix section, was approximately 1500 pages. Sadly, within 24 hours of the Hoffman Report's release, many members of APA's Council of Representatives acted inappropriately and concluded that military psychologists conspired to commit torture.

The author of the Report, David Hoffman (an attorney from Chicago), while presenting his finding in person at the August 2015 meeting, said: "I can find no evidence that any military psychologist has harmed anyone" (Hoffman, Personal Communication Note, APA Convention in Toronto during the Executive Session of the APA Convention). Regardless, innuendo and personal attacks upon military psychologists were commonplace. These shameful behaviors underscored the belief of the authors of this chapter that these well-educated scholars with PhDs held a deep dislike for, a hate for, and a prejudice against **ALL** military psychologists.

In summary, examples of prejudice against the military are abound. In spite of this, military psychologists continue to be at the forefront in research, teaching, and innovative practices in behavioral health and protecting the safety of Americans around the world.

References

ACLU. (2018). *Guantanamo by the numbers*. https://www.aclu.org/issues/national-security/detention/guantanamo-numbers

American Psychological Association Council of Representatives. (2015, August). *Resolution to ban military psychologists from detention facilities around the world, item #23B*. Retrieved from: http://www.apa.org/independent-review/psychologists-interrogation.pdf

American Psychological Association. (2008). *APA members approve petition resolution that limits psychologists' roles in settings that violate international law or the U.S. constitution*. Retrieved from http://www.apa.org/news/press/releases/2008/09/detainee-petition.aspx

American Psychological Association. (2017). Multicultural Guidelines: An ecological approach to context, idendity and intersectionality. Retrived from: http://www.apa.org/about/policy/multicutural-guidelines.pdf

Amnesty International: 14 years of Injustice. (2017). Retrieved from: https://www.amnesty.org.uk/guantanamo-bay-human-rights

Burns, K. (2007). *The War*. New York, NY: PBS Publications.

Eidelson, R. (2013). *The torture debate echoes: An army psychologist's job search*. https://www.psychologytoday.com/us/blog/dangerous-ideas/201301/the-torture-debate-echoes-army-psychologist-s-job-search

Flores, D. (2014). Memories of war: Sources of Vietnam veteran pro- and antiwar political attitudes. *Sociological Forum, 29*(1), 98–119. https://doi.org/10.1111/socf.12071

Glover, H. (1984). Themes of mistrust and the posttraumatic stress disorder in Vietnam veterans. *American Journal of Psychotherapy, 37*(3), 445–452.

Greenberg Quinlan, Rosner, Research, and Public Opinion Strategies. (2012). *A new generation of leaders: A report on America's perceptions of Iraq and Afghanistan Veterans*. Retrieved March 12, 2018 from https://www.missioncontinues.org/uploads/A-New-Generation-of-Leaders.pdf

Hoffman, D. (2015). *The Hoffman Report*. Retrieved from April 1, 2018 from https://www.apa.org/news/press/releases/2015/07/independent-review-release

James, L. C. (2008). *Fixing hell: An army psychologist confronts Abu Ghrib*. New York, NY: Grand Central Press.

Jindial, S. (2018). Psychologists vote no return to Guantanamo amid heated debate over torture legacy. *The Intercept*. Retrieved from: https://theintercept.com/2018/08/09/guantanamo-bay-psychology-tort

Jones, J., & Dovidio, J. (2013). *The psychology of diversity: Beyond prejudice & racism*. New York, NY: Wiley-Blackwell.

MacLean, A., & Kleykamp, M. (2014). Coming home: Attitudes towards U.S. veterans returning from Iraq. *Social Problems, 61*(1), 131–154. https://doi.org/10.1525/sp.2013.12074

Meyer, E. G. (2015). The importance of understanding military culture. *Academic Psychiatry, 39*, 416–418. https://doi.org/10.1007/s40596-015-0285-1

Paige, R. U. (2007). Proceedings of the American Psychological Association for the legislative year 2006: Minutes of the Annual Meeting of the Council of Representatives, February 17–19, 2006, Washington, DC; and August 17 and 21, 2006, New Orleans, LA; and minutes of the February, June, August, and December 2006 meetings of the Board of Directors. *American Psychologist, 6*(5), 400–490.

Pew Research Center. (2011). *The military-civilian gap: War and sacrifice in the post-9/11 era*. Retrieved March 10, 2018 from http://assets.pewresearch.org/wp-content/uploads/sites/3/2011/10/veterans-report.pdf

Powell, C. (1995). *My journey*. New York, NY: Random House.

Redding, R. (2001). Sociopolitical diversity in psychology: The case of pluralism. *The American Psychologist, 56*(3), 205–215.

Reger, M. A., Etherage, J. R., Reger, G. M., & Gahm, G. A. (2008). Civilian psychologists in an Army culture: The ethical challenge of cultural competence. *Military Psychology, 20*, 21–35. Retrieved from http://www.informaworld.com/smpp/title_db_all_content_t775653681

Rosenthal, A. (2015). Did psychologists help the government torture? *The New York Times*. https://www.nytimes.com/search?query=psychologist%20and%20torture

Society of Military Psychology. (2015). Response to the Hoffman Independent Review. *The Division 19 Task Force Report*. Washington, DC.

SAMHSA. (2017). *Veterans and military families*. Retrieved March 10, 2018 from https://www.samhsa.gov/veterans-military-families

Schreger, C., & Kimble, M. (2017). Assessing civilian perceptions of combat veterans: An IAT study. *Psychological Trauma: Theory, Research, Practice, and Policy, 9*(1), 12–18. https://doi.org/10.1037/tra0000191

Sue, D. W. (2010). *Micro aggression in everyday life: Race, gender & sexual orientation*. New York, NY: Wiley.

Strom, T. Q., Leskela, J., Gavian, M. E., Possis, E., & Seigel, W. (2012). Cultural and ethical considerations when working with military personnel and veterans: A primer for VA training programs. *Training and Education in Professional Psychology, 6*(2), 67–75. https://doi.org/10.1037/a0028275

Intersecting and Multiple Identities in Behavioral Health

Kayla Sargent

Abstract

This chapter explores the complexities that exist beyond the basic categories of single-identity status (i.e., "race," "sex," "religion" independently) and dwells upon the ways in which interconnectedness influences experiences and outcomes of oppression relevant to applied and research-oriented behavioral healthcare settings. Implications of neglecting intersectional theory are discussed with personal, clinical, and empirical consideration. As this chapter explores issues surrounding multiple identities, particularly multiple minority or marginalized identities, an examination of the history of the concept of intersectionality and its eventual application in behavioral healthcare is presented. It also describes prominent theories and research. Because identity-based distinctions are the basis of prejudicial discrimination, this chapter evaluates intersectionality in terms of the cultural, societal, political, and institutional forces that mold our conceptions of difference. Finally, the chapter will conclude with a discussion of intersectionality and multiple minority status within behavioral sciences with a focus on the application of an intersectional framework holistically throughout one's life rather than as a "technique" or "statistical consideration" solely within one's work.

Keywords

Intersectionality · Multiple identities · Cultural competence · Multiculturalism · Feminist theory · Antiracist theory · Queer theory

> The way I try to understand the interconnection of all forms of subordination is through a method I call "ask the other question." When I see something that looks racist, I ask, "Where is the patriarchy in this?" When I see something that looks sexist, I ask, "Where is the heterosexism in this?" When I see something that looks homophobic, I ask, "Where are the class interests in this?" Working in coalition forces us to look for both the obvious and non-obvious relationships of domination, helping us to realize that no form of subordination ever stands alone. If this is true, we've asked each other, then isn't it also true that dismantling any one form of subordination is impossible without dismantling every other? And more and more, particularly in the women of color movement, the answer is that no person is free until the last and the least of us is free. (Matsuda, 1991)

Up until the present chapter, this text has offered nine chapters worth of information about the experiences of specific marginalized communities. As Western communities diversify, a basic understanding of the unique social, cultural, political, and institutional issues faced by women,

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L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_10

by immigrants, by native populations, by Muslims—and the list continues—is increasingly important in the field of behavioral healthcare. For ourselves, a basic understanding can mean the difference between a good and a bad first impression, a successful and a failed job interview, a pleasant and a disastrous date, or an inviting and a skeptical connection with a patient. For those we interact with, a basic understanding is instrumental in avoiding unintentional and preventable microaggressions, such as asking a dark-complected acquaintance "Where are you from?" or assuming that your new Asian American client is timid and concealing because her eye contact is less persistent than that of your white American clients. Generally speaking, the more differences we can tally between ourselves and the "other" before us in any setting, the more we stand to benefit and the more likely we are to access a genuine connection with others, if we have engaged with the fundamental qualities and behaviors that make specific identities unique. Most importantly, being able to knowledgeably interact with people different from ourselves in genuine but sensitive ways fosters compassion, trust, and friendship among communities that might otherwise readily embrace conflict or disconnection.

As a species (i.e., *Homo sapiens*), we have a lot to gain when we prioritize connection with one another despite our hundreds-of-thousands-of-years-long inclination toward conflict. Stronger and more long-lasting than our conflictual tendencies is our ability to cooperate. Historic cooperation with one another in symbolic activities like language, agriculture, money, law, and even sex roles is what allowed our species to rapidly rise from the middle to the top of the food chain. Modern-day cooperation with one another will be what allows our species to preserve our habitat, prevent world wars, and address poverty. Yuval Noah Harari explains this human shift and our current emotional predicament nicely in his book *Sapiens* (2015):

> Genus *Homo's* position in the food chain was, until quite recently, solidly in the middle. For millions of years, humans hunted smaller creatures and gathered what they could, all the while being hunted by larger predators. It was only 400,000 years ago that several species of man began to hunt large game on a regular basis, and only in the last 100,000 years—with the rise of *Homo sapiens*—that man jumped to the top of the food chain. That spectacular leap from the middle to the top had enormous consequences. Other animals at the top of the pyramid, such as lions and sharks, evolved into that position very gradually, over millions of years. This enabled the ecosystem to develop checks and balances that prevent lions and sharks from wreaking too much havoc. As lions became deadlier, so gazelles evolved to run faster, hyenas to cooperate better, and rhinoceroses to be more bad-tempered. In contrast, humankind ascended to the top so quickly that the ecosystem was not given time to adjust. Moreover, humans themselves failed to adjust. Most top predators of the planet are majestic creatures. Millions of years of domination have filled them with self-confidence. Sapiens by contrast is more like a banana republic dictator. Having so recently been one of the underdogs of the savannah, we are full of fears and anxieties over our position, which makes us doubly cruel and dangerous. Many historical calamities, from deadly wars to ecological catastrophes, have resulted from this over-hasty jump. (pp. 11–12)

As Harari (and decades of work in cognitive and neuropsychology) explains, biological and adaptive explanations exist for why our species is domineering, anxious, and discriminative. The human condition is paradoxical because although our unique development as a species is partly to blame for our propensity to oppress and discriminate against one another, it is our cooperation with one another—despite differences—that allowed us to rise to the top. It is cooperation, at its core, that allows us to dominate. At various points in our history, we cooperated to prioritize agriculture over nomadic living structures. We cooperated to acknowledge that geography and kinship matter but that money can be transferred between vastly different communities in order to provide mutual benefit. The same process that created human: the ill-equipped dictator is the one that can also create human: the healer. Thus, the endeavor of connection and cooperation with people different from ourselves is deeply relevant today, both in the most fundamental terms of biological survival and in the most nuanced aspects of psychology, such as minimizing oppression and abuse of power. At the most fundamental level, our ability to eliminate identity-based oppression and inequality can be boiled down to whether humans, as a species, are willing to prioritize it in the service of greater cooperation. We must collectively decide that equity is more important than patriarchy, white supremacy, heteronormativity, and the host of other dominance-oriented ideologies plaguing our communities today.

In this chapter, however, we will explore the complexities that exist beyond the basic categories of single-identity status and focus upon the ways in which interconnectedness influences experiences and outcomes of oppression. After all, even though the evolutionary remnants of *my* tribe versus *your* tribe have persisted into the modern era, the *number* of tribes on our planet has exponentially increased: there is no human on Earth who is just American, just female, just disabled, or just Jewish; rather, there are American Jewish women with disabilities, and the diversity within that subgroup is also prolific. The truth inherent within all of our individual experiences is that none of us can be boiled down to one identity, and none of us will wholly overlap with the general characteristics that apply to *any* of our identities in isolation. Similarly, our experiences with oppression and power will also vary in significant ways.

To offer a personal example, I presently identify with a variety of categories in no particular order: woman, lesbian, wife, mother, white American, feminist, southerner, teacher, vegetarian, academic, to name a few. Although I have never permanently resided outside of the American southeast, I do not eat biscuits and gravy, go to church on Sundays, or use the term *y'all*. Further, the degree to which I adopt the culture of *mother* versus the culture of *feminist academic* changes depending upon the context I am in: in terms of basic characteristics of single identities, when I leave work early to take my child to tennis practice, *mother* has overpowered *academic,* but when I miss bedtime stories to meet a deadline, the reverse is true. It is more accurate, then, to describe my behavior in terms of *all* of my identities rather than one.

Simply listing all of my affiliations, however, is also insufficient (as well as wholly inefficient for conversational purposes!). The degree to which I am likely to be marginalized versus in a position of power also varies by context: as Professor Sargent, I am in a relative position of power over the students in my classroom, but at a departmental gathering or as a lesbian mother at a PTA meeting in the South, I am relatively underpowered and likely to encounter anything from annoying microaggressions to outright hostility. In other words, whereas single-identity-based generalities are helpful in identifying trends among and developing questions about large groups of people, they are woefully incomplete in their ability to describe or predict an individual's feelings, behavior, intentions, or position in terms of power in the absence of nuance and context. Furthermore, because all people have multifaceted identifications, a generalized description of *one* component of an identity (e.g., "mother") does little to capture the full picture of any mother's life, struggles, or triumphs.

The intersections of our various identities are meaningful both in theory and in the practical, day-to-day activities of living. Acknowledging and understanding the intersections of multiple identity statuses is particularly relevant in behavioral healthcare because mental and behavioral health concerns cannot be conceptualized as mutually exclusive with identity conflicts. For example, if a client reports that he "doesn't feel like he's been a good father lately" or she is "having problems balancing home and work life," these presenting problems are intertwined with intersections and conflicts of having multiple identities. They are also intertwined with the multiple power structures (e.g., patriarchy, heteronormativity, capitalism, etc.) that contribute to confusion and shame. Thus, in order to alleviate suffering and improve behavioral functioning, we must be able to identify, deconstruct, and place these intersections into a helpful context in order to help our clients navigate their lives with less struggle. This is the first step in beginning the hard work to dismantle power structures that confine our access to the full range of opportunity and experience.

As this chapter explores the issues surrounding multiple identities, particularly multiple minority or marginalized identities, it will begin with examining the history of the concept of intersectionality and its eventual application in behavioral healthcare, particularly within the field of psychology. We will also explore prominent theories and research. Because identity-based distinctions are the basis of prejudicial discrimination, this chapter will evaluate intersectionality in terms of cultural, societal, political, and institutional forces that mold our concepts of difference. Finally, the chapter will conclude with a discussion of intersectionality and multiple minority status within behavioral sciences from the perspective of the consumer and the practitioner.

History of Intersectionality

For the purpose of understanding the rich history of intersectionality, we must distinguish the concept from the term as the concept came into existence long before the term itself was coined. In the early 1970s, delegates attending the National Black Feminist Organization (NBFO) created the Combahee River Collective (CRC), a group with the specific goal in mind to organize black lesbian feminists (Collier-Thomas & Franklin, 2001). The collective held various retreats throughout the New England area, and by 1977 they had published *The Combahee River Collective Statement*, which highlighted—among other things—the exclusion of black women's voices, perspectives, and issues within both the white feminist movement and the antiracist and black power movements. The manifesto (Combahee River Collective, 1977) includes powerful statements describing the group's origins, which hint at the birth of intersectional thought, such as "A combined anti-racist and anti-sexist position drew us together initially, and as we developed politically we addressed ourselves to heterosexism and economic oppression under capitalism." It also attempted to appeal to the responsibility of white feminists to combat their racism and strive for "more than a superficial understanding of race, color, and black history and culture." Shortly after the CRC's statement was released, the first black feminist digest was published under a title that laid plain the exclusion of black female voices from within the two major political movements under which they should have felt inclusion: *All the Women Are White, All the Blacks Are Men, But Some of Us Are Brave: Black Women's Studies* (Hull, Bell-Scott, & Smith, 1982). Whereas intersectionality today can be thought of as an analytical framework or critical thinking process that paints a more accurate picture of human functioning, it began as a scholarly attempt to grapple with the way that experiences of marginalization and oppression differ among in-groups that were previously assumed to be inherently similar.

Whereas the concept of intersectionality already existed in the minds and experiences of multiply-marginalized communities, the *term* intersectionality was first introduced in the late 1980s by legal scholar and activist Kimberlé Crenshaw. In her canonical paper, Crenshaw (1989) detailed the significant discrepancies that exist within the white feminist movement between the experiences of black and white women. Crenshaw called for an intentional centering of black women and their perspectives in ongoing social and political movements in order to prevent their continued exclusion and erasure from cultural and political discourse. She demonstrated that a single-axis framework, such as *women*—absent of intersecting identities like race—inherently centers those within the framework that are most powerful. In the case of feminism, issues of white feminists were and continue to be front and center in the feminist movement. In the case of antiracists movements, dialogue centered around the experiences of black men. Thus, the nuanced and multifaceted experiences of black women were dismissed as afterthoughts in both important movements. Crenshaw advised that "this focus on the most privileged group members marginalizes those who are multiply-burdened and obscures claims that cannot be understood as resulting from discrete sources of discrimination" (p. 140). She suggests further that the "focus on otherwise privileged group members creates a distorted analysis of racism and sexism because the operative conceptions of race and sex become grounded in experiences that actually represent only a subset of a much more complex phenomenon" (p. 140).

The result of these black theorists' and scholars' writings was the shape of a blurry and often ignored phenomenon coming into focus. Intersectionality as a modern concept refers to the interactions among gender, race, and other categories of difference in individual lives, social practices, institutional arrangements, and cultural ideologies, as well as the outcomes of these interactions in terms of power dynamics (Davis, 2009). In her book on the topic, Vivian May describes intersectionality as "a form of resistant knowledge developed to unsettle conventional mindsets, challenge oppressive power, think through the full architecture of structural inequalities and asymmetrical life opportunities, and seek a more just world" (May, 2015, p. xi).

However necessary it has revealed itself to be, considering multiple identity and structural factors in a research paradigm is easier said than done (Parent, DeBlaere, & Moradi, 2013). Much debate exists regarding how researchers conceptualize these factors statistically and theoretically in terms of whether features of identity have additive, multiplicative, and/or intersectional outcomes.

From its provenance, intersectionality as a concept has been heralded as one of the single most influential contributions to feminist theory, and it cannot be overstated that the contribution comes directly from black feminist discourse and publications (e.g., Collins, 1990; Combahee River Collective, 1977; Crenshaw, 1991; Davis, 1981; Hooks, 1989). Although Crenshaw articulated the need for intersectionality as an activist and law professor, scholars apply the concept today from a wide range of disciplines from the social sciences to economy and politics. Intersectionality is now so pervasive in theory and practice that members of most social media forums—much less members of the academy—can scarcely afford to remain willfully ignorant or neglectful of difference and diversity among women and other groups of people. It is a required topic of discussion and debate in classrooms and a necessary consideration in academic publications that seek to research the complexities and outcomes associated with identity.

Does Intersectionality Belong in Psychology?

A large and growing body of psychological research confirms the harmful consequences of oppression, prejudice, stigma, and inequality, both at interpersonal and structural levels (e.g., Hatzenbuehler, Phelan, & Link, 2013; Livingston & Boyd, 2010). Stigma itself is pervasive in that it is likely to be experienced by affected individuals in their own communities, homes, work environments, and recreational settings. It is also pervasive in terms of the vast array of identities that are impacted, such as Latino adolescents (Benner & Graham, 2011), women at risk for HIV (Choi, Bowleg, & Neilands, 2011), people with chronic illnesses (Earnshaw & Quinn, 2012), aging populations (Sabik, 2013), sexual minorities (Brenick, Romano, and Kegler et al., 2017; Sarno, Mohr, Jackson, & Fassinger, 2015), and minority academics (Settles, Cortina, Stewart, & Malley, 2007), to name a few. Whereas this is by no means an exhaustive list, it serves to demonstrate that psychology has been hard at work identifying marginalized identities and the risk and benefits associated with them in the last few decades. Less research, however, has endeavored to understand the experiences of people with multiple marginalized identities and even less than that has evaluated the complex power structures that underlie these categories and their consequences.

At an institutional level, stigma and discrimination are apparent in nearly all systems within Western society, including employment, education, healthcare, financial, and housing systems (e.g., Pager & Shepherd, 2008). Because there is no way to reasonably exist in Western culture without engaging with systems and institutions, stigmatic institutional practices naturally have a corrosive and widespread impact on the health, relationships, coping skills, and behavior of those impacted (Hatzenbuehler et al., 2013). Much like the intersections of multiple identities are relevant considerations for understanding behavioral health, so are the intersections among interlocking systems of power and their resulting consequences for the people beholden to them.

Feminist psychologists have been advocating for intersectionality as a serious and primary research consideration for decades (Reid, 2000). As both an interpersonal and structural hurdle to individual and community well-being, intersectional issues are well within the realm of topics that should be studied and addressed by the field of psychology. Primarily, structural and institution-level changes are needed in order to relieve intersectional systems of oppression, and psychologists are in a unique position as researchers, clinicians, and educators to play a role in creating that change (Rosenthal, 2016). Unfortunately, the majority of literature produced in psychology has largely focused on the *identity* rather than the *social and political change* components of intersectionality (Alexander-Floyd, 2012; Bilge, 2013; Collins, 2015). An unwelcome side effect of identity-focused research is the subsequent naturalizing of marginalized identities as risk factors, that is, that a consistent focus on the negative outcomes associated with a specific identity or intersection of identities may play a role in perpetuating stereotypes about those identities, as well as instill in the mind of our collective culture that negative outcomes are inherent or organic to the identities themselves rather than to the systems of oppression that marginalize them. Without a strong awareness of systems of oppression (e.g., classism, heterosexism, patriarchy, etc.) and supporting activism within psychology, marginalized communities will continue to carry the burden of systemic oppressions that have cumulative and long-lasting social and political consequences on behavioral health. Thus, further research is needed to adequately and empirically describe the particular power structures that impact mental and behavioral health concerns that are indirectly related to "identity." This type of theoretical and empirical work has the potential to immerse the field of psychology wholly into intersectional practice by bridging the alluring "identity" analysis with the structural analyses needed to truly make gains toward the social justice goals that will drastically improve the health and functioning of many communities suffering in disempowered contexts.

Counseling psychologists have made a significant effort to put forth progressive ideas for social justice activism within the field of psychology. In a 2006 handbook entitled *Handbook for Social Justice in Counseling Psychology* (Toporek et al., 2006), a number of relevant recommendations were made. First, community involvement is an integral component in understanding the issues that any given demographic is facing; much like the client is the expert on their own problems, the same is true for communities. Second, interdisciplinary coalition is vital. Drawing upon the knowledge within political science, women's studies, sociology, public health, and so on increases the likelihood of developing approaches and programs that will comprehensively achieve social justice goals. From a practitioner's perspective, the handbook states that "to be most effective, psychologists must move beyond micro-level interventions, recognize the range of types of oppression and the intersections among these oppressions, focus on privilege as well as oppression, and receive training that prepares them for these roles" (pp. 8–9). Other applied as well as research-focused fields in psychology would do well to adapt similar goals and values.

Thus, it is abundantly clear that intersectionality, as an analytical framework, belongs in all aspects of psychology: the theoretical, the empirical, and the applied. For psychologists working in any of these domains, intersectionality is best defined as the process of considering the whole person (or family or community etc.), including all of his, her, or its identities, motivations, and cultures, in the most appropriate and accurate context possible with a strong emphasis on power structures that underlie, create, or interact with those contexts. This framework of analysis allows for the most accurate and nuanced case conceptualization, hypotheses, and theories that will produce the most effective treatments and scientific answers to some of Homo sapiens' pressing modern-day crises: from individual mental and behavioral health concerns to broader concerns of human cooperation and compassion that will enable us to alleviate suffering systemically by addressing abuses of power and climate change.

Intersectional Research in Psychology

The beginnings of psychological research investigating intersectional frameworks emanated out of disciplines and subdisciplines that were already focused on studying the interactions of identities, institutions, oppression, and power structures (e.g., community psychology, public health, and multicultural psychology, to name a few). After all, critical feminist and race theorists developed intersectionality as an analytical framework that could potentially capture a more nuanced and accurate of individual and collective behavior. Many psychologists, however, have been somewhat lethargic in their motivations to integrate intersectional frameworks into their research questions (McCall, 2005). Historically, a variety of apathetic explanations have been given for psychology's reticence: intersectionality is too methodologically challenging; it is interesting but not relevant to the discipline of psychology; expertise is lacking; thus, we must defer (Shields, 2002, 2008). As a result, the collective "we" of psychology has done a lot of *mentioning* intersectional issues without actually addressing them. In other words, we may refer to intersections among race-class-gender but leave the responsibility of incorporating it into our own work to a futurized other, who will be theoretically, practically, or demographically more competent than ourselves. In reality, where genuine lack of expertise, competence, or awareness exists, it is our responsibility to seek appropriate training. Further, substantive changes to our social lives require that we become willing to do this work. Only recently have we begun to take up this responsibility we have so dutifully left to "future research"; as a result of this delayed effort, our depth and breadth of influence will increasingly expand to include people and perspectives that have been overshadowed, and we will be equipped to effectively address the behavioral health concerns of many more people and communities.

Most scholars today agree that intersectionality is essential to feminist, antiracist, and multicultural theory. Shields (2008) argued that it "first and foremost reflects the reality of lives" (p. 304). Some suggest that intersectionality is a theory, others regard it as a concept or heuristic device, and others see it as a cognitive strategy for doing feminist analysis. Controversies have emerged about whether intersectionality should be conceptualized as a junction (Crenshaw, 1991), as "axes" of difference (Yuval-Davis, 2006), or as a dynamic process (Staunæs, 2003). It is unclear whether intersectionality should be limited to understanding individual experiences or to theorizing about identity statuses or whether it should be taken as a property of social structures and cultural/political conversations. Moreover, arguments exist regarding whether it should be used theoretically in terms of formulating research questions, specifically employed within statistical methodologies, or both. Further, there is no one standardized, agreed-upon approach for how to incorporate intersectionality paradigms within research methodologies, which leads rule- and process-driven but hopeful scientists scratching their heads at how to proceed. Whereas this may seem chaotic and undisciplined at first glance, what is hidden among these diverse strategies is that which represents the core veracity of intersectionality: that it is inherently flexible enough as a framework to adapt to varying goals and concerns raised by varying disciplines.

Across the practice of intersectionality in psychological research, procedures for evaluating intersectionality statistically appear to fall within one of two camps: (1) identity statuses as additive or multiplicative predictors of outcomes or (2) identity statuses as unique and categorical experiences of a specific group of multiply-marginalized communities (Hancock, 2007; Parent et al., 2013; Stewart & McDermott, 2004). Additive and multiplicative approaches can be achieved statistically by testing main effects and interaction terms

(Babbitt, 2013); however, significant limitations (e.g., large sample size requirements for smaller, marginalized communities) exist that contribute to the barriers that researchers encounter when attempting to explore interactions such as race, class, and gender in the same analysis. Phenomenological experiences, however, have been captured by qualitative studies in psychology and are best able to reflect unique aspects within multiple-minority status individuals' experiences.

Because intersectionality research gained traction within the feminist movement, the concept of gender has been deeply explored in the intersectionality literature. Shields (2008) provided a comprehensive analysis of gender from an intersectional perspective and offered suggestions on how to include intersectionality within theoretical and empirical research models. First, she describes the term intersectionality as having consistent features across a variety of definitions whereby social identities are organized by social relationships that mutually constitute (i.e., categories, such as gender, take meaning in relation to other categories), reinforce (i.e., we are *active participants* in our identities in addition to being *recipients* of an identity from the broader culture), and naturalize (i.e., identities within a category tend to become self-evident or seen as "naturally occurring" rather than socially constructed). Sheilds argues that because gender and other identity groups have been naturalized, the field of psychology has been narrowly focused on identifying group differences with an occasional mention of group similarities. Thus, regarding gender, the question of "how are men and women different?" appears to be immortal. This phenomenon and its resulting consequences for women and research in psychology are well documented elsewhere (see Fine, 2011, and Chap. 11 of this text). Because categories like gender and race are seemingly "natural" and easily quantified with zeroes and ones, psychological research has engaged liberally in unnecessary or exaggerated oversimplifications and misattributions about gender and race (Helms, Jernigan, & Mascher, 2005). These misattributions ultimately reinforce identity-based stereotypes (Richards, 2002), which are then used to validate and excuse institutional and system oppression against those groups.

As mentioned above, intersectionality is paradoxical in that its success as a concept may actually lie in its ability to be vague enough to apply in a variety of theoretical frameworks, toward a variety of demographics, across a variety of disciplines, and within a variety of research protocols. Cole (2009) speaks to the utilization of intersectionality as a process that should underlie all aspects of research and practice, proposing three conceptual questions to assist psychologists while they endeavor to include intersectional paradigms and perspectives into their research:

1. Who is included within this category?
2. What role does inequality play?
3. Where are there similarities?

These questions are intended to draw our attention to the diversity within social categories, the hierarchies of privilege and power intertwined, and finally the similarities that can be found across categories assumed to be significantly dissimilar.

Lisa Bowleg describes some of the qualitative and quantitative barriers to intersectional research in psychology in her 2008 paper on this subject. Specifically, she argued that the method of applying intersectionality additively (e.g., black + lesbian + woman), which is a widely used statistical technique, contradicts the premise and purpose of intersectionality itself. That is to say that identities are not, in fact, mutually exclusive and should not be treated as such empirically, theoretically, or practically. We cannot, under this proposition, assume that three marginalized identities equate to three times the problems in living. Rather, we must understand the qualitative, holistic differences between black + lesbian + female experiences and that of the lesbian experience alone, for example. In 2012, Bowleg demonstrated an intersectional qualitative framework with gay and bisexual black men. Although only 12 men were recruited for the study, all highly educated, middle class, and living in the Washington, DC, area, Bowleg was able to attain rich and detailed information about how these men interact with the intersections of their identities in daily life, looking at perceived benefits, as well as oppressions. For example, she found that these men tended to identify as black first rather than gay or bisexual and that this primary identity led to intersectional conflict regarding heterosexism and expectations of masculinity in black communities. Participants also reported experiencing racism (e.g., microaggressions, negative stereotyping) as black men within mainstream gay communities. In addition to capturing perceived difficulties, Bowleg highlighted that an intersectional analytical framework can be helpful in examining the strengths or benefits of having multiple marginalized identities rather than solely focusing on resulting oppression. The men in her study reported that they had benefitted from the relative gender role freedom they experience in comparison to that of heterosexual men, as well as a generalized feeling of psychological and personal growth.

This focus on opportunity and advantage is an important component of intersectional analysis as it is necessary to evaluate privilege comprehensively, including the inherent avoidance of oppression and also the increased access to opportunity, social rewards, and higher positioning. Further, as Shields (2008) points out, “an intersectional position may be disadvantaged relative to one group, but advantaged relative to another” (p. 302).

If we are to truly incorporate multiple identities within our work as psychologists, research questions, as well as questions in clinical work, should be posed intersectionally (Bowleg, 2012) rather than attempting to compartmentalize separate aspects of identity. For example, when a researcher or clinician is interested in understanding the day-to-day activities of an individual, they will ask questions such as “I’d like you to tell me about some of the challenges you face as a black lesbian woman” rather than “Tell me about some challenges you face as a person of color,” as individual identities cannot feasibly be separated in real life. Therefore, identities should not be implied to be mutually exclusive in theory or conceptually. Intersectional research in psychology should focus on constructs like stress, prejudice, and discrimination in context rather than demographic cataloguing alone (Bowleg, 2012). As psychology strives to infuse multicultural perspectives pervasively throughout its work, we must acknowledge that the demographic variables we are interested in are often socially constructed (e.g., gender, race, class) and are symbolic rather than literally meaningful in and of themselves. This acknowledgement is increasingly relevant if we are to truly integrate intersectionality into psychological work, not just as a tool to describe identities but also as a mechanism for understanding and disempowering power structures that cause direct and indirect harm for many communities. Oftentimes, these power structures are responsible for the creation of socially constructed identities like race, class, and gender. For example, “race” was not a meaningful or powerful categorical marker until those in power (i.e., slave traders) needed it to justify a focus on the African continent instead of their former focus on low economic class slave trade across various African, European, and Asian countries. Because power structures intentionally use categories to reinforce their ideological dominance over others, psychologists *must* make immediate efforts to expand their knowledge of identity-based differences to the power structures that made these identities meaningful in individual lives, as well as group functioning.

Intersectionality as a Framework for Life

Beyond the myriad complexities of conceptualizing and implementing intersectionality within psychological research and behavioral health, the concept of intersectionality is foundational to the human experience. As the introduction to this chapter highlighted, our species has a deeply rooted tendency to discriminate. It began with the need to pick healthy from poison berries: an innocent and pure discrimination fueled by the valid anxiety to avoid premature death. It has culminated, however, in a habit of domination and struggle for power, fueled by anxieties of a symbolic sort: to appear “masculine,” to be “on top," to avoid symbolic and context-dependent emotions like shame and embarrassment. We have, in fact, given a necessary and beneficial cognitive process (i.e., discrimination) quite a bad name. Luckily, it is well established that a thoughtful, compassionate, and intersectional approach to understanding human behavior can shed light both on the etiology and on the antidote for our abuse of discrimination as this is the approach that provides the most nuanced and accurate analyses of human behavior in context. As discussed above, scientists, theorists, and practitioners in diverse disciplines have approached this task in various ways: it is likely that the "correct" way to go about it does not exist; rather, each strategy may reflect the most effective option in its own context. This, then, is the goal of your work as you move forward: to integrate intersectionality in your particular context but flexibly understanding the whole person, community, and culture in context with a strong focus on power structures.

We run the risk, if we are not careful, of becoming rigidly attached to identities as discrete categories or the concept of intersectionality as the sole mechanism for preventing oppression and creating equity. We could, if we chose to, dissect infinite intersections in our lives, but that would be inarguably unhelpful. In other words, intersectionality should not be pursued for its own sake, but it should be pursued to the extent that it is able to meet the aims we set for it: coalition, social justice, equity, reduction of human suffering. In therapy, for example, probing a patient for identity-related information to aid in our understanding of their context should not be an activity motivated by voyeurism; rather, it should be motivated by a therapeutic goal of eventually helping the patient develop insight or strategies for how to cope and reposition themselves where they are underpowered, to encourage compassion and connection where they may be overpowered, etc. Similarly, whereas it may be seductive and interesting to research isolated identities and their corresponding health disparities, this type of scientific endeavor should be bolstered by a specific goal, such as to inform lawmakers, inform therapists, to disempower structures that are identified as harmful to these groups of people. There are also significant limitations to employing a solely problem-focused or oppression-oriented perspective as there are aspects of privilege, opportunity, knowledge, growth, and resilience inherent within all people, at all cross-sections of identity and power, that ought not to be ignored. As demonstrated above, empirical practices aimed and simply describing specific identifies as being riddled with health disparities is an incomplete attempt at intersectional research—this type of research must be coupled by an analysis of the power structures that make these relations possible.

Intersectionality itself asserts that identities should not be tallied, quantified, and stacked upon one another for the purpose of predicting the most marginalized and oppressed among us; several feminist scholars have in fact cautioned against this occurrence, labeling it *oppression olympics* (Hancock, 2011; Yuval-Davis, 2012). The term *oppression olympics* in and of itself refers to conflict that arises when we are narrowly focused on determining who is least and most oppressed, irrespective of individual nuance, perspectives, or intersectionality. Where, then, is the boundary between understanding of the differences and the priority of human connection and coalition? This is another common pitfall of the failure to specify the goal of the intersectional activity as the purpose of intersectional analysis *should not* be to serve as a talking point to win arguments with others or a mechanism for seeking attention. Rather, intersectionality is a form of analysis that aims to bring a blurry picture in to focus, and that focus engenders cooperation, not conflict. It is important, however, to distinguish between conflict and discomfort when making suggestions about applying intersectionality in our lives and work.

In attempting to implement a practical, compassionate, and intersectional approach, a few considerations come to mind. In general, the process of change is a difficult one. Anyone who has experienced a conflict and compromise with a partner, or the process of sleep training a young child, understands that personal and behavioral change involves patience, discomfort, and care for the people around them. These are the same qualities that are required to implement an intersectional approach in conversation with others, in our research, or in our clinical practices.

First and foremost, it is imperative—in the practice of psychology, as well as in life—that we acknowledge the educational role of discomfort in personal and human progress. If we rely upon the metaphor of discrimination between healthy and poison berries, the anxiety or discomfort that we feel about a food choice can mean the difference between life and death. In other words, discomfort can indicate an actual physical threat; thus, the experience of fear in the face of present-moment danger is an important one that helps us to quickly react—quickly change—when we need to for survival. In modern society, human anxieties are future oriented and often have imagined or symbolically threatening consequences that are reminiscent of our ancient berry-picking dilemma; we go to great lengths to avoid the discomfort of embarrassment, of being incorrect, of appearing atypical, none of which are likely to kill us or cause sickness in the same way that a poison berry would. Yet our minds consistently conflate emotional or bodily discomfort with immediate threat, and this bleeds into all aspects of our functioning. This conflation has had a detrimental effect on behavioral health and human coping in the last several decades. Being able to notice and reflect upon internal discomfort, before acting on it as if it is a real-time threat, is a life skill that our society does not currently hold in high esteem. Simultaneously, it is the life skill that is necessary in order to create the awareness and action required to dismantle oppressive hierarchies. It is the exact practice we utilize to tolerate fatigue when we exercise, when we tolerate the infinite chewiness of kale, when we tolerate pregnancy and birth. Individuals and institutions with the most power must be willing to tolerate discomfort if we are to expect them to relinquish their power and privilege in order to alleviate suffering for those experiencing the consequences of their power. White feminists must be willing to tolerate discomfort in order to listen to black feminists and their valid concerns about erasure and feminist goals. Men must be able to tolerate discomfort in order to understand the experience of women. College students must be able to tolerate discomfort rather than escaping to a comfortable "safe space" in order to avoid perspectives outside of their own. Therefore, the first step to effective activism—and effective utilization of intersectionality—is normalizing the role of discomfort, from an early age, not as a threat but as a guide and resource to help us identify and overcome our own blind spots. Psychologists working directly with students and clients are uniquely positioned to address this concern.

The best and most effective way to increase our sensitivity and skill around people who are different than us is to actually engage with people who are different than ourselves on a personal level. This is not to suggest the pursuit of a collection of token minority friends for consumption—it implies a genuine, authentic, and open connection, developed over time, with people who have different experiences, identities, and values than your own. This process begins with the awareness of the boundaries that we have placed around our social lives, which limit our exposure to people unlike ourselves. Do the people in your schools, neighborhoods, and workplaces look and think like you? If so, are there workable steps, in your specific context, that can help to diversify and include "others" into your social circle? Are you willing to be open and forgiving as they struggle to learn about you? This requires tolerance and openness to the discomforts that underlie interactions among people with differences: being wrong, saying something unintentionally insensitive, hearing something insensitive, feeling embarrassed, experiencing confusion, being excluded from some topics of discussion, being willing to forgive and remediate unintended offenses for the sake of coalition, and so on. Again, if the goal of intersectionality is through cooperation, these interactions can be embraced with flexibility to encourage connection rather than with hostility to draw deeper identity-based battle lines.

We must also acknowledge that no one is absent of identity, and identity itself is dimensional and diverse. Some identities fluctuate or change over time, such as physical ability or sexual identity, either of which can change gradually or suddenly result from a significant life event. Some are invisible to others (e.g., mental illnesses), whereas others are given to us at birth and visible for the world to see (e.g., race). All of us have socially recognized races, we have a sex, we have cultures and languages, we have social roles to play, and these factors interact in dynamic, interconnected, and influential ways on our minds and behavior. Intersectionality helps us to bear in mind that as one aspect of our identity changes, our other identities also change. For example, a devout mother who becomes an atheist will likely experience a change in her identity in terms of what it means to be a mother and how she parents her children. A formerly heterosexual man who enters into a homosexual relationship will also experience a shift in his relationship with gender. A significant amount of suffering can be experienced when people are rigidly attached to a specific identity and are unwilling to allow its salience wax and wane as other parts of their life flow in reaction to their environments. For example, if a person is rigidly attached to their identity as a scientist, they may have trouble connecting with family members at a traditional religious service over the holidays—perhaps they become resentful and disconnected in the face of what they see as ignorance. When we argue with our contexts, we fail to flexibly enter in and out of our identities successfully. As discussed above, flexible interaction with our environments means that we must be able to tolerate some discomfort when a specific environment is incompatible with an identity we hold dear. The task, then, is to notice the discomfort and make informed choices that move toward desired goals and values rather than making reactionary choices that are aimed at avoiding discomfort.

An identity can be adopted by choice with pride (e.g., feminist), it can be imposed upon us by a broader culture (e.g., gender), or a combination of the two can be present simultaneously. As a rule, the way in which a person describes their identity is not exactly predictive of their lifestyle, behavior, attitudes, or values. Particularly in the case of sexuality, a person's self-identification does not precisely overlap with the full complexity of their actual attractions or sexual behaviors. Much of the psychological research investigating bisexual and homosexual behavior focuses on demographics such as "men who sleep with men" (MSM; Smith, Herbst, Zhang, & Rose, 2015) rather than "men who identify as gay" for this reason: many heterosexually identified people engage in homosexual behavior or experience homosexual attractions. The inverse of this is also true: many homosexual-identified people experience heterosexual attraction and engage in heterosexual behavior, and the same complexities can exist in many other identity categories.

Identities like race and sex are visible and relatively difficult to conceal from others, whereas some aspects of identity can be concealed (e.g., sexual identity, mental health diagnoses, etc.). Different but equally negative mental health outcomes are associated with self-concealment of stigmatized identities (Masuda, Anderson, & Edmonds, 2012), as well as the inescapable stress that accompanies having a visible identity that cannot be concealed from others (Carter, 2007). We must, therefore, keep in mind that any person at any given time can hold identities that are invisible to others regardless of how deeply and personally influential they are.

There are a number of important take-home messages regarding intersectionality in psychology. The first and most pressing is that human cooperation and coalition are necessary in order to improve the behavioral functioning and sustain the viability of our species, which is presently facing significant environmental challenges that are exacerbated by significant identity-based conflict (e.g., strengthening in rigid political party affiliations). Intersectionality is a necessary component of that goal, and psychology is a necessary discipline with which to study it: just as interlocking systems of oppression act in service to maintain a hierarchy of power and dominance over groups of people, those same systems act in ways that subjugate nonhuman animals and the sustainability of the planet (Jensen, McBay, & Keith, 2011). The second is that psychology has only begun to wrap its mind around the inevitability of intersectionality as a fundamental aspect of its theory, research, and practice; as it begins to develop an increasingly consistent habit of intersectional practice, it must bear in mind that psychological science can and should inform activism that works to dismantle oppressive hierarchies, rather than focusing on studying identity for identity's sake. Stephanie Shields (2008) described the goal of activist science eloquently as follows:

> The goal of activist science itself is not to create policy, but to inform it. Research undertaken from an intersectionality perspective does originate from a point of view which includes an agenda for positive social change, but the agenda requires data to support it. This approach reflects a belief that science can be beneficial to society and that it is our obligation to study scientifically those problems and issues that bear on real people's lived experience. Intersectionality has consequences for how social issues are construed and the construction of systematic explanation, including empirical strategies with a foundation in scientific method. Bograd (1999), for example, describes how focusing on gender alone as the central issue in domestic violence hindered theory development and empirical research. In another vein, Burman (2005) shows how prevailing research approaches to cultural psychology, such as multiculturality, each in their own way marginalize or erase gender. Intersectionality is urgent because it gets us as researchers to go beyond the individually informed perspective that we each inevitably bring to our scholarship and science. Walker (2003) points out that "the attempt to understand intersectionality is, in fact, an effort to see things from the worldview of others and not simply from our own unique standpoints" (p. 991). The intersectionality perspective is thus an invitation to move beyond one's own research comfort zone. (p. 309)

Finally, as we endeavor to increase human cooperation and improve science with intersectionality, we must also rely upon intersectionality to create a culture of compassion that supersedes our culture of needing to be correct or needing to avoid uncomfortable experiences. We are too quick to walk away from others who are different from us, too sensitive to tolerate discomfort long enough to learn, and too sensitive to tolerate discomfort long enough to educate. The goal of intersectionality cannot and should not be to attain a global sense of emotional safety, free of discomfort, change, or instability, because there will be discomfort, change, and uncertainty in living. If we end interactions at the moment that we are offended or misunderstood, connection and cooperation that brings healing can never manifest.

Similarly, there is no single pathway to perfect intersectionality in our personal or our professional lives, and we must resist the temptation to try to force there to be. A precisely unoffensive environment will never exist, just as all of the questions of science will never be definitively answered, and we must find a way to accept this reality with humility while still attempting to create change. Each context will dictate which methods, which type of analysis, which type of identity is most salient or workable for a specific purpose, whether that be personal and conversational or empirical and philosophical. Lisa Bowleg (2012) described this inevitability best in the context of her research, given that a few of the projects she has collaborated on have asked similar questions that ultimately revealed different answers:

> Overzealous focus on designing the perfect qualitative or quantitative question harkens back to positivism's ontological tenet that there is some single fixed reality (see Tashakkori & Teddlie, 1998) about intersectionality that can be measured if only the researcher had just the right question. … there is no single reality about the experience of one's intersecting identities, only multiple constructed realities about one's own experience of intersectionality. (p. 317)

References

Alexander-Floyd, N. G. (2012). Disappearing acts: Reclaiming intersectionality in the social sciences in a post-Black feminist era. *Feminist Formations, 24*, 1–25.

Babbitt, L. G. (2013). An intersectional approach to Black/White interracial interactions: The roles of gender and sexual orientation. *Sex Roles, 38*, 791–802.

Bilge, S. (2013). Intersectionality undone: Saving intersectionality from feminist intersectionality studies. *Du Bois Review: Social Science Research on Race, 10*, 405–424.

Benner, A. D., & Graham, S. (2011). Latino adolescents' experiences of discrimination across the first 2 years of high school: Correlates and influences on educational outcomes. *Child Development, 82*, 508–519.

Bograd, M. (1999). Strengthening domestic violence theories: Intersections of race, class, sexual orientation, and gender. *Journal of Marital and Family Therapy, 25*, 275–289.

Bowleg, L. (2012). Once you've blended the cake, you can't take the parts back to the main ingredients: Black gay and bisexual men's descriptions and experiences of intersectionality. *Sex Roles, 68*, 754–767.

Brenick, A., Romano, K., Kegler, C., & Eaton, L. A. (2017). Understanding the influence of stigma and medical mistrust on engagement in routine healthcare among black women who have sex with women. *LGBT Health, 4*(1).

Burman, E. (2005). Engendering culture in psychology. *Theory & Psychology, 15*, 527–548.

Carter, R. T. (2007). Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress. *The Counseling Psychologist, 35*(1), 13–105.

Choi, K. H., Bowleg, L., & Neilands, T. B. (2011). The effects of sexism, psychological distress, and difficult sexual situations on U.S. women's sexual risk behaviors. *AIDS Education and Prevention, 23*, 397–411.

Cole, E. R. (2009). Intersectionality and research in psychology. *American Psychologist, 64*(3), 170–180.

Collier-Thomas, B., & Franklin, V. P. (2001). *Sisters in the struggle: African American women in the civil rights-black power movement*. New York, NY: New York University Press.

Collins, P. H. (1990). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. New York, NY: Routledge.

Collins, P. H. (2015). Intersectionality's definitional dilemmas. *Annual Review of Sociology, 41*, 1–20.

Combahee River Collective. (1977, April). *A Black Feminist Statement*. https://americanstudies.yale.edu/sites/default/files/files/Keyword%20Coalition_Readings.pdf

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of anti discrimination doctrine, feminist theory and antiracist politics. *The University of Chicago Legal Forum, 140*, 139–167.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*, 1241–1299.

Davis, A. Y. (1981). *Women, race, and class*. New York, NY: Random House.

Davis, K. (2009). Intersectionality as a buzzword: A sociology of science perspective on what makes a feminist theory successful. *Feminist Theory, 9*(1), 67–85.

Earnshaw, V. A., & Quinn, D. M. (2012). The impact of stigma in healthcare on people living with chronic illnesses. *Journal of Health Psychology, 17*, 157–168.

Fine, C. (2011). *Delusions of gender: How our minds, society, and neurosexism create difference*. New York, NY: W. W. Norton & Company.

Hancock, A. (2007). Examining intersectionality as a research paradigm: Multiplication doesn't equal quick addition. *Perspectives on Politics, 5*, 63–79.

Hancock, A. (2011). *Solidarity politics for millennials: A guide to ending the oppression olympics (The politics of intersectionality)*. New York, NY: Palgrave Macmillan.

Harari, Y. N. (2015). *Sapiens*. New York, NY: HarperCollins.

Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a fundamental cause of population health inequalities. *American Journal of Public Health, 103*, 813–821.

Helms, J. E., Jernigan, M., & Mascher, J. (2005). The meaning of race in psychology and how to change it. *The American Psychologist, 60*, 27–36.

Hooks, B. (1989). *Talking back: Thinking feminist, thinking black*. Boston, MA: Sound End Press.

Hull, A. G. T., Bell-Scott, P., & Smith, B. (Eds.). (1982). *All the women are white, all the blacks are men, but some of us are brave*. Old Westbury, NY: Feminist Press.

Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science and Medicine, 71*, 2150–2161.

Jensen, D., McBay, A., & Keith, K. (2011). *Deep green resistance: Strategy to save the planet*. New York, NY: Seven Stories Press.

Matsuda, M. J. (1991). Beside my sister, facing the enemy: Legal theory out of coalition. *Stanford Law Review, 43*(6), 1183–1192.

McCall, L. (2005). The complexity of intersectionality. *Signs, 30*, 1771–1800.

Masuda, A., Anderson, P. L., & Edmonds, J. (2012). Help-seeking attitudes, mental health stigma, and self-concealment among African-American college students. *Journal of Black Studies, 43*(7), 773–786.

May, V. M. (2015). *Pursuing intersectionality, unsettling dominant imaginaries*. New York, NY: Routledge.

Pager, D., & Shepherd, H. (2008). The sociology of discrimination: Racial discrimination in employment, housing, credit, and consumer markets. *Annual Review of Sociology, 34*, 181–209.

Parent, M., DeBlaere, C., & Moradi, B. (2013). Approaches to research on intersectionality: Perspectives on gender, LGBT, and racial/ethnic identities. *Sex Roles, 68*, 639–645.

Reid, P. T. (2000). Multicultural psychology: Bringing together gender and ethnicity. *Cultural Diversity & Ethnic Minority Psychology, 8*, 103–114.

Richards, G. (2002). The psychology of psychology: A historically grounded sketch. *Theory & Psychology, 12*, 7–36.

Rosenthal, L. (2016). Incorporating intersectionality into psychology: An opportunity to promote social justice and equity. *American Psychologist, 71*(6), 474–485.

Sabik, N. J. (2013). Ageism and body esteem: Associations with psychological well-being among late middle-aged African American and European American women. *The Journals of Gerontology Series B, Psychological Sciences and Social Sciences, 70*, 191–201.

Sarno, E. L., Mohr, J. J., Jackson, S. D., & Fassinger, R. E. (2015). When identities collide: Conflicts in allegiances among LGB people of color. *Cultural Diversity & Ethnic Minority Psychology, 21*, 550–559.

Settles, I. H., Cortina, L. M., Stewart, A. J., & Malley, J. (2007). Voice matters: Buffering the impact of a negative climate for women in science. *Psychology of Women Quarterly, 31*, 270–281.

Shields, S. A. (2002). *Speaking from the heart: Gender and the social meaning of emotion*. New York, NY: Cambridge University Press.

Shields, S. A. (2008). Gender: An intersectionality perspective. *Sex Roles, 59*, 301–311.

Smith, D. K., Herbst, J. H., Zhang, X., & Rose, C. E. (2015). Condom effectiveness for HIV prevention by consistency of use among men who have sex with men in the United States. *Journal of Acquired Immune Deficiency Syndromes, 68*(3), 337–344.

Staunæs, D. (2003). Where have all the subjects gone? Bringing together the concepts of intersectionality and subjectification. *Nordic Journal of Feminist and Gender Research, 11*(2), 101–110.

Stewart, A. J., & McDermott, C. (2004). Gender in psychology. *Annual Review of Psychology, 55*, 519–544.

Tashakkori, A., & Teddlie, C. (1998). Introduction to mixed method and mixed model studies in the social and behavioral sciences: Paradigm wars and mixed methodologies. In *Mixed methodology: Combining qualitative and quantitative approaches* (pp. 3–19). Thousand Oaks, CA: Sage.

Toporek, R. L., Gerstein, L., Fouad, N., & Israel, T. (2006). *Handbook for social justice in counseling psychology: Leadership, vision, and action*. Thousand Oaks, CA: Sage.

Walker, A. (2003). Methods, theory and the practice of feminist research: A response to Janet Chafetz. *Journal of Family Studies, 25*, 990–994.

Yuval-Davis, N. (2006). Intersectionality and feminist politics. *European Journal of Women's Studies, 13*, 193–209.

Yuval-Davis, N. (2012). Dialogical epistemology—An intersectional resistance to the "oppression olympics". *Gender and Society, 26*, 46–54.

Identifying and Remediating Personal Prejudice: What Does the Evidence Say?

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Abstract

In behavioral health settings, prejudice is a serious problem with significant implications for service delivery. Despite genuine efforts to help, clinicians behave in prejudiced ways toward clients and patients, often leading to problems in treatment or to the abandonment of treatment altogether. In this chapter, we outline the history of prejudice research, discuss definitions of prejudice, and review the empirical research on prejudice reduction interventions. We then critique prejudice reduction research from the perspective that collective action may more effectively produce social change. Finally, we return to the necessity of prejudice reduction in behavioral health care, offering practical suggestions from the literature and from our own experience as clinicians, researchers, and educators.

Keywords

Prejudice · Bias · Behavioral health · Prejudice reduction · Collective action

Susan, a 61-year-old white clinical psychologist in private practice, agreed to an initial consult with Elías, a 24-year-old light-skinned Dominican American man who has been struggling with insomnia. Susan specializes in sleep disorders, and typically uses a cognitive-behavioral approach that has been very effective for many of her patients. On the day of the appointment, Susan noticed Elías's eyes darting to the framed paintings and certificates in her office. When asked if he was comfortable, Elías assured Susan that he was. Elías answered all of Susan's questions quickly and directly, and he listened closely as Susan described the treatment approach. Finally, at the end of the hour, Susan asked Elías about the fee. Would he be able to afford the $250 per session Susan normally charges, or would he need a sliding scale? To Susan's surprise, Elías looked her in the eye and said, "That's racist." Susan was taken aback, and stumbled over her reply. "I—I'm sorry, I didn't mean to—" Elías then drew out his checkbook and said, "I'm assuming I pay you for this one?" He quickly wrote a check and handed it to Susan, who was blushing with embarrassment. As Elías got up

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L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_11

to leave, he said, “See you next week, doc. I hope you can help me sleep.”

Bella, a Taiwanese American counseling psychologist, has been seeing Julie, a 46-year-old white law clerk who became disabled after a car accident one year ago, and now uses a wheelchair. Bella has worked with patients with physical disabilities before, but accommodating a patient in a wheelchair is a new experience for her. Each week at the time of their appointment, Bella goes to the waiting area of the community mental health clinic and greets Julie. She then wheels Julie into her small office, where she has carefully rearranged the furniture to provide adequate space. On the day of their fifth appointment, Bella completed this ritual and sat down in her chair when she noticed Julie looking at her anxiously. “Dr. Lin, I want to thank you for all the help you’ve been, but I don’t think we can work together anymore. Ever since the accident, I have been educating myself about disability rights. I need someone who is a bit more aware of those issues. I’m very sorry.” Bella looked at Julie in disbelief, wondering what had prompted this.

Introduction

In behavioral health settings, prejudice is a serious problem with significant implications for service delivery. Despite genuine efforts to help, clinicians behave in prejudiced ways toward clients and patients, often leading to problems in treatment or to the abandonment of treatment altogether (Fitzgerald & Hurst, 2017; Institute of Medicine, 2003). Like the general population, clinicians engage in behaviors that are racist (Burke et al., 2017; Cheng, Iwamoto, & McMullen, 2016; Shin, Smith, Welch, & Ezeofor, 2016), gender biased (Ali, Caplan, & Fagnant, 2010; Colbert et al., 2015), classist (Garb, 1997; Thompson, Cole, & Nitzarim, 2012), homophobic and homonegative (J. A. Hayes & Erkis, 2000; Shelton & Delgado-Romero, 2011), transphobic and transnegative (Mizock & Lundquist, 2016; Riggs & Sion, 2017), ableist (Shyman, 2016; Smith, Foley, & Chaney, 2008), xenophobic (Alda Díez, García Campayo, & Sobradiel, 2010; Johnson & Orrell, 1996), or prejudiced in other ways against marginalized groups. Historically, prejudice research has typically focused on single dimensions of identity and has failed to reflect the fact that every individual belongs to many groups. Recent research has begun to document more complex forms of prejudice at the intersections of race and age (Burgess et al., 2014), HIV status and age (Emlet, 2006), and sexual orientation and race (Calabrese, Earnshaw, Underhill, Hansen, & Dovidio, 2014), to name a few examples. See Table 1 for brief descriptions of the above findings.

Prejudice and bias in the helping professions have been identified as contributing factors to disparities in the quality of care to racial/ethnic minority populations, sexual minorities, the poor, and other oppressed groups (Dovidio & Fiske, 2012; Herek & Garnets, 2007; Institute of Medicine, 2003). As the population becomes increasingly diverse, individual-level prejudice may increase rather than decrease over time. In the United Kingdom in the 1960s, where comparably less racial and cultural diversity existed than today, severity of diagnosis predicted clinician assessments of insight in psychiatric inpatients, whereas patient race and ethnicity did not (Johnson & Orrell, 1996). By the 1990s, as immigration and racial diversity increased in the UK, patient race and ethnicity were the *only* predictors of how much insight patients were believed to possess, with White British patients rated as having more insight than Black Caribbean and Black African patients (Johnson & Orrell, 1996). Clearly, to improve the quality of care and reduce service inequities, interventions are needed to reduce prejudicial attitudes among mental health providers and the harmful behaviors that stem from them. But the science surrounding this obvious need is not straightforward.

In this chapter, we take a seemingly simple task—reviewing the empirical literature on prejudice reduction—and complicate it. Prejudice has received more attention in social psychological research than almost any other subject. For that reason, one might expect the literature to be brimming with well-documented, practical strategies that anyone could use to identify and reduce their own prejudicial attitudes and behaviors. That is unfortunately not the case. In the first part of this chapter, we briefly outline the history of prejudice research, discuss definitions of prejudice, and then review the (surprisingly limited)

Table 1 Examples of prejudice in behavioral health settings

Finding	Reference
Instructors' disparaging remarks encourage trainee racial bias	Burke et al. (2017)
Model minority stereotype predicts underdiagnosis of Asian Americans	Cheng et al. (2016)
Clinicians are less likely to invite a prospective client with an African American name to start therapy than a prospective client with a White name	Shin et al. (2016)
Women are less likely to be referred for effective treatment for heart disease	Colbert et al. (2015)
Women are overdiagnosed in terms of mood and personality disorders	Ali et al. (2010)
Therapists display status symbols in their offices that convey elitism	Thompson et al. (2012)
Low-income clients are overdiagnosed	Garb (1997)
Microaggressions against LGBTQ people occur in therapy (e.g., pathologizing sexual orientation)	Shelton and Delgado-Romero (2011)
Therapist homophobia predicts blaming HIV+ clients for their status	Hayes and Erkis (2000)
Cisgender men psychologists are more negative toward transgender people than cisgender women psychologists	Riggs and Sion (2017)
Transgender clients are burdened with educating their therapist	Mizock and Lundquist (2016)
Medical model reinforces ableist assumptions about clients	Shyman (2016)[a]
(Dis)ability-related competence training is lacking	Smith et al. (2008)[a]
Immigrants are offered less treatment and are subject to greater security restraints than native-born inpatients	Alda Díez et al. (2010)
White native-born patients are rated most insightful by clinicians; Black Africans and Caribbeans are rated least insightful	Johnson and Orrell (1996)
Older Black veterans are given more pain medication for low-intensity pain than Whites; younger Black veterans are given less pain medication for high-intensity pain than Whites	Burgess et al. (2014)
Clinicians are less likely to prescribe PrEP to Black men than White men	Calabrese et al. (2014)

[a] Indicates theoretical paper. Other references are empirical studies or literature reviews

empirical research on prejudice reduction interventions. Next, we discuss a critique of prejudice reduction research, the possibility that *collective action* is a more effective mechanism to produce social change. Finally, we return to the necessity of prejudice reduction in behavioral health care and offer practical suggestions drawn from the empirical literature and our own experience.

A few words about who we are and how we approached this topic. We are a professor (Doris F. Chang) and her current and former doctoral students in clinical psychology at The New School for Social Research in New York, New York. As clinicians, researchers, and educators who represent diverse social identities and are explicitly guided by social justice frameworks, we approached this chapter with a critical perspective, keeping the following questions in mind: what assumptions do social scientists tend to make about prejudice? Is there received wisdom about prejudice research that needs to be challenged? How do institutional and historical factors shape scientific questions and answers about prejudice and its remedies? We encourage the reader to critically engage these questions with us.

A Brief History of Prejudice Research

Before prejudice became a subject of scientific inquiry, group differences were typically explained through biological narratives of inherited superiority (Duckitt, 1992; Samelson, 1978). When empirical data challenged these narratives, findings were often interpreted in ways that reinforced the biases of the dominant group. For example, in an 1895 study of reaction times between African and European participants, the *faster* reaction times of African participants were interpreted as evidence of their "primitiveness" and presumed lower intelligence (Samelson, 1978). In another example, after the Immigration Act of 1924 dramatically limited the immigration of certain nationalities to the United States, many comparative intelligence studies were abandoned, given that "it was no longer necessary to justify scientifically the exclusion of these undesirable and inferior aliens" (Samelson, 1978, pp. 270–271). These examples illustrate a type of institutional bias known as "scientific racism" (Fairchild, 1991; S. Sue, 1999). In addition to racism, "scientific" sexism, heterosexism, classism, ableism, and other oppressive systems are also readily apparent in the history of research on group differences and have significantly shaped the kind of scientific questions both asked and answered. Although our focus is on prejudice reduction, see Chap. 2 in this volume for a discussion of the impact of scientific "isms" in (Topics).

In the 1920s and 1930s, serious scientists backed away from essentialist notions of individual difference and began looking instead at *perceived* differences between groups (Samelson, 1978). In the 1940s and 1950s, these questions became urgent as the scope of the Holocaust, and the Nazi obsession with racial purity that led to it, came to light (Duckitt, 1992). Over time, "prejudice" became the catchall term for mental operations hypothesized to undergird behaviors such as discrimination, exclusion, and violence perpetrated by members of one group against members of another. In the decades since, prejudice has preoccupied social scientists like no other issue, producing an enormous body of scholarship (Paluck & Green, 2009).

The concept of prejudice has intuitive appeal. Prejudice, or "pre-judgement," is typically considered an error in thinking—a troubling bit of code in the human psyche that might be deleted, or at least edited, if only we knew how. But researchers have struggled to demonstrate this due to competing theories about what prejudice is and how it works. An ongoing debate centers on levels of analysis and definitions of the problem: does prejudice operate primarily at the societal level or at the individual level? Sociologists tend to look at societal-level explanations, while psychologists tend to focus on the individual level. If we restrict our lens to individual-level or "personal" prejudice, other questions arise. Is there such a thing as a "prejudiced personality"? How is prejudice learned? How is it unlearned (and can it be)? Should the focus of prejudice reduction be on explicit attitudes, implicit attitudes, or both?

A historical review of the psychological understandings of prejudice chronicles the field's changing perspectives on the fundamental nature of prejudice (Dovidio, 2001; Duckitt, 1992). In the 1920s and 1930s, prejudice was seen as "irrational and unjustified"; in the 1930s and 1940s, as an "unconscious defense"; in the 1950s, as an "expression of a pathological need"; in the 1960s, as a "social norm"; in the 1970s, as an "expression of group interests"; and in the 1980s, as an "inevitable outcome of social categorization" (Duckitt, 1992, p. 1184). Dovidio (2001) described eras of prejudice research in terms of "waves." In first wave studies, prejudice was seen as psychopathological; in the second wave, it was understood to be rooted in normal processes, and in the third and current wave, prejudice is considered as a multidimensional phenomenon comprised of implicit and explicit processes (Dovidio, 2001). Reflecting the biological and mechanistic turn in psychological research, contemporary conceptualizations of the construct of prejudice describe more general universal cognitive processes that contribute to social stratification. For example, in a recent book edited by some of the field's most renowned scholars, prejudice is defined as "an individual-level attitude (whether subjectively positive or negative) toward groups and their members that creates or maintains hierarchical status relations between groups" (Dovidio, Hewstone, Glick, & Esses, 2010, p. 7). In this definition, the valence of the attitude is irrelevant; it can be "subjectively positive or negative." This definition may come as a surprise to those who think of prejudice as a negative evaluation of the other. Although that idea has been influential for decades (e.g., in Allport's (1954) definition of prejudice as "antipathy based upon a faulty and inflexible generalization" (p. 9)), more recent scholarship suggests that prejudice includes positive attitudes, as well as negative. Glick and Fiske's (2001) theory of *ambivalent sexism* illustrates this by proposing both hostile and "benevolent" forms of sexism. In benevolent sexism, girls and women are seen as fragile creatures requiring protection and provision. The hostile and benevolent forms are hypothesized to work together as two sides of the same coin: women are punished when they seek power and rewarded with chivalrous tokens when they accept lower status (Glick & Fiske, 2001).

Gender-based oppression is not the only area in which "ambivalent" dynamics can be observed.

When chattel slavery was legal in the United States, White slaveholders were more likely to think of themselves as noble and genteel than cruel or oppressive (Ferguson, 1996; Green, 2015). Accordingly, enslaved Africans were often viewed as pitiable and deserving of decency so long as they remained subordinate. This double bind exists today in the form of "respectability politics," which suggests that Black individuals bring violence and oppressive force on themselves by not behaving "respectably" enough (Obasogie & Newman, 2016). The model minority stereotype creates a similar paradox for Asian individuals, who are expected to be both high achieving and nondominant (Berdahl & Min, 2012). Like ambivalent sexism, these race-based examples show that when members of a target group seek more power or inclusion, they are often perceived by the dominant group to be dangerous or needing to be "put in their place." If members of a target group are not actively challenging power structures, the dominant group's attitudes toward them may not be negative, in the usual sense. Returning to the current definition of prejudice given above, the active ingredient in prejudice is not the valence of the attitude but rather its impact—for example, whether or not it "creates or maintains hierarchical status relations between groups" (Dovidio et al., 2010, p. 7). (Space limitations prevent us from delving into an analysis of the processes through which an individual attitude can *create* or *maintain* group dynamics; however see Chap. 3 in this volume for more on this topic. For our purposes, it is important that "prejudice" be understood as a complex construct rooted in larger sociocultural attitudes, and which has changed over time, spawning a diversity of theoretical frameworks and empirical approaches. This helps to explain why prejudice reduction research has taken so many different directions and resulted in so little consensus.

Prejudice Reduction: Review of Reviews

If conceptual and definitional challenges have made prejudice difficult to study, identifying markers of *reduced prejudice* has proven even more difficult. Prejudice reduction has been operationalized in many different ways, and thousands of experiments have been conducted to test the effectiveness of a variety of prejudice reduction interventions. In this section, we summarize recent reviews on this topic. See Table 2 for a summary of interventions most commonly studied.

Among the recent articles, chapters, and books reviewing prejudice reduction research, a comprehensive review by Paluck and Green (2009) stands out in terms of its scope and reach. Those authors reviewed research on all types of prejudice except sexist prejudice (see below for an explanation) and included nonpeer reviewed and unpublished studies in their search. Paluck and Green's (2009) final database included 985 reports, representing most of the available work on prejudice reduction up to that point. The authors excluded studies on sexism due to its "qualitatively different nature" and the opinion that such literature deserves its own review (Paluck & Green, 2009, p. 342). Relevant to that decision, they define prejudice as "a negative bias toward a social category of people, with cognitive, affective, and behavioral components" (p. 340).

Paluck and Green (2009) used the following three categories to organize their review: nonexperimental research in the field, experimental research conducted in the laboratory, and experimental research conducted in the field. Nonexperimental research in the field, a large category making up 60% of the reviewed studies, was judged by those authors to be useful only for "descriptive" purposes due to lack of internal validity. They therefore drew no conclusions about what effectively reduces prejudice from those studies. The next category, experimental laboratory research, made up 29% of the reviewed studies. Paluck and Green (2009) organized those studies according to the theories informing them: *intergroup* approaches, including the contact hypothesis and social identity and categorization, and *individual* approaches, including instruction; expert opinion and norm information; manipulating accountability; consciousness raising; targeting emotions; and targeting value consistency

Table 2 Commonly studied interventions for prejudice reduction

Intervention	Conception of the problem	Proposed solution	Description	Reference
Contact	Prejudice stems from lack of contact with outgroup members	Increase contact but under specific conditions	Conditions must promote equality between individuals; otherwise, hierarchical power relations will occur automatically	Paluck and Green (2009)
Cooperative learning	Prejudice stems from competition between members of different groups	Facilitate cooperation by working toward common goals	Students are divided into teams, and each is given content to teach the rest of the team	Paluck and Green (2009)
Counterstereotypic exemplar	Prejudice is maintained by automatically activated stereotypes	Think of exceptions to stereotypes in order to make stereotypes less influential	Participants think of examples that contradict stereotypes of outgroup members (e.g., thinking of Barack Obama when interacting with a Black man)	Devine, Forscher, Austin, and Cox (2012); Carnes et al. (2015)
Education/ diversity training/ multicultural competence	Prejudice stems from ignorance	Acquire accurate information about self and others	(Training objectives, content, and processes vary widely. See reference for overview)	Bezrukova, Spell, Perry, and Jehn (2016)
Evaluative conditioning	Prejudice is maintained by negative affect toward outgroup members	Change valence of attitudes toward outgroup members	Participants undergo repeated conditioning tasks in which representations of outgroup members are paired with positive stimuli	Hofmann, De Houwer, Perugini, Baeyens, and Crombez (2010)
Expert opinion/ norm information	Prejudice is believed to be normal or inevitable	Challenge normalcy/ inevitability of prejudice	Authority figures and respected information sources are used to challenge the idea that prejudice is “normal”	Paluck and Green (2009)
Increase of self-worth	Prejudice stems from low self-worth	Increase sense of self-worth	Participants affirm themselves by writing about important values or receiving positive feedback about personal traits	Paluck and Green (2009)
Individuation	Prejudice is maintained by stereotypes, which are automatically activated	Attend to individual characteristics of outgroup members	Participants focus on outgroup members’ clothing, mannerisms, or other features instead of focusing on group membership (e.g., race)	Devine et al. (2012); Carnes et al. (2015)
Manipulating accountability	Prejudice persists because individuals have not thought about how irrational their prejudices are	Think about the irrationality of prejudice	Participants provide concrete reasons for choices (e.g., how much money to divide between different charities, how to judge disciplinary cases)	Paluck and Green (2009)
Mindfulness-based approaches	Prejudiced behavior occurs outside of awareness	Increase awareness of unconscious prejudice	Participants develop mindfulness through the practice of nonjudgmental attending to thoughts and feelings, with the goal of having more agency over behavior	Burgess, Beach, and Saha (2017); Masuda, Hill, Morgan, and Cohen (2012)

(continued)

Table 2 (continued)

Intervention	Conception of the problem	Proposed solution	Description	Reference
Perspective taking	Prejudice stems from a lack of empathy	Increase empathy through imaginal exercises	Participants imagine what it feels like to be the target of harmful stereotypes (e.g., being thought of as lazy or dangerous)	Devine et al. (2012); Carnes et al. (2015)
Prejudice habit-breaking intervention	Prejudice is a "habit"	Break the habit through training and practice	Participants learn and practice five strategies: stereotype replacement, counterstereotypic exemplars, individuation, perspective taking, and increasing contact (see elsewhere in this table for descriptions)	Devine et al. (2012); Carnes et al. (2015)
Social identity/ categorization	Prejudice stems from categorization, which is malleable	Reassign self and others to new or different categories	Participants are asked to "decategorize" (focus on individual identity versus group identity) or "recategorize" (focus on membership in superordinate group, e.g., "Americans")	Paluck and Green (2009)
Stereotype replacement	Prejudice is maintained by automatically activated stereotypes	Replace stereotypic responses with nonstereotypic responses	After a stereotypic response has occurred (e.g., avoiding eye contact with someone), participants (1) label it as a stereotypical response, (2) evaluate the situation to try to learn from it, and (3) replace the stereotypic response with a nonstereotypic one (e.g., looking at the person and smiling)	Devine et al. (2012); Carnes et al. (2015)
Thought suppression	Prejudice is maintained by automatically activated stereotypes	Suppress stereotypic thoughts	Participants attempt to ignore the characteristics of outgroup members (e.g., gender) or put stereotypic thoughts out of mind when they arise	Paluck and Green (2009)
Value consistency	Prejudice has not been considered in relation to other important values	Highlight contradiction between prejudices and other held values	Participants are asked to write statements of support for outgroup members	Paluck and Green (2009)

and self-worth (see Table 2 for definitions and examples). Paluck and Green (2009) noted the success of many of the reviewed experiments but argued that researchers' drive for simplification and abstraction compromised the external validity of laboratory studies. They therefore drew no conclusions about what works to reduce prejudice from that category either. The final category, experimental field research, was seen as meeting the highest standard of evidence, given the balanced considerations of external and internal validity. However, that category included only 107 studies (11% of the total). Furthermore, over a third of the studies in that category focused on one intervention, cooperative learning, in which classrooms are split into small teams and students educate each other. Of the 71 remaining studies, 40 tested interventions that lasted 1 day or less. The lack of longer-term interventions is an issue that we will return to in the following pages. Overall, Paluck and Green (2009) concluded that no method they reviewed definitively "works" to reduce prejudice due to methodological limitations and a push to rolling out packaged solutions that have not been sufficiently tested, if at all.

Other recent reviews have used less restrictive evaluation criteria than Paluck and Green's (2009) and have drawn slightly more optimistic conclusions. For example, Bartoş, Berger, and Hegarty (2014) reviewed 146 published and unpublished reports on interventions to reduce "sexual prejudice" (the term those authors prefer to homophobia or homonegativity), approximately half of which were randomized experiments. They concluded that four types of interventions were effective: *education*, which effectively increased knowledge but had modest effects on attitudes and emotions; *contact* (i.e., real or imagined interactions with lesbian, gay, and bisexual people under specific conditions), which produced moderately positive effects on attitudes; *contact and education together*, which produced moderate improvements in attitudes, emotions, and participants' intentions for future actions; and the *induction of tolerant social norms*, which improved behavior but not attitudes (Bartoş et al., 2014, pp. 376–377). Among the limitations of the reviewed studies, the authors noted that the most commonly used outcome measures were self-reported attitudes and that measures of cognition (including implicit bias), emotion, and behavior were rarely used.

Aboud et al. (2012) conducted a systematic review of 32 ethnic prejudice reduction interventions for children eight and younger. The authors defined prejudice in terms of "negative evaluations of people on the basis of their group membership," thereby limiting the scope of the review to antipathy-based theories only. Contact (i.e., exposure to members of the target group under specific conditions) was the intervention used in 14 of the studies, whereas some form of media or instruction were used in the remaining studies. Outcome measures were improved attitudes toward members of a target group or improved relations or other behavioral markers. Using a frequency count of effects reported in all studies, the authors found 40% positive effects (i.e., improvements in at least one domain), 50% nonsignificant effects, and 10% negative effects (i.e., change for the worse in at least one domain). They found slightly more support for effects on attitudes (55% positive effects) than for peer relations or behavior (25% positive effects). Media and instruction were more effective (47% of overall effects positive) than contact (36% positive). Somewhat problematically, studies that produced positive attitude changes for *all* children were rated more highly by the authors than studies that produced positive attitude changes for one group only (Aboud et al., 2012, p. 313). This means that interventions that effectively changed the attitudes or behaviors of White children, but not children of color, received lower quality ratings by those authors.

Bezrukova et al. (2016) conducted a meta-analysis of 40 years' worth of diversity training evaluations, a dataset comprised of 260 samples. Noting that previous systematic reviews of the diversity training literature had produced contradictory results, Bezrukova et al. (2016) undertook a larger, more comprehensive meta-analysis. Their primary findings showed that diversity training has not been particularly effective in changing attitudes or behaviors and that changes in those domains tend to decay over time, whereas cognitive learning persists, and occasionally increases, over time. Other findings included participants' more positive reactions to diversity training in educational settings compared to organizational settings and increased effectiveness of diversity training when it is part of a larger program of institutional efforts, versus a stand-alone intervention. Regarding differences between voluntary and mandatory trainings (an issue often debated in the field), the authors found no statistically significant overall effect. However, they observed that mandatory diversity training has had greater effects on behavioral outcomes (such as discouraging prejudiced comments or jokes), whereas voluntary trainings tend to be rated more favorably by attendees. The authors found no strong effects for the focus of the trainings (e.g., if the topic focused on one dimension of identity versus multiple dimensions). They did find a strong and significant relationship between the *length* of trainings and effect size, indicating that longer training programs tend to be more effective (Bezrukova et al., 2016). The comparative effectiveness of longer trainings has been observed elsewhere in the literature (Pedersen, Walker, Paradies, & Guerin, 2011).

To summarize, reviews of interventions to reduce personal prejudice report the following trends: (1) interventions tend to focus on reducing negative attitudes toward target groups (reflecting antipathy-based conceptualizations of prejudice); (2) interventions show modest or null effects with differential impacts on cognitive learning, attitudes, and behaviors; (3) interventions tend to be brief, which diminishes effect sizes across outcome domains; and (4) most studies tend to focus on self-report outcomes, with fewer focusing on real-world interpersonal outcomes.

Prejudice Reduction Research: Noteworthy Recent Work

Interventions to Address Implicit Bias

Implicit bias is a major focus in "third wave" prejudice research (Dovidio, 2001), which uses newer technologies to examine the automatic and unconscious processes influencing prejudiced behaviors. Interventions targeting implicit bias are typically designed and tested in the laboratory, and long-term effects have not been sufficiently examined (Paluck & Green, 2009). To address external validity issues in this area of research, Lai and colleagues tested 17 single-session interventions to reduce implicit racial bias (Lai et al., 2014) and then retested the most effective of those to determine the durability of the effects (Lai et al., 2016). The results were published in two separate articles. For the first article, the authors collected and analyzed data from 17,021 participants via the Project Implicit website (https://implicit.harvard.edu). A significant reduction in implicit racial bias was observed for 8 of the 17 interventions tested; however, the posttest measurements of implicit racial bias were administered immediately after the interventions, a fact noted by the authors as a limitation (Lai et al., 2014). In the follow-up article, the authors addressed that limitation by testing the eight most effective interventions from the earlier studies, plus one sham intervention as a control group, on 6321 students from multiple American universities. The interventions tested used counterstereotypical exemplars, appeals to egalitarian values, evaluative conditioning (e.g., repeatedly pairing Black faces with positive words and White faces with negative words), and intentional strategies to overcome bias (e.g., "If I see a Black face, then I will respond by thinking 'good'"; Lai et al., 2016, p. 1006). Implicit racial bias was measured at intervals ranging from several hours to several days after the interventions. The analyses produced a discouraging result: whereas all nine interventions significantly reduced implicit bias immediately, the effects did not hold after a delay (Lai et al., 2016). Although the authors concluded that implicit biases may be "stable over time and are not susceptible to long-term change" (Lai et al., 2016, p. 1012), this conclusion may be overstated due to the fact that only single-session interventions were tested. In fact, single-session studies dominate this area of research. A meta-analysis of 494 implicit bias studies notes that only 3% of the reviewed studies tested multiple-session implicit bias interventions, and only 6.6% of the studies were longitudinal (Forscher et al., 2019).

The Prejudice Habit-Breaking Intervention

Unlike single-session intervention research, the work of Patricia Devine and colleagues is based on the perspective that prejudice is a complex "habit" whose component parts require repeated, intentional effort and engagement to dismantle

(Carnes et al., 2015; Devine et al., 2012; Forscher, Mitamura, Dix, Cox, & Devine, 2017). Devine and colleagues' model is less theoretically specific than others due to its utilization of several mechanisms of change simultaneously. The prejudice habit-breaking intervention includes two sections, one for education and one for training (Forscher, Mitamura, et al., 2017). In the education section, participants first take the Implicit Association Test (Greenwald, McGhee, & Schwartz, 1998) and then navigate through a semi-interactive slideshow to learn about the nature and consequences of automatic bias. (Readers are encouraged to read through the slideshow text, available online at https://osf.io/gkjxs/.) This material links social problems such as faulty medical decisions, police brutality, and discriminatory hiring practices to automatic (i.e., implicit) bias. The concepts are explained in a way that normalizes implicit bias and invites acceptance versus defensiveness. Participants are then shown their score on the IAT in order to increase awareness and concern about their own implicit bias. Finally, they are given five strategies to counter the effects of implicit bias: stereotype replacement, counterstereotypic imaging, individuation, perspective taking, and increasing opportunities for contact (see Devine et al., 2012, for the descriptions of these strategies in a racial bias context, and Carnes et al., 2015, for their use in a gender-bias context). Following the education section, participants begin an unsupervised "training" section in which they are asked to practice the strategies in their day-to-day lives (Forscher, Mitamura, et al., 2017).

Among the handful of interventions that have been tested in experimental field studies, the prejudice habit-breaking intervention is one of the most effective. Participants in these studies have outperformed control conditions on several measures, including "long term" (from 12 weeks to 2 years) increases in the awareness of personal bias, changes in IAT scores, and concern about the effects of bias (Carnes et al., 2015; Devine et al., 2012; Forscher, Mitamura, et al., 2017). Notably, a 2-year follow-up to Carnes et al.'s (2015) study of a gender-bias intervention for academic departments showed promising real-world results: the proportion of women hired increased 18% in the departments that utilized the intervention, whereas there was no increase in the control group departments (Devine et al., 2017). Compared to the bleak picture painted by Paluck and Green in 2009, the prejudice reduction landscape is decidedly more hopeful as a result of this work.

What explains the comparative success of Devine and colleagues' model? One important, and strangely novel, contribution of the habit-breaking intervention is the idea that "because one-shot interventions must counteract a large accretion of associative learning, they are unlikely to produce enduring change in automatic responses. Such change is likely only after the application of considerable goal-directed effort over time" (Forscher & Devine, 2014, p. 475). Furthermore, Devine and colleagues tap into the motivation necessary for prejudice reduction by turning "situational awareness" (e.g., knowledge of one's own IAT score) into "chronic awareness" of the harmful effects of bias in society (Forscher & Devine, 2014). By making both the effects of bias and the reality of one's own bias concrete and clear, and eliciting more attention and energy for the work it takes to reduce implicit bias, the habit-breaking intervention engages a critical motivational component that other interventions do not as successfully engage.

As is the case for all promising new work, the habit-breaking intervention will benefit from further innovation and experimentation. In particular, the bias reduction strategies bear revisiting. In most of Devine and colleagues' studies (e.g., Carnes et al., 2015; Devine et al., 2012), participants were not asked which of the five strategies they used, and effectiveness of the strategies was measured collectively. However, in a recent study (Forscher, Mitamura, et al., 2017), the use of each strategy was measured and correlated with outcome variables. Troublingly, the use of counterstereotypic exemplars was associated with *decreased* concern about racial discrimination in society (Forscher, Mitamura, et al., 2017). Additional research is needed to determine whether that was an anomalous finding or evidence of a problem with the strategy itself.

Another potential challenge for the prejudice habit-breaking intervention is the assumption that individuals need only to learn about implicit bias and its harmful effects in order to be motivated to change it. But is it safe to assume that *all* clinicians, teachers, and researchers will be motivated by that information? If not, how do we deal with more resolute and explicit demonstrations of prejudice in our field?

Mindfulness-Based Approaches

Mindfulness-based approaches offer another promising direction in prejudice reduction research (Burgess et al., 2017). Mindfulness involves learning metacognitive skills to regulate voluntary attention to a chosen stimulus, leading to present-focused awareness, sustained attention, nonjudgmental acceptance, enhanced emotional regulation, increased compassion, stress reduction, and improved cognitive functioning (MacLean et al., 2010; Rosenberg et al., 2015; Shapiro, Astin, Bishop, & Cordova, 2005; van den Hurk, Janssen, Giommi, Barendregt, & Gielen, 2010). Although the application of mindfulness to the area of prejudice reduction is still in its infancy, there are some indications that it can be effective. However, the significant variability across studies regarding the type and length of the mindfulness-based interventions and study designs has made it difficult to compare results across studies. Lueke and Gibson (2015) found that a 10-minute mindfulness intervention caused a decrease in implicit race bias and age bias due to weaker automatically activated associations as measured by the IAT. Another study found that a 7-minute loving-kindness meditation exercise led to decreased automatic processing, increased controlled processing, and reduced implicit prejudice toward members of specific racial groups (Stell & Farsides, 2016). In a longer study, 6 weeks of loving-kindness meditation was more effective than a discussion-based control group in reducing implicit bias against two populations, Black people and homeless people (Kang, Gray, & Dovidio, 2014). More broadly, a study of experienced meditators from a range of religious traditions showed significantly lower levels of self-reported racial prejudice and higher levels of empathy compared to individuals who did not have a meditation practice (Hunsinger, Livingston, & Isbell, 2014).

Indirectly related to prejudice reduction, a systematic review of 29 studies of mindfulness-based stress reduction (MSBR) found that health care professionals who practiced MBSR reported significant improvement in their ability to identify and accept their own emotions, as well as identify others' emotions (Lamothe, Rondeau, Malboeuf-Hurtubise, Duval, & Sultan, 2016). Health care providers in an MBSR study not included in that review reported an enhanced ability to regulate attention and emotion during clinical encounters, as well as an increased awareness of their thoughts in a nonjudgmental way (Irving et al., 2014), which may facilitate self-awareness and intentional responding regarding automatically activated biases and stereotypes. Related findings have shown mindfulness and loving-kindness meditation to reduce reactivity to stress, increase cognitive and affective dimensions of empathy, improve client- and patient-centered communication, and modulate the activation of prejudiced behaviors (Dobkin, Bernardi, & Bagnis, 2016; Krasner et al., 2009; Lamothe et al., 2016; Regehr, Glancy, Pitts, & LeBlanc, 2014). These studies suggest that mindfulness may promote cognitive, affective, and attitudinal processes conducive to prejudice reduction efforts.

The mindfulness-based psychotherapy modality, acceptance and commitment therapy (ACT), offers strategies for prejudice reduction by targeting behaviors independent of cognitions (S. C. Hayes, 2004). In the ACT model, it is theoretically possible to increase behaviors consistent with one's values (e.g., respect and care for clients and patients) in the presence of contradictory cognitions (e.g., prejudiced attitudes), through the practice of skills such as cognitive defusion, acceptance, and present-moment awareness. ACT's behavioral focus can be seen in the title of a recent literature review of an "intervention for *modulating the impact* of stigma and prejudice" (emphasis added) versus *reducing* prejudice, the focus of most other interventions (Masuda et al., 2012). In a study of substance abuse counselors, a 1-day ACT anti-stigma training was tested against a multicultural competence training and a biologically oriented educational control condition in order to see which was most effective in reducing counselor stigma and burnout (S. C. Hayes et al., 2004). Three months after the interventions, only the ACT training succeeded in reducing the *believability* of statements such as "My client is not going to change no matter what I do" and "If my clients really wanted to get sober, they would." Recipients of the ACT training also reported the lowest postintervention levels of stigmatizing attitudes toward clients, compared to the other two groups (S. C. Hayes et al., 2004). A similar study found that ACT significantly reduced mental health stigma among college students regardless of their preintervention levels of psychological flexibility, whereas an education control condition reduced stigma only for students who were already high in psychological flexibility (Masuda et al., 2007). In a study of prejudice reduction for undergraduate students, ACT concepts were used to teach mindful noticing of prejudicial thoughts and choosing value-consistent behaviors despite the thoughts (Lillis & Hayes, 2007). Compared to a prejudice awareness training control condition, the ACT intervention led to significant changes in students' behavioral intentions, including their interest in seeking contact with students of other races or ethnicities, joining diversity-related organizations, and attending events where they would be the only person of their race present (Lillis & Hayes, 2007). As ACT becomes better known in behavioral health, it is likely to be used more frequently in prejudice reduction interventions.

From "What Works?" to What Is Already Working: Allies, Accomplices, Costrugglers, and Followers

Another approach to identifying effective prejudice reduction strategies is examining the qualities and behaviors of individuals who have already successfully reduced personal prejudice. Literature in this area includes research on "allies," "accomplices," and "co-strugglers," as well as the concept of "followership" (Villalobos, 2015). These terms share an emphasis on action and connection, suggesting that effective prejudice reduction is neither passive nor solitary work. The "White Allies: Current Perspectives" special issue of *The Counseling Psychologist* (Volume 45, Issue 5) provides a helpful starting point for this topic as it relates to race. In the introduction to the issue, Spanierman and Smith (2017) urge White psychologists to work in solidarity with colleagues of color and caution against paternalistic styles of helping. Articles from the special issue include a qualitative study of 12 White researchers working in the area of multicultural psychology, a theoretical article on White professors teaching about race and racism, and a qualitative study of 12 White clinicians working with people of color. Sue's (2017) reaction to the special issue's articles provides a useful contextualization of the findings.

In a qualitative study on allyship, Gross (2015) observed that most research has focused on specific kinds of allies (e.g., men learning antisexist practices) or contexts (e.g., college campuses) and addressed relevant gaps in the literature by exploring ally identity development more generally. Gross (2015) and her team interviewed 28 individuals who had been identified as allies by their peers or colleagues and then analyzed the interviews using constant comparative analysis. She found that "being" an ally and "becoming" an ally are not separate processes; instead, learning and action work together iteratively. Participants in the study learned about systemic oppression and their own privilege, sharpened their knowledge through dialogue with others, and then acted to support members of oppressed groups while challenging members of their own group. Lessons learned from action then translated into deeper conceptual knowledge, recursively, over participants' lifetimes. Although not referenced in the paper, this dynamic interaction is similar to the concept of *praxis*, in which reflection and action are seen to be interrelated components of social transformation (Freire, 1970).

Conclusions Drawn from Reviewed Research

Our review of the literature indicates that, despite the extraordinary amount of research conducted in this area, surprisingly few interventions have been able to demonstrate empirical evidence of prejudice reduction. However, absence of evidence is not evidence of absence, and it is likely that effective interventions are currently in use but are simply not being studied empirically (e.g., semester-long undergraduate and graduate courses, affinity groups). It appears that many interventions that *are* being studied empirically suffer from faulty assumptions. The fact that single-session interventions are so common in this area of research suggests that the field has yet to fully grapple with the deeply rooted, habitual nature of prejudice. Devine and colleagues are among the few researchers who embed this perspective in their intervention by asking study participants to consider lifelong socialization processes that have led to their own bias and also to repetitively practice learned strategies over days or weeks in order to “break” the prejudice habit. Similarly, in Bezrukova et al.’s (2016) review of diversity training, longer trainings were correlated with better outcomes, indicating the importance of time and effort.

A Radical Aside: The “Beyond Prejudice” Argument

Critiquing status quo theories of prejudice and efforts to remediate it, Dixon and colleagues argue that psychology must move “beyond prejudice” to address social inequality (Dixon, Durrheim, & Tredoux, 2005; Dixon, Levine, Reicher, & Durrheim, 2012; Dixon & Levine, 2012). Psychological understandings of prejudice tend to presume a theory of action flowing from the micro level (e.g., an individual whose attitudes need to be changed) to a meso level (e.g., through intervention, people learn to reject harmful stereotypes) to a macro level (e.g., prosocial interpersonal interactions positively influence institutional and intergroup relations, ostensibly decreasing discrimination and creating a more just society). In other words, most psychological research on prejudice is based on the idea that what happens inside our heads directly influences other levels of social reality. In a cheekily titled paper, Dixon and colleagues ask, “Are negative evaluations the problem and is getting us to like one another more the solution?” (Dixon et al., 2012). “Getting us to like one another more” seems like an obvious goal, and anyone who has taught an undergraduate class on race or facilitated a diversity training may rightly balk at the question. But the authors provide a poignant critique of the assumptions embedded within the prejudice reduction model, which, they argue (and our review of the research literature largely corroborates), has done very little to change social relations in the real world. After critiquing prejudice as an intervention target, Dixon and colleagues make a case for *collective action* as a more effective mechanism for social change. Compared to prejudice reduction paradigms, which problematically individualize historical, structural, and political facets of intergroup conflict, collective action acknowledges that members of dominant groups rarely give away power or privilege. Social change requires mass mobilization, a process that typically produces conflict between historically disadvantaged groups and historically advantaged groups (Dixon et al., 2012; Wright & Baray, 2012). The analytic focus therefore shifts away from the member of the dominant group whose attitudes need to change and toward the resistance of target group individuals and their allies demanding social change. Importantly, all units of analysis are relevant. One of the primary psychological questions in collective action is, what motivates individuals to join resistance efforts?

Although it would seem that prejudice reduction and collective action would complement each other, the two models entail psychological processes that appear to work in opposing directions (Dixon et al., 2012; Wright, 2003; Wright & Baray, 2012; Wright & Lubensky, 2013). Historically, prejudice reduction has attempted to attenuate an "us" versus "them" thinking and has worked to engender positive emotions, such as empathy and trust, toward outgroup members. The objective in this model of social change is to reduce intergroup conflict in historically divided societies. But does this model work together with, or work against, a collective action toward social change? In one set of studies, positive contact with White people led to a *decreased* support for social change among people of color (Dixon, Durrheim, & Tredoux, 2007; Dixon, Tropp, Durrheim, & Tredoux, 2010). In collective action, "us" and "them" are useful heuristics that allow members of disadvantaged groups to display in-group loyalty, form coalitions with other groups, and act together in the service of common interests. Collective action sees anger as constructive, rather than destructive, and works to heighten, not diminish, awareness of social conditions. This allows individuals to recognize injustice and strive to change it (Dixon et al., 2012). Although combining collective action and prejudice reduction models may be challenging, in our view, this is the necessary course for behavioral health professionals.

Identifying and Remediating Personal Prejudice: Tools and Strategies for Behavioral Health Professionals

Despite arguments favoring collective action over prejudice reduction, behavioral health professionals have an ethical responsibility to address personal prejudice. We owe it to our clients and patients, students, and research participants. It is a both/and, not an either/or: in addition to engaging collective action for social change, we also have the opportunity to identify and address personal prejudices that negatively impact the individuals we serve.

As the vignettes that open the chapter illustrate, each of us harbor engrained biased associations to different social identity groups. The Implicit Association Test (IAT) can help bring those associations into conscious awareness. We invite readers to take an IAT via the website https://implicit.harvard.edu/implicit/. After you have completed a test of your choosing, we recommend reading through the text of Devine's (2016) prejudice habit-breaking intervention (available online at https://osf.io/gkjxs/) as a way of reflecting on your own biased associations to various target groups. To the degree that it is conceivable that bias is part of your repertoire and that biased behavior may be having a negative impact on your work, even unintentionally, the following pages provide more actionable suggestions.

To readers who are open to the idea that cultural influences have led to your being biased against particular groups (whether you consciously endorse those biases or not), we offer the following recommendations from our own experiences as clinicians, educators, and researchers. First, given the preponderance of single-session interventions that have failed to produce change, we recommend abandoning the idea that addressing personal prejudice will be a quick or painless process. One of the only consistent findings in the prejudice reduction literature is that time and effort tend to produce more reliable change. In this regard, Devine et al.' (2012) framing of prejudice as a "habit" is especially useful. We would not expect a decades-long smoking habit to be broken overnight, nor would we expect someone who grew up speaking one language to be able to learn another in only a few weeks. Addressing the roots of your own prejudices, and learning new, more equitable behaviors, will take time and effort.

Second, we recommend developing at least a cursory knowledge of the histories of the groups whose members you regularly interact with. As there are many sources for this kind of learning, we invite the reader to consider the thought "But I don't know where to start!" as resistance to the challenge of delving in. Even if you don't know where to start, we recommend searching for information that will provide a more contextual understanding of a current patient's, client's, or student's reality. This might involve searching for

"History of ______" in scholarly databases, on websites, or on YouTube; attending a lecture or workshop that you would not normally attend; or following a scholar or activist on Twitter. We encourage mindful, active *listening* and *learning* as the most important aspects of early work in this area. In meetings and classrooms, we recommend noting and checking urges to challenge what is said by members of target groups. Be ready to ask yourself, "What is coming up for me right now? Is my bias being activated?" In line with the mindfulness-based approaches reviewed above, we recommend mindfully noting any reactions or associations that arise without judgment and working to reengage with humility, openness, and curiosity.

At some point in your process, you are likely to experience negative emotion. This is not only normal but is also a potentially powerful part of the process. In accordance with the ACT model, we believe that it is neither desirable nor beneficial to push these feelings away when they arise; however, displaying strong emotions can be disruptive in certain contexts. Although it is important to be able to feel guilt and sadness about one's participation in systems of oppression, it is *not* helpful to expect members of oppressed groups to comfort and soothe us when those feelings arise. A mindfulness practice, along with a supportive community of other multiculturally oriented colleagues, can help you develop the skills necessary to acknowledge, name, explore, and regulate these emotions when they come up.

Using Assessment Tools to Reduce the Effects of Bias

In addition to these intentional efforts to reduce bias and prejudice at the individual level, procedural interventions may help limit the impact that conscious or unconscious biases have on clinical assessment, case conceptualization, and treatment. For example, to counteract biases affecting clinical judgment (e.g., assuming that African American women are less vulnerable to developing eating disorders than White women; Gordon, Brattole, Wingate, & Joiner, 2006), clinicians can implement strategies to improve both the quality of information we obtain from the client or patient (the clinical "data") and the clinical decisions we make based on that information.

In addition to bias against members of outgroups, clinical judgments are often shaped by other cognitive biases, such as pathology bias, confirmatory bias, hindsight bias, misestimation of covariance, decision heuristics, false consensus effect, and overconfidence in clinical judgment (Garb, 1998; Shemberg & Doherty, 1999). To minimize diagnostic errors stemming from such biases, Suhr (2015) recommends viewing the initial interview as an opportunity to develop hypotheses about the symptoms and problems presented by the client or patient and then systematically obtaining data to both confirm and disconfirm various diagnostic possibilities as the alliance develops. Along these lines, clinicians can use standardized diagnostic interviews to ensure that a comprehensive history and assessment of symptoms are conducted for all clients and patients. In medical settings, the use of checklists has been found to reduce errors in complex procedures such as surgery to improve clinical outcomes (van Klei et al., 2012). Similarly, using standardized diagnostic interviews such as the SCID-5, rather than relying on biased diagnostic impressions, prompts clinicians to systematically assess for all diagnostic categories, including those that may not immediately come to mind.

Using multiple methods of assessment, such as administering a standardized self-report measure alongside the clinical interview, also provides an opportunity to confirm or disconfirm initial hypotheses. Given cultural variability in self-disclosure norms, psychiatric stigma, and cultural mistrust, offering clients and patients alternative means of conveying symptoms and concerns improves the likelihood of obtaining a complete and accurate diagnostic picture. However, clinicians should take care to use measures that have been validated (and translated, if necessary) for use with the clients or patients being assessed.

To avoid over- or underpathologizing the patient, we also recommend that clinicians regularly consider how patients' group memberships and social locations may be affecting their key concerns, symptom presentation, and interpersonal style. The Cultural Formulation Interview (CFI) is a useful tool as it systematizes the assessment of cultural background information to obtain a "mini-ethnography" of the client or patient in context (Lewis-Fernández, Aggarwal, Hinton, Hinton, & Kirmayer, 2016). To minimize biased interpretations of the information collected, clinicians also should consider consulting with culturally knowledgeable peers and clinical experts (Kirmayer, Groleaud, Guzder, Blake, & Jarvis, 2003).

Institutional-Level Interventions

Finally, we recommend going beyond individual-level interventions to implement changes at the institutional level. Focusing on prejudice reduction at the individual level tends to center dominant group members' efforts to appear "politically correct" or be "good allies" since the very nature of inequality is to center dominant identities (Nnawulezi, Ryan, & O'Connor, 2016). Although individual efforts to reduce prejudice may involve learning extensively about oppression and demonstrating how aligned one is with those who are oppressed, individuals often struggle to acknowledge the ways that one benefits from and perpetuates privilege and hegemony (Helms, 2017). A model proposed by Villalobos (2015) addresses these problems through the framework of "followership." In this model, which was developed to address racist dynamics that occur in racial justice work, White individuals are encouraged to actively follow the lead of people of color. Principles of White followership include investing time and thought in followership, doing homework (e.g., learning the history of White supremacy and efforts to dismantle it), "showing your cards" (being authentic, humble, and unafraid), connecting (being present and making the time to develop networks), practicing acts of followership (e.g., asking "what do you need?" instead of making assumptions), and being strategic (using racial justice frames for organizing and action). Although this model was developed specifically for racial power dynamics, members of any dominant group would arguably be more effective through the practice of followership (Villalobos, 2015). Furthermore, dominant group members' adoption of a followership stance may allow leadership styles from nondominant cultures to emerge, such as collectivism, authenticity, and "pushing from behind" (Chin, 2013).

Evidence from organizational settings also suggests that greater equity is achieved by increasing awareness of the systems of oppression and the effects of biases within institutions or organizations and of the ways that clients and patients experience discrimination in treatment settings (Block, 2016). Institutional considerations include the ability to see individuals' behaviors as embedded within social relations, for example, recognizing how being evaluated by a White clinician may be experienced differently by a White patient versus a patient of color or the effect of being an LGBT trainee in an organization where members of one's group are underrepresented (Block, 2016). Because people of color experience cognitive depletion and poorer cognitive performance after interacting with White people who act racially color-blind (Holoien & Shelton, 2012), it also is important to consider whether an organization is racially diverse in its leadership, its staff, and the clients or patients it serves (Abramovitz & Blitz, 2015). Similarly, organizations should work to recruit and retain staff that represent other diverse social identities (sexual and gender identity, religion, etc.) to reflect the communities and populations that they serve. Explicit accountability practices, such as goal setting, monitoring, and reporting on diversity, can increase minority representation in leadership roles (Motel, 2016). Additionally, organizations can benefit from identity-based caucuses or affinity groups meeting separately on an ongoing basis in order to become more aware of the processes particular to their groups in the organization (e.g., identifying stereotype threat, implicit biases in hiring, etc.) and then finding ways to integrate this feedback toward accountability for organizational change (Nnawulezi et al., 2016). In light of Dixon and Levine's

(2012) argument above, these recommendations may be considered examples of collective action in the service of institutional change.

Vignettes, Revisited

After Elías left her office, Susan took a deep breath and began to process her thoughts and feelings. She reviewed the interaction with openness and curiosity, practicing non-judgmental awareness of her feelings of embarrassment, shame, and—to her surprise—irritation. Rather than criticizing herself for being irritated, Susan worked to make space for that feeling, along with the others. She thought, "I've been offering sliding scale to patients for decades, and have never been accused of being racist… What just happened?" At that moment, Susan was able to speculate about Elías' unique experience. In the past, he may have had bad experiences with White people, clinicians, people older than him, or other groups she represents. After reviewing the incident to see if there was anything she would want to do differently in the future, Susan decided that her fee discussion language did not need to be overhauled. Instead, she needed to repair the rupture with this patient. She thought of calling Elías that afternoon, but decided to address the issue in person at their next meeting. Elías arrived on time for their scheduled session, and appeared focused and ready to begin. Susan asked, "If it's OK, I'd like to address what happened last week?" Elías froze for a moment, and then nodded. Susan continued, "I'm sorry that my offer of sliding scale came across the way that it did. Would you be able to say a little about how that affected you, or what was coming up for you in that moment?" Elías cautiously described his experience of being offered "favors" by white people in the past, and how patronizing it was. Susan responded non-defensively to this, and thanked Elías for taking the risk to open up. He then shared that he regretted his reaction last week, and had felt embarrassed about it after he left. Susan helped to normalize his reaction, given his previous experiences. After a few more minutes of discussion, both Elías and Susan were ready to work on his insomnia.

Bella quickly composed herself and said, "Julie, wow—this just comes as a surprise! Are you able to say more about what you need? If I'm not the right therapist for you, maybe I can find a good referral for you." Julie considered for a moment, and then said, "I'm sorry Dr. Lin, I know it must seem rude, or at least very abrupt. I've actually already found another therapist I think I will be more comfortable with. No offense. And thank you again!" Bella worked to contain her feelings of disappointment. "If that's your decision, Julie, I can't force you to stay. But I do wonder if you'd be willing to share what made you uncomfortable. I want to learn, and my patients deserve the best possible care I can give them. If you'd rather not, I completely understand." Julie thought for a moment, and then said, "I didn't like the way you always wheeled me in here without asking if I wanted that. And the way you totally rearranged your office for me… I don't know, it just made me feel weird. I appreciate the effort, but it made me uncomfortable. I found it kind of… distracting?" Bella thanked Julie for her honesty, and confirmed again that Julie wished to terminate therapy. In the days following, Bella thought hard about what Julie had said. She found articles online about disability rights, and was surprised to learn that it is considered a violation of personal space to touch an assistive device without permission. When thinking about her upbringing in Taiwan, Bella realized she had never heard of this rule before. This helped her understand why she was so caught off guard by Julie's concerns, and also made her want to learn more about disability rights. Bella brought the incident up with her supervisor, discussed it in her multicultural peer supervision group, and consulted coworkers who had extensive experience working with patients with disabilities. After working through the incident in this way, Bella had a much richer understanding of what had happened, and what she would do differently in the future. She regretted not being able to continue seeing Julie, but felt better knowing that Julie had found a provider with whom she felt com-

fortable and that she, Bella, would be better prepared the next time.

Conclusion

Our initial goal for this chapter was to conduct a straightforward literature review of empirically supported prejudice reduction interventions. What we found was an enormous research literature with little consensus on the nature of its primary construct and an array of interventions so diverse that making solid evidence-based recommendations presented a significant challenge. As a result, our recommendations for reducing personal prejudice draw on available empirical evidence alongside ours and others' practice-based experiences as clinicians, educators, and social justice advocates.

As the vignettes above illustrate, prejudices and biases can affect professional practice in unexpected ways. Even as we proactively deepen our knowledge base, explore our biases in a supportive community, and engage in intentional efforts to dismantle inaccurate associations, it is inevitable that misattunements and missteps will occur. In these moments, as Bella and Susan demonstrate, cultivating an open and compassionate approach to self-reflection may enable us to learn from these moments and take corrective action.

We believe that the question "What does the evidence say?" will be answered more satisfactorily when our field is able to address a few key issues. First, although experts on prejudice argue that antipathy does not adequately capture the essence of prejudice, virtually every review we summarized used an antipathy-based definition of prejudice. The field therefore needs definitions of prejudice, and related interventions, which address "ambivalent" forms of prejudice. Second, the vast majority of research has been conducted on single-session interventions for prejudice reduction, none of which have produced reliable long-term effects. On the other hand, the few interventions that *do* require more motivation and effort on the part of participants show promise. The field should therefore make a concerted move in this direction by developing creative, engaging interventions that acknowledge that reducing prejudice takes significant work. We suspect that Devine and colleagues' habit-breaking intervention is the best documented of those types of interventions but not the only approach that can be effective. Finally, rather than focusing primarily on individual prejudice reduction interventions, which do not address the institutional structures that create and perpetuate societal inequities, more psychological research should be devoted to the study of collective action. This will require scientific gatekeepers to evaluate research proposals through a critical lens and will likely include more emphasis on longitudinal studies and real-world behavioral outcomes. Despite the tangled history of prejudice reduction research, we remain optimistic that scientific questions can be asked, and answers produced, that can lead to more equity and justice in behavioral health and in society at large.

References

Aboud, F. E., Tredoux, C., Tropp, L. R., Brown, C. S., Niens, U., & Noor, N. M. (2012). Interventions to reduce prejudice and enhance inclusion and respect for ethnic differences in early childhood: A systematic review. *Developmental Review, 32*(4), 307–336. https://doi.org/10.1016/j.dr.2012.05.001

Abramovitz, M., & Blitz, L. (2015). Moving toward racial equity: The Undoing Racism Workshop and organizational change. *Race and Social Problems, 7*(2), 97–110. https://doi.org/10.1007/s12552-015-9147-4

Alda Díez, M., García Campayo, J., & Sobradiel, N. (2010). Differences in the diagnosis and treatment of immigrant and local psychiatric inpatients admitted to a general hospital in Spain: A controlled study. *Actas Espanolas De Psiquiatria, 38*(5), 262–269.

Ali, A., Caplan, P. J., & Fagnant, R. (2010). Gender stereotypes in diagnostic criteria. In J. C. Chrisler & D. R. McCreary (Eds.), *Handbook of gender research in psychology* (pp. 91–109). New York, NY: Springer. https://doi.org/10.1007/978-1-4419-1467-5

Allport, G. W. (1954). *The nature of prejudice*. Oxford, UK: Addison-Wesley.

Bartoş, S. E., Berger, I., & Hegarty, P. (2014). Interventions to reduce sexual prejudice: A study-space analysis and meta-analytic review. *The Journal of Sex Research, 51*(4), 363–382. https://doi.org/10.1080/00224499.2013.871625

Berdahl, J. L., & Min, J. (2012). Prescriptive stereotypes and workplace consequences for East Asians in North America. *Cultural Diversity and Ethnic Minority Psychology, 18*(2), 141–152. https://doi.org/10.1037/a0027692

Bezrukova, K., Spell, C. S., Perry, J. L., & Jehn, K. A. (2016). A meta-analytical integration of over 40 years of research on diversity training evaluation. *Psychological Bulletin, 142*(11), 1227–1274. https://doi.org/10.1037/bul0000067

Block, C. J. (2016). The impact of color-blind racial ideology on maintaining racial disparities in organizations. In H. A. Neville, M. E. Gallardo, & D. W. Sue (Eds.), *The myth of racial color blindness: Manifestations, dynamics, and impact* (pp. 243–259). Washington, DC: American Psychological Association. https://doi.org/10.1037/14754-015

Burgess, D. J., Beach, M. C., & Saha, S. (2017). Mindfulness practice: A promising approach to reducing the effects of clinician implicit bias on patients. *Patient Education and Counseling, 100*(2), 372–376. https://doi.org/10.1016/j.pec.2016.09.005

Burgess, D. J., Nelson, D. B., Gravely, A. A., Bair, M. J., Kerns, R. D., Higgins, D. M., … Partin, M. R. (2014). Racial differences in prescription of opioid analgesics for chronic noncancer pain in a national sample of veterans. *Journal of Pain, 15*(4), 447–455. https://doi.org/10.1016/j.jpain.2013.12.010

Burke, S. E., Dovidio, J. F., Perry, S. P., Burgess, D. J., Hardeman, R. R., Phelan, S. M., … van Ryn, M. (2017). Informal training experiences and explicit bias against African Americans among medical students. *Social Psychology Quarterly, 80*(1), 65–84. https://doi.org/10.1177/0190272516668166

Calabrese, S. K., Earnshaw, V. A., Underhill, K., Hansen, N. B., & Dovidio, J. F. (2014). The impact of patient race on clinical decisions related to prescribing HIV pre-exposure prophylaxis (PrEP): Assumptions about sexual risk compensation and implications for access. *AIDS and Behavior; New York, 18*(2), 226–240. http://dx.doi.org.libproxy.newschool.edu/10.1007/s10461-013-0675-x

Carnes, M., Devine, P. G., Manwell, L. B., Byars-Winston, A., Fine, E., Ford, C. E., … Kaatz, A. (2015). Effect of an intervention to break the gender bias habit for faculty at one institution: A cluster randomized, controlled trial. *Academic Medicine, 90*(2), 221–230. https://doi.org/10.1097/ACM.0000000000000552

Cheng, A. W., Iwamoto, D. K., & McMullen, D. (2016). Model minority stereotype and the diagnosis of alcohol use disorders: Implications for practitioners working with Asian Americans. *Journal of Ethnicity in Substance Abuse, 17*(3), 255–272. https://doi.org/10.1080/15332640.2016.1175990

Chin, J. L. (2013). Diversity leadership: Influence of ethnicity, gender, and minority status. *Open Journal of Leadership, 2*(1), 1–10. https://doi.org/10.4236/ojl.2013.21001

Colbert, J. D., Martin, B. J., Haykowsky, M. J., Hauer, T. L., Austford, L. D., Arena, R. A., … Stone, J. A. (2015). Cardiac rehabilitation referral, attendance and mortality in women. *European Journal of Preventive Cardiology, 22*(8), 979–986. https://doi.org/10.1177/2047487314545279

Devine, P. G. (2016). *Outline of new intervention*. Retrieved from https://osf.io/gkjxs/

Devine, P. G., Forscher, P. S., Austin, A. J., & Cox, W. T. L. (2012). Long-term reduction in implicit race bias: A prejudice habit-breaking intervention. *Journal of Experimental Social Psychology, 48*(6), 1267–1278. https://doi.org/10.1016/j.jesp.2012.06.003

Devine, P. G., Forscher, P. S., Cox, W. T. L., Kaatz, A., Sheridan, J., & Carnes, M. (2017). *A gender bias habit-breaking intervention led to increased hiring of female faculty in STEMM departments*. Retrieved from https://psyarxiv.com/tdvy7/

Dixon, J., Durrheim, K., & Tredoux, C. (2005). Beyond the optimal contact strategy: A reality check for the contact hypothesis. *American Psychologist, 60*(7), 697–711. https://doi.org/10.1037/0003-066X.60.7.697

Dixon, J., Durrheim, K., & Tredoux, C. (2007). Intergroup contact and attitudes toward the principle and practice of racial equality. *Psychological Science, 18*(10), 867–872.

Dixon, J., & Levine, M. (2012). *Beyond prejudice: Extending the social psychology of conflict, inequality and social change*. Cambridge, UK: Cambridge University Press. https://doi.org/10.1177/0094306114522415i

Dixon, J., Levine, M., Reicher, S., & Durrheim, K. (2012). Beyond prejudice: Are negative evaluations the problem and is getting us to like one another more the solution? *Behavioral and Brain Sciences, 35*(6), 411–425. https://doi.org/10.1017/S0140525X11002214

Dixon, J., Tropp, L. R., Durrheim, K., & Tredoux, C. (2010). "Let them eat harmony": Prejudice-reduction strategies and attitudes of historically disadvantaged groups. *Current Directions in Psychological Science, 19*(2), 76–80. https://doi.org/10.1177/0963721410363366

Dobkin, P. L., Bernardi, N. F., & Bagnis, C. I. (2016). Enhancing clinicians' well-being and patient-centered care through mindfulness. *Journal of Continuing Education in the Health Professions, 36*(1), 11–16. https://doi.org/10.1097/CEH.0000000000000021

Dovidio, J. F. (2001). On the nature of contemporary prejudice: The third wave. *Journal of Social Issues, 57*(4), 829–849. https://doi.org/10.1111/0022-4537.00244

Dovidio, J. F., & Fiske, S. T. (2012). Under the radar: How unexamined biases in decision-making processes in clinical interactions can contribute to health care disparities. *American Journal of Public Health, 102*(5), 945–952. https://doi.org/10.2105/AJPH.2011.300601

Dovidio, J. F., Hewstone, M., Glick, P., & Esses, V. M. (2010). Prejudice, stereotyping and discrimination: Theoretical and empirical overview. In J. F. Dovidio, M. Hewstone, P. Glick, & V. M. Esses (Eds.), *The SAGE handbook of prejudice, stereotyping and discrimination* (pp. 3–28). London, UK: Sage Publications. https://doi.org/10.4135/9781446200919

Duckitt, J. H. (1992). Psychology and prejudice: A historical analysis and integrative framework. *American Psychologist, 47*(10), 1182–1193. https://doi.org/10.1037/0003-066X.47.10.1182

Emlet, C. A. (2006). "You're awfully old to have this disease": Experiences of stigma and ageism in adults 50 years and older living with HIV/AIDS. *The Gerontologist, 46*(6), 781–790. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/17169933

Fairchild, H. H. (1991). Scientific racism: The cloak of objectivity. *Journal of Social Issues, 47*(3), 101–115. https://doi.org/10.1111/j.1540-4560.1991.tb01825.x

Ferguson, S. H. (1996). Christian violence and the slave narrative. *American Literature, 68*(2), 297–320. Retrieved from http://www.jstor.org/stable/2928299

Fitzgerald, C., & Hurst, S. (2017). Implicit bias in healthcare professionals: A systematic review. *BMC Medical Ethics, 18*(1), 19. https://doi.org/10.1186/s12910-017-0179-8

Forscher, P. S., & Devine, P. G. (2014). Breaking the prejudice habit: Automaticity and control in the context of a long-term goal. In J. W. Sherman, B. Gawronski, & Y. Trope (Eds.), *Dual process theories of the social mind* (pp. 468–482). New York, NY: Guilford Press.

Forscher, P. S., Lai, C. K., Axt, J. R., Ebersole, C. R., Herman, M., Devine, P. G., & Nosek, B.A. (2019). A meta-analysis of procedures to change implicit measures. *Journal of Personality & Social Psychology, 117,* 522–559. https://doi.org/10.1037/pspa0000160

Forscher, P. S., Mitamura, C., Dix, E. L., Cox, W. T. L., & Devine, P. G. (2017). Breaking the prejudice habit: Mechanisms, timecourse, and longevity. *Journal of Experimental Social Psychology, 72*, 133–146.

Freire, P. (1970). *Pedagogy of the oppressed*. New York, NY: Bloomsbury.

Garb, H. N. (1997). Race bias, social class bias, and gender bias in clinical judgment. *Clinical Psychology: Science and Practice, 4*(2), 99–120. https://doi.org/10.1111/j.1468-2850.1997.tb00104.x

Garb, H. N. (1998). Clinical judgment. In *Studying the clinician: Judgment research and psychological assessment* (pp. 173–206). Washington, DC: American Psychological Association. https://doi.org/10.1097/NND.0000000000000054

Glick, P., & Fiske, S. T. (2001). An ambivalent alliance: Hostile and benevolent sexism as complementary justifications for gender inequality. *American Psychologist, 56*(2), 109–118. https://doi.org/10.1037/0003-066X.56.2.109

Gordon, K. H., Brattole, M. M., Wingate, L. R. R., & Joiner, T. E. (2006). The impact of client race on clinician detection of eating disorders. *Behavior Therapy, 37*(4), 319–325. https://doi.org/10.1016/j.beth.2005.12.002

Green, K. M. (2015). *Bound to respect: Antebellum narratives of black imprisonment, servitude, and bondage, 1816–1861*. Tuscaloosa, AL: University of Alabama Press.

Greenwald, A. G., McGhee, D. E., & Schwartz, J. L. (1998). Measuring individual differences in implicit cognition: The implicit association test. *Journal of Personality and Social Psychology, 74*(6), 1464–1480. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/9654756

Gross, A. L. (2015). *Being and becoming an ally: The lived experience of social justice action from privileged spaces* (Unpublished master's thesis). University of Massachusetts Boston.

Hayes, J. A., & Erkis, A. J. (2000). Therapist homophobia, client sexual orientation, and source of client HIV infection as predictors of therapist reactions to clients with HIV. *Journal of Counseling Psychology, 47*(1), 71–78. https://doi.org/10.1037//0022-0167.47.1.71

Hayes, S. C. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. *Behavior Therapy, 35*, 639–665. https://doi.org/10.1016/S0005-7894(04)80013-3

Hayes, S. C., Bissett, R., Roget, N., Padilla, M., Kohlenberg, B. S., Fisher, G., … Niccolls, R. (2004). The impact of acceptance and commitment training and multicultural training on the stigmatizing attitudes and professional burnout of substance abuse counselors. *Behavior Therapy, 35*(4), 821–835. https://doi.org/10.1016/S0005-7894(04)80022-4

Helms, J. E. (2017). The challenge of making whiteness visible: Reactions to four whiteness articles. *The Counseling Psychologist, 45*(5), 717–726. https://doi.org/10.1177/0011000017718943

Herek, G. M., & Garnets, L. D. (2007). Sexual orientation and mental health. *Annual Review of Clinical Psychology, 3*(1), 353–375. https://doi.org/10.1146/annurev.clinpsy.3.022806.091510

Hofmann, W., De Houwer, J., Perugini, M., Baeyens, F., & Crombez, G. (2010). Evaluative conditioning in humans: A meta-analysis. *Psychological Bulletin, 136*(3), 390–421. https://doi.org/10.1037/a0018916

Holoien, D. S., & Shelton, J. N. (2012). You deplete me: The cognitive costs of colorblindness on ethnic minorities. *Journal of Experimental Social Psychology, 48*(2), 562–565. https://doi.org/10.1016/j.jesp.2011.09.010

Hunsinger, M., Livingston, R., & Isbell, L. (2014). Spirituality and intergroup harmony: Meditation and racial prejudice. *Mindfulness, 5*(2), 139–144. https://doi.org/10.1007/s12671-012-0159-5

Institute of Medicine. (2003). Assessing potential sources of racial and ethnic disparities in care: The clinical encounter. In *Unequal treatment: Confronting racial and ethnic disparities in healthcare* (pp. 160–179). Washington, DC: National Academy Press.

Irving, J. A., Park-Saltzman, J., Fitzpatrick, M., Dobkin, P. L., Chen, A., & Hutchinson, T. (2014). Experiences of health care professionals enrolled in mindfulness-based medical practice: A grounded theory model. *Mindfulness, 5*(1), 60–71. https://doi.org/10.1007/s12671-012-0147-9

Johnson, S., & Orrell, M. (1996). Insight, psychosis and ethnicity: A case-note study. *Psychological Medicine, 26*, 1081–1084.

Kang, Y., Gray, J. R., & Dovidio, J. F. (2014). The nondiscriminating heart: Lovingkindness meditation training decreases implicit intergroup bias. *Journal of Experimental Psychology: General, 143*(3), 1306–1313. https://doi.org/10.1037/a0034150

Kirmayer, L., Groleaud, D., Guzder, J., Blake, C., & Jarvis, E. (2003). Cultural consultation: A model of mental health services for multicultural societies. *Canadian Journal of Psychiatry, 48*(3), 145–153. https://doi.org/10.1176/foc.4.1.125

Krasner, M. S., Epstein, R. M., Beckman, H., Suchman, A. L., Chapman, B., Mooney, C. J., & Quill, T. E. (2009). Association of an educational program in mindful communication with burnout, empathy and attitudes among primary care physicians. *JAMA, 302*(12), 1284–1293.

Lai, C. K., Marini, M., Lehr, S. A., Cerruti, C., Shin, J.-E. L., Joy-Gaba, J. A., … Nosek, B. A. (2014). Reducing implicit racial preferences: I. A comparative investigation of 17 interventions. *Journal of Experimental Psychology: General, 143*(4), 1765–1785. https://doi.org/10.1037/a0036260

Lai, C. K., Skinner, A. L., Cooley, E., Murrar, S., Brauer, M., Devos, T., … Nosek, B. A. (2016). Reducing implicit racial preferences: II. Intervention effectiveness across time. *Journal of Experimental Psychology: General, 145*(8), 1001–1016. https://doi.org/10.1037/xge0000179

Lamothe, M., Rondeau, É., Malboeuf-Hurtubise, C., Duval, M., & Sultan, S. (2016). Outcomes of MBSR or MBSR-based interventions in health care providers: A systematic review with a focus on empathy and emotional competencies. *Complementary Therapies in Medicine, 24*, 19–28. https://doi.org/10.1016/j.ctim.2015.11.001

Lewis-Fernández, R., Aggarwal, N. K., Hinton, L., Hinton, D. E., & Kirmayer, L. J. (2016). *DSM-5 handbook on the cultural formulation interview*. Washington, DC: American Psychiatric Association Publishing.

Lillis, J., & Hayes, S. C. (2007). Applying acceptance, mindfulness, and values to the reduction of prejudice: A pilot study. *Behavior Modification, 31*(4), 389–411. https://doi.org/10.1177/0145445506298413

Lueke, A., & Gibson, B. (2015). Mindfulness meditation reduces implicit age and race bias: The role of reduced automaticity of responding. *Social Psychological and Personality Science, 6*(3), 284–291. https://doi.org/10.1177/1948550614559651

MacLean, K. A., Ferrer, E., Aichele, S. R., Bridwell, D. A., Zanesco, A. P., Jacobs, T. L., … Saron, C. D. (2010). Intensive meditation training improves perceptual discrimination and sustained attention. *Psychological Science, 21*(6), 829–839. https://doi.org/10.1177/0956797610371339

Masuda, A., Hayes, S. C., Fletcher, L. B., Seignourel, P. J., Bunting, K., Herbst, S. A., … Lillis, J. (2007). Impact of acceptance and commitment therapy versus education on stigma toward people with psychological disorders. *Behaviour Research and Therapy, 45*(11), 2764–2772. https://doi.org/10.1016/j.brat.2007.05.008

Masuda, A., Hill, M. L., Morgan, J., & Cohen, L. L. (2012). A psychological flexibility-based intervention for modulating the impact of stigma and prejudice: A descriptive review of empirical evidence. *Psychology, Society, & Education, 4*(2), 211–223. https://doi.org/10.25115/psye.v4i2.492

Mizock, L., & Lundquist, C. (2016). Missteps in psychotherapy with transgender clients: Promoting gender sensitivity in counseling and psychological practice. *Psychology of Sexual Orientation and Gender Diversity, 3*(2), 148–155. https://doi.org/10.1037/sgd0000177

Motel, L. (2016). Increasing diversity through goal-setting in corporate social responsibility reporting. *Equality, Diversity and Inclusion: An International Journal, 35*(5/6), 328–349.

Nnawulezi, N., Ryan, A., & O'Connor, R. C. (2016). Reducing prejudice within community-based organizations. *Journal of Community Practice, 24*, 182–204. https://doi.org/10.1080/10705422.2016.1157541

Obasogie, O. K., & Newman, Z. (2016). Black lives matter and respectability politics in local news accounts of officer-involved civilian deaths: An early empirical assessment. *Wisconsin Law Review, 3*, 541–574.

Paluck, E. L., & Green, D. P. (2009). Prejudice reduction: What works? A review and assessment of research and practice. *Annual Review of Psychology, 60*(1), 339–367. https://doi.org/10.1146/annurev.psych.60.110707.163607

Pedersen, A., Walker, I., Paradies, Y., & Guerin, B. (2011). How to cook rice: A review of ingredients for teaching anti-prejudice. *Australian Psychologist, 46*(1), 55–63. https://doi.org/10.1111/j.1742-9544.2010.00015.x

Regehr, C., Glancy, D., Pitts, A., & LeBlanc, V. R. (2014). Interventions to reduce the consequences of stress in physicians: A review and meta-analysis. *The Journal of Nervous and Mental Disease, 202*(5), 353–359. https://doi.org/10.1097/NMD.0000000000000130

Riggs, D. W., & Sion, R. (2017). Gender differences in cisgender psychologists' and trainees' attitudes toward transgender people. *Psychology of Men and Masculinity, 18*(2), 187–190. https://doi.org/10.1037/men0000047

Rosenberg, E. L., Zanesco, A. P., King, B. G., Jacobs, T. L., MacLean, K. A., Shaver, P. R., … Saron, C. D. (2015). Intensive meditation training influences emotional responses to suffering. *Emotion, 15*(6), 775–790. https://doi.org/10.1037/emo0000080

Samelson, F. (1978). From "race psychology" to "studies in prejudice": Some observations on the thematic reversal in social psychology. *Journal of the History of the Behavioral Sciences, 14*(3), 265–278. https://doi.org/10.1002/1520-6696(197807)14:3<265::AID-JHBS2300140313>3.0.CO;2-P

Shapiro, S. L., Astin, J. A., Bishop, S. R., & Cordova, M. (2005). Mindfulness-based stress reduction for health care professionals: Results from a randomized trial. *International Journal of Stress Management, 12*(2), 164–176. https://doi.org/10.1037/1072-5245.12.2.164

Shelton, K., & Delgado-Romero, E. A. (2011). Sexual orientation microaggressions: The experience of lesbian, gay, bisexual, and queer clients in psychotherapy. *Journal of Counseling Psychology, 58*(2), 210–221. https://doi.org/10.1037/a0022251

Shemberg, K. M., & Doherty, M. E. (1999). Is diagnostic judgment influenced by a bias to see pathology? *Journal of Clinical Psychology, 55*(4), 513–518. https://doi.org/10.1002/(SICI)1097-4679(199904)55:4<513::AID-JCLP13>3.0.CO;2-W

Shin, R. Q., Smith, L. C., Welch, J. C., & Ezeofor, I. (2016). Is Allison more likely than Lakisha to receive a callback from counseling professionals? A racism audit study. *The Counseling Psychologist, 44*(8), 1187–1211. https://doi.org/10.1177/0011000016668814

Shyman, E. (2016). The reinforcement of ableism: Normality, the medical model of disability, and humanism in applied behavior analysis and ASD. *Intellectual and Developmental Disabilities, 54*(5), 366–376. https://doi.org/10.1352/1934-9556-54.5.366

Smith, L., Foley, P. F., & Chaney, M. P. (2008). Addressing classism, ableism, and heterosexism in counselor education. *Journal of Counseling and Development, 86*(3), 303–310. https://doi.org/10.1002/j.1556-6678.2008.tb00513.x

Spanierman, L. B., & Smith, L. (2017). Roles and responsibilities of white allies: Implications for research, teaching, and practice. *The Counseling Psychologist, 45*(5), 606–617. https://doi.org/10.1177/0011000017717712

Stell, A. J., & Farsides, T. (2016). Brief loving-kindness meditation reduces racial bias, mediated by positive other-regarding emotions. *Motivation and Emotion, 40*, 140–147. https://doi.org/10.1007/s11031-015-9514-x

Sue, D. W. (2017). The challenges of becoming a white ally. *The Counseling Psychologist, 45*(5), 706–716. https://doi.org/10.1177/0011000017719323

Sue, S. (1999). Science, ethnicity, and bias: Where have we gone wrong? *American Psychologist, 54*(12), 1070–1077. https://doi.org/10.1037/0003-066X.54.12.1070

Suhr, J. A. (2015). *Psychological assessment: A problem-solving approach*. New York, NY: Guilford Press.

Thompson, M. N., Cole, O. D., & Nitzarim, R. S. (2012). Recognizing social class in the psychotherapy relationship: A grounded theory exploration of low-income clients. *Journal of Counseling Psychology, 59*(2), 208–221. https://doi.org/10.1037/a0027534

van den Hurk, P. A. M., Janssen, B. H., Giommi, F., Barendregt, H. P., & Gielen, S. C. (2010). Mindfulness meditation associated with alterations in bottom-up processing: Psychophysiological evidence for reduced reactivity. *International Journal of Psychophysiology, 78*(2), 151–157. https://doi.org/10.1016/j.ijpsycho.2010.07.002

van Klei, W. A., Hoff, R. G., Van Aarnhem, E. E. H. L., Simmermacher, R. K. J., Regli, L. P. E., Kappen, T. H., … Peelen, L. M. (2012). Effects of the introduction of the WHO "Surgical Safety Checklist" on in-hospital mortality: A cohort study. *Annals of Surgery, 255*(1), 44–49. https://doi.org/10.1097/SLA.0b013e31823779ae

Villalobos, J. (2015). Applying white followership in campus organizing: A leadership tool for Latinx students working for racial justice. In A. Lozano (Ed.), *Latina/o college student leadership: Emerging theory, promising practice* (pp. 167–184). Lanham, MD: Lexington Books.

Wright, S. C. (2003). Strategic collective action: Social psychology and social change. In R. Brown & S. L. Gaertner (Eds.), *Blackwell handbook of social psychology: Intergroup processes* (pp. 409–430). Oxford, UK: Blackwell Publishers, Ltd.. https://doi.org/10.1002/9780470693421.ch20

Wright, S. C., & Baray, G. (2012). Models of social change in social psychology: Collective action or prejudice reduction? Conflict or harmony? In J. Dixon & M. Levine (Eds.), *Beyond prejudice: Extending the social psychology of conflict, inequality, and social change* (pp. 225–247). New York, NY: Cambridge University Press.

Wright, S. C., & Lubensky, M. E. (2013). The struggle for social equality: Collective action versus prejudice reduction. In S. Demoulin, J. Leyens, & J. F. Dovidio (Eds.), *Intergroup misunderstandings: Impact of divergent social realities* (pp. 291–310). New York, NY: Psychology Press. https://doi.org/10.4324/9780203848814

Microaggressions, Stereotypes, and Social Stigmatization in the Lived Experiences of Socially Marginalized Patients/Clients: A Social Justice Perspective

Marilyn Y. Byrd and Jasmine T. Austin

Abstract

Mental health practitioners have an ethical and moral responsibility to practice social justice principles in their work with their socially marginalized patients/clients. Using a social justice lens, this chapter will bring awareness of social injustice in the form of microaggressions, stereotypes, and social stigmatization experienced by socially marginalized patients/clients in interactions with their healthcare practitioners. The lack of practitioner cultural competence is discussed as a possible contributor to the unjust treatment that patients/clients experience. A philosophical and moral framework will be used to problematize the biases of practitioners who enact these behaviors in interactions with their clients. Social justice education will be suggested as a curriculum-based or professional development-based means to expose and modify unjust behaviors and attitudes.

Keywords

Microaggression · Stereotypes · Social stigmatization · Social justice

The literature exploring prejudice, bias, and unjust treatment in healthcare shows a growing concern for socio-cultural disparities toward the socially marginalized. Socially marginalized group members are those who are oppressed in society and lack the systemic advantages bestowed on privileged groups (Ratts et al., 2015). Socio-cultural disparities are encountered at organizational (leadership/workforce), structural (processes of care), and clinical (practitioner/patient encounter) levels in settings like healthcare (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2016). Generally, socially marginalized groups can experience a double disadvantage when these disparities are combined with life conditions such as being poor, elderly, mentally ill, illiterate, etc. and all other social conditions that, according to societal standards, are considered less than the norm. This chapter will focus on people with mental illness who are not only challenged by the debilitating physical and mental effects of the illness; group members are often subjected to demeaning and unjust treatment that result from biases and misconceptions about their illness.

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© Springer Nature Switzerland AG 2020
L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_12

Socially marginalized groups are often dependent upon larger structural systems (such as healthcare) that provide a specialized service for overall, fundamental well-being. However, the healthcare system itself is a social determinant that influences the effect of other social determinants (Marmot, Friel, Bell, Houweling, & Taylor, 2008). Rather than arguing against the larger structural system that decides access and the quality of care, this chapter will shift the conversation to the individual level and unveil behaviors and attitudes that socially marginalized patients/clients endure in their encounters with healthcare service practitioners. It is unfortunate, although a reality, that despite their role as providers of care, healthcare practitioners often share the same unjust behaviors and stigmatizing view of their patients/clients that is held by society in general (Hanafiah & Van Bortel, 2015; Shor & Sykes, 2002). Microaggression, stereotypes, and social stigmatization will be discussed as demeaning behaviors experienced by the patient/client, which are perceived as a social injustice enacted by the practitioner.

The lack of practitioner cultural competence is discussed in this chapter as a possible contributor to the unjust treatment that patients/clients experience. A philosophical and moral framework will be used to problematize the biases of "those who deliver these insidious [behaviors] … an unexplored terrain in both scholarly and practitioner communities" (Hopkins, 2010, p. 167). In addition to bringing insight on how social injustice is counter to the mission of a helping profession, this chapter will emphasize how giving voice to the everyday reality of social marginalization can be an empowering mechanism for making meaning and minimizing oppressive encounters (Sheared, 1996).

The purpose of this chapter is therefore contained in the following question: *To what extent do healthcare practitioners enact biased behaviors and attitudes in interactions with patient/clients?* This question, however, raises another concern: *To what extent do healthcare service practitioners demonstrate social justice, moral agency, and social responsibility in their duty of care to socially marginalized patient/clients*? Social justice education will be suggested as a curriculum-based or professional development-based means to expose and modify unjust behaviors and attitudes not normally integrated into traditional educational or training platforms. The term patients/clients will be used in this chapter in reference to individuals who seek service from a healthcare practitioner in relation to their mental health illness. Healthcare practitioners will refer primarily to professionals who provide diagnostic or therapeutic care to a patient/client. In addition to practitioners, researchers, and graduate students, instructional designers who are responsible for developing curricula that adhere to healthcare committee standards would also benefit from this chapter.

Unjust Behaviors: Beyond Discrimination

Historically, socially marginalized populations have experienced social injustice in the form of discrimination and exclusion. Social injustice is the repression of a person's individual and civil rights, which has the capacity to deny equal participation within a society that sets standards for that which is considered to be normal (Byrd, 2014). On one hand, the passing of an antidiscrimination policy and the establishment of federal agencies that enforce antidiscrimination policy have provided some measure of redress for social injustice in workplace discrimination. On the other hand, employment relationship does not necessarily apply in patient/client interactions. Socially marginalized populations are oftentimes subjected to open and unjust behaviors such as disrespectful treatment, display of unkind attitudes, and/or derisive and discourteous interactions (Aneshensel, 2012). Unjust behaviors and attitudes are difficult to define within workplace antidiscrimination case law and legal mandates. Given that unjust behaviors and attitudes are difficult to define within workplace antidiscrimination case law and legal mandates, Hamilton et al. (2014) question the application of the term when applying it to social, behavioral types of issues. Consequently, addressing unjust behaviors and attitudes shifts the focus from discrimination as a denial of equal rights and participation to social injustice (denial of equal and respectful treatment).

Although studies examining the consequences of social injustice in healthcare has increased, the investigation of experiences with microaggressions, stereotypes, and social stigmatization in the lived experiences of socially marginalized mental health patients/clients is practically nonexistent (Walls, Gonzalez, Gladney, & Onello, 2015). Even though the term discrimination highlights a denial of rights, the concept does not immediately invoke images of lived experiences and everyday realities and indignities that are associated with unjust treatment and behaviors. To comprehend more fully how the lived experiences of marginalized groups are impacted by social injustice requires a deeper explanation of the phenomena enacted.

Microaggressions are subtle, often brief, verbal, behavioral, or environmental indignities that send demeaning messages to individuals and groups based on their perceived social identity or group affiliation (Sue, 2010). Though brief, these messages convey behaviors that are disrespectful, humiliating, inhumane, and unjust (Byrd, 2014).

The study by Walls et al. (2015) of chronically ill American Indian adults described the participants' encounters in a healthcare setting where the provider's behavior or words (consciously or unconsciously) conveyed a microaggressive message. A troublesome implication in this study was the cumulative effect of the microaggressive encounter with an existing chronic illness and the potential for a worsening health condition. The researchers concluded that experiences of microaggression in exchanges between healthcare practitioners and their patients/clients undermines the ideals of patient-centered care, which can complicate the expectation of favorable health outcomes. Despite the recent questioning of the conceptual soundness of the term microaggression (see Lilienfeld, 2017), any recurring encounter or experience perceived as derogatory, humiliating, and demeaning from the worldview of social marginalization is perceived as unjust with the intent to harm, regardless of the naming construct.

Stereotypes are considered social constructions of identity that represent collectively agreed upon notions of group affiliation (Corrigan & Watson, 2002). Stereotypes are cognitively biased behaviors that categorize people on the basis of visible characteristics such as race or sex and then attribute those characteristics to all individuals in that category (Snyder, 1981). Furthermore, stereotypes are fixed images associated with social group identity that control cognitive, affective, and behavioral outcomes and can often cause people to form judgments that are unfounded and perceptually skewed (Byrd, 2016). As a result, impressions are quickly generated regarding who belongs to a stereotyped group and how that group conforms to societal expectations. Stereotypes can be deeply engrained in societal perception. Depicting people with mental illness as being dangerous is a common stereotype that can carry over into the practitioner and patient/client interaction and trigger a bias that prevents patient-centered, humanitarian care.

Stereotypes can be either explicitly or implicitly expressed and reinforce the notion of individual difference and defect (Corrigan, 2005; Gaertner & Dovidio, 2005). Explicit stereotypes operate in a conscious mode, whereas implicit stereotypes commonly function in an unconscious and unintentional fashion. Similar to microaggressions, implicit stereotypes are manifested in subtle, indirect, or rationalizable ways that conceal biased behaviors and prejudices.

Healthcare professionals are not immune from biased behaviors, stereotypes, and prejudicial attitudes. FitzGerald and Hurst's (2017) review of relevant literature spanning a 10-year period found that healthcare professionals exhibit the same implicit attitudes and behaviors as the wider population. It is disconcerting, however, that over a period of time, the stereotype becomes engrained in the practitioner's cognition and is the point of reference during encounters with their patient/client and can subconsciously trigger a reaction to the client's social group identity.

A stigma is another social construction of identity that "links a person to an undesirable stereotype, leading other people to reduce the bearer from a whole and usual person to a tainted, discounted one" (Goffman, 1963, p. 11). A stigma involves an individual experience or interaction and encompasses structural, social phenomena such as power relations and historical patterns (Stuber, Meyer, & Link, 2008). Social stigma impacts mental health patients/clients on multiple levels (often simultaneously): structural, intrapersonal, and intrapersonal (Knaak, Mantler, & Szeto, 2017).

Manifesting the social stigma of mental illness is the complexities of other intersecting, marginalized social identities that have the potential to provoke microaggressive behaviors toward the patient/client (Ratts et al., 2015). Jones and McEwen's (2000) conceptual model of multiple dimensions of social identities further highlights the significance of visible, intersecting forms of social identities that can grant privileges as well as oppression. The study suggests that "the relative salience of multiple identities is influenced by those identities that are privileged and by those that are externally scrutinized" (p. 412). As an illustration, Bowleg's (2013) study of gay, Black men explained how socially marginalized identities are additive rather than mutually constitutive. Data from this qualitative study suggested that race played a dominant role in the participants' experiences as both gay and Black. In the U.S., racial prejudice has been predicated on the visibility of race and the pervasive, historical existence of racism, with White being associated with acceptance and the norm and Black being associated with nonacceptance and marginalization. A mentally ill, gay, Black male veteran is therefore likely to encounter higher incidents of microaggressions than a mentally ill, gay, White male veteran, not so much as an outcome of multiple, marginalized social identities, rather as an outcome of the visibility and saliency of race.

It is therefore alarming that there is scarcity of research that has studied intersecting identities, unjust behaviors, and social marginalization of persons with mental illness (Gonzales, Davidoff, Nadal, & Yanos, 2015). Further compounding this lack of research is the combined systemic effects of social marginalization (Ratts et al., 2015). The Implicit Association Test (IAT) (Greenwald, McGhee, & Schwartz, 1998) has been useful in a number of research studies to measure social behaviors that are attributed to marginalization (see Rudman, Greenwald, Mellott, & Schwartz, 1999; Shor & Sykes, 2002). Because social marginalization operates as both structural (organizational level) and social injustice (individual level), further consideration of power and privilege in the practitioner and client encounter is needed.

The Harmful Effects of Microaggressions, Stereotypes, and Social Stigmatization

A healthcare practitioner plays a highly influential role in the relationship with the patient/client. In fact, an alliance exists between the two parties whereby trust in the practitioner is a central feature of the relationship (Granger, 2012; Pearson & Raeke, 2000). Microaggressions that are unconsciously (or consciously for that matter) delivered jeopardizes the strength of that alliance. When a healthcare practitioner engages in demeaning behaviors, "the exchange may undermine the attempted provision of care, and trust may be broken" (Walls et al., 2015, p. 232). As a result, the affective and behavioral nature of the experience could adversely impact the patient's/client's mental condition and minimize successful health outcomes.

Another detrimental effect of demeaning behavior is the inherent power differential whereby authority and prestige favor the practitioner. Both practitioner and patient/client have specific attitudes, beliefs, and expectations about the role that each plays in the relationship, which can lead to social categorization in the interaction (Dovidio et al., 2008). However, social categorization and the unspoken presence of privilege held by the practitioner strengthen power differentials and reinforce marginalization during a microaggressive encounter.

Microaggressive and demeaning behaviors may also contribute to feelings of social rejection and stereotype threat (Burgess, Warren, Phelan, Dovidio, & Van Ryn, 2010; Gonzales et al., 2015). Social rejection results when a person is labeled based on a preconception (e.g., mentally ill people are dangerous), which in turn activates behaviors toward the labeled person (Link, Cullen, Frank, & Wozniak, 1987). In this case, a label of dangerous would likely activate a negative reaction and behavior,which leads the target to feel "less than" and "unworthy." Stereotype threat is a social-psychological predicament that causes one to "buy-in" to stereotypes commonly associated with their social identity group (Steele & Aronson, 1995). This means that a mentally ill person labeled as dangerous is at risk of confirming that characteristic of that socially marginalized group. Exposing, minimizing, and eliminating the harmful effects of unjust behaviors and treatment toward the socially marginalized requires cultural competence.

The Critical Role of Cultural Competence

Culture is not a distinct entity to which a person belongs; rather, it is a community of society to which a person affiliates that structures the way that an individual views the world and makes meaning through interacting with others outside the community (SAMSHA, 2016). Moreover, culture "involves the particular set of beliefs, norms, and values concerning the nature of relationships, the way people live their lives, and the way people organize their environments" (p. 12).

Cultural competence is the proficiency for practitioners to effectively interact with patients/clients who are marginalized and stigmatized according to society's standards and perceptions of the norm. Cultural competence proficiency plays a critical role in a practitioner/patient relationship by bringing awareness of that social group's history, which includes values and beliefs that may not be readily understood. In addition, cultural competence requires practitioners to have the ability to recognize how the history and background of socially assigned stigmas place their clients at a disadvantage. It is encouraging that a significant source of literature exists on cultural competence in the healthcare system as a response to the socio-disparities in care (Betancourt et al., 2016).

Cultural competence is a process that requires changing a mindset of behaviors and attitudes that are biased and discriminatory and developing a sense of cultural acceptance that is reflected in respectful and responsive patient-centered care. Moreover, cultural competence requires cultural awareness and an empathetic approach to the patient's/client's experience. Creating cultural awareness is one facet in positively contributing to fair and unbiased treatment.

However, cultural competence alone is not enough for addressing microaggressions, stereotypes, and social stigma. While cultural competence will help increase knowledge of the history, beliefs, and practices of socially marginalized groups, it does not develop social justice values for empathy, compassion, and a critical consciousness of one's own biases, assumptions, and internalized beliefs (Kumagai & Lypson, 2009). Critical consciousness is "an active, ongoing practice of questioning that is grounded in the construct of social justice and requires reflexivity within the immediate context and critical reflection following an interaction or decision toward creating new pathways for action" (O'Neill, 2015, p. 628). For healthcare practitioners, critical consciousness involves reflecting on the behaviors that can emerge from working with socially marginalized patients/clients and reflecting on the internalized beliefs that are reinforced through power and privilege.

The impact of cultural competence on the experiences of socially marginalized groups has been studied within a range of topics, including quality of care, economic disadvantage, expectation of care, adherence to medications, etc. (Betancourt et al., 2016). A renewed focus on culturally competent, patient-centered care recognizes the deleterious effects of unjust and demeaning behaviors on socially marginalized groups (Walls et al., 2015). It is troubling, though, that the conscious and unconscious biased assumptions and implicit worldviews that the practitioner brings to the interaction is an aspect of cultural competence that has not been adequately captured in this renewed interest. Also missing is philosophical and moral discourse, which is needed to conceptualize how demeaning and unjust behaviors influence the perceptions and responses by healthcare practitioners. Cultural competence involves philosophical and moral worldviews that recognize how respect, sensitivity, and empathy toward a patient/client is required for providing the same quality and care as to the society at large (SAMSHA, 2016).

Developing cultural competence is an evolving, dynamic process that requires time (SAMSHA, 2016) and a purpose-driven goal for social change. To this end, practitioners must demonstrate the willingness to acquire skills to work with patients/clients from varying social contexts to ensure that individuals from all walks of life feel accepted and respected.

Philosophical and Moral Worldviews

Equality, liberty, and fraternity are philosophical and moral worldviews that are foundational to a just society (Jost & Kay, 2010; Malik, 1996). In helping professions like healthcare, these principles are critical, particularly to clients like mental ill patients, who are relegated to the margins of society. In an ordinary day, practitioners may interact with clients who are shabbily dressed, belligerent, and disheveled; lack good hygiene; and appear to be out of sync with reality. Or they may interact with clients who are well-dressed, groomed, articulate, and well-spoken with obvious signs of privilege. Moral responsibility dictates that the practitioner's interaction with both clients will be based on a value system of universal respect and dignity for all people (Dewees & Lax, 2008). Fundamental to this value system is shared power and equal social justice outcomes in practitioner and client interactions and envisioning a state of equilibrium between privilege and marginalization (Byrd, 2018a). Philosophical and moral worldviews therefore provide a platform for understanding how marginalization and privilege are forces that can deny power to some and grant power to others (Byrd, 2018b).

First, a philosophical worldview explains how the everyday, lived experiences of social marginalization affects targeted individuals and groups (Byrd, 2018a). Second, moral worldviews are needed for recognizing human agency and the duty to respond on their behalf. The goal is to gain knowledge from these worldviews that will ignite a moral duty to respond to social injustice.

Three philosophical assumptions converge and interact to inform worldviews about social marginalization and the lived experiences of mentally ill patients/clients: epistemology, ontology, and axiology. From an epistemological perspective (study of being and reality), a philosophical framework contributes to a practitioner's moral duty to be cognizant of the ways that microaggressions contribute to and perpetuate social marginalization (Bisel & Adame, 2017). An ontological perspective (study of knowledge and knowing) provides the practitioner with a lens to view lived experiences (Bisel & Adame, 2017). Sharpening this perspective requires acknowledging the significance of history in the everyday, lived experiences of the patient/client. Axiology (the nature of value and valuation) contributes to recognizing the universality of human rights and enacts a patient-centered responsibility (Bisel & Adame, 2017). Drawing parallels from Kant's (1996) categorical imperative for human rights, a practitioner might reflect on the following questions:

- What can I know (about the everyday, lived experiences of my client)?
- What ought I to do (on behalf of my client to minimize further harm)?
- What may I hope (will create social justice responsibility in myself and others)?

An axiological perspective is critical to self-reflection and encompassing a broader understanding of lived experiences and the end goal of high-quality, culturally safe care (Walls et al., 2015).

Social justice refers to "the process of remedying oppression due to race, ethnicity, interracial conflict, class conflict, gender distinction, religious differences including exploitation, marginalization, and powerlessness. Questions that implicate issues of a power imbalance within society are considered social justice issues" (Edwards & Vance, 2001, p. 63). Consequently, a social justice perspective applied to the lived experiences of people with mental illness is consistent with Kant's (1996) philosophy that all people are fundamentally equal and share the right to humane treatment, dignity, and respect. Respect is a key component in the patient/client and practitioner relationship. McLaughlin (2011) further describes respect as a transformative process of valuing others and realizing the negative impact that unjust treatment can inflict. Transformative respect validates people as having equal positions in a relationship in that all people are human beings first. It is essential then that the practitioner realizes their role in that equation.

Ethics of Care and the Moral Duty to Respond

Healthcare practitioners have an ethical and moral responsibility to demonstrate social justice in their work with their clients (Manis, 2012). Few practitioners will admit inflicting harmful actions against socially marginalized groups, particularly since doing so contradicts their self-image as honorable, moral professionals that provide a humanitarian service (Byrd, 2018b).

Moral agency is a self-regulating, philosophical set of values and beliefs that guides or deters an individual from behaving in an inhumane, unjust, or unethical way, and it espouses the duty to respond to social injustice (Bandura, 1991). Socially marginalized groups are often targets of microaggression, which is a social *in*justice that can be hidden within a larger institutional system. Moral agency is grounded in Rawls' (2001) philosophy of justice that calls to action the moral duty to uphold impartiality, fairness, and justice. A dilemma surrounding patient-centered care is how practitioners enact a moral duty to uphold an ethics of care when the practitioner is the root of the social *in*justice. Rosenberg (2013) pointed out how a golden rule of reciprocity and mutuality is fitting for helping professions and should be deemed an ethical and moral mandate. That point alone makes the mere mention of social injustice in association with a helping profession an alarming idea.

Social justice is most often viewed as economic in nature (Swenson, 1998). However, social justice also applies to situations whereby people experience unjust, disrespectful, and undignified treatment as a consequence of their social identity. Therefore, social justice can be applied in any situation where the outcome intended is to level the playing field for socially marginalized groups—socially as well as economically. Balancing the scale between power and privilege is a matter of ethics (Byrd, 2014). Gilligan (1982) eloquently expresses the ethics of justice and care:

> …the ideals of the human relationship is the vision that self and others will be treated as of equal worth, that despite differences in power, things will be fair: the vision that everyone will be responded to and included, that no one will be left alone or hurt. (p. 210)

In praxis, social justice means that practitioners should recognize how the marginalized individuals they serve deconstruct and make meaning of behaviors that emerge from the everyday, social realities of their clients' lives. Practitioners who advocate social justice principles are actively concerned with the ways in which systemic power controls their client's well-being and acknowledge the saliency of social power (e.g., the powerful vs the powerless) in the practitioner to patient/client relationship. Finally, developing critical consciousness and a willingness to acknowledge personal biases and prejudice in the quest to "know thyself" (Rousseve, 1969) is fundamental to social justice in praxis. Corrigan, Watson, Byrne, and Davis (2005) believe that a social justice perspective

> brings into relief the intersecting identifications and situations of people with mental illness so that the impact of potentially multiple stigmas can be

> explained. People with mental illness face the most egregious injustices are most often those who are also stigmatized because of these additional stigmas. (p. 366)

The first step toward social justice is understanding the experiences of the socially marginalized by giving voice to marginalization and oppression (Byrd, 2014; Craig, Bejan, & Muskat, 2013). Giving voice to those experiencing marginalization helps identify the issues and concerns that directly affect them and positions them as agents of change (Feldman, 1999).

Giving Voice to Lived Experiences of Social Marginalization

The voices of people with mental illness who encounter microaggressions and other unjust behaviors in healthcare environments are silenced within a master narrative. The master narrative is a story line with a plot, characters, a setting, etc. that is told in highly publicized arenas and (accurate or not) has the potential to "fix" the image of socially marginalized people as "unworthy," "less than," and "not deserving" (Solorzano & Yosso, 2002). In general, the master narrative correlates marginalization with poverty, lower class, bad neighborhoods, and lack of education (Solorzano & Yosso, 2002). However, the stories emanating from the perspective of mental health clients who are also marginalized from multiple labels (race, gender, age, poverty, homelessness, sexual minority, etc.) are unique and represent an important but perhaps overlooked addition to the literature (Bjorkman & Malterud, 2009; Ford & Yep, 2003; Johnson et al., 2004; Stevens, 1993). The voices of the socially marginalized are therefore needed to offer counter stories to expose, analyze, and challenge the master narrative (Solorzano & Yosso, 2002).

In all aspects of healthcare, each patient/client has a story to tell. Counter-stories are needed to learn more about the lived experiences of mental health clients. Counter-stories are a form of narrative that gives voice and shifts the master narrative to the socially marginalized. Their perspectives provide a means for understanding the everyday realities and social stigmas related to mental illness. In addition, counter-stories open a space for creating change in large systems, like healthcare, which can overtly and covertly sustain social injustice.

The tendency to exclude the voices of patients/clients was reported by Rogers and Pilgrim (1993) almost 25 years ago. Although qualitative research that utilizes interviews, focus groups, and forms of narrative reporting has been valuable in learning about the lived experiences of people with mental illness and the healthcare professionals who provide their care (Gaston-Johansson, Hill-Briggs, Oguntomilade, Bradley, & Mason, 2007; Grady & Edgar, 2003; Hatzfeld, Cody-Connor, Whitaker, & Gaston-Johansson, 2008), the voices of the socially marginalized are still faint in the healthcare literature (Connor & Wilson, 2006).

Narrative and stories are a form of giving voice and are relevant for developing critical consciousness and empathizing with others' suffering in subtle yet significant ways (Kumagai & Lypson, 2009). Equally significant is critically reflecting on personal biases and assumptions, as well as recognizing personal privileges that contribute to the unjust treatment of another (Boler, 2004; Kiselica, 2004). Giving voice renders the invisible visible and is essential in creating an empathetic relationship between the healthcare practitioner and the patient/client. Empathy is a vicarious and spontaneous sharing of emotion provoked by witnessing another's emotional state and/or hearing about another's condition (Keen, 2006). The concept of narrative empathy describes how imagining, reading, hearing, or viewing narratives of another's situation, experience, and/or condition evokes an emotion of character identification (Keen, 2006). Patients/clients as characters have the ability to garner reciprocal relationships with consumers or healthcare practitioners. The creation of this empathy-driven relationship requires convincing the practitioner of the reality of an event in order to engage them emotionally (Louchart & Aylett, 2004).

Lived experiences lend an intuitive-subjective way of knowing and recognizing demeaning behaviors (Ross, Lypson, & Kumagai, 2012). "Intuitive ways of knowing is an interpretive process of heightened consciousness of the social world through previous encounters and experiences with language, gestures, and behaviors. It also includes a conscious attribution judgment of the communication and behaviors" (p. 533). Socially marginalized people attribute their "knowing" with previous encounters and similar contexts. For example, gestures, verbal and nonverbal (expressive rolling of eyes, appearing not wanting to be bothered, wanting to rush through and be done with the visit, tone of voice, and use of sarcasm (yeah, right)), are recognizable forms of marginalization.

People with lived experiences of mental illness place value in a humanistic approach by professionals, in which they feel valued and respected by the healthcare professionals with whom they come into contact (Connor & Wilson, 2006). Empathy is a key component in responsiveness to others and can therefore become a motivator to develop that relationship from a more genuine and emotion-based perspective (Keen, 2006). Valuing and empathizing with the narratives of the patient's/client's experience can motivate practitioners to guard their personal biases and positively contribute to that experience.

Understanding the human experience extends beyond a practical and specialized skill. For practitioners' work to encompass the lived experiences of their patient/client, they should obligate themselves to use their power and privilege to empower those they serve and value their stories (Richardson, 1990). However, giving voice to the stories of injustice is not sufficient for producing the intended goal of social justice (Kumagai & Lypson, 2009). Rather, it is the deconstructing of voice using a structured, pedagogic approach that is the crucial link to bringing about social justice.

Deconstructing Voice Through Structured Dialogue

Structured dialogue is a "process in which a climate is created that facilitates dialogue between professionals and mental health clients" (Shor & Sykes, 2002, p. 64). Unlike traditional training, structured dialogue moves beyond developing interaction skills; rather, this process aims to change behaviors and attitudes and challenge negative treatment of socially marginalized people by engaging in difficult conversations. Structured dialogue is based on two basic premises. First is the understanding that in the traditional therapeutic context, there is a provider (holder of power) and a recipient of care (typically powerless), which shapes and limits the perceptions of both parties, a perception that is rarely questioned. Second, in order to change these perceptions, a different encounter needs to be created where both parties meet as equals.

Shor and Sykes (2002) used a structured dialogue model as the basis of a research project that brought together people with a mental illness and social work students in a simulated business-type setting. The aim was to create opportunities for students to learn from interactions with persons having a mental illness as an individual, not as a client or patient. The narratives of the participants in that study suggest that structured dialogue would not only enable practitioners to develop a more humanistic insight of their client, but clients would also be "positively affected by being seen and related to in ways that validated their worth" (p. 65). Dialogue models are powerful for disclosing the experiences of vulnerable populations and forcing practitioners to confront their own biases and often unjust perceptions (Scheyett & Kim, 2004; Shor & Sykes, 2002). Listening to their stories and engaging in dialogue encourage practitioners to relate and think about their clients in fresh, new ways (Shor & Sykes, 2002). Structured dialogue creates an opportunity for critical analysis of self in relationship with others with the possibility for systemic and social change (Dessel, Rogge, & Garlington, 2006). While giving voice and structured dialogue provides practitioners a closer insight on the lived realities of marginalization and the influence of power and privilege, contexts that are dedicated to learning social justice principles and expected outcomes are needed.

Social Justice Education: A Liberatory Approach to Unlearning Bias

> Education is the most powerful weapon which you can use to change the world. (Nelson Mandela)

The most comprehensively examined approach for modifying behaviors toward socially marginalized groups is education (Corrigan & Watson, 2002; Stull, McGrew, Salyers, & Ashburn-Nardo, 2013). However, a multidimensional approach is needed for practitioners to perceive worldviews beyond the self and to experience microaggressions, stereotypes, and social stigmatization through the lens of the other (Dewees & Lax, 2008). The practitioner's way of thinking about marginalized groups must be liberated from former biases, attitudes, and unjust behaviors to activate a changed way of thinking and knowing about human experience (Rhodes, 1995). Therefore, a changed and more informed reality about marginalized people is the end goal for liberatory education.

Liberatory education is a postmodern worldview that can be used to construct, deconstruct, and/or reconstruct previous worldviews and in the process free the mind from privileged ways of thinking and create space for new and deeper insights on the human condition (Rhodes, 1995). The liberatory approach to education requires the practitioner to examine self, a process that is necessary for growth and transformation. Moreover, a pedagogical approach is needed to prepare practitioners to enact humanistic values, as well as professional expertise, for holistic, patient-centered care (Dewees & Lax, 2008).

Lipkin, Quill, and Napodano (1984) suggest simulating encounters with marginalized patients/clients as a means of developing practitioners' humanistic sensitivity. Curricula that include developing the ability to elicit, understand, and integrate the social aspect of a client's care with a clinical aspect should be required at the educational level. Practitioners need to recognize the power and privilege they bring to the relationship with their patient/client.

The types of behaviors discussed in this chapter are learned behaviors that require a venue beyond traditional training settings for deeper reflection, deconstruction, and transformed thinking. Training venues focus more on superficial, physiological differences rather than on value systems and philosophical worldviews (see, think, and act) and consequently are not as effective for modifying and deconstructing behaviors (Chavez & Weisinger, 2008). Additionally, training programs using difference as the central platform tend to focus on creating harmony in group interactions rather than self-examination, reflection, and critical consciousness (Byrd & Scott, 2018). Finally, training is more skill based, with the objective of improved performance, rather than concept based, with the objective of deeper understanding for making decisions and taking appropriate action. This suggests that academic programs that integrate social justice principles within a curriculum may be more effective than traditional training for unlearning biases.

Social Justice in Academic Programs

Although social justice coursework in academic programs is not a novel idea (Hatchett, Elster, Wasson, Anderson, & Parsi, 2015), social justice curricula that are designed for self-reflection and critical consciousness toward explicit behaviors in the patient/client relationship are needed to enable practitioners to deliver socially responsible, compassionate, and patient-centered care (Schieff & Rieth, 2012). The goal is for practitioners to become more culturally competent for enacting social justice principles in their profession.

Practitioners are educated in the specialized skill they deliver to patients/clients and are likely to adopt the argument that their major concern should be diagnostic and therapeutic outcomes. While this is true, by the same token, evidence-based research on social behaviors strongly suggests that cultural competence, critical consciousness, moral agency, and other social learning are fundamental to their education.

Earlier in this chapter, a philosophical framework based on Kant's (1996) categorical imperative was presented. The three questions posed in the framework (know, do, hope) cannot be accomplished without a critical analysis of self and perceptions of marginalized groups. This chapter has been purposefully written for healthcare practitioners with the overarching question of practicing moral responsibility and social justice in caring for mentally ill clients who are representative of a socially marginalized group. A moral duty to care extends beyond systems that create and sustain oppression; rather, it is the people who make up the systems, produce unjust behaviors, and contribute to microaggressive experiences. Less understood are the elusive yet damaging effects of microaggressive experiences. Therefore, social justice education should be centered around building awareness of microaggressive experiences with the goals of 1) building empathy toward marginalized clients, and 2) motivating health professionals to intervene and enhance the client's experience.

An exemplary model for liberatory social justice education is the Social Justice Critical Reflection Model (SJCRM) (Ingram & Walters, 2007). The basic premise of the SJCRM is to activate intellectual processes for cultivating a more culturally informed understanding of the meaning of difference and a goal for social justice outcomes. The model integrates concepts of descriptive thinking, dialogic thinking, critical reflection, critical consciousness, and praxis.

First, descriptive thinking employs the use of reading materials and then reiterating what was read. For example, *A Mind That Found Itself* by Clifford Beers tells the compelling story of a young man with a mental illness, who suffered abuse during hospitalization and during encounters with healthcare professionals. While Beers' story includes structural as well as individual accounts of mistreatment, recanting his story is a powerful example of descriptive thinking. Second, descriptive thinking ignites dialogic thinking. Dialogic thinking occurs when an individual engages in discourse with another (e.g., structured dialogue) in an attempt to deconstruct what was read. Third, critical reflection encourages an individual to reexamine personal encounters or events that were similar or had similar outcomes to what was read. Fourth, cultural consciousness describes how a realization of personal beliefs begins to evolve and how this belief system has been enacted in everyday practices. Finally, praxis places into action what has been gathered and reflected upon. The ultimate goal and expected outcome is a greater sense of self and a more informed sense of how individuality fuels and sustains the larger system of socio-disparities.

Professional development venues (e.g., conferences, workshops) are another resource for learning and play a pivotal role for learning beyond educational settings. Practitioners who are actively involved in professional associations are uniquely positioned to advance moral agency and social responsibility in a community of practice that is dedicated to the mission of the helping (and healing) profession (Pellegrino, 1978). Integrating professional development with social justice education principles and purposefully seeking to desilence sensitive topics could make a significant impact toward addressing and correcting embedded biased behaviors.

Conclusion

The purpose of this chapter was twofold. First, returning to the question *do practitioners enact biased behaviors and attitudes in interactions with patient/clients,* professional ethics would lead to believe that there is a separation of personal bias and professionalism. However, as studies show, practitioners are human beings first and professionals second. This means that practitioners take their personal biases and perceptions into their professional encounters with people who are marginalized by societal standards.

The question *do healthcare service practitioners demonstrate social justice and social responsibility in their duty of care to socially marginalized patient/clients* lacks the acknowledgement of cultural competency to enact these attributes. Realistically, the question should be *where* do healthcare service practitioners learn these attributes? The logical answer is in educational curricula that allow opportunities for future practitioners to engage in service learning and actually experience working with socially disadvantaged patient/clients to gain a perspective of the "other." Studies show that structured learning approaches that promote critical reflection and deep self-examination are fundamental for modifying and unlearning detrimental behaviors.

Microaggressions, stereotypes, and social stigmatization are possible in any intercultural exchange and are liable to be enacted by all of us, including the most caring, sensitive healthcare practitioner (Walls et al., 2015). While education is fundamental for transforming ways of thinking and acting, the most effective way to address the enduring impact of these behaviors is for the practitioner to have the courage, integrity, and foresight to face the hidden biases that are embedded within the self.

References

Aneshensel, C. S. (2012). *Theory-based data analysis for the social sciences*. Thousand Oaks, CA: Sage Publications.

Bandura, A. (1991). Social cognitive theory of self-regulation. *Organizational Behavior and Human Decision Processes, 50*(2), 248–287.

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O. (2016). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports, 118*(4), 293–302. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497553/pdf/12815076.pdf

Bisel, R. S., & Adame, E. A. (2017). Post-positivist/functionalist approaches. In C. R. Scott & L. Lewis (Eds.), *The international encyclopedia of organizational communication* (pp. 1–22). Hoboken, NJ: John Wiley & Sons. https://doi.org/10.1002/9781118955567

Bjorkman, M., & Malterud, K. (2009). Lesbian women's experiences with health care: A qualitative study. *Scandinavian Journal of Primary Health Care, 27*(4), 238–243.

Boler, M. (2004). *Feeling power: Emotions and education*. New York, NY: Routledge.

Bowleg, L. (2013). Once you've blended the cake, you can't take the parts back to the main ingredients: Black gay and bisexual men's descriptions and experiences of intersectionality. *Sex Roles, 68*(11–12), 754. https://doi.org/10.1007/s11199-012-0152-4

Burgess, D. J., Warren, J., Phelan, S., Dovidio, J., & Van Ryn, M. (2010). Stereotype threat and health disparities: What medical educators and future physicians need to know. *Journal of General Internal Medicine, 25*(2), 169–177.

Byrd, M. Y. (2014). Diversity Issues. *Advances in Developing Human Resources 16*(4):515–528.

Byrd, M. Y. (2016). Selective incivility: A micro aggression targeting racial and ethnic groups in the workplace. In M. F. Karsten (Ed.), *Gender, race, and ethnicity in the workplace: Emerging issues and enduring challenges* (pp. 123–149). Santa Barbara, CA: Praeger.

Byrd, M. Y. (2018a). Re-conceptualizing and re-visioning diversity in the workforce: Toward a social justice paradigm. In M. Y. Byrd & C. L. Scott (Eds.), *Diversity in the workforce: Current issues and emerging trends* (pp. 334–346). New York, NY: Routledge.

Byrd, M. Y. (2018b). Does HRD have a moral duty to respond to matters of social injustice? *Human Resource Development International, 21*(1), 3–11.

Byrd, M. Y., & Scott, C. L. (Eds.). (2018). *Diversity in the workforce: Current issues and emerging trends* (2nd ed.). New York, NY: Routledge.

Chavez, C. I., & Weisinger, J. Y. (2008). Beyond diversity training: A social infusion for cultural inclusion. *Human Resource Management, 47*(2), 331–350.

Connor, S. L., & Wilson, R. (2006). It's important they learn from us for mental health to progress. *Journal of Mental Health, 15*(4), 461–474.

Corrigan, P. W. (2005). *On the stigma of mental illness: Practical strategies for research and social change*. Washington, DC: American Psychological Association.

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry, 1*(1), 16–20.

Corrigan, P. W., Watson, A. C., Byrne, P., & Davis, K. E. (2005). Mental illness stigma: Problem of public health or social justice? *Social Work, 50*(4), 363–368.

Craig, S. L., Bejan, R., & Muskat, B. (2013). Making the invisible visible: Are health social workers addressing the social determinants of health? *Social Work in Health Care, 52*(4), 311–331.

Dessel, A., Rogge, M. E., & Garlington, S. B. (2006). Using intergroup dialogue to promote social justice and change. *Social Work, 51*(4), 303–315.

Dewees, M., & Lax, L. K. (2008). A critical approach to pedagogy in mental health. *Social Work in Mental Health, 7*(1–3), 82. https://doi.org/10.1080/15332980802072421

Dovidio, J. F., Penner, L. A., Albrecht, T. L., Norton, W. E., Gaertner, S. L., & Shelton, J. N. (2008).

Disparities and distrust: The implications of psychological processes for understanding racial disparities in health and health care. *Social Science & Medicine, 67*(3), 478–486.

Edwards, P., & Vance, S. (2001). Teaching social justice through legal writing. *The Journal of the Legal Writing Institute, 7*, 63–86.

Feldman, S. (1999). Please don't call me "dear": Older women's narratives of health care. *Nursing Inquiry, 6*, 269–276. https://doi.org/10.1046/j.1440-1800.1999.00041.x

FitzGerald, C., & Hurst, S. (2017). Implicit bias in healthcare professionals: A systematic review. *BMC Medical Ethics, 18*(1), 19.

Ford, L. A., & Yep, G. A. (2003). Working along the margins: Developing community-based strategies for communicating about health with marginalized groups. In T. L. Thompson, A. Dorsey, R. Parrott, & K. Miller (Eds.), *Handbook of health communication* (pp. 241–261). New York, NY: Routledge.

Gaertner, S. L., & Dovidio, J. F. (2005). Understanding and addressing contemporary racism: From aversive racism to the common ingroup identity model. *Journal of Social Issues, 61*(3), 615–639.

Gaston-Johansson, F., Hill-Briggs, F., Oguntomilade, L., Bradley, V., & Mason, P. (2007). Patient perspectives on disparities in healthcare from African-American, Asian, Hispanic, and native American samples including a secondary analysis of the Institute of Medicine focus group data. *Journal of Black Nurses Association, 18*(2), 43–52.

Gilligan, C. (1982). New maps of development: New visions of maturity. *The American Journal of Orthopsychiatry, 52*(2), 199–212. https://doi.org/10.1111/j.1939-0025.1982.tb02682.x

Goffman, E. (1963). *Stigma*. Englewood Cliffs, NJ: Spectrum.

Gonzales, L., Davidoff, K. C., Nadal, K. L., & Yanos, P. T. (2015). Micro-aggressions experienced by persons with mental illnesses: An exploratory study. *Psychiatric Rehabilitation Journal, 38*(3), 234.

Grady, M., & Edgar, T. (2003). Racial disparities in healthcare: Highlights from focus group findings. In B. D. Smedley, A. Y. Stith, & A. R. Nelson (Eds.), *Unequal treatment: Confronting racial and ethnic disparities in healthcare* (pp. 392–405). Washington, DC: The National Academies Press.

Granger, N. (2012). Micro-aggressions and their effects on the therapeutic process. *Society for Humanistic Psychology*. Retrieved from: http://www.apadivisions.org/division-32/publications/newsletters/humanistic/2012/10/microaggressions.aspx

Greenwald, A. G., McGhee, D. E., & Schwartz, J. L. (1998). Measuring individual differences in implicit cognition: The implicit association test. *Journal of Personality and Social Psychology, 74*(6), 1464.

Hamilton, S., Lewis-Holmes, E., Pinfold, V., Henderson, C., Rose, D., & Thornicroft, G. (2014). Discrimination against people with a mental health diagnosis: Qualitative analysis of reported experiences. *Journal of Mental Health, 23*(2), 88–93.

Hanafiah, A., & Van Bortel, T. (2015). A qualitative exploration of the perspectives of mental health professionals on stigma and discrimination of mental illness in Malaysia. *International Journal of Mental Health Systems, 9*(1), 10–22.

Hatchett, L., Elster, N., Wasson, K., Anderson, L., & Parsi, K. (2015). Integrating social justice for health professional education: Self-reflection, advocacy, and collaborative learning. *Online Journal of Health Ethics, 11*(1). https://doi.org/10.18785/ojhe.1101.04

Hatzfeld, J. J., Cody-Connor, C., Whitaker, V. B., & Gaston-Johansson, F. (2008). African-American perceptions of health disparities: A qualitative analysis. *Journal of National Black Nurses' Association: JNBNA, 19*(1), 34–41.

Hopkins, P. (2010). Practitioner know thyself! Reflections on the importance of self-work for diversity and social justice practitioners. *Tamara: Journal of Critical Organization Inquiry, 8*(4), 157–171.

Ingram, I. L., & Walters, T. S. (2007). A critical reflection model to teach diversity and social justice. *Journal of Praxis in Multicultural Education, 2*(1), 23–41.

Johnson, J. L., Bottorff, J. L., Browne, A. J., Grewal, S., Hilton, B. A., & Clarke, H. (2004). Othering and being othered in the context of health care services. *Health Communication, 16*(2), 255–271.

Jones, S. R., & McEwen, M. K. (2000). A conceptual model of multiple dimensions of identity. *Journal of College Student Development, 41*(4), 405–414.

Jost, J., & Kay, A. C. (2010). Social justice: History, theory, and research. In S. T. Fiske, D. Gilbert, & G. Lindzey (Eds.), *Handbook of social psychology* (Vol. 2, 5th ed., pp. 1122–1165). Hoboken, NJ: Wiley.

Kant, I. (1996). *Kant: The metaphysics of morals*. Cambridge: United Kingdom, Cambridge University Press.

Keen, S. (2006). A theory of narrative empathy. *Narrative, 14*(3), 207–236.

Kiselica, M. S. (2004). When duty calls: The implications of social justice work for policy, education, and practice in the mental health professions. *The Counseling Psychologist, 32*(6), 838–854.

Knaak, S., Mantler, E., & Szeto, A. (2017). Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. *Healthcare Management Forum, 30*(2), 111–116.

Kumagai, A. K., & Lypson, M. (2009). Beyond cultural competence: Critical consciousness, social justice, and multicultural education. *Academic Medicine, 84*(6), 782–787.

Lilienfeld, S. O. (2017). Micro-aggressions: Strong claims, inadequate evidence. *Perspectives on Psychological Science, 12*(1), 138–169.

Link, B. G., Cullen, F. T., Frank, J., & Wozniak, J. F. (1987). The social rejection of former mental patients: Understanding why labels matter. *American Journal of Sociology, 92*(6), 1461–1500.

Lipkin, M., Quill, T. E., & Napodano, R. J. (1984). The medical interview: A core curriculum for residencies in internal medicine. *Annals of Internal Medicine, 100*(2), 277–284.

Louchart, S., & Aylett, R. (2004). Narrative theory and emergent interactive narrative. *International Journal of Continuing Engineering Education and Life Long Learning, 14*(6), 506–518.

Malik, K. (1996). *The meaning of race: Race, history and culture in western society*. New York, NY: Macmillan.

Manis, A. A. (2012). A review of the literature on promoting cultural competence and social justice agency among students and counselor trainees: Piecing the evidence together to advance pedagogy and research. *Professional Counselor, 2*(1), 48–57.

Marmot, M., Friel, S., Bell, R., Houweling, T. A. J., & Taylor, S. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. *Lancet, 372*, 1661–1669.

McLaughlin, A. (2011). Exploring social justice for clinical social work practice. *Smith College Studies in Social Work, 81*(2–3), 234–251.

O'Neill, M. (2015). Applying critical consciousness and evidence-based practice decision-making: A framework for clinical social work practice. *Journal of Social Work Education, 51*(4), 624–637.

Pearson, S. D., & Raeke, L. H. (2000). Patients' trust in physicians: Many theories, few measures, and little data. *Journal of General Internal Medicine, 15*(7), 509–513.

Pellegrino, E. (1978). Ethics and the moral center of the medical enterprise. *Bulletin of the New York Academy of Medicine, 54*, 625–640.

Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., McCullough, J. R., & Hipolito-Delgado, C. (2015). *Multicultural and social justice counseling competencies*. Alexandria, VA: AMCD.

Rawls, J. (2001). *Justice as fairness: A restatement*. Cambridge, MA:Harvard University Press.

Rhodes, W. C. (1995). Liberatory pedagogy and special education. *Journal of Learning Disabilities, 28*(8), 458–467.

Richardson, L. (1990). Narrative and sociology. *Journal of Contemporary Ethnography, 19*, 116–135.

Rogers, A., & Pilgrim, D. (1993). Service users' views of psychiatric treatments. *Sociology of Health & Illness, 15*(5), 612–631.

Rosenberg, R. A. (2013). *The human magnet syndrome: Why we love people who hurt us*. Eau Claire, WI: PESI Publishing & Media.

Ross, P. T., Lypson, M. L., & Kumagai, A. K. (2012). Using illness narratives to explore African American perspectives of racial discrimination in health care. *Journal of Black Studies, 43*(5), 520–544.

Rousseve, R. J. (1969). Counselor, know thyself!: In quest of a viable model of the human condition as a prerequisite for professional effectiveness. *The Personnel and Guidance Journal, 47*, 628–633. https://doi.org/10.1002/j.2164-4918.1969.tb02965.x

Rudman, L. A., Greenwald, A. G., Mellott, D. S., & Schwartz, J. L. (1999). Measuring the automatic components of prejudice: Flexibility and generality of the Implicit Association Test. *Social Cognition, 17*(4), 437–465.

SAMSHA. (2016). *Improving cultural competence. HHS publication no. (SMA) 16-4932. Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment*. Rockville, MD: Department of Health and Human Services. Retrieved from: https://store.samhsa.gov/shin/content//SMA16-4932/SMA16-4932.pdf

Scheyett, A., & Kim, M. (2004). Can we talk? Using facilitated dialogue to positively change student attitudes towards persons with mental illness. *Journal of Teaching in Social Work, 24*(1–2), 39–54.

Schieff, T., & Rieth, K. (2012). Projects in medical education: Social justice in medicine a rationale for an elective program as part of the medical education curriculum at John A. Burns School of Medicine. *Hawai'i Journal of Medicine & Public Health, 71*(4 Suppl 1), 64.

Sheared, V. (1996). Giving voice in an adult education context. *College of Education Review* (San Francisco State University)*, 8*, 97–103.

Shor, R., & Sykes, I. J. (2002). Introducing structured dialogue with people with mental illness into the training of social work students. *Psychiatric Rehabilitation Journal, 26*(1), 63–69.

Snyder, M. (1981). On the self-perpetuating nature of social stereotypes. In D. L. Hamilton (Ed.), *Cognitive processes in stereotyping and intergroup behavior* (pp. 183–212). Hillsdale, NJ: Erlbaum.

Solorzano, D. G., & Yosso, T. J. (2002). Critical race methodology: Counter-storytelling as an analytical framework for education research. *Qualitative Inquiry, 8*(1), 23–44.

Steele, C. M., & Aronson, J. (1995). Stereotype threat and the intellectual test performance of African Americans. *Journal of Personality and Social Psychology, 69*(5), 797–811.

Stevens, P. E. (1993). Marginalized women's access to health care: A feminist narrative analysis. *Advances in Nursing Science, 16*(2), 39–56.

Stuber, J., Meyer, I., & Link, B. (2008). Stigma, prejudice, discrimination and health. *Social Science & Medicine (1982), 67*(3), 351–357. https://doi.org/10.1016/j.socscimed.2008.03.023

Stull, L. G., McGrew, J. H., Salyers, M. P., & Ashburn-Nardo, L. (2013). Implicit and explicit stigma of mental illness: Attitudes in an evidence-based practice. *The Journal of Nervous and Mental Disease, 201*(12), 1072–1079.

Sue, D. W. (2010). *Micro-aggressions in everyday life: Race, gender, and sexual orientation*. Hoboken, NJ: John Wiley & Sons.

Swenson, C. R. (1998). Clinical social work's contribution to a social justice perspective. *Social Work, 43*(6), 527–537.

Walls, M. L., Gonzalez, J., Gladney, T., & Onello, E. (2015). Unconscious biases: Racial micro-aggressions in American Indian health care. *The Journal of the American Board of Family Medicine, 28*(2), 231–239.

Bias in the Diagnostic and Statistical Manual 5 and Psychopathology

Akihiko Masuda, Joanne Qinaʻau, Michael Juberg, and Timothy Martin

Abstract

This chapter discusses bias in diagnostic decision making within the Diagnostic Statistical Manual of Mental Disorders (DSM) and its use. More specifically, we address three aspects of DSM and psychiatric diagnosis that make clinicians and researchers vulnerable to making a biased diagnostic decision. These are (a) value-laden, and yet vague, concepts of mental disorder, upon which the entire DSM nosology is based; (b) criterion biases, biases within diagnostic criteria for specific disorders themselves; and (c) clinician bias, bias unfolding in a clinician–client interaction. We then argue that great attention should be paid to the intersection of psychiatric diagnosis and diversity, where the mismatch of a client's social contingencies with a clinician's social contingencies are likely to unfold. Finally, we recommend further clarification and examination of bias in psychiatric diagnosis in order to best understand it and how diagnostic decision making may be linked to clinical competency so that we may position ourselves to better serve the clients who seek our help.

Keywords

Biases in psychiatric diagnosis · DSM · Criterion bias · Clinician bias · Psychiatric diagnosis

In the field of behavioral health, the meaning of bias is twofold. First, a bias involves preconception. It is one's unwarranted judgment, views, and reaction to a given individual on the basis of perceived membership in a particular social category(ies) while ignoring other category memberships and other personal attributes of that individual (Fiske, 2002; Snowden, 2003). Second, bias involves favoritism or unfairness. Bias in this way is viewed as a preconceived opinion or attitudes in favor of or against one person or group relative to another, usually in a way considered to be inequitable (Lewis-Fernández et al., 2010). Furthermore, biases, which can be held knowingly or unknowingly, are also theorized to regulate a particular action or inaction accordingly (Merino, Adams, & Hall, 2018). From a functional analytic perspective (Roche & Barnes-Holmes, 2003; Roche, Barnes-Holmes, Barnes-Holmes, & Hayes, 2001), bias can be understood functionally as a verbal antecedent or more broadly as its functional relation with

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© Springer Nature Switzerland AG 2020
L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_13

subsequent behavior and consequences. Furthermore, whether a given judgment, belief, attitude, or reaction is unjustifiable is not determined by the private event itself: instead, it is judged socially and contextually.

The behavior of clinicians in the field of behavioral health is also subject to bias. This claim is somewhat antithetical to common views of clinician behavior as bias free and context independent (Insel et al., 2010; Poland & Caplan, 2004; Wakefield, 2007). However, as discussed extensively below, clinicians' activities, such as diagnostic decision making, conducting a psychological assessment, and working with a client in therapy, are *social behaviors* (i.e., verbal and rule-governed behaviors) that operate under particular sets of social contingencies (FitzGerald & Hurst, 2017; Hayes, Niccolls, Masuda, & Rye, 2002; Merino et al., 2018; Skinner, 1974). As such, their behaviors are also prone to bias, and studies have shown the bias-prone nature of clinician behavior.

For example, in their seminal study, Langer and Abelson (1974) demonstrated the effect of labels (i.e., "patient") on clinicians' judgments. The study compared clinicians representing two different schools of thought, behavioral and psychoanalytic, in their responses to the same video of a male interviewee. Half of each group was told that he was a "job applicant," and the other half was told that he was a "patient." Following the end of the videotape, all clinicians were asked to complete a questionnaire evaluating the interviewee. The interviewee was described as fairly well adjusted by the behavioral therapists, regardless of the label supplied. For the psychoanalytic therapists, however, when the interviewee was labeled as "patient," he was described as significantly more disturbed than when he was labeled as "job applicant." This study supports the notion that clinician behaviors are prone to bias based upon a series of preconceptions that they inadvertently draw upon and that the extent of bias may be moderated by clinician factors (e.g., the nature of behavioral health training). It has been 40 years since Langer and Abelson's groundbreaking study, and while researchers have detailed an array of bias-related errors in clinical judgment, behavioral health professionals know relatively little about how to counterbalance the negative impact of clinician bias and bias found in psychiatric diagnosis tools (Lilienfeld & Lynn, 2015).

Present Chapter

The present chapter will address bias in psychiatric diagnosis by focusing on the Diagnostic Statistical Manual of Mental Disorders-5 (DSM-5) (American Psychiatric Association, 2013). More specially, we argue that biases are unavoidable in psychiatric diagnosis because the very behavior of diagnostic decision making is a stream of verbal and rule-governed behaviors (Hayes, Barnes-Holmes, & Roche, 2001; Skinner, 1974) that are shaped and maintained within value-laden and context-dependent social contingencies (Frances, 2013c; Lacasse, 2014; Poland & Caplan, 2004). We then argue that great attention should be paid to the intersection of psychiatric diagnosis and diversity, where the mismatch of a client's social contingencies with a clinician's social contingencies are likely to unfold (Delphin-Rittmon et al., 2015; Hunsley & Mash, 2007; Jani, Johnson, Banu, & Shah, 2016; Snowden, 2003). Broadly, we propose that understanding what DSM nosology measures and what it does not (Frances, 2013b; Lacasse, 2014), being aware of the inevitability of bias in psychiatric diagnosis, and using the DSM nosological system accordingly are important steps for promoting clinical competency in psychiatric diagnosis (Haynes & O'Brien, 2000; Haynes, Smith, & Hunsley, 2011; Poland & Caplan, 2004). Finally, we end the chapter with six actionable evidence-based recommendations to address bias in the DSM-5 and psychopathology: reposition the DSM-5 as a descriptive heuristic tool; increase the professional and public awareness of value-laden and biased nature of psychiatric diagnosis; take DSM diagnostic nosology lightly; promote cognitive flexibility, perspective taking, and empathy; clarify the goals of diagnostic assessment and potential biases in the diagnostic process; and create a safe and nonthreatening learning context.

Psychiatric Diagnosis

Psychiatric diagnosis has been a dominant topic of debate in the field of behavioral health for years. This is because psychiatric diagnosis often serves as the basis of other major clinical activities, such as case formulation, assessment, and therapy. As such, in some contexts, psychiatric diagnosis is viewed as an overarching activity of a clinician that permeates into a range of clinical activities. For example, Alarcón (2009) refers to psychiatric diagnosis as follows:

> Understood as the processing of complex information regarding symptoms, behaviors, emotional correlates and eventual neurobiological substrates by means of history-taking and actual observation of psychopathological events, psychiatric diagnosis aims at reaching a comprehensive perspective of the patient's experience, so that the most appropriate treatment can be offered, and result in clinical improvement, more efficient personal functioning, and a more comfortable quality of life of the patient and his/her family (p 131).

In other contexts, the term *psychiatric diagnosis* refers more narrowly to either the assignment of a particular diagnostic label (e.g., "Alcohol Use Disorder") to a set of symptoms or implicitly to an individual who experiences these symptoms. In the literature of biases in psychiatric diagnosis (e.g., Benson, Donnellan, & Morey, 2017; Delphin-Rittmon et al., 2015; Merino et al., 2018), psychiatric diagnosis is often referred to as the assignment of a particular diagnosis(es). Even for this latter account, the aim of the psychiatric diagnosis is clinical utility. In fact, the DSM-5 states that "The diagnosis of a mental disorder should … help clinicians to determine prognosis, treatment plan, and potential treatment outcomes for their patients" (American Psychiatric Association, 2013, p. 20).

To date, the DSM has been the standard of psychology and psychiatry in North America for the past 30 years. However, the DSM continues to pose several heated controversies (Bredström, 2017; Frances, 2013b; Gazzaniga, Heatherton, & Halpern, 2016; Lacasse, 2014). One such controversy centers around bias directed toward particular groups of individuals (Merino et al., 2018). We find this controversy to be particularly alarming as both professionals and the general public often view the DSM and the process of diagnostic decision making by a clinician to be objective and bias free (Poland & Caplan, 2004).

In response to this discrepancy, this chapter addresses three aspects of DSM and psychiatric diagnosis that make clinicians and researchers vulnerable to making a biased diagnostic decision. These are (a) *value-laden, and yet vague, concepts of mental disorder*, upon which the entire DSM nosology is based (Frances, 2013a, 2013b); (b) *criterion biases*, biases within diagnostic criteria for specific disorders themselves (Hartung & Widiger, 1998; Jane, Oltmanns, South, & Turkheimer, 2007; Widiger, 1998; Widiger & Spitzer, 1991); and (c) *clinician bias*, bias unfolding in a clinician–client interaction (e.g., Merino et al., 2018; Poland & Caplan, 2004).

We do not suggest that the field of behavioral health replace DMS-5 with an alternative, such as the Research Domain Criteria (RDoC) (Insel et al., 2010). Instead, at this point in time, we simply advocate that we use the DSM-5 wisely. More specifically, we argue that clinicians must scrutinize how the DSM defines a mental disorder and the underlying assumptions behind that definition. Additionally, we argue that clinicians take the inevitability of bias into consideration throughout the entire course of diagnostic decision making. The issue of bias is complicated because of its socially derived nature. Finally, we argue that this careful use of the DSM diagnostic system should be emphasized, especially when clinicians work with clients from sociocultural backgrounds other than their own (Masuda, 2014a, 2014b; Neighbors et al., 1999).

Ambiguity Within the Definition of Mental Disorder

As noted above, the general public continues to believe that the process of psychiatric decision making (by clinicians) and psychiatric nosology (e.g., DSM) are objective, context neutral, and bias free (Houts, 2001; Lacasse, 2014; Poland & Caplan, 2004; Wakefield, 1999). For example, common mental disorders, such as depression (i.e., major depressive disorder) and alcoholism (i.e., alcohol use disorder), are presented to the public as *diseases with known etiologies* that are objectively identified by a biological test (Deacon, 2013; Lacasse & Leo, 2005). However, according to the DSM-5, a mental disorder is simply a set of behavioral, cognitive, and emotional symptoms (Frances, 2013b; Lacasse, 2014), and the DSM is a descriptive, not etiological, classification system (Frances, 2013a). The DSM-5 does not make reference to causality in its definition of *mental disorder* at all:

> A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental process underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities (American Psychiatric Association, 2013, p. 20).

It is important to note that mental disorder, being a descriptive term, is not itself the source of bias. What is problematic is that the concept of mental disorder in the DSM-5, as well as in its predecessors, is *descriptively vague* (Follette & Houts, 1996; Houts, 2001; Rogers & Mintzker, 2016). In particular, the definition of mental disorder used by the DSM-5 does not provide sufficient descriptive clarity regarding the boundaries between what is a mental disorder and what is not and how a mental disorder is different from normal distress in life (Frances, 2013c).

With the definition of mental disorder vaguely defined, clinicians are required to rely on a series of their own judgments to determine whether a client's experiences fit the criteria and threshold of a given mental disorder (Follette & Houts, 1996; Frances, 2013b; Houts, 2001; Lacasse, 2014; Lilienfeld, 2014). Take the concept of "clinically significant disturbance" as an example: according to the DSM-5, for any set of symptoms to be judged as a mental disorder, it has to co-occur with "clinically significant disturbance." For the DSM-5, it is the clinically significant disturbance that differentiates a mental disorder from normal distress in life. However, it is challenging for clinicians to first define what disturbance is and then to judge whether disturbance associated with the set of symptoms reaches the threshold of *clinical significance*. As such, it is easy to imagine that two clinicians are likely to have different levels of diagnostic thresholds for a given disorder or for a given client. It is also easy to imagine that the diagnostic threshold of clinically significant disturbance set by a clinician drifts over time.

Harmful dysfunction (Wakefield, 1999, 2007) and maladaptiveness are constructs that are relevant to that of clinically significant disturbance. Although these terms are not included in the definition of mental disorder, they are implied in the discussion of a DSM account of mental disorder. Proponents of the DSM argue that the constructs of harmful dysfunction and maladaptiveness implied within the DSM definition of mental disorder help clinicians differentiate a mental disorder from socially deviated behaviors, as well as from normal distress in life (Ghaemi, 2013; Wakefield, 2007). However, once again, these constructs themselves do not specify any categorical parameter (e.g., diagnostic threshold or criteria) for diagnostic decision making (Follette & Houts, 1996; Houts, 2001). Furthermore, while harmful dysfunction and maladaptiveness can be identified, it is quite challenging to attribute them solely to a mental disorder while ruling out other potential precipitating or causal factors, such as social climate, economic crisis, and cultural norms.

Another area of difficulty within the construct of mental disorder is to judge whether symptoms experienced by a client are *culturally approved*. In its definition of *mental disorder*, the DSM-5 describes the role of cultural norms in diagnostic decision making as follows:

> An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviated behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorder unless the deviance or conflict results from a dysfunction in the individual, as described above (American Psychiatric Association, 2013, p. 20).

According to the DSM-5, a given set of symptoms should not be judged as a mental disorder if it is judged to be culturally approved. This is the case even when the set of symptoms is associated with clinically significant disturbance. Once again, judging whether the client's symptoms are culturally approved depends heavily on the clinician's personal values and judgment, as well as his or her awareness of the client's sociocultural background and social norms (Poland & Caplan, 2004). An example of this challenge is illustrated by Merino et al. (2018) as follows:

> Consider, for example, a Black man who has grown up in a society where men and boy of colors are disproportionately targeted by law enforcement... His vigilance in everyday life might be perceived as a natural consequence of racial profiling by one provider, whereas that same behavior might be interpreted as paranoia related to schizophrenia by another… This single difference in how a provider interprets symptom presentation can dramatically alter subsequent discussions surrounding the patient's psychiatric symptoms or screening for a specific condition (p. 2).

In this exemplar, we do not necessarily argue that one of the clinicians makes a *right* or *better* diagnostic decision and the other one does not. Instead, we attempt to highlight the extreme difficulty in judging whether the behavior of a client (e.g., client's vigilance in the example above) is culturally approved or acceptable. Reading the exemplar above, many of us may feel that the first provider makes the *correct, and culturally sensitive*, diagnostic decision and the second one does not. However, depending on the circumstance and the client, the decision made by the first clinician can be extremely stereotypical and biasing (e.g., "All Black men are hypervigilant because of their upbringing in a racist environment"). Furthermore, given the nature of the DSM nosological system, as well as the reliance on the clinician's subjective judgment, we may not want to assume that there is an *ontologically correct diagnostic decision*. Diagnostic decision making is a social and interpersonal phenomenon: perhaps it is something to be justified, not to be discovered. As such, our recommendation for clinicians is to use the DSM diagnostic system wisely by explicitly acknowledging and identifying factors that contribute to their diagnostic decision making, including potential biases.

Regarding cultural considerations, it is important to acknowledge that the DSM-5 offers a guideline for the cultural formulation of psychiatric diagnosis (APA, 2013, pp. 749–759). This section is added to the DSM-5 to assist clinicians in making a correct psychiatric diagnosis and avoiding misdiagnosis. However, this effort seems to fall short because the DSM-5 does not clearly state how to use the guideline to promote an *accurate* diagnosis, for example, by taking biases into consideration in diagnostic construct, diagnostic thresholds, application of diagnostic criteria, and interpretation of assessment data (Bredström, 2017).

In sum, given this vague definition of mental disorder, clinicians need to rely on their own criteria of a mental disorder, rendering them vulnerable to making biased decisions. More specifically, a clinician may attend to certain information of the client while deemphasizing or overlooking other information somewhat subjectively (Merino et al., 2018; Whooley, 2014). By definition, this resultant process itself can be viewed as bias (Poland & Caplan, 2004). Allen Frances, the chair of the task force for the DSM-IV, and one of the most well-known psychiatrists in the world, critiques this diagnostic decision-making process for reliance on "fallible subjective judgements" (Frances, 2013c, p. 111).

Criterion Bias: Biases Within the Diagnostic Criteria Themselves

One of the controversies in the DSM-5 and the foundational predecessors from which it was developed (i.e., DSM-III-R, DSM-V, DSM-V-TR) is *criterion bias,* a bias toward particular sociocultural groups of individuals that is built into the diagnostic criteria themselves (Hartung & Widiger, 1998). This form of bias is said to occur because the DSM diagnostic criteria appear to be determined based primarily on the social and moral standards of a particular sociocultural group.

It is important to note that taking account of group differences (e.g., racial, ethnic, or gender differences) does not in itself constitute bias. In many circumstances, responding to these differences is essential, and ignoring these differences reflects a kind of bias (Snowden, 2003). For example, although major depressive disorder (MDD) is subject to gender bias at the level of construct, not adequately acknowledging gender difference due to the types of MDD symptoms endorsed by men and women may undermine the understanding and treatment for women and men diagnosed with MDD.

It is also important to note that not all mental disorders and their diagnostic criteria are subject to criterion bias. For example, the diagnosis of enuresis, an elimination disorder in the DSM, appears to be relatively bias free, especially when behavioral criteria (i.e., repeated voiding of urine into bed or cloths at least twice a week for at least three consecutive months) and age criteria (i.e., at least five years) are met. What we will address is that, ideally, diagnostic criterion sets would be neutral for any social categorizations (e.g., gender neutral, race neutral, or ethnicity neutral). However, as the DSM stands, the criterion sets of certain mental disorders may disproportionally favor the manner in which a given disorder appears in one group more so than in another (Bredström, 2017).

Gender Criterion Biases

One such criterion bias that has been discussed extensively for the past 35 years is gender bias (Jane et al., 2007; Kaplan, 1983; Widiger & Spitzer, 1991). For example, in a discussion on the potential gender bias in the diagnosis of mental disorder in DSM-IV, Hartung and Widiger (1998) elucidate the following point:

> … an inaccurate estimate of the differential sex prevalence of a disorder will… be obtained in a fully representative epidemiologic study if the diagnostic criteria for the disorder are themselves biased in favor of one sex relative to the other (p. 267).

Gender bias in this context is a form of criterion bias that unfairly assumes that stereotypical masculine or feminine characteristics are pathological. To date, scholars have argued that personality disorders, mood disorders, conduct disorder, somatization disorder (now called somatic symptom disorder in DSM-5), schizophrenia, and schizoaffective disorder are subject to gender bias (see Hartung & Widiger, 1998; Widiger, 1998). In this section, we will review gender criterion biases in personality disorders and mood disorders.

Personality disorders that are subject to gender bias include histrionic personality disorder (HPD), borderline personality disorder (BPD), dependent personality disorder (DPD), narcissistic personality disorder (NPD), antisocial personality disorders (APD), and paranoid personality disorder (PPD). Widiger (1998) argues that gender criterion bias unfolds in diagnostic constructs, diagnostic thresholds, and applications of diagnostic criteria. Consider DPD as an example. As seen in the DSM-5, defining diagnostic features of DPD have continued to include difficulty in making everyday decisions without advice and reassurance from others and difficulty in expressing disagreement with others because of fear of loss of support or approval. As discussed extensively elsewhere (Ford & Widiger, 1989; Hartung & Widiger, 1998; Kaplan, 1983), these criterion features are known to be a stereotypically feminine form of socialization in many Western sociocultural contexts. Given the general criterion set of a mental disorder, these symptoms included in the diagnostic criteria of DPD can be viewed as culturally approved behaviors at least for some individuals in some sociocultural contexts. As such, more women diagnosed with DPD than men in Western sociocultural contexts may reflect a biased view of considering culturally regulated practice as a mental disorder (Grant et al., 2004; Trull, Jahng, Tomko, Wood, & Sher, 2010).

Regarding the application of diagnostic criteria, recent research has also shown that part of the diagnostic criteria for a disorder, not necessarily the whole diagnostic criteria, may possess gender bias (Benson et al., 2017; Hoertel et al., 2018).

For example, the chronic feeling of emptiness is a defining feature of BPD. A study shows that the experience of emptiness is related to the diagnosis of BPD, particularly for women but less so for men (Benson et al., 2017). Similarly in the diagnostic criteria of BPD, suicidal or self-mutilation behavior and affective instability are found to be relevant to women but less so to men (Hoertel, Peyre, Wall, Limosin, & Blanco, 2014). Finally, for the diagnostic criteria of NPD, lack of empathy is found to be more relevant to men than women (Hoertel et al., 2018). This *differential relevance,* not differential ratio or degree, of particular symptoms warrants careful attention. Diagnostic criteria groups should not be biased around social categorization: gender difference in this domain suggests difference in the *very construct* of these mental disorders across gender.

Another mental disorder that is subject to gender criterion bias is major depressive disorder (MDD). Epidemiological studies have consistently shown a higher prevalence of MDD in women relative to men with the ratio close to 2:1. Nevertheless, this gender imbalance in depression has been one of the major unsolved issues in psychiatric epistemology (Piccinelli & Wilkinson, 2000). Whereas there are several hypotheses for the discrepancy, criterion bias is one possible explanation. More specifically, some scholars argue that the diagnostic criteria of MDD are systematically skewed toward symptoms more frequently endorsed by women while overlooking those more frequently experienced by men (Romans, Tyas, Cohen, & Silverstone, 2007). A recent meta-analysis shows that depressed women are more likely to report depressed mood, appetite disturbance or weight change, and sleep disturbance than depressed men, while depressed men are more likely to report alcohol or drug misuses and risk taking or poor impulse control than depressed women (Cavanagh, Wilson, Kavanagh, & Caputi, 2017). Results of this meta-analysis have several key implications regarding gender biases. One such implication is the underdiagnosis of MDD in men due to fewer items within the diagnostic criteria of MDD that reflects the behavior of depressive men.

Finally, once again, it is important to clarify that taking account of group differences is not itself a bias. In many circumstances, responding to these differences is essential, and ignoring these differences reflect a kind of bias (Snowden, 2003). The DSM-5 reports that some mental disorders are more prevalent in men than women (e.g., APD and pedophilic disorder have been found to be more common in men). Gender difference in the prevalence ratio of these mental disorders, if measured accurately, is not necessarily indicative of bias at a measurement level. However, viewing these conditions as mental disorders may involve biases (e.g., subjective moral, ethical, and legal judgment) at a conceptual level.

Ethnic and Racial Criterion Biases

In addition to gender criterion bias, researchers have found the DSM-5 to have criterion bias toward particular racial and ethnic groups of individuals (Delphin-Rittmon et al., 2015; Merino et al., 2018). From a functional analytic perspective (Masuda, 2014a, 2016), ethnic- and racial-criterion bias is inevitable as the DSM criterion sets are based on the topographically defined behavioral phenomenology of particular sociocultural groups and the symptom expression of a given disorder often varies across cultures. To date, clinicians and scholars argue that ethnic- and racial-criterion bias exists most impactfully in the context of anxiety disorders, schizophrenia spectrum disorders, and personality disorders (Grant et al., 2004; Lewis-Fernández et al., 2010; Marques, Robinaugh, LeBlanc, & Hinton, 2011; Schwartz & Blankenship, 2014). In this section, due to the limited space, we will focus on ethnic- and racial-criterion bias in anxiety disorders.

In a review of culture and anxiety disorders, Lewis-Fernández and colleagues (2010) highlight "possible mismatches" between the DSM criteria and local phenomenology of particular anxiety disorders. More specifically, they identify panic disorder (PD), social phobia, social anxiety disorder (SAD), generalized anxiety disorder (GAD), agoraphobia without panic disorder (AWOPD), and obsessive-compulsive disorder (OCD) to be subject to this mismatch. In their review, they first present cross-cultural differences in prevalence ratios of these anxiety disorders:

> Perhaps, the most striking aspect of this review is the degree of cross-cultural variability in documents in the prevalence of the anxiety disorders, even when the same diagnostic instrument is applied. Whereas US and European rates generally converge, their position relative to prevalence in other countries is not always high or low. Studies in the United States and Europe show higher prevalence rates of PD, Specific Phobia, and SAD than most other national surveys. In contrast, for AWOPD, OCD, and GAD, US and European rates fall within the international range. With some exceptions, the lowest rates are consistently found in Asia and Africa, and are usually replicated by lower rates of disorder among US populations of Asian and African descent (p. 225).

The authors then argue that the *mismatch* between the DSM criteria and the local symptom expression of these anxiety disorders may serve as the source of criterion bias:

> The cause for this degree of variability remains unclear. Although measurement limitations are likely involved, these do not necessarily invalidate concerns over lack of validity or precision in DSM-IV-TR criteria, as the two issues are intimately linked. Throughout the review, we have noted possible mismatches between the DSM criteria and the local phenomenology of the disorder in a specific cultural context (pp. 225–226).

The three most salient examples of mismatches between DSM-defined symptoms and cross-cultural conceptions of anxiety disorders presented in the review include the unexpectedness and ten-minute crescendo criteria in PD, the definition of social anxiety and social reference group in SAD, and the priority given to psychological symptoms of worry in GAD. Whether or not a PA is expected is inevitably informed by culture. As an example, if someone in Vietnam knows that he or she is prone to *trung gio´*, a locally known condition related to PAs said to be caused by the wind, then he or she may anticipate a PA on a windy day, thereby increasing his or her chances of experiencing a PA. Additionally, PAs are expected after traumatic events in many cultures, which makes clients experiencing PAs less likely to be diagnosed with PD and more likely to be diagnosed with PTSD. The authors suggest that PD should be defined by PD symptoms, such as autonomic arousal, catastrophic cognitions, and postattack behaviors, rather than by unexpected PAs.

In the case of SAD in Japan, fear of offending others—allocentric fear—is extremely common and is also somewhat common in Western cases of SAD. Integrating this cross-cultural understanding of SAD symptomology would serve to elevate the DSM's utility across a broader range of contexts.

Similarly, in case of GAD, the authors recommend expanding criteria to include symptoms more commonly found in cultures other than Western ones, congruent with a GAD diagnosis. Somatic symptoms, such as palpitations, bowel symptoms, dizziness, and indigestion, could be added to reduce criterion biases; this recommendation is especially critical as clients who present with somatic anxiety tend to exhibit more intense levels of distress, disability, and use of medical services, relative to clients presenting with psychological symptoms (Lewis-Fernández et al., 2010). The DSM-5 does not include any of the recommendations made in the Lewis-Fernández and colleagues (2010) review. As the DSM nosology is increasingly applied to other cultural settings, there should be a careful and systematic revisiting of data that inform the current criteria.

Criterion Bias: Summary

In sum, the DSM-5 is subject to criterion bias because its diagnostic criteria seem to primarily reflect the phenomenological, social, and moral standards of a particular sociocultural group while not taking into account those of other sociocultural groups (Bredström, 2017; Pilgrim, 2014). In fact, the diagnostic criteria of mental disorders in the DSM-5 were determined by a small group of experts. Whooley (2014) describes the group decision-making processes unfolding in the development and finalization of DSM-5 as follows:

> With the DSM we get a rare thing: experts in a room making decisions on how to define disease categories. Rarely does the social construction of disease occur so deliberately and consciously. Rarely is the logic behind certain diagnostic choices made so explicit. And rarely are the conceptual fissures so exposed (p. 94).

Clinician Bias: Functional Analytic Perspectives

Of all the biases discussed in the context of the DSM, clinician bias has been the most controversial one. As described above, a clinician's diagnostic decision making is bias laden as it relies "exclusively on fallible subjective judgements (Frances, 2013c, p. 111)." To highlight the inevitability of clinician bias in psychiatric diagnosis, Poland and Caplan (2004) describe the social contingencies that perpetuate it as follows:

> …there is a widespread assumption that therapists overcome their biases. But the assumption is a myth because biases are unavoidable … The process of trying to understand the nature of people's anguish, fears, and depression is quite complex; there are usually many unknowns, and settling on a tidy diagnosis can reduce one's anxiety. As a result, the clinician's human need to simplify the picture comes into play. This is intensified under pressures from health maintenance organizations and insurance companies or when the patient is dangerous. Thus, in making clinical diagnoses, the therapist will attend to, emphasize, and use certain information while de-emphasizing or ignoring other information, and biases shape the nature of that selectivity (p. 11).

From a functional analytic perspective, the claim that biases are unavoidable is not so surprising, given that the underlying behavioral process of biasing is ordinary human linguistic and cognitive process (Hayes et al., 2002; Masuda, Hill, Morgan, & Cohen, 2012; Roche et al., 2001). The following sections review a contemporary functional analytic model of behavioral process that underlies a bias.

Contemporary Functional Analytic Accounts of Bias, Prejudice, and Stigma

For the past 30 years, modern functional analytic accounts of complex human behaviors have been applied to social processes, such as bias, stigma, and prejudice (Hayes et al., 2002; Lillis & Levin, 2014; Masuda et al., 2012; Roche et al., 2001; Roche, Barnes-Holmes, Barnes-Holmes, Stewart, & O'Hora, 2002). One such conceptual model is relational frame theory (RFT; Hayes et al., 2001).

From an RFT perspective (Roche et al., 2001), a bias or biasing is an example of human language or cognition that has been "inappropriately" applied. Human language or cognition in this sense is a *generalized verbal operant* (i.e., verbal behavior) that operates under particular processes of a contingency. Although a detailed account of RFT is beyond the scope of the present chapter (see Hayes et al., 2001 for a full treatment), a brief summary regarding its implications for bias is warranted here.

First, a generalized verbal operant is relational. The term *relational* refers to a particular functional quality within the contingency of reinforcement. From an RFT account, a generalized verbal operant is relational in that a *response to a given event reflects the particular association of that event to other events* (Hayes et al., 2001). Let us give an example. In a social context, a generalized verbal operant allows us to respond to a given person in such a way that reflects image, attitudes, and perceptions associated with that person. When a clinician meets a given client, the clinician's perception of the encounter with that client is shaped by his or her *direct* experience with that client, as well as any preconception, stereotype, or bias that is automatically evoked by the presence of the client. If the client reminds the clinician of someone whom he or she extremely dislikes, the clinician may respond to the client in a particular way that reflects that previous personal experience of dislike (Poland & Caplan, 2004). If a clinician attends to a certain demographic feature of a client (e.g., ethnic background and neighborhood) more so than other information, the clinician's personal history relevant to that demographic information may shape the way the clinician interprets the client's statement during a diagnostic assessment. This relational feature of generalized verbal operant (i.e., responding to one in terms of its relation to another) reflects the defining feature of bias.

Second, the relational features of the generalized verbal operant are *automatically derived*, oftentimes without awareness. This derived quality is an essential feature of human language and cognition that differentiates it from other forms of operant behavior (Hayes et al., 2001). In psychological science literature, this derived learning is often referred to as latent learning, indirect learning, or learning without direct reinforcement (Roche et al., 2001). This derived quality of verbal behavior is also acknowledged in the literature of attitude formation and implicit vs. explicit attitudes or biases in social psychology.

It is important to note that given the involuntary or automatically derived nature of implicit attitudes, one's implicit attitudes often contradict with explicit attitudes. For example, while explicitly opposing or denying any prejudiced attitudes, individuals often demonstrate implicit racial bias toward a particular ethnic or racial group of individuals (Green et al., 2007; Greenwald, McGhee, & Schwartz, 1998). These implicit attitudes seem to reflect well-established and general schemas (i.e., relational network) that have been steadily shaped throughout one's history and maintained independently from explicitly stated attitudes. Extant literature shows that these derived implicit biases also regulate clinical decision making in psychiatric diagnostic procedures for a particular client (Merino et al., 2018).

Third, a bias is often unavoidable as it can occur in virtually every context. This is because the occurrence of a generalized verbal operant is not restricted to the physical properties of the environmental context (Hayes et al., 2001, 2002). For example, the occurrence of taking an illicit drug is limited to the environment where that illicit drug is available. On the other hand, the behavior of biasing can occur in every waking moment regardless of the situation.

Fourth, RFT suggests that various forms of bias (e.g., racial bias, gender bias, sexuality bias), although varying in content, may not be qualitatively distinct from one another in process (Levin et al., 2016; Lillis & Levin, 2014). This conceptual position is supported in part by the finding that prejudiced biases and attitudes toward various groups tend to co-occur and comprise a single latent variable (Bäckström & Björklund, 2007). Evidence shows that individuals who are prejudiced toward Black Americans are also likely to be biased against other groups, such as other ethnic minorities, women, and sexual minorities (Akrami, Ekehammar, & Bergh, 2011). The applied implication of this claim is that we should target this meta- or generalized process, as opposed to each distinct form of bias, when increasing awareness of bias in the context of psychiatric decision making.

Fifth, according to RFT, bias, stigma, and prejudice are also inherently rigid once they are formed (Hayes et al., 2002). New ideas are met with resistance when they are not aligned with stereotype-consistent beliefs (Moxon, Keenan, & Hine, 1993; Watt, Keenan, Barnes, & Cairns, 1991), and efforts to change unwanted thoughts often paradoxically increase their frequency and intensity (Wegner, 1994; Wenzlaff & Wegner, 2000). Even if the expression of a biased attitude is extinguished in a particular context, it still remains in a person's repertoire (Wilson, Lindsey, & Schooler, 2000).

Finally, as implied throughout the chapter, the behavior of biasing is socially shaped by the member of the sociocultural community (Hayes & Brownstein, 1986; Skinner, 1957, 1974). Evidence shows that the behavior of biasing is developed and reinforced early in childhood and continues throughout one's lifetime (Baron & Banaji, 2006; Hayes et al., 2001; Pauker, Ambady, & Apfelbaum, 2010; Pauker, Williams, & Steele, 2016). This may be because across many cultural contexts, biases allow humans to navigate themselves more easily through complex sociocultural interactions (Macrae, Bodenhausen, Milne, & Jetten, 1994).

Clinician Biases: Exemplars

The previous section addresses the underlying behavioral processes of clinician bias. In this section, we are going to present specific examples of clinician biases manifested in the context of psychiatric diagnosis.

In their comprehensive review of clinician bias, Poland and Caplan (2004) identify several exemplars of how ordinary human cognitive and behavioral processes unfold as biases in the context of psychiatric diagnosis. One such exemplar is the clinician's general attitudes and beliefs about certain groups of individuals. These attitudes and beliefs may reflect some of the explicit and implicit stereotypical notions of particular groups, such as "Asian Americans are a model minority" (Chou & Feagin, 2015) and "Black men don't like to work" (Way & Rogers, 2015). These implicit and explicit attitudes toward particular groups of individuals may influence a clinician's diagnostic decision for a given client even when a standardized diagnostic tool, such as the Structured Clinical Interview for DSM, is used.

In the context of behavioral health in the United States, research has continued to report that particular groups of individuals are disproportionately diagnosed with certain mental disorders (Delphin-Rittmon et al., 2015; Schwartz & Blankenship, 2014). One such mental disorder is schizophrenia. Research continuously shows that Black Americans are three to four times more likely to be diagnosed with psychotic disorders compared to White Americans (Schwartz & Blankenship, 2014). There are several explanations for these differential rates, such as the collection of situational stressors (e.g., safety, employment status) that are differentially more salient to Black American clients. In addition to those factors, clinician bias is also said to contribute to this differential ratio (Merino et al., 2018). More specifically, advocates for clinician bias suggest that presenting symptoms are interpreted differently by clinicians, depending on the racial and ethnic background of the client. For example, some authors suggest that, in part, due to the clinicians' implicit and explicit preconceptions toward Black Americans, socially deviant and disruptive behavior tends to be interpreted as psychotic symptoms when presented by members of this group (Schwartz & Blankenship, 2014).

Similarly, clinician biases toward particular ethnic groups are also reported in the diagnosis of mood disorders (Delphin-Rittmon et al., 2015) and personality disorders (Grant et al., 2004). A cautionary note here is that the majority of clinicians in these studies were White Americans. As such, it is unclear whether clinician biases against Black Americans are observed among ethnic minority clinicians or whether, conversely, ethnic minority clinicians may have biased views against White American clients.

On a related note, Poland and Caplan (2004) also suggest that clinician bias is especially likely when the clinician's cultural background differs from those of clients, and this is the second exemplar. From a functional analytic perspective, the collection of information and the development of clinical understanding essentially depend on the features of the clinician–client interaction. Cultural differences in this sense are indicative of differences not in racial and ethnic characteristics but in social norms and sociocultural contingencies that maintain these norms. Interpretation of a behavioral sign (e.g., "My ancestors always guide me") using one social norm may be quite different from one made using another cultural norm (Merino et al., 2018; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Sue & Zane, 1987).

Third, according to Poland and Caplan (2004), well-known cognitive tendencies are also pervasive in the field of behavioral health, and they are often manifested as the form of clinician biases in psychiatric diagnosis. These general cognitive tendencies are as follows:

- confirmation bias,
- availability bias,
- stereotype-based memory bias,
- illusory correlations,
- halo effects,
- anchoring effects,
- actor-observer bias.

Confirmation bias is our strong tendency to place greater importance on evidence that supports our own existing beliefs while downplaying evidence that does not match what we believe. For example, when a clinician believes that men are less likely to be diagnosed with a major depressive disorder (MDD) than women, he or she may be less likely to interpret sadness or lack of interest experienced by a male client as a symptom of MDD.

Availability bias is our propensity to give priority to information that is highly salient or more easily remembered. This form of bias is problematic as it may give rise to a mental shortcut of diagnostic decision making (e.g., MDD) by merely attending to one form of information (e.g., "the client appears to be extremely sad during the initial interview") while neglecting to assess other relevant information.

Stereotype-based memory bias is the inclination to recall information that is stereotype confirming to a given client even when the information is not applied to that client. Similarly, *illusory correlation* is the propensity to see a significant association between an observed characteristic and an unobserved characteristic because that association is prevalent in some contexts.

Halo effect is the tendency to assign positive or negative traits to a client who exhibits other desirable or undesirable traits, even though the traits are not correlated. Stereotype-based memory bias, illusory correlation, and halo effect are good examples of the derived and relational nature of human language and cognition. When a clinician attends to one form of information of a client, its associated information automatically and unconsciously become available to the clinician, although the derived information may not be applicable to the client.

In the context of psychiatric diagnosis, *anchoring effect* is a clinician's tendency to outweigh the first impression of a given client over subsequently collected information in clinical decision making. Finally, the *actor-observer bias* is the tendency to see one's own problem or the problems of someone with whom one identifies as resulting from situational factors while regarding the problems of others, especially those with whom one does not identify, as resulting from an intrinsic cause. The actor-observer bias may be particularly relevant to clinician bias as this general tendency is said to occur when a clinician's sociocultural background is significantly different from that of a client in a particular way (Poland & Caplan, 2004).

Clinician Bias: Summary

In sum, this section argues that ordinary human linguistic and cognitive process of clinicians can manifest as clinician bias in the context of psychiatric diagnosis. Human linguistic and cognitive processes are prone to obscuring a clinician's direct experience with a given client by automatically evoking stereotypical attitudes and images associated with the client, oftentimes without his or her awareness. Furthermore, the sociocultural contexts of clinicians, like those of the general public, maintain such linguistic and cognitive practices, or at least do not extinguish them.

Summary and Recommendations

The present chapter addresses three primary biases within the context of psychiatric diagnosis: *value-laden, and yet vague, concepts of mental disorder*; *criterion biases*; and *clinician bias*. We argue that diagnostic decision making is highly vulnerable to bias because clinicians must rely on their fallible subjective judgments without a clear and reliable diagnostic guideline. From a functional analytic perspective, bias within this context (i.e., variability in decision making) is unavoidable as the act of diagnostic decision making is a generalized verbal operant regulated under ambiguous verbal control (Barnes-Holmes, Hayes, Barnes-Holmes, & Roche, 2001; Roche et al., 2001; Skinner, 1974).

As a solution for bias in psychiatric diagnosis, many scholars and clinicians appear to implicitly advocate making an *accurate diagnosis* by minimizing biases. Whereas this clinical recommendation is sound and well intentioned, we must carefully examine its underlying assumptions, its intended outcomes, and the feasibility of achieving this goal. At least four assumptions are made when we advocate making accurate diagnostic decisions by minimizing biases.

The first assumption is of an ontological nature: we are presuming that there is an *absolutely correct* diagnostic picture for a given clinical case, and the clinician's job is to discover it. Relevant to the topic of the present chapter, this assumption also implies that although there is a true diagnostic picture, biases and other factors prevent it from being discovered. This may be the case for some mental disorders, such as enuresis and encopresis, but it is difficult to maintain this assumption for the diagnosis of most other mental disorders, such as anxiety and mood disorders, which require subjective judgments.

The second assumption is that we can objectively identify a bias and clearly differentiate it from unbiased attitudes and beliefs. Throughout the present chapter, we have argued that psychiatric decision making is subjective and value laden. We argue that the same dilemma is also applied to the case of bias. Judging whether a given attitude or cognitive process is a bias is extremely subjective, and it depends on one's subjective point of view. Just as there is no objective test to identify a mental disorder, there is no objective method for bias. It is important to note that our intention here is not to downplay the significance of bias; what we usually refer to as biases certainly contribute to behavioral health services disparities. Rather, we attempt to elucidate the complex and nuanced nature of bias as it relates to decision making.

The third assumption, which is particularly aligned with the recommended efforts to minimize bias to make an accurate diagnosis, regards the ontological status of mental disorders. When biases within psychiatric diagnosis are discussed, experts often assume that a mental disorder is a concrete entity (e.g., medical disease) that exists in somewhat consistent form across all areas of the world while in reality, its symptom presentation may vary substantially cross-culturally. In this ontological assumption, a bias is viewed as an error or variability that obscures accurate diagnostic decision making (e.g., "misdiagnosis = bias + accurate diagnosis").

Finally, the pursuit of an accurate—absolutely correct—diagnosis is based on the assumption that doing so is absolutely necessary for greater clinical competency for determining prognosis, a treatment plan, and evaluating treatment effectiveness. We partially agree with this assumption in that psychiatric diagnosis has been part of our routine practice from the very nascent phases of the field and the DSM nosological system provides a common language across various stakeholders in the context of behavioral healthcare. However, we also argue that its clinical utility for developing and conducting effective treatment is questionable (see Follette & Houts, 1996). From a functional analytic perspective, the DSM diagnostic system is incomplete for treatment because it does not inform clinicians of any functional relations between the client's presenting concerns and their maintaining factors. Such functional understandings are crucial for formulating case conceptualization, treatment plan, and treatment evaluation and modification (Hayes & Hofmann, 2018).

The truth is that the DSM-5 is subject to many controversies, and the descriptive and value-laden nature of the DSM-5's definition of a mental disorder and subsequent diagnostic criteria are merely a few examples of such disputes. Jeffrey Lacasse (2014) uses the term *conjecture* to identify nine notable issues addressed by the critics of DSM (e.g., Frances, 2013b; Pilgrim, 2014):

- Conjecture 1: The DSM-5 definition of mental disorder is inadequate.
- Conjecture 2: DSM-5's claim that all mental disorders are medical diseases is unsupported.
- Conjecture 3: The DSM-5 is more political and less transparent than previous editions.
- Conjecture 4: The DSM-5 is unreliable.
- Conjecture 5: The ramifications of unreliable diagnosis are significant.
- Conjecture 6: The accuracy of knowledge dissemination regarding psychiatric diagnosis is poor.
- Conjecture 7: The primary utility of the DSM continues to be financial, not scientific.
- Conjecture 8: Applying DSM-5 diagnoses to clients can cause harm.
- Conjecture 9: There are viable alternatives to conventional diagnosis.

With vague value-laden concepts of mental disorders to work from, a host of criterion biases plaguing our diagnostic tools, and an array of clinician biases to contend with, how might we utilize what we know to provide fair and useful diagnoses to clients?

Recommendations

When considering how best to address the issue of bias in the DSM, the overarching recommendation is to use the DSM-5 diagnostic system wisely. As its clinical utility has come under critical scrutiny since its inception, the DSM-5 requires a more nuanced and critical understanding of its strengths and weaknesses. As such, we offer the following six recommendations.

Reposition the DSM-5 as a descriptive heuristic tool It is of vital importance for behavioral health stakeholders and the general public to know how the DSM authors came to define modern mental disorders and the diagnostic criteria of a specific mental disorder (Frances, 2013b; Lacasse, 2014). As such, our first specific recommendation to counteract bias in DSM diagnosis is to use DSM-5 diagnostic categories *descriptively* rather than etiologically or ontologically.

Increase the awareness of value-laden and the biased nature of psychiatric diagnosis Our second recommendation is to increase the awareness among behavioral health stakeholders and the general public that psychiatric diagnosis relies on potentially biased tools and fallible subjective judgment.

Awareness of personal biases is a vital step toward mitigating their deeply ingrained patterns. To this point, enhancing awareness of one's own cognitive processes, both implicit and explicit, is a cornerstone of multicultural competency training in the field of counseling psychology (Sue, Zane, Hall, & Berger, 2009). Also, raising awareness about the gap between implicit and explicit bias (Monteith & Mark, 2005) has great potential as a first step in evidence-informed strategies to address cognitive bias. For example, encouraging awareness of one's own implicit and explicit cognitive process (e.g., prejudicial attitudes) can reduce discriminatory behavior among individuals with low-explicit and high-implicit prejudice (Son Hing, Li, & Zanna, 2002).

Although the field of behavioral health in the United States is still very much in the era of the DSM, where the medical industry markets mental disorders as medical diseases, the important issue of bias can be explored, and potentially assuaged, through a variety of mediums. One such arena is in graduate training programs (Poland & Caplan, 2004). When future behavioral health professionals enter into a graduate training program (e.g., Ph.D. in Clinical Psychology), they may already assume that a mental disorder is a medical disease, and yet few graduate training programs address the subjective nature of clinical decision making in psychiatric diagnosis (Poland & Caplan, 2004). In their six-point framework for integrating implicit bias training into training for health professionals, Sukhera and Watling (2018) suggest the following:

1. creating a safe and nonthreatening learning context,
2. increasing knowledge about the science of implicit bias,
3. emphasizing how implicit bias influences behaviors and patient outcomes,
4. increasing self-awareness of existing implicit biases,
5. improving conscious efforts to undermine the behavior regulatory impact of implicit bias,
6. enhancing awareness of how implicit bias influences others.

This training framework, which is designed to be generic to implicit biases in the field of behavioral health, can be easily tailored to the issues associated with bias in psychiatric diagnosis. Although a detailed account of this training framework is beyond the scope of this chapter, it is worthwhile to note that its guiding conceptual framework and recommended training targets, such as metacognition and mindfulness, are consistent with implications and recommendations suggested by a functional analytic account of social categorization and prejudice (Masuda, Donati, Schaefer, & Hill, 2015; Masuda et al., 2012).

Take DSM diagnostic nosology lightly Our third recommendation is to take a DSM psychiatric diagnosis lightly in clinical decision-making. Many controversies concerning the DSM-5 stem from placing a greater weight on DSM-5 diagnosis in clinical decision making than we should. When we take the DSM lightly, such as using a psychiatric diagnosis as an entry point for more thorough assessment and treatment plan, the negative impact of bias unfolding in the context of DSM psychiatric diagnosis also decreases.

Promote cognitive flexibility, perspective taking, and empathy From a functional analytic perspective (Masuda et al., 2012), the problem of cognitive bias is not in its content but its discriminative function that limits response options (leading to reach a particular decision, while alternative decisions are also plausible). Cognitive flexibility, perspective taking, and empathy in the context of psychiatric diagnosis are behavioral repertories of (a) becoming aware of one's decision-making process while examining alternative hypotheses, (b) viewing the client's psychiatric experience from the standpoint of the client, and (c) becoming connected to the sense of what it is like to be that client for seeking contextual information that may be relevant to the client's presenting concern.

Clarify the goals of diagnostic assessment and potential biases in the diagnostic process From a functional analytic perspective, whether a certain diagnostic decision is biased or not is contextually and socially determined. As such, in order to avoid further chaos caused by relativism, it is useful to clearly state the purpose of psychiatric diagnosis in a given clinical case, the process of reasoning in psychiatric diagnosis, and potential implicit and explicit cognitive biases (Roche & Barnes-Holmes, 2003; Roche et al., 2001; Roche et al., 2002). The diagnostic information can be used for various purposes, ranging from simply labeling and categorizing a person to implying the severity of current psychological condition and predicting future behavior in a legal context. Given the social nature of psychiatric diagnosis, psychiatric decision making is something to be justified, not discovered. The clearly stated goal of the psychiatric diagnosis behavioral health stakeholders and the general public to examine the extent to which the psychiatric decision and process of reasoning made by a clinician is justified.

It is also important for clinicians to document the process of reasoning in psychiatric decision making, including potential biases in a given clinical case. For example, it may be beneficial to address the extent of cultural match between the client and the clinician, as well as common cognitive biases (e.g., anchoring effect) that might have influenced a diagnostic decision in a diagnostic report. While clinician bias has been a central topic in the field of behavioral health, evidence remains limited regarding when and how bias unfolds in the course of psychiatric diagnosis and other clinical activities (Merino et al., 2018). It is therefore extremely important to continue to examine—and document—how we best conceptualize and target bias in the context of psychiatric diagnosis (Lilienfeld, 2017).

Create a safe and nonthreatening learning context Finally, bias reduction training is often tricky to successfully perform (Twohig, Domenech Rodriguez, & Enno, 2014). It often evokes unwanted effects and attitudes in both training facilitators and participants. When teaching about bias, stereotyping, and prejudice, there should be explicit recognition that the removal of all biases is impossible, although one can change the ways to relate to them (see Sukhera & Watling, 2018, for a mindful and metacognitive awarenss of bias). Collectively acknowledging the inevitability of bias in a training group allows the group members to learn alternative ways to relate to their biases without being defensive or reactive.

In a bias reduction training, it is also important to be mindful of one's own sense of self-righteousness (Masuda, 2014a). Once again, it is the sense of self-righteousness that makes us become dismissive, defensive, and reactive toward others. Finally, it is also important to acknowledge that "remedies" can promote biases further. For example, taking a cultural diversity class may promote a stereotypical belief toward a given person (e.g., "Asians are collectivists, and Aki is an Asian, therefore, Aki must be collectivist"). To minimize the effect of bias on our clinical decision making, it is important to become aware of these very cognitive process when we engage in that activity.

Conclusion

The present chapter has discussed bias in psychiatric diagnosis by focusing on the Diagnostic Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 2013). More specially, we argue that biases in psychiatric diagnosis are unavoidable because the very behavior of diagnostic decision making is a stream of verbal and rule-governed behaviors that are socially shaped and maintained under a vague set of rules (Frances, 2013c; Lacasse, 2014; Poland & Caplan, 2004). We then argue that great attention should be paid to the intersection of psychiatric diagnosis and diversity, where the mismatch of a client's social contingencies with a clinician's social contingencies is likely to unfold (Delphin-Rittmon et al., 2015; Hunsley & Mash, 2007; Jani et al., 2016; Snowden, 2003). Furthermore, we propose that we take diagnostic decisions drawn from the DSM nosology with vigilance as such conclusions are inevitably value laden and bias prone (Frances, 2013b; Lacasse, 2014). Finally, we recommend further clarification and examination of bias in psychiatric diagnosis in order to best understand it and how it may be linked to clinical competency so that we may position ourselves to better serve the clients and patients who seek our help.

References

Akrami, N., Ekehammar, B., & Bergh, R. (2011). Generalized prejudice:Common and specific components. *Psychological Science, 22*(1), 57–59. https://doi.org/10.1177/0956797610390384

Alarcón, R. D. (2009). Culture, cultural factors and psychiatric diagnosis: Review and projections. *World Psychiatry, 8*(3), 131–139.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub, Washington, DC.

Bäckström, M., & Björklund, F. (2007). Structural modeling of generalized prejudice: The role of social dominance, authoritarianism, and empathy. *Journal of Individual Differences, 28*(1), 10–17.

Barnes-Holmes, Y., Hayes, S. C., Barnes-Holmes, D., & Roche, B. (2001). Relational frame theory: A post-Skinnerian account of human language and cognition. *Advances in Child Development and Behavior, 28*, 101–138. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/11605362

Baron, A. S., & Banaji, M. R. (2006). The development of implicit attitudes: Evidence of race evaluations from ages 6 and 10 and adulthood. *Psychological Science, 17*(1), 53–58.

Benson, K. T., Donnellan, M. B., & Morey, L. C. (2017). Gender-related differential item functioning in DSM-IV/DSM-5-III (alternative model) diagnostic criteria for borderline personality disorder. *Personality Disorders: Theory, Research, and Treatment, 8*(1), 87–93.

Bredström, A. (2017). Culture and context in mental health diagnosing: Scrutinizing the DSM-5 revision. *Journal of Medical Humanities*. https://doi.org/10.1007/s10912-017-9501-1

Cavanagh, A., Wilson, C. J., Kavanagh, D. J., & Caputi, P. (2017). Differences in the expression of symptoms in men versus women with depression: A systematic review and meta-analysis. *Harvard Review of Psychiatry, 25*(1), 29–38.

Chou, R. S., & Feagin, J. R. (2015). *Myth of the model minority: Asian Americans facing racism*. Routledge, New York.

Deacon, B. J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. *Clinical Psychology Review, 33*(7), 846–861.

Delphin-Rittmon, M. E., Flanagan, E. H., Andres-Hyman, R., Ortiz, J., Amer, M. M., & Davidson, L. (2015). Racial-ethnic differences in access, diagnosis, and outcomes in public-sector inpatient mental health treatment. *Psychological Services, 12*(2), 158.

Fiske, S. T. (2002). What we know now about bias and intergroup conflict, the problem of the century. *Current Directions in Psychological Science, 11*(4), 123–128.

FitzGerald, C., & Hurst, S. (2017). Implicit bias in healthcare professionals: A systematic review. *BMC Medical Ethics, 18*(1), 19.

Follette, W. C., & Houts, A. C. (1996). Models of scientific progress and the role of theory in taxonomy development: A case study of the DSM. *Journal of Consulting and Clinical Psychology, 64*(6), 1120–1132. https://doi.org/10.1037/0022-006X.64.6.1120

Ford, M. R., & Widiger, T. A. (1989). Sex bias in the diagnosis of histrionic and antisocial personality disorders. *Journal of Consulting and Clinical Psychology, 57*(2), 301.

Frances, A. (2013a). The new crisis of confidence in psychiatric diagnosis. *Annals of Internal Medicine, 159*(3), 221–222.

Frances, A. (2013b). The past, present and future of psychiatric diagnosis. *World Psychiatry, 12*(2), 111–112. https://doi.org/10.1002/wps.20027

Frances, A. (2013c). *Saving normal: An insider's revolt against out-of-control psychiatric diagnosis, DSM-5, Big Pharma, and the medicalization of ordinary life*. New York, NY: William Morrow &.

Gazzaniga, M., Heatherton, T., & Halpern, D. (2016). *Psychological science* (5th ed.). WW Norton & Company, New York.

Ghaemi, S. N. (2013). Requiem for DSM. *Psychiatric Times, 30*(7), 16.

Grant, B. F., Hasin, D. S., Stinson, F. S., Dawson, D. A., Chou, S. P., Ruan, W., & Pickering, R. P. (2004). Prevalence, correlates, and disability of personality disorders in the United States: Results from the national epidemiologic survey on alcohol and related conditions. *The Journal of Clinical Psychiatry, 65*, 948.

Green, A. R., Carney, D. R., Pallin, D. J., Ngo, L. H., Raymond, K. L., Iezzoni, L. I., & Banaji, M. R. (2007). Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. *Journal of General Internal Medicine, 22*(9), 1231–1238.

Greenwald, A. G., McGhee, D. E., & Schwartz, J. L. (1998). Measuring individual differences in implicit cognition: The implicit association test. *Journal of Personality and Social Psychology, 74*(6), 1464–1480.

Hartung, C. M., & Widiger, T. A. (1998). Gender differences in the diagnosis of mental disorders: Conclusions and controversies of the DSM-IV. *Psychological Bulletin, 123*(3), 260–278. Retrieved from http://www.sciencedirect.com/science/article/pii/S147101531200089X

Hayes, S. C., Barnes-Holmes, D., & Roche, B. (2001). *Relational frame theory: A post-Skinnerian account of human language and cognition*. New York, NY: Kluwer Academic/Plenum Publishers.

Hayes, S. C., & Brownstein, A. J. (1986). Mentalism, behavior-behavior relations, and a behavior-analytic view of the purposes of science. *The Behavior Analyst, 9*(2), 175–190. Retrieved from http://ezproxy.gsu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1988-31398-001&site=ehost-live

Hayes, S. C., & Hofmann, S. G. (Eds.). (2018). *Process-based CBT: The science and core clinical competencies of cognitive behavioral therapy*. Oakland, CA: New Harbinger Publications.

Hayes, S. C., Niccolls, R., Masuda, A., & Rye, A. K. (2002). Prejudice, terrorism and behavior therapy. *Cognitive and Behavioral Practice, 9*(4), 296–301. https://doi.org/10.1016/s1077-7229(02)80023-2

Haynes, S. N., & O'Brien, W. H. (2000). *Principle and practice of behavioral assessment*. New York, NY: Kluwer Academic/Plenum Publication.

Haynes, S. N., Smith, G. T., & Hunsley, J. D. (2011). *Scientific foundations of clinical assessment*. Taylor & Francis, New York.

Hoertel, N., Peyre, H., Lavaud, P., Blanco, C., Guerin-Langlois, C., René, M., … Limosin, F. (2018). Examining sex differences in DSM-IV-TR narcissistic personality disorder symptom expression using Item Response Theory (IRT). *Psychiatry Research, 260*, 500–507. https://doi.org/10.1016/j.psychres.2017.12.031

Hoertel, N., Peyre, H., Wall, M. M., Limosin, F., & Blanco, C. (2014). Examining sex differences in DSM-IV borderline personality disorder symptom expression using Item Response Theory (IRT). *Journal of Psychiatric Research, 59*, 213–219. https://doi.org/10.1016/j.jpsychires.2014.08.019

Houts, A. C. (2001). Harmful dysfunction and the search for value neutrality in the definition of mental disorder:

Response to Wakefield, part 2. *Behaviour Research and Therapy, 39*(9), 1099–1132.

Hunsley, J., & Mash, E. J. (2007). Evidence-based assessment. *Annual Review of Clinical Psychology, 3*(1), 29–51. https://doi.org/10.1146/annurev.clinpsy.3.022806.091419

Insel, T., Cuthbert, B., Garvey, M., Heinssen, R., Pine, D. S., Quinn, K., … Wang, P. (2010). Research domain criteria (RDoC): Toward a new classification framework for research on mental disorders. *American Journal of Psychiatry, 167*(7), 748–751.

Jane, J. S., Oltmanns, T. F., South, S. C., & Turkheimer, E. (2007). Gender bias in diagnostic criteria for personality disorders: An item response theory analysis. *Journal of Abnormal Psychology, 116*(1), 166.

Jani, S., Johnson, R. S., Banu, S., & Shah, A. (2016). Cross-cultural bias in the diagnosis of borderline personality disorder. *Bulletin of the Menninger Clinic, 80*(2), 146–165.

Kaplan, M. (1983). A woman's view of DSM-III. *American Psychologist, 38*(7), 786–792.

Lacasse, J. R. (2014). After DSM-5: A critical mental health research agenda for the 21st century Sage Publications Sage CA: Los Angeles, CA.

Lacasse, J. R., & Leo, J. (2005). Serotonin and depression: A disconnect between the advertisements and the scientific literature. *PLoS Medicine, 2*(12), e392.

Langer, E. J., & Abelson, R. P. (1974). A patient by any other name...: Clinician group difference in labeling bias. *Journal of Consulting and Clinical Psychology, 42*(1), 4.

Levin, M. E., Luoma, J. B., Vilardaga, R., Lillis, J., Nobles, R., & Hayes, S. C. (2016). Examining the role of psychological inflexibility, perspective taking, and empathic concern in generalized prejudice. *Journal of Applied Social Psychology, 46*(3), 180–191.

Lewis-Fernández, R., Hinton, D. E., Laria, A. J., Patterson, E. H., Hofmann, S. G., Craske, M. G., … Liao, B. (2010). Culture and the anxiety disorders: Recommendations for DSM-V. *Depression and Anxiety, 27*(2), 212–229.

Lilienfeld, S. O. (2014). The Research Domain Criteria (RDoC): An analysis of methodological and conceptual challenges. *Behaviour Research and Therapy, 62*, 129–139.

Lilienfeld, S. O. (2017). Microaggressions: Strong claims, inadequate evidence. *Perspectives on Psychological Science, 12*(1), 138–169. https://doi.org/10.1177/1745691616659391

Lilienfeld, S. O., & Lynn, S. J. (2015). Errors/biases in clinical decision making. In R. L. Cautin & S. O. Lilienfeld (Eds.), *The encyclopedia of clinical psychology* (Vol. 2, pp. 1098–1107). Hobooken, NJ: Wiley.

Lillis, J., & Levin, M. (2014). Acceptance and mindfulness for undermining prejudice. In A. Masuda (Ed.), *Mindfulness and acceptance in multicultural competency: A contextual approach to sociocultural diversity in theory and practice. Oakland, CA: New Harbinger* (pp. 181–196). Oakland, CA: Context Press.

Macrae, N. C., Bodenhausen, G. V., Milne, A. B., & Jetten, J. (1994). Out of mind but back in sight: Stereotypes on the rebound. *Journal of Personality and Social Psychology, 67*(5), 808–817.

Marques, L., Robinaugh, D. J., LeBlanc, N. J., & Hinton, D. (2011). Cross-cultural variations in the prevalence and presentation of anxiety disorders. *Expert Review of Neurotherapeutics, 11*(2), 313–322. https://doi.org/10.1586/ern.10.122

Masuda, A. (2014a). Psychotherapy in cultural context. In A. Masuda (Ed.), *Mindfulness and acceptance in multicultural competency: A contextual approach to sociocultural diversity in theory and practice* (pp. 39–55). Oakland, CA: New Harbinger Publication.

Masuda, A. (Ed.). (2014b). *Mindfulness and acceptance in multicultural competency: A contextual approach to sociocultural diversity in theory and practice*. Oakland, CA: Context Press/New Harbinger Publications.

Masuda, A. (2016). Principle-based cultural adaptation of cognitive behavior therapies: A functional and contextual perspective as an example. *Japanese Journal of Behavior Therapy, 42*(1), 11–19. Retrieved from http://ezproxy.gsu.edu:2048/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyhref&AN=JJBT.CD.ACG.MASUDA.ACTAJC&site=ehost-live

Masuda, A., Donati, M. R., Schaefer, L. W., & Hill, M. L. (2015). Terrorism as an act in context. In M. Taylor, J. Roach, & K. Pease (Eds.), *Evolutionary psychology and terrorism* (pp. 124–148).

Masuda, A., Hill, M. L., Morgan, J., & Cohen, L. L. (2012). A psychological flexibility-based intervention for modulating the impact of stigma and prejudice: A descriptive review of empirical evidence. *Psychology, Society & Education, 4*(2), 211–223. Retrieved from.

Merino, Y., Adams, L., & Hall, W. J. (2018). Implicit bias and mental health professionals: Priorities and directions for research. *Psychiatric Services, 0*(0), appi.ps.201700294. https://doi.org/10.1176/appi.ps.201700294

Monteith, M. J., & Mark, A. Y. (2005). Changing one's prejudiced ways: Awareness, affect, and self-regulation. *European Review of Social Psychology, 16*(1), 113–154.

Moxon, P. D., Keenan, M., & Hine, L. (1993). Gender-role stereotyping and stimulus equivalence. *The Psychological Record, 43*(3), 381–394.

Neighbors, H. W., Trierweiler, S. J., Munday, C., Thompson, E. E., Jackson, J. S., Binion, V. J., & Gomez, J. (1999). Psychiatric diagnosis of African Americans: Diagnostic divergence in clinician-structured and semistructured interviewing conditions. *Journal of the National Medical Association, 91*(11), 601–612.

Pauker, K., Ambady, N., & Apfelbaum, E. P. (2010). Race salience and essentialist thinking in racial stereotype development. *Child Development, 81*(6), 1799–1813. https://doi.org/10.1111/j.1467-8624.2010.01511.x

Pauker, K., Williams, A., & Steele, J. R. (2016). Children's racial categorization in context. *Child Development*

Perspectives, 10(1), 33–38. https://doi.org/10.1111/cdep.12155

Piccinelli, M., & Wilkinson, G. (2000). Gender differences in depression: Critical review. *British Journal of Psychiatry, 177*(6), 486–492. https://doi.org/10.1192/bjp.177.6.486

Pilgrim, D. (2014). Historical resonances of the DSM-5 dispute: American exceptionalism or Eurocentrism? *History of the Human Sciences, 27*(2), 97–117. https://doi.org/10.1177/0952695114527998

Poland, J., & Caplan, P. J. (2004). The deep structure of bias in psychiatric diagnosis. In P. J. Caplan & L. Cosgrove (Eds.), *Bias in psychiatric diagnosis* (pp. 9–23). Lanham, MD: Jason Aronson.

Roche, B., & Barnes-Holmes, D. (2003). Behavior analysis and social constructionism: Some points of contact and departure. *The Behavior Analyst, 26*(2), 215–231. Retrieved from http://ezproxy.gsu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2003-10336-003&site=ehost-live. Bryan.T.Roche@may.ie

Roche, B., Barnes-Holmes, D., Barnes-Holmes, Y., & Hayes, S. C. (2001). Social processes. In S. C. Hayes, D. Barnes-Holmes, & B. Roche (Eds.), *Relational frame theory: A post-Skinnerian account of human language and cognition* (pp. 197–209). New York, NY: Kluwer Academic/Plenum Publishers.

Roche, B., Barnes-Holmes, Y., Barnes-Holmes, D., Stewart, I., & O'Hora, D. (2002). Relational frame theory: A new paradigm for the analysis of social behavior. *The Behavior Analyst, 25*(1), 75–91. https://doi.org/10.1007/bf03392046

Rogers, W. A., & Mintzker, Y. (2016). Casting the net too wide on overdiagnosis: Benefits, burdens and non-harmful disease. *Journal of Medical Ethics, 42*, 717. https://doi.org/10.1136/medethics-2016-103715

Romans, S. E., Tyas, J., Cohen, M. M., & Silverstone, T. (2007). Gender differences in the symptoms of major depressive disorder. *The Journal of Nervous and Mental Disease, 195*(11), 905–911.

Schwartz, R. C., & Blankenship, D. M. (2014). Racial disparities in psychotic disorder diagnosis: A review of empirical literature. *World journal of Psychiatry, 4*(4), 133.

Skinner, B. F. (1957). *Verbal behavior*. East Norwalk, CT: Appleton Century Crofts.

Skinner, B. F. (1974). *About behaviorism*. Oxford, UK: Alfred A. Knopf.

Snowden, L. R. (2003). Bias in mental health assessment and intervention: Theory and evidence. *American Journal of Public Health, 93*(2), 239–243. https://doi.org/10.2105/ajph.93.2.239

Son Hing, L. S., Li, W., & Zanna, M. P. (2002). Inducing hypocrisy to reduce prejudicial responses among aversive racists. *Journal of Experimental Social Psychology, 38*(1), 71–78. https://doi.org/10.1006/jesp.2001.1484

Sue, S., Fujino, D. C., Hu, L.-T., Takeuchi, D. T., & Zane, N. W. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology, 59*(4), 533.

Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist, 42*(1), 37–45. https://doi.org/10.1037/0003-066x.42.1.37

Sue, S., Zane, N., Hall, G. C. N., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology, 60*, 525–548. https://doi.org/10.1146/annurev.psych.60.110707.163651

Sukhera, J., & Watling, C. (2018). A framework for integrating implicit bias recognition into health professions education. *Academic Medicine, 93*(1), 35–40.

Trull, T. J., Jahng, S., Tomko, R. L., Wood, P. K., & Sher, K. J. (2010). Revised NESARC personality disorder diagnoses: Gender, prevalence, and comorbidity with substance dependence disorders. *Journal of Personality Disorders, 24*(4), 412–426.

Twohig, M. P., Domenech Rodriguez, M. M., & Enno, A. M. (2014). Promoting the multicultural comptency of psychological professionals though acceptance- and mindfulness-based methods. In A. Masuda (Ed.), *Mindfulness and acceptance in multicultural competency: A contextual approach to sociocultural diversity in theory and practice* (pp. 147–163). Oakland, CA: New Harbinger Publication.

Wakefield, J. C. (1999). The concept of disorder as a foundation for the DSM's theory-neutral nosology: Response to Follette and Houts, Part 2. *Behaviour Research and Therapy, 37*(10), 1001–1027.

Wakefield, J. C. (2007). The concept of mental disorder: Diagnostic implications of the harmful dysfunction analysis. *World Psychiatry, 6*(3), 149–156.

Watt, A., Keenan, M., Barnes, D., & Cairns, E. (1991). Social categorization and stimulus equivalence. *The Psychological Record, 41*(1), 33–50. Retrieved from http://ezproxy.gsu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1991-17495-001&site=ehost-live

Way, N., & Rogers, O. (2015). "[T] hey say Black men won't make it, but I know I'm gonna make it": Ethnic and racial identity development in the context of cultural stereotypes. In K. C. McLean & M. Syed (Eds.), *The Oxford handbook of identity development* (pp. 296–285). New York, NY: Oxford University Press.

Wegner, D. M. (1994). Ironic processes of mental control. *Psychological Review, 101*(1), 34–52.

Wenzlaff, R. M., & Wegner, D. M. (2000). Thought suppression. *Annual Review of Psychology, 51*(1), 59–91.

Whooley, O. (2014). Nosological reflections: The failure of DSM-5, the emergence of RDoC, and the decontextualization of mental distress. *Society and Mental Health, 4*(2), 92–110.

Widiger, T. A. (1998). Invited essay: Sex biases in the diagnosis of personality disorders. *Journal of Personality Disorders, 12*(2), 95–118.

Widiger, T. A., & Spitzer, R. L. (1991). Sex bias in the diagnosis of personality disorders: Conceptual and methodological issues. *Clinical Psychology Review, 11*(1), 1–22.

Wilson, T. D., Lindsey, S., & Schooler, T. Y. (2000). A model of dual attitudes. *Psychological Review, 107*(1), 101–126. https://doi.org/10.1037/0033-295x.107.1.101

Discrimination, Prejudice, and Oppression and the Development of Psychopathology

Esha Vaid and Amy Hughes Lansing

Abstract

Experiences of discrimination, prejudice, and oppression across the life span have been evidenced to impact developmental processes, including the development of psychopathology. Potential mechanisms and links underpinning this impact were reviewed in this chapter. First, a developmental framework was reviewed to provide a life span developmental context to marginalization experienced by children and their parents. Experiences of discrimination, prejudice, and oppression were also conceptualized within previously studied stress models, including the diathesis-stress model and biopsychosocial stress processes. Then important biological and psychosocial mechanisms were discussed. This review highlights the importance of examining marginalization, as well as coping skills, formation of racial/cultural identity, and institutionalized/systemic marginalization from a developmental psychopathology perspective. Future directions proposed include conducting research that examines the impact of discrimination, prejudice, and oppression from an intersectional perspective, which incorporate an individual's culture, multiple identities, and statuses in addition to biosocial systems that explain trajectories of risk and resilience of psychopathology.

Keywords

Discrimination · Prejudice · Stress · Developmental psychopathology

Discrimination, Prejudice, and Oppression and the Development of Psychopathology

Discrimination, prejudice, oppression, and related experiences across childhood, adolescence, and adulthood are known to play a key role in human development and health disparities, including the developmental of psychopathology (Stuber, Meyer, & Link, 2008). In this chapter, we will discuss evidence supporting the ways in which perceptions of discrimination, prejudice, and oppression in ethnically and racially marginalized groups contribute to the development of psychopathology. First, we will describe discrimination, prejudice, and oppression and provide a developmental context for considering the experience of marginalization across the life span. We will also introduce the diathesis-stress model, which is frequently used

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L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_14

to link discrimination, prejudice, and oppression with impairments in health in ethnically and racially marginalized groups. Second, we will discuss evidence linking perceived discrimination, prejudice, and oppression with psychopathology in multiethnic children, adolescents, and adults. Third, we will describe research that has begun to elucidate the biopsychosocial stress processes that link perceptions of discrimination, prejudice, and oppression with the development of psychopathology across the life span. Finally, we will draw conclusions from this evidence and discuss future directions for research examining discrimination, prejudice, and oppression and the development of psychopathology in ethnically and racially marginalized groups.

Discrimination, Prejudice, Oppression, and Psychopathology

Discrimination, prejudice, and oppression may be key to understanding disparities in the development of psychopathology in marginalized groups, i.e., groups that are kept in an unimportant, peripheral, or powerless position in society. Prejudices, biased attitudes and beliefs about an individual's characteristics that are based on their social group, discrimination, engaging in biased behaviors that are based on those prejudices, oppression, and institutional and systemic social inequalities comprised of discrimination and prejudice all contribute to the daily lived experiences of marginalized individuals and groups (Stuber et al., 2008). Perceptions of discrimination, prejudice, and oppression are theorized to influence the development of psychopathology via changes in psychological, biological, and social stress processes across the life span, and we will discuss these mechanisms throughout this chapter.

Developmental Context of Discrimination, Prejudice, and Oppression

As we consider the role of discrimination, sigma, prejudice, and oppression in the development of psychopathology, it is critical to understand the age at which children first begin to understand and process the experience of discrimination, prejudice, and oppression, which provides a developmental time frame for this research. Children are able to develop an understanding of discrimination and prejudice at an early age (Quintana, 1998; Spears Brown & Bigler, 2005). For example, research suggests that exclusion based on membership of a social group is recognized as unfair by preschool-age children (Theimer, Killen, & Stangor, 2001). By elementary school age, children are able to define the word discrimination and are able to report experiencing discrimination (Verkuyten, Kinket, & van der Wielen, 1997). Further, among 10–12-year-old African American children, research has found that the majority report experiences of at least one incident of racial discrimination (Simons et al., 2002). Not only are school-age children able to define discrimination, but many children of marginalized groups report having experienced discrimination, prejudice, and oppression by middle school. Thus, children's experiences of discrimination, prejudice, and oppression may begin to influence developmental trajectories, including those related to psychopathology, at a young age.

At the same time, a key component of the child's developmental context also includes the parent. Parental experiences of discrimination, prejudice, and oppression will also affect the health of their children throughout development, possibly beginning at the earliest perinatal stages where stress is known to affect genetic and biological development (Dunkel Schetter & Tanner, 2012). Thus, links between discrimination, prejudice, and oppression and psychopathology can be considered from the developmental perspective of the child's perceptions of discrimination, prejudice, and oppression, as well as how parental experiences of discrimination, prejudice, and oppression may influence the health of the parent and, in turn, their child. As we explore the association of experiences of discrimination, prejudice, and oppression with the development of psychopathology and the biopsychosocial mechanisms that might explain those links in this chapter, it will be beneficial to keep both of these developmental perspectives in mind.

Diathesis-Stress Model

There is increasing research, largely grounded in the diathesis-stress model, that has examined and supported the link between discrimination, prejudice, and oppression and psychopathology in children and adolescents, as well as adults. The diathesis-stress model is highly relevant to perceptions of discrimination, prejudice, and oppression as those perceptions are known to exacerbate psychological and physiological stress systems. For example, merely the anticipation of potential experiences of prejudice has been found to lead to responses consistent with psychological stress (Meyer, 2003). Further, adolescents of all minority ethnicities in the U.S. report experiencing distress related to discrimination both from their peers and educational institutions (Fisher, Wallace, & Fenton, 2000). Research has also found that by middle childhood, biological changes to stress regulatory systems, such as changes in cortisol regulation, are associated with mothers' reports of racial and socioeconomic disadvantage (Tackett, Herzhoff, Smack, Reardon, & Adam, 2017). These findings highlight the importance of understanding how increased environmental stress related to experiences of discrimination, prejudice, and oppression might increase the risk for psychopathology. Specifically, the diathesis-stress model purports that perceptions of discrimination, prejudice, and oppression contribute to the onset and maintenance of psychopathology by increasing environmental stress in biologically vulnerable individuals from marginalized groups (Krieger, 1990). Research on this model has begun to identify multiple psychological, biological, and social stress processes that may mediate the link between discrimination, prejudice, and oppression and psychopathology.

Drawing on this diathesis-stress model research, we will first begin by describing studies that link perceptions of discrimination, prejudice, and oppression with psychopathology across the life span. Then we will discuss research that examines the biopsychosocial stress processes that have been found to link perceptions of discrimination, prejudice, and oppression with psychopathology. It should be noted that most of this research has used measures of perceived discrimination, prejudice, and oppression as research and theory suggest that perceptions of discrimination, prejudice, and oppression (as opposed to "actual experiences") are most proximal and relevant to individuals' experiences of stress and distress (Pascoe & Richmond, 2009). Further, this research has employed largely cross-sectional and longitudinal methodologies as experimental designs that subject youths to repeated discrimination across time to study specific causal downstream effects on the development of psychopathology would be unethical.

Perceptions of Discrimination, Prejudice, and Oppression and Development of Psychopathology Across the Life Span

Multiple studies have found a link between perceptions of discrimination, prejudice, and oppression and internalizing symptoms in youths and adults from ethnically and racially marginalized groups. For example, in a sample of African American adolescents, perceptions of racial discrimination were linked with lower levels of psychological functioning, including increased perceived stress, increased depression symptoms, and poorer general psychological well-being (Sellers, Copeland-Linder, Martin, & Lewis, 2006). Similar evidence has also been found in African American boys where perceived experiences of racism have been linked with internalizing symptoms broadly (Nyborg & Curry, 2003) and with depressive symptoms specifically (Simons et al., 2002). Additionally, research in a sample of Puerto Rican adolescents found associations between perceived discrimination and both increased depression and stress (Szalacha et al., 2003). Research also suggests that some ethnic groups may be at greater risk. For example, Caribbean Black youth in the US evidence greater vulnerability to depressive symptoms when reporting greater perceived experiences of discrimination compared to African American and White American youth (Seaton, Caldwell, Sellers, & Jackson, 2008). Last, these associations with internalizing symptoms persist, with longitudinal research examining Black, Latino, and Asian adolescents finding evidence that perceptions of discrimination from both peers and adults was associated with increased depressive symptoms across time (Greene, Way, & Pahl, 2006).

In addition, researchers have also linked perceptions of discrimination, oppression, and stigma with increases in externalizing behavior in young people. For example, in African American adolescent boys, perceived experiences of racism have been linked with not only internalizing symptoms but also increases in externalizing behaviors (Nyborg & Curry, 2003). Early perceptions of discrimination have also been linked with conduct disorder diagnoses in African American children (Gibbons et al., 2007). Among African American families, perceptions of racism have been linked to substance use in both parents and children in the family (Gibbons, Gerrard, Cleveland, Wills, & Brody, 2004). Perceptions of discrimination have also been linked with increases in violent behavior of female and male African American emerging adults (Caldwell et al., 2005). The diathesis-stress model theorizes that perceptions of discrimination, prejudice, and oppression may serve as catalysts for externalizing symptomatology (Gibbons et al., 2004). For example, increased stress might potentiate violent behaviors and substance use, and, in turn, these behaviors may be further reinforced by buffering the effects of stressful experiences.

Further, Prelow, Danoff-Burg, Swenson, and Pulgiano (2004) explored these same links while attempting to clarify if perceived discrimination or cumulative ecological risk (i.e., neighborhood disadvantage and ecologically salient stressful events) might each be uniquely linked with psychopathology in African American and European American adolescents. Cumulative ecological risk evidenced unique associations with internalizing and externalizing symptoms across both groups. However, in African American adolescents only, perceived discrimination moderated the link between ecological risk and externalizing symptoms, in particular delinquency. Higher perceived discrimination exacerbated the link between greater ecological risk and greater delinquency.

Research examining discrimination, prejudice, oppression, and psychopathology in adult populations supports the robustness of the link between perceptions of discrimination, prejudice, and oppression and psychopathology, as well as the likely continuity of the link between these perceptions and the development of psychopathology from childhood into adulthood. For example, perceptions of racism have been found to have both immediate and cumulative impacts on physical and mental health in African American adults (Jackson et al., 1996). Perceived racial discrimination has been suggested to significantly increase the likelihood of mental health symptomatology in marginalized adults including explaining upward of 15% of the variance in African American adults' psychopathology symptoms and increase psychopathology rates in Asian, Hispanic, and African American adults (Chou, Asnaani, & Hofmann, 2012; Klonoff, Landrine, & Ullman, 1999). A meta-analytic review of 138 empirical studies examining racism and health in adults noted consistent links between racism and negative mental health and health-related behaviors (Paradies, 2006). For example, greater perceptions of racism have been linked with both greater psychiatric symptoms and increased frequency of cigarette smoking (Landrine & Klonoff, 1996).

These findings linking perceptions of discrimination, prejudice, and oppression with internalizing and externalizing symptoms in childhood, adolescence, and adulthood support the importance of better understanding the developmental processes by which discrimination, prejudice, and oppression are linked with psychopathology in ethnically and racially marginalized groups. Specifically, research points to biopsychosocial stress processes as key mechanisms that might underlie links between discrimination, prejudice, and oppression and psychopathology.

Biopsychosocial Stress Processes Linking Discrimination, Prejudice, Oppression, and Psychopathology

Consistent with the diathesis-stress model, psychological perceptions of stress and changes in biological stress regulatory systems have been the primary foci of research examining biopsychosocial mechanisms that might explain the link between discrimination, prejudice, and oppression and psychopathology. Psychological research on perceived stress has also examined intrapersonal, interpersonal, and institutional social factors that might exacerbate perceived stress in the context of experiences of discrimination, prejudice, and oppression, further increasing the risk for psychopathology. Factors examined in this research include poor coping skills, internalized discrimination, in which marginalized individuals internalize, and integrate into their own identity and schemas, the social biases (prejudice and discrimination) levied against their group, racial/cultural identity, how one develops their identity associated to their race and culture, impaired family and peer relationships, and institutionalized oppression, in which marginalization via methods of discrimination and prejudice occurs systemically at an institutional level, including employment and access to education and healthcare. Similarly, biological research on stress mechanisms linking discrimination, prejudice, and oppression and psychopathology has examined multiple mechanisms of risk, including cumulative changes in stress regulatory systems (i.e., allostatic load), impairment in specific stress systems (e.g., cortisol regulation, heart rate variability), and gene by environment interactions in genes associated downstream with stress regulatory systems. This research suggests that a complex, transactional, and biopsychosocial process must be further elucidated to better understand the stress mechanisms linking discrimination, prejudice, and oppression with psychopathology in ethnically and racially marginalized groups.

Psychological Mechanisms

With regard to perceived stress, research in African American children and adolescents has found that greater discrimination serves to increase the strength of the association between higher cumulative perceived stress and poorer psychological well-being (Murry, Brown, Brody, Cutrona, & Simons, 2001). Further, increases in perceived stress related to discrimination are also associated with increased anxiety and depression (Gaylord-Harden & Cunningham, 2009). Among Hispanic youth, increased acculturative stress, defined as the stress that is experienced by immigrants, refugees, and other nonnatives as they are adapting to the new surrounding cultures, is associated with both increased experiences of discrimination and greater symptoms of anxiety (Suarez-Morales & Lopez, 2009). In African American children, problems with emotion dysregulation, including increased feelings of anger and sadness, an overlapping construct with perceived distress, have also been found to explain the association between perceived discrimination and increased delinquency (Simons, Chen, Stewart, & Brody, 2003). Similarly, among African American adolescents, perceived discrimination and increased distress (measured as negative affect) have also been associated with increased affiliation with deviant peers and more frequent engagement in risky sexual behaviors (Roberts et al., 2012). In Black American adults, similar associations are found where perceived racial discrimination is associated with increased psychological distress and likelihood of experiencing depression (Brown et al., 2000). An ecological momentary assessment study in multiethnic adults also supported that even daily perceptions of discrimination are directly associated with known predictors of psychopathology, increased negative mood states, and negative interpersonal events at a daily level (Broudy et al., 2007). These findings support that perceived stress is a critical psychological mechanism linking discrimination, prejudice, and oppression and psychopathology.

Moreover, psychological research suggests that individuals' coping skills, self-control, internalization of discrimination, and formation of racial/cultural identity may serve to further mediate, buffer, or exacerbate the link between discrimination, prejudice, and oppression; perceived stress; and psychopathology. For example, among African American adults, research has found that the use of avoidance coping, i.e., making efforts to avoid dealing with or escape a stressor, in response to perceptions of race-related marginalization, was associated with exacerbations in race-related perceived stress, lower self-esteem, and poorer quality of life (Utsey, Ponterotto, Reynolds, & Cancelli, 2000). Among African American adolescents, increased discrimination has been associated with reductions in self-control capacity, along with increased reports of anger and, in turn, increased substance use (Gibbons et al., 2012). Acceptance or internalization of negative stereotypes, commonly held and maintained in American culture, may also contribute to increased stress and psychopathology via increased negative self-evaluations (King, 2005; R. Williams & Williams-Morris, 2000). For example, among Latino adolescents, perceived ethnic discrimination in early high school predicted changes in self-esteem across high school and worse self-esteem for males, as well as increased depressive symptoms in early high school (Zeiders, Umaña-Taylor, & Derlan, 2013). Finally, among African American young adults, there is also evidence that low centrality of race to identity is associated with worse psychological well-being in part through exacerbations in perceived stress in response to discrimination (Sellers, Caldwell, Schmeelk-Cone, & Zimmerman, 2003).

There is also research to suggest that high-centrality race identity, positive race identity, and level of acculturation may be protective with regard to stress and psychopathology. For example, although African Americans who report higher centrality for race identity report more frequent experiences of discrimination, those experiences do not result in similar increases in perceived stress or impairment in psychological well-being (Hunter & Schmidt, 2010; Sellers et al., 2003). Similarly, among African American adolescents, the association between perceived discrimination and poor academic performance is buffered by a positive connection to racial identity (Wong, Eccles, & Sameroff, 2003). Among adults of Mexican origin, U.S. native vs. immigrant status moderated the link between acculturation and perceived discrimination, which in turn predicted depression symptoms, with high acculturation protective for native but not immigrant individuals and moderate acculturative stress a risk for U.S. native individuals (Finch, Kolody, & Vega, 2000). These studies support the importance of cognitive, behavioral, and emotional processes, such as coping skills, self-control, racial identity, acculturation, and internalized discrimination, in predicting and moderating the links between discrimination, prejudice, and oppression; perceived stress; and psychopathology. More research is needed to clarify how these processes function in different marginalized groups and across the life span in explaining psychopathology.

Social Mechanisms

Research also provides evidence that family and peer relationships, as well as institutionalized/systemic oppression, are intricately associated with stress and the development of psychopathology. For example, parental support was shown to buffer the association of perceived discrimination and increased anger in African American adolescents, where increased parental support was associated with lower anger and, in turn, decreased engagement in violent behaviors (Simons et al., 2006). Similarly, active parental communication about positive self-worth and interracial equality and coexistence, as well as family engagement in activities or behaviors involving the minority culture, were associated with enhanced academic achievement in African American adolescents, perhaps counteracting experiences of discrimination (Neblett, Philip, Cogburn, & Sellers, 2006). Research also suggests that problematic peer relationships might exacerbate the link between discrimination, prejudice, and oppression and externalizing behaviors. For example, early experiences of racial discrimination have been associated with increased cannabis use in adolescence, and this association is partially explained via increased affiliations with friends who also use drugs (Gibbons et al., 2007). Attentive parenting, though, may buffer the link between discrimination, greater affiliation with deviant peer groups, and greater engagement in risk behaviors (Roberts et al., 2012). Healthy interpersonal relationships may provide a buffer to the negative outcomes of discrimination, prejudice, and oppression, while unhealthy interpersonal relationships may exacerbate those problematic outcomes, including via increased perceptions of distress or associated changes in behaviors (e.g., substance use) that are linked with psychopathology.

Moreover, institutional and systemic oppression in broader social ecosystems may serve to foment discrimination and prejudice and exacerbate the associations of those experiences with perceived stress and psychopathology (Pearlin, Schieman, Fazio, & Meersman, 2005). For example, research has suggested that observed disparities in the mental and physical health of Black and White Americans that are explained by discrimination and perceived stress are diminished in higher educated and higher income Black families (Williams, Yan Yu, Jackson, & Anderson, 1997). Disparities in the use of mental health services (i.e., less frequent access to services, greater use of emergency departments, and experiencing more coercive referrals) to prevent or treat psychiatric symptoms among minority individuals in the U.S. have also been linked to neighborhood poverty (Chow, Jaffee, & Snowden, 2003). Research also suggests that racial segregation, or separation based on race, above and beyond education and income, may further exacerbate health disparities for Black Americans (Subramanian, Acevedo-Garcia, & Osypuk, 2005). Systemically maintained differences in the socio-economic status of Black, and other minority groups, compared to White Americans may exacerbate the risk for psychopathology and limit access to preventive and treatment services. Although upward social mobility may buffer that risk, systemic oppression continues to limit opportunities for upward mobility by hindering access to important health resources and healthy living conditions that are associated with improved physical and mental health (R. Williams & Williams-Morris, 2000).

Further, there is also evidence that systemic oppression and family relationships interact across development in explaining adolescent psychopathology. In a longitudinal study of youths in families of Mexican origin, evidence was found that mothers' experiences of economic stress were associated with more harsh parenting style, which, in turn, was associated with greater externalizing problems for adolescents (White, Liu, Nair, & Tein, 2015). Similar associations were also found for fathers' experiences of economic and neighborhood stress, which led to decreased paternal warmth and greater internalizing problems for adolescents. Yet when mothers portrayed a strong orientation to the value of family, the association between experiences of economic pressure and changes in parenting style were decreased, providing a protection to the adolescent in terms of the development of psychopathology.

Psychosocial research clearly supports that perceived stress is a critical psychological mechanism linking discrimination, prejudice, and oppression and psychopathology; however, knowledge about key psychological and social factors that might exacerbate or mitigate that risk is more limited. Further research is needed to better elucidate the intrapersonal, interpersonal, and institutional/systemic social processes by which marginalized groups experience increased risk for psychopathology across the life span.

Biological Mechanisms

Research on changes in biological stress regulatory systems in marginalized individuals has also provided evidence for physiological pathways that link discrimination, prejudice, and oppression with the development of psychopathology (Berger & Sarnyai, 2015). For example, allostatic load is an index that is often used to measure cumulative dysregulation in biological stress regulatory systems. High allostatic load is theorized as a key mechanism underlying the development of psychopathology (Koss & Gunnar, 2018). By age 20, African American youths who have reported experiencing high levels of discrimination as adolescents evidenced elevated allostatic load, as indexed by impairment across cardiovascular, metabolic, immune, and neuroendocrine systems (Brody et al., 2014). Among African American adults, increased frequency of perceived everyday experiences of discrimination remain associated with increased allostatic load (Ong, Williams, Nwizu, & Gruenewald, 2017). Similarly, midlife African American women with less income and lower education are more likely to experience discrimination and perceived stress and, in turn, greater allostatic load (Upchurch et al., 2015). Notably, the link between marginalization in adolescence and allostatic load in African American emerging adults was buffered by the provision of high levels of emotional support from parents and peers during the transition to emerging adulthood (Brody et al., 2014). This research suggests that transactional associations between discrimination, prejudice, and oppression, social support, and later health outcomes associated with high allostatic load will be important to elucidate in understanding how discrimination, prejudice, and oppression are linked with the development of psychopathology.

In addition, specific biological stress subsystems, including heart rate variability and patterns of cortisol regulation, have also been examined in marginalized populations toward understanding health disparities. For example, research has found that in young Latino children, economic hardship and acculturation interacted to predict average salivary cortisol levels, with greater economic hardship or low economic hardship, along with high acculturation associated with lower mean cortisol levels (Mendoza, Dmitrieva, Perreira, Hurwich-Reiss, & Watamura, 2017). Lower mean cortisol levels have been suggested to contribute to greater impairments in psychological functioning (Gunnar & Vazquez, 2001). In addition, research conducted in a sample of preschool-aged Hispanic children found that greater economic stress was associated to greater cortisol reactivity during a challenging task, suggesting impaired stress regulation, with the effect strongest for children of Hispanic immigrants, a population experiencing high levels of marginalization and economic stress (McFadyen-Ketchum et al., 2016). In African American young adults, a greater burden of discrimination has been associated with lower resting heart rate variability, an indicator of impairment in the responsivity of the stress regulatory system, which may exacerbate emotion dysregulation and psychopathology (Hill et al., 2017).

Last, evidence from gene by environment studies suggests that biological vulnerabilities in genes that affect the functioning of neural systems involved in the experience and regulation of stress interact with repeated discrimination, prejudice, and oppression to exacerbate the risk for the development of psychopathology. For example, the 5-HTTLPR gene is known to promote the encoding of proteins related to serotonin transportation and to impact social processing via the amygdala. Among African American adolescent males, individuals carrying the higher risk variants of the 5-HTTLPR gene (i.e., one or two copies of the short allele) evidenced stronger associations between perceived discrimination and conduct problems (Brody et al., 2011). Similarly, among multiethnic adolescent males, research found that gene polymorphisms associated with low MAOA enzyme production, which is involved in the processing of dopamine and serotonin and affects frontal neural processes, exacerbated the association between perceptions of prejudice and probability of being arrested, a key indicator of externalizing psychopathology in the youth (Schwartz & Beaver, 2011).

These findings from biological research suggest strong associations between discrimination, prejudice, and oppression and impairments in biological stress regulatory systems, which are then linked with impairments in physical and mental health (Causadias, Telzer, & Lee, 2017). These studies also highlight the role that genetic biological vulnerabilities might have in explaining differential susceptibility to the development of psychopathology in response to discrimination, prejudice, and oppression across childhood and adolescence. Although there are robust findings related to biological stress mechanisms, it is important to note that there are many subtle dimensions of the experience of discrimination, prejudice, and oppression that are not captured by biological metrics alone. For example, Brody et al., 2014, found that emotional support from family and peers might mitigate the effects of perceived discrimination on allostatic load. Thus, a multifaceted biopsychosocial approach to understanding discrimination, prejudice, and oppression and psychopathology is critical (Harrell, Hall, & Taliaferro, 2003; Lewis, Cogburn, & Williams, 2015).

Conclusions and Future Directions

Research on psychological perceptions of stress and biological stress regulatory processes support the diathesis-stress model, wherein increased stress is a key mechanism through which discrimination, prejudice, and oppression are linked with the development of psychopathology in ethnically and racially marginalized groups. In addition, this research suggests that individuals' coping skills, internalization of discrimination, and formation of racial/cultural identity, as well as family and peer relationships, and institutionalized/systemic marginalization also mediate and exacerbate the links between discrimination, prejudice, and oppression; increased perceived stress; changes in biological stress regulatory systems; and psychopathology. Although the focus of this chapter is on psychopathology outcomes, it is worth noting that changes in psychological and biological stress regulatory systems drive not only changes in psychopathology but also disparities in physical health (Everson-Rose et al., 2015), which may, in turn, place marginalized individuals at even greater risk for psychopathology.

Intergenerational Transmission of Risk for Psychopathology

Returning to the developmental context, not only is there evidence that discrimination, prejudice, and oppression affect perceived stress, biological stress systems, and psychopathology in children and adolescents—this process is simultaneously occurring among parents, too. Intergenerational transmission of risk for psychopathology is highly relevant to the study of discrimination, prejudice, and oppression and psychopathology (Bifulco et al., 2002; Goodman & Gotlib, 1999; Serbin & Karp, 2004). For example, in African American mothers, research has found that mothers' perceptions of discrimination were associated with increased stress-related health problems and symptoms of depression in mothers (Brody et al., 2008), as would be expected given the body of work reviewed above. Notably, those symptoms of depression in African American mothers were then, in turn, associated with greater impairments in parenting, a key contributor to intergenerational transmission of psychopathology (Hammen, Shih, & Brennan, 2004). Researchers have also theorized that stress experiences of marginalized groups, such as acculturation stress in first-generation Hispanic Americans, might explain intergenerational transmission of chronic health conditions via prenatal changes in fetal programming in metabolic, immune, and neuroendocrine systems (Fox, Entringer, Buss, DeHaene, & Wadhwa, 2015). Continued research on intergenerational transmission is needed to better understand how disparities in psychopathology and other chronic health conditions are transmitted via biopsychosocial mechanisms across generations in ethnically and racially marginalized families.

Future Directions

First, future research examining how discrimination, prejudice, and oppression lead to the development of psychopathology must continue to elucidate the complex, transactional, and developmental biopsychosocial mechanisms that confer risk or protection. In particular, there have been increased calls to examine not only discrimination, prejudice, and oppression but also culture and cultural identity from the developmental psychopathology perspective (Causadias, 2013). The developmental psychopathology approach examines the transactional associations of biological vulnerabilities, psychological functioning, and the environment across time to identify trajectories of risk and resilience for psychopathology (Cicchetti & Rogosch, 2002).

Second, beyond adopting a developmental psychopathology approach, future research should also aim to examine subgroup differences, as well as intersectionality in multiethnic groups, including differences by race/ethnicity, gender, and native vs. immigrant vs. refugee status, and for immigrants, the number of generations in the U.S. Causadias (2013) provides a framework for future developmental psychopathology research to address these complexities in the links between culture and psychopathology. In addition, research must also expand to understudied groups. For example, research indicates that adolescent refugees in the U.S. also experience increased stress and psychopathology in response to experiences of discrimination, prejudice, and oppression; however, there are limited studies on biopsychosocial mechanisms in this group (Ellis, MacDonald, Lincoln, & Cabral, 2008).

Third, research should also aim to clarify the overlapping and unique processes that link discrimination, prejudice, and oppression and psychopathology to facilitate the development of tailored prevention and intervention programs. In this regard, there has been limited research on interventions that might directly combat the impact of discrimination, prejudice, and oppression on the development of psychopathology. However, social emotion learning and character development programs for minority and low socioeconomic status youths have been shown to provide resources to children and adolescents to better cope with and respond to experiences of marginalization by allowing them to better find and use their own voice. Although the extent to which these programs specifically address discrimination, prejudice, and oppression are not well documented, it has been noted that these programs are helpful for youths at risk of developing psychopathology (Kroeger et al., 2016; Sellman, 2009).

Fourth, the life span developmental context for discrimination, prejudice, and oppression and the development of psychopathology suggest that prevention and intervention approaches should begin early in life, perhaps even prenatally (Braveman & Barclay, 2009). For example, recommendations have been made for preventive interventions to limit health disparities for children to focus on increasing parents' behavioral skills for reducing their own and their child's stress, especially related to experiences of discrimination, prejudice, and oppression, rather than providing parenting education only (Finch et al., 2000). Preventive models in childhood should also focus on systemic or institutional oppression and barriers to upward social mobility. For example, food supplementation programs in schools have been shown to reduce the association between low socioeconomic status and a key developmental outcome linked with the development of psychopathology and poor academic performance (Weinreb et al., 2002).

Finally, given the likely importance of intergenerational transmission of disparities in psychopathology among ethnically and racially marginalized groups, research should also aim to enhance prevention among multiethnic parents with psychopathology (Beardslee, Gladstone, & O'Connor, 2011). Research on such programs is positive, suggesting that prevention is effective in reducing the development of psychopathology in youths (for a review, see Siegenthaler, Munder, & Egger, 2012), although adaptations may be needed to address parents' experiences specific to discrimination, prejudice, and oppression and related distress.

References

Beardslee, W. R., Gladstone, T. R. G., & O'Connor, E. E. (2011). Transmission and prevention of mood disorders among children of affectively ill patents: A review. *Journal of the American Academy of Child & Adolescent Psychiatry, 50*(11), 1098–1109. https://doi.org/10.1016/j.jaac.2011.07.020

Berger, M., & Sarnyai, Z. (2015). "More than skin deep": Stress neurobiology and mental health consequences of racial discrimination. *Stress, 18*(1), 1–10. https://doi.org/10.3109/10253890.2014.989204

Bifulco, A., Moran, P. M., Ball, C., Jacobs, C., Baines, R., Bunn, A., & Cavagin, J. (2002). Childhood adversity, parental vulnerability and disorder: Examining intergenerational transmission of risk. *Journal of Child Psychology and Psychiatry, 43*(8), 1075–1086. https://doi.org/10.1111/1469-7610.00234

Braveman, P., & Barclay, C. (2009). Health disparities beginning in childhood: A life-course perspective. *Pediatrics, 124 Suppl 3*(Supplement 3), S163–S175. https://doi.org/10.1542/peds.2009-1100D

Brody, G. H., Beach, S. R. H., Chen, Y.-F., Obasi, E., Philibert, R. A., Kogan, S. M., & Simons, R. L. (2011). Perceived discrimination, serotonin transporter linked polymorphic region status, and the development of conduct problems. *Development and Psychopathology, 23*(2), 617–627. https://doi.org/10.1017/S0954579411000046

Brody, G. H., Chen, Y.-F., Kogan, S. M., Murry, V. M., Logan, P., & Luo, Z. (2008). Linking perceived discrimination to longitudinal changes in African American mothers' parenting practices. *Journal of Marriage and Family, 70*(2), 319–331. https://doi.org/10.1111/j.1741-3737.2008.00484.x

Brody, G. H., Lei, M.-K., Chae, D. H., Yu, T., Kogan, S. M., & Beach, S. R. H. (2014). Perceived discrimination among African American adolescents and allostatic load: A longitudinal analysis with buffering effects. *Child Development, 85*(3), 989–1002. https://doi.org/10.1111/cdev.12213

Broudy, R., Brondolo, E., Coakley, V., Brady, N., Cassells, A., Tobin, J. N., & Sweeney, M. (2007). Perceived ethnic discrimination in relation to daily moods and negative social interactions. *Journal of Behavioral Medicine, 30*(1), 31–43. https://doi.org/10.1007/s10865-006-9081-4

Brown, T. N., Williams, D. R., Jackson, J. S., Neighbors, H. W., Torres, M., Sellers, S. L., & Brown, K. T. (2000). "Being black and feeling blue": The mental health consequences of racial discrimination. *Race and Society, 2*(2), 117–131. https://doi.org/10.1016/S1090-9524(00)00010-3

Caldwell, L. C., Schweinsburg, A. D., Nagel, B. J., Barlett, V. C., Brown, S. A., & Tapert, S. F. (2005). Gender and adolescent alcohol use disorders on BOLD (blood oxygen level dependent) response to spatial working memory. *Alcohol and Alcoholism, 40*(3), 194–200. agh134 [pii]. https://doi.org/10.1093/alcalc/agh134

Causadias, J. M. (2013). A roadmap for the integration of culture into developmental psychopathology. *Development and Psychopathology, 25*(4 Pt 2), 1375–1398. https://doi.org/10.1017/S0954579413000679

Causadias, J. M., Telzer, E. H., & Lee, R. M. (2017). Culture and biology interplay: An introduction. *Cultural Diversity and Ethnic Minority Psychology, 23*(1), 1–4. https://doi.org/10.1037/cdp0000121

Chou, T., Asnaani, A., & Hofmann, S. G. (2012). Perception of racial discrimination and psychopathology across three U.S. ethnic minority groups. *Cultural Diversity and Ethnic Minority Psychology, 18*(1), 74–81. https://doi.org/10.1037/a0025432

Chow, J. C.-C., Jaffee, K., & Snowden, L. (2003). Racial/ethnic disparities in the use of mental health services in poverty areas. *American Journal of Public Health, 93*(5), 792–797. https://doi.org/10.2105/AJPH.93.5.792

Cicchetti, D., & Rogosch, F. (2002). A developmental psychopathology perspective on adolescence. *Journal of Consulting and Clinical Psychology, 70*, 6–20.

Dunkel Schetter, C., & Tanner, L. (2012). Anxiety, depression and stress in pregnancy: Implications for mothers, children, research, and practice. *Current Opinion in Psychiatry, 25*(2), 141–148. https://doi.org/10.1097/YCO.0b013e3283503680

Ellis, B. H., MacDonald, H. Z., Lincoln, A. K., & Cabral, H. J. (2008). Mental health of Somali adolescent refugees: The role of trauma, stress, and perceived discrimination. *Journal of Consulting and Clinical Psychology, 76*(2), 184–193. https://doi.org/10.1037/0022-006X.76.2.184

Everson-Rose, S. A., Lutsey, P. L., Roetker, N. S., Lewis, T. T., Kershaw, K. N., Alonso, A., & Diez Roux, A. V. (2015). Perceived discrimination and incident cardiovascular events. *American Journal of Epidemiology, 182*(3), 225–234. https://doi.org/10.1093/aje/kwv035

Finch, B. K., Kolody, B., & Vega, W. A. (2000). Perceived discrimination and depression among Mexican-origin adults in California. *Journal of Health and Social Behavior, 41*(3), 295. https://doi.org/10.2307/2676322

Fisher, C. B., Wallace, S. A., & Fenton, R. E. (2000). Discrimination distress during adolescence. *Journal of Youth and Adolescence, 29*(6), 679–695. https://doi.org/10.1023/A:1026455906512

Fox, M., Entringer, S., Buss, C., DeHaene, J., & Wadhwa, P. D. (2015). Intergenerational transmission of the effects of acculturation on health in Hispanic Americans: A fetal programming perspective. *American Journal of Public Health, 105 Suppl 3*(Suppl 3), S409–S423. https://doi.org/10.2105/AJPH.2015.302571

Gaylord-Harden, N. K., & Cunningham, J. A. (2009). The impact of racial discrimination and coping strategies on internalizing symptoms in African American youth. *Journal of Youth and Adolescence, 38*(4), 532–543. https://doi.org/10.1007/s10964-008-9377-5

Gibbons, F. X., Gerrard, M., Cleveland, M. J., Wills, T. A., & Brody, G. (2004). Perceived discrimination and substance use in African American parents and their children: A panel study. *Journal of Personality and Social Psychology, 86*(4), 517–529. https://doi.org/10.1037/0022-3514.86.4.517

Gibbons, F. X., O'Hara, R. E., Stock, M. L., Gerrard, M., Weng, C.-Y., & Wills, T. A. (2012). The erosive effects of racism: Reduced self-control mediates the relation between perceived racial discrimination and substance use in African American adolescents. *Journal of Personality and Social Psychology, 102*(5), 1089–1104. https://doi.org/10.1037/a0027404

Gibbons, F. X., Yeh, H.-C., Gerrard, M., Cleveland, M. J., Cutrona, C., Simons, R. L., & Brody, G. H. (2007). Early experience with racial discrimination and conduct disorder as predictors of subsequent drug use: A critical period hypothesis. *Drug and Alcohol Dependence, 88*, S27–S37. https://doi.org/10.1016/j.drugalcdep.2006.12.015

Goodman, S. H., & Gotlib, I. H. (1999). Risk for psychopathology in the children of depressed mothers: A developmental model for understanding mechanisms of transmission. *Psychological Review, 106*(3), 458–490. https://doi.org/10.1037/0033-295X.106.3.458

Greene, M. L., Way, N., & Pahl, K. (2006). Trajectories of perceived adult and peer discrimination among Black, Latino, and Asian American adolescents: Patterns and psychological correlates. *Developmental Psychology, 42*(2), 218–236. https://doi.org/10.1037/0012-1649.42.2.218

Gunnar, M. R., & Vazquez, D. M. (2001). Low cortisol and a flattening of expected daytime rhythm: Potential indices of risk in human development. *Development and Psychopathology, 13*(3), 515–538. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/11523846

Hammen, C., Shih, J. H., & Brennan, P. A. (2004). Intergenerational transmission of depression: Test of an interpersonal stress model in a community sample. *Journal of Consulting and Clinical Psychology, 72*(3), 511–522. https://doi.org/10.1037/0022-006X.72.3.511

Harrell, J. P., Hall, S., & Taliaferro, J. (2003). Physiological responses to racism and discrimination: An assessment of the evidence. *American Journal of Public Health, 93*(2), 243–248. https://doi.org/10.2105/AJPH.93.2.243

Hill, L. K., Hoggard, L. S., Richmond, A. S., Gray, D. L., Williams, D. P., & Thayer, J. F. (2017). Examining the association between perceived discrimination and heart rate variability in African Americans. *Cultural Diversity and Ethnic Minority Psychology, 23*(1), 5–14. https://doi.org/10.1037/cdp0000076

Hunter, L. R., & Schmidt, N. B. (2010). Anxiety psychopathology in African American adults: Literature review and development of an empirically informed sociocultural model. *Psychological Bulletin, 136*(2), 211–235. https://doi.org/10.1037/a0018133

Jackson, J. S., Brown, T. N., Williams, D. R., Torres, M., Sellers, S. L., & Brown, K. (1996). Racism and the physical and mental health status of African Americans: A thirteen year national panel study. *Ethnicity & Disease, 6*(1–2), 132–147. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/8882842

King, K. R. (2005). Why is discrimination stressful? The mediating role of cognitive appraisal. *Cultural Diversity and Ethnic Minority Psychology, 11*(3), 202–212. https://doi.org/10.1037/1099-9809.11.3.202

Klonoff, E. A., Landrine, H., & Ullman, J. B. (1999). Racial discrimination and psychiatric symptoms among Blacks. *Cultural Diversity & Ethnic Minority Psychology, 5*(4), 329–339. https://doi.org/10.1037/1099-9809.5.4.329

Koss, K. J., & Gunnar, M. R. (2018). Annual research review: Early adversity, the hypothalamic-pituitary-adrenocortical axis, and child psychopathology. *Journal of Child Psychology and Psychiatry, 59*(4), 327–346. https://doi.org/10.1111/jcpp.12784

Krieger, N. (1990). Racial and gender discrimination: Risk factors for high blood pressure? *Social Science & Medicine, 30*(12), 1273–1281. https://doi.org/10.1016/0277-9536(90)90307-E

Landrine, H., & Klonoff, E. A. (1996). The schedule of racist events: A measure of racial discrimination and a study of its negative physical and mental health consequences. *Journal of Black Psychology, 22*(2), 144–168. https://doi.org/10.1177/00957984960222002

Lewis, T. T., Cogburn, C. D., & Williams, D. R. (2015). Self-reported experiences of discrimination and health: Scientific advances, ongoing controversies, and emerging issues. *Annual Review of Clinical Psychology, 11*, 407–440. https://doi.org/10.1146/annurev-clinpsy-032814-112728

McFadyen-Ketchum, L. S., Hurwich-Reiss, E., Stiles, A. A., Mendoza, M. M., Badanes, L. S., Dmitrieva, J., & Watamura, S. E. (2016). Self-regulation and economic stress in children of Hispanic immigrants and their peers: Better regulation at a cost? *Early Education and Development, 27*(7), 914–931. https://doi.org/10.1080/10409289.2015.1036345

Mendoza, M. M., Dmitrieva, J., Perreira, K. M., Hurwich-Reiss, E., & Watamura, S. E. (2017). The effects of economic and sociocultural stressors on the well-being of children of Latino immigrants living in poverty. *Cultural Diversity and Ethnic Minority Psychology, 23*(1), 15–26. https://doi.org/10.1037/cdp0000111

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

Murry, V. M., Brown, P. A., Brody, G. H., Cutrona, C. E., & Simons, R. L. (2001). Racial discrimination as a moderator of the links among stress, maternal psychological functioning, and family relationships. *Journal of Marriage and Family, 63*(4), 915–926. https://doi.org/10.1111/j.1741-3737.2001.00915.x

Neblett, E. W., Philip, C. L., Cogburn, C. D., & Sellers, R. M. (2006). African American adolescents' discrimination experiences and academic achievement: Racial socialization as a cultural compensatory and protective factor. *Journal of Black Psychology, 32*(2), 199–218. https://doi.org/10.1177/0095798406287072

Nyborg, V. M., & Curry, J. F. (2003). The impact of perceived racism: Psychological symptoms among African American boys. *Journal of Clinical Child & Adolescent Psychology, 32*(2), 258–266. https://doi.org/10.1207/S15374424JCCP3202_11

Ong, A. D., Williams, D. R., Nwizu, U., & Gruenewald, T. L. (2017). Everyday unfair treatment and multisystem biological dysregulation in African American adults. *Cultural Diversity and Ethnic Minority Psychology, 23*(1), 27–35. https://doi.org/10.1037/cdp0000087

Paradies, Y. (2006). A systematic review of empirical research on self-reported racism and health. *International Journal of Epidemiology, 35*(4), 888–901. https://doi.org/10.1093/ije/dyl056

Pearlin, L. I., Schieman, S., Fazio, E. M., & Meersman, S. C. (2005). Stress, health, and the life course: Some conceptual perspectives. *Journal of Health and Social Behavior, 46*(2), 205–219. https://doi.org/10.1177/002214650504600206

Prelow, H. M., Danoff-Burg, S., Swenson, R. R., & Pulgiano, D. (2004). The impact of ecological risk and perceived discrimination on the psychological adjustment of African American and European American youth. *Journal of Community Psychology, 32*(4), 375–389. https://doi.org/10.1002/jcop.20007

Quintana, S. M. (1998). Children's developmental understanding of ethnicity and race. *Applied and Preventive Psychology, 7*(1), 27–45. https://doi.org/10.1016/S0962-1849(98)80020-6

Williams, D. R., & Williams-Morris, R. (2000). Racism and mental health: The African American experience. *Ethnicity & Health, 5*(3–4), 243–268. https://doi.org/10.1080/713667453

Roberts, M. E., Gibbons, F. X., Gerrard, M., Weng, C.-Y., Murry, V. M., Simons, L. G., … Lorenz, F. O. (2012). From racial discrimination to risky sex: Prospective relations involving peers and parents. *Developmental Psychology, 48*(1), 89–102. https://doi.org/10.1037/a0025430

Schwartz, J. A., & Beaver, K. M. (2011). Evidence of a gene × environment interaction between perceived prejudice and MAOA genotype in the prediction of criminal arrests. *Journal of Criminal Justice, 39*(5), 378–384. https://doi.org/10.1016/j.jcrimjus.2011.05.003

Seaton, E. K., Caldwell, C. H., Sellers, R. M., & Jackson, J. S. (2008). The prevalence of perceived discrimination among African American and Caribbean Black youth. *Developmental Psychology, 44*(5), 1288–1297. https://doi.org/10.1037/a0012747

Sellers, R. M., Caldwell, C. H., Schmeelk-Cone, K. H., & Zimmerman, M. A. (2003). Racial identity, racial discrimination, perceived stress, and psychological distress among African American young adults. *Journal of Health and Social Behavior, 44*(3), 302. https://doi.org/10.2307/1519781

Sellers, R. M., Copeland-Linder, N., Martin, P. P., & Lewis, R. L. (2006). Racial identity matters: The relationship between racial discrimination and psychological functioning in African American adolescents. *Journal of Research on Adolescence, 16*(2), 187–216. https://doi.org/10.1111/j.1532-7795.2006.00128.x

Serbin, L. A., & Karp, J. (2004). The intergenerational transfer of psychosocial risk: Mediators of vulnerability and resilience. *Annual Review of Psychology, 55*(1), 333–363. https://doi.org/10.1146/annurev.psych.54.101601.145228

Siegenthaler, E., Munder, T., & Egger, M. (2012). Effect of preventive interventions in mentally ill parents on the mental health of the offspring: Systematic review and meta-analysis. *Journal of the American Academy of Child & Adolescent Psychiatry, 51*(1), 8–17.e8. https://doi.org/10.1016/j.jaac.2011.10.018

Simons, R. L., Chen, Y.-F., Stewart, E. A., & Brody, G. H. (2003). Incidents of discrimination and risk for delinquency: A longitudinal test of strain theory with an African American sample. *Justice Quarterly, 20*(4), 827–854. https://doi.org/10.1080/07418820300095711

Simons, R. L., Murry, V., Mcloyd, V., Lin, K.-H., Cutrona, C., & Conger, R. D. (2002). Discrimination, crime, ethnic identity, and parenting as correlates of depressive symptoms among African American children: A multilevel analysis. *Development and Psychopathology, 14*(2), 371–393. https://doi.org/10.1017/S0954579402002109

Simons, R. L., Simons, L. G., Burt, C. H., Drummund, H., Stewart, E., Brody, G. H., … Cutrona, C. (2006). Supportive parenting moderates the effect of discrimination upon anger, hostile view of relationships, and violence among African American boys. *Journal of Health and Social Behavior, 47*(4), 373–389. https://doi.org/10.1177/002214650604700405

Spears Brown, C., & Bigler, R. S. (2005). Children's perceptions of discrimination: A developmental model. *Child Development, 76*(3), 533–553. https://doi.org/10.1111/j.1467-8624.2005.00862.x

Stuber, J., Meyer, I., & Link, B. (2008). Stigma, prejudice, discrimination and health. *Social Science & Medicine (1982), 67*(3), 351–357. https://doi.org/10.1016/j.socscimed.2008.03.023

Suarez-Morales, L., & Lopez, B. (2009). The impact of acculturative stress and daily hassles on pre-adolescent psychological adjustment: Examining anxiety symptoms. *The Journal of Primary Prevention, 30*(3–4), 335–349. https://doi.org/10.1007/s10935-009-0175-y

Subramanian, S. V., Acevedo-Garcia, D., & Osypuk, T. L. (2005). Racial residential segregation and geographic heterogeneity in black/white disparity in poor self-rated health in the US: A multilevel statistical analysis. *Social Science & Medicine, 60*(8), 1667–1679. https://doi.org/10.1016/j.socscimed.2004.08.040

Szalacha, L. A., Erkut, S., Coll, C. G., Alarcón, O., Fields, J. P., & Ceder, I. (2003). Discrimination and Puerto Rican children's and adolescents' mental health. *Cultural Diversity and Ethnic Minority Psychology, 9*(2), 141–155. https://doi.org/10.1037/1099-9809.9.2.141

Tackett, J. L., Herzhoff, K., Smack, A. J., Reardon, K. W., & Adam, E. K. (2017). Does socioeconomic status mediate racial differences in the cortisol response in middle childhood? *Health Psychology, 36*(7), 662–672. https://doi.org/10.1037/hea0000480

Theimer, C. E., Killen, M., & Stangor, C. (2001). Young children's evaluations of exclusion in gender-stereotypic peer contexts. *Developmental Psychology, 37*(1), 18–27. https://doi.org/10.1037/0012-1649.37.1.18

Upchurch, D. M., Stein, J., Greendale, G. A., Chyu, L., Tseng, C.-H., Huang, M.-H., … Seeman, T. (2015). A longitudinal investigation of race, socioeconomic status, and psychosocial mediators of allostatic load in midlife women: Findings from the study of women's health across the nation. *Psychosomatic Medicine, 77*(4), 402–412. https://doi.org/10.1097/PSY.0000000000000175

Utsey, S. O., Ponterotto, J. G., Reynolds, A. L., & Cancelli, A. A. (2000). Racial discrimination, coping, life satisfaction, and self-esteem among African Americans. *Journal of Counseling & Development, 78*(1), 72–80. https://doi.org/10.1002/j.1556-6676.2000.tb02562.x

Verkuyten, M., Kinket, B., & van der Wielen, C. (1997). Preadolescents' understanding of ethnic discrimination. *The Journal of Genetic Psychology, 158*(1), 97–112. https://doi.org/10.1080/00221329709596655

Weinreb, L., Wehler, C., Perloff, J., Scott, R., Hosmer, D., Sagor, L., & Gundersen, C. (2002). Hunger: Its impact on children's health and mental health. *Pediatrics, 110*(4), e41–e41. https://doi.org/10.1542/peds.110.4.e41

White, R. M. B., Liu, Y., Nair, R. L., & Tein, J.-Y. (2015). Longitudinal and integrative tests of family stress model effects on Mexican origin adolescents. *Developmental Psychology, 51*(5), 649–662. https://doi.org/10.1037/a0038993

Williams, D. R., Yan Yu, Y., Jackson, J. S., & Anderson, N. B. (1997). Racial differences in physical and mental health. *Journal of Health Psychology, 2*(3), 335–351. https://doi.org/10.1177/135910539700200305

Wong, C. A., Eccles, J. S., & Sameroff, A. (2003). The influence of ethnic discrimination and ethnic identification on African American adolescents' school and socioemotional adjustment. *Journal of Personality, 71*(6), 1197–1232. https://doi.org/10.1111/1467-6494.7106012

Zeiders, K. H., Umaña-Taylor, A. J., & Derlan, C. L. (2013). Trajectories of depressive symptoms and self-esteem in Latino youths: Examining the role of gender and perceived discrimination. *Developmental Psychology, 49*(5), 951–963. https://doi.org/10.1037/a0028866

Pascoe, E. A. & Richmond, L. S. (2009) Perceived discrimination and health: A meta-analytic review. Psychological Bulletin 135 (4):531–554

Kroeger, S., Burton, C., Comarata, A., Combs, C., Hamm, C., Hopkins, R., Kouche, B. (2016) Student Voice and Critical Reflection. TEACHING Exceptional Children 36 (3):50–57

Sellman, E. (2009) Lessons learned: student voice at a school for pupils experiencing social, emotional and behavioural difficulties. Emotional and Behavioural Difficulties 14 (1):33–48

DSM Revisions and the "Western Conundrum"

Craig L. Frisby

Abstract

The Diagnostic and Statistical Manual of Mental Disorders is the most widely used classification system of mental health disorders in the world. Currently in its fifth edition (DSM-5; American Psychiatric Association, Diagnostic and statistical manual of mental disorders, 5th edn. American Psychiatric Publishing, Arlington, 2013), the DSM has been continually revised over the past 60 years as new research is made available to users. There is a robust movement among psychiatric and psychological scholars to upgrade the DSM with each of its revisions to incorporate and modify, when appropriate, findings that enable DSM users to better understand how to accurately serve individuals from diverse countries and diverse cultural, racial, ethnic, language, and immigrant backgrounds. A common template used by many in this movement is to characterize mental health services and nosology as being influenced by "Western" vs. "Non-Western" influences. This chapter argues that the terms "Western" and "Non-Western" do not enjoy a universal consensus in how they are defined. The boundaries between these two terms are fuzzy and permeable, and many groups worldwide share similar and dissimilar Western and Non-Western characteristics simultaneously. The difficult issues inherent in these observations and problems are elucidated, and suggestions are advanced for ways in which cultural supplements to the DSM can appropriately address these issues.

Keywords

Diagnostic and Statistical Manual of Mental Disorders · DSM

The DSM-5 Revision Process

The Diagnostic and Statistical Manual of Mental Disorders is a name given to a classification system of mental health disorders (revised five times during the past 60 years) that has become the standard reference for clinical practice in the mental health field. A list of specific criteria is itemized for each disorder, which assists clinicians by identifying the most prominent symptoms that should be considered when making valid diagnoses. In most cases, a diagnosis from this manual is necessary for third-party payment. At the time of this writing, the current iteration of the DSM is the *Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition* (DSM-5; American Psychiatric Association, 2013a). The DSM-5 defines a mental disorder as follows:

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© Springer Nature Switzerland AG 2020
L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_15

> A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above. (American Psychiatric Association, 2013a, p. 20)

The first edition of the DSM was published in 1952 (American Psychiatric Association, 2018). When the DSM-IV was about to undergo a significant revision, three planning conferences were held by the American Psychiatric Association and the National Institute of Mental Health in 2000 to create a research agenda for the upcoming revision (Kupfer, First, & Regier, 2002). Hundreds of white papers, monographs, and journal articles were generated from these conferences that provided the field with summaries of the state of the science relevant to psychiatric diagnoses, the presence of significant gaps in this research, and direction for further research to fill such gaps (First, 2017a, 2017b). Next, in 2007, a coordinating task force was formed, leading to a second wave of 13 separate diagnostic work groups, each of which focused on a specific constellation of disorders (e.g., personality disorders, neurodevelopmental disorders, sexual and gender identity disorders; Clay, 2011).

The work groups comprised over 160 mental health and medical professionals considered leaders in their respective fields (i.e., psychiatrists, psychologists, pediatric neurologists, and statisticians/epidemiologists). This group represented over 90 academic and mental health institutions throughout the world (American Psychiatric Association, 2013c). These work groups came to a consensus on proposed changes, then sent said changes out for comment from thousands of psychological clinicians, psychological researchers, and family/patient advocacy groups (e.g., see Arehart-Treichel, 2010). The work groups then reviewed the submitted comments to further refine the proposed changes. In the fall of 2010, field trials aimed at understanding how proposed revisions would affect clinical practice and patient outcomes were designed and conducted in academic settings, large clinical/medical centers, and smaller individual practice settings. Finally, the work groups' proposals were evaluated by the coordinating DSM task force, and two panels convened specifically to evaluate the proposals (i.e., a Scientific Review Committee and a Clinical and Public Health Committee, American Psychiatric Association, 2013b).

Cultural Criticisms of the DSM

One long-standing criticism of each DSM revision is that its content and application within clinical settings may not be universally generalizable to diverse racial, religious, cultural, and/or language groups throughout the world. These critics urge DSM developers to utilize insights gleaned from increasing ethnic and cultural diversity in geographical locations, as well as advances in cross-cultural research (Mezzich et al., 1999). Mezzich et al. (1999) argue that "culture is involved in psychiatric assessment and diagnosis in at least the following five ways" (p. 458):

> First, culture shapes the phenomenology of symptoms themselves, their content, meaning, and configuration. Second, culture is manifested through ethnopsychiatric diagnostic rationales and practices of grouping symptoms together into patterns that include but are not limited to the familiar culture-bound syndromes found in various societies including our own Western culture. Third, culture provides the matrix for the interpersonal situation of the diagnostic interview. Fourth, because the clinical encounter is often intercultural, the dynamics of cross-cultural work are crucial for understanding and refining diagnostic categories and practices. Finally, culture informs the overall conceptualization of diagnostic systems, which are children of their time and circumstances.

To underscore the importance of this awareness, scholars typically make demographic projections that the United States will become a "majority-minority" nation in the approaching decades (e.g., see DeSilva, Aggarwal, & Lewis-Fernández, 2015). Scholars will also highlight advances in disciplines such as cross-cultural psychiatry, cross-cultural psychology, medical anthropology, and medical sociology (e.g., see Cockerham, 2015; Manderson, Cartwright, & Hardon, 2016; Shiraev & Levy, 2017), all of which specialize in varying degrees in the study of culture-psychopathology interactions (both domestically and internationally).

This general criticism is substantially complicated by qualitative differences in the extent to which cultural features influence the diagnosis and interpretation of particular DSM syndromes. Awareness of these differences calls for a more nuanced understanding of the extent to which culture may or may not influence the validity of DSM usage in different cultural contexts. These nuances can be differentiated into the following four critical narratives.

Narrative #1 (Universalist Perspective)

According to this narrative, mental health problems are strikingly similar across cultural contexts (e.g., see review by Canino & Alegria, 2008). The psychiatric disorders described in the World Health Organization World Mental Health Surveys and the DSM are "real entities" in an absolute sense, rather than entities whose validity can shift due to differences in cultural interpretations (Scott, de Jonge, Stein, & Kessler, 2018). As such, mental health problems are potentially discoverable in various proportions in all or at least most human groups worldwide (Foulks, 1996, p. 244). In addition, physical problems (e.g., bodily cancers, limb amputations, appendicitis, etc.) are universal among all human populations. There is no well-developed or coherent theory which holds that human psychological reactions to these afflictions differ as a function of the country in which one lives. The importance of cultural differences is de-emphasized, in favor of an emphasis on universal behaviors and beliefs that all human groups share in common (e.g., see Brown, 1991, 2000; Pinker, 2003). This position is supported by studies showing that many disorders have a genetic predisposition, where symptom clusters are consistent even across widely divergent cultural groups living in different geographic locations. Schizophrenia is an example of this type of disorder (Charlson et al., 2018; Patel, 2016).

Although different cultural groups may vary as to how pathology is defined or what pathological features may or may not be culturally viewed as permissible or aberrant, judgments concerning pathology are applied by clinicians on the basis of universal principles and/or markers. This narrative is most salient in professional opinions and writings related to substance-related disorders. As examples, some clinicians would consider any drug use prohibited by law within a jurisdiction as pathological regardless of cultural norms within that jurisdiction. Other clinicians would view the excessive use of substances that have the potential to injure the body (e.g., biological indicators of intoxication, withdrawal, or organ damage) or are associated with significant danger when used (e.g., a commercial airline pilot flying while drunk) as pathological even though they may be widely available (Westermeyer, 1996). The comments of Westermeyer (1996) succinctly summarize this point:

> Culturally sanctioned substances and doses may not be safe in particular subgroups of persons. Scientifically derived safe limits … should transcend more liberal cultural limits (p. 84).

Narrative #2 (Biology Versus Socialization)

According to this narrative, there is an essential distinction between mental disorders that have their etiology in biology and/or heredity and mental disorders that are thought to result from cultural/environmental upbringing and socialization factors (González & Griffith, 1996; Martinez, 2013).

With respect to the former group, the biologically/genetically based diagnostic categories are valid cross-culturally and can be applied universally anywhere in the world (see Narrative #1). However, the fact that a particular diagnosis may be universal does not necessarily mean that its prevalence (relative to their respective populations) should be roughly equivalent anywhere on the globe (as in schizophrenia; see Charlson et al., 2018; Patel, 2016). If the prevalence of identified persons diagnosed with a particular malady is significantly different across geographical locations, it is primarily due to one or more of these culturally based factors:

Cultural differences that can be attributable to differences in the level of caregivers' competence, training, and/or diagnostic sophistication in understanding and/or properly diagnosing the disorder across cultural groups and settings;

Different rates of help-seeking behavior in indigenous populations;

Genetic factors associated with variations in race/ethnicity;

Differences in the effectiveness with which language can describe symptoms; or for reasons that remain unknown (Kleinman, 1996, p. 18).

With respect to the latter group of disorders that have their etiology in environmental/cultural factors (such as somatoform and dissociative disorders; see González & Griffith, 1996; Paniagua, 2013), cultural contexts may show significant variation in the prevalence of severe emotional childhood trauma, psychosocial stress, threats of physical injury or death, and stress resulting from military combat or its equivalents (Bryant-Davis, Ellis, & Edwards, 2013; Yamada, Atuel, & Weiss, 2013). In this narrative, the uneven distribution of significantly different symptom frequencies and/or prevalence rates across locations reflects the fact that the cultural conditions within particular locations may not support the development of the diagnostic condition, or cultural conditions may exacerbate the diagnostic condition (which is why these occur with greater or lesser frequency in certain areas; see Cheung & Mak, 2018). For example, Kleinman (1996) argues that the course of mental illness is "social, not natural" (p. 19), and despite poor countries' limited health services, the outcomes for some schizophrenic patients are better because families and communities provide better support for these patients (p. 19; see also Kohn, Wintrob, & Alarcón, 2009).

Narrative #3 (Conditions as Cultural Artifacts)

This narrative differs from the previous narrative, in that some disorders may not be real in an "absolute" sense. That is, cultural conditions within other locations may erroneously look like the psychiatric condition (as determined by another cultural context) but is merely a cultural artifact in a different context (see Lin, 1996b, p. 56). Here, pathology is not identified in situations that do not exceed the "indigenous boundaries of normalcy" (González & Griffith, 1996, p. 138) and produce no "major personal or societal disruption" (p. 139). As examples, Manson (1996) argues that different cultural groups around the world either encourage or discourage displays of extreme sadness and sorrow, which has implications for how individuals may or may not be able to adequately elaborate on their emotional experiences. Lin (1996b) argues that sustained exposure to racism and discrimination among North American Blacks may be at least partially responsible for higher levels of "healthy paranoia" (p. 54).

With respect to personality disorders, this narrative holds that whether or not a personality trait is or is not maladaptive or causes functional impairment or subjective stress varies as a function of cultural context. Here, labeling deviations from the "normal personality" is a culturally relative exercise that reflects culturally specific values, ideals, worldviews, and social structures – as "different cultures have tended to emphasize different traits of personality as ideal" (Foulks, 1996, p. 245). Therefore, conditions meeting the diagnostic criteria for a personality disorder may be considered normal in other cultural contexts (p. 248).

Narrative #4 (Conditions as Socially Constructed)

This narrative holds that DSM diagnostic conditions are not "real" in any universal sense. This is because culture differences are so profound (as are the political conditions within cultures), that the nature of conceptualizing mental illness (as well as constructing methods for their identification) are qualitatively different from one cultural context to another (see also McNally, 2012). Therefore, significant differences in prevalence rates of some conditions across locations cannot be accurately interpreted. Said differently, mental illness is entirely culturally determined and/or socially constructed (Kleinman, 1996). This means that the concepts and rules of science for constructing the diagnosis (within a particular cultural context) are also culturally relative; hence, mental illness is socially constructed by a particular context. For example, Lin (1996a, 1996b) argues that dependent, borderline, and narcissistic personality disorders are "irrelevant and inapplicable in most Asian cultures" (p. 36), because the socialization process of Asians within these cultures encourages attitudes and behaviors that allow parents and employers to make most of an individual's important life decisions, generate different concepts of the self in relation to the surrounding social structure, and construct culturally determined opportunities for "acting out."

Culture-bound syndromes (e.g., Dhat syndrome, Shenjing shuairuo) first appeared in the DSM-IV (American Psychiatric Association, 2000). A bit earlier, Littlewood and Lipsedge (1985) described "culture-bound syndromes" as "episodic and dramatic reactions, specific to a particular community … locally identified as discrete patterns of behavior" (p. 105) or "a collection of signs and symptoms (excluding notions of cause) which is restricted to a limited number of cultures primarily by reason of certain of their psychosocial features" (Prince & Tcheng-Laroche, 1987, p. 3). Culture-bound syndromes can be sometimes referred to as "psychogenic psychoses," "ethnic psychoses," "ethnic neuroses," "hysterical psychoses," "exotic psychoses," "atypical psychoses," or "culture-reactive syndromes" (Hughes, 1985, 1996). Balhara (2011) defined a culture-bound syndrome as "a broad rubric that encompasses certain behavioral, affective and cognitive manifestations seen [only] in specific cultures" (see Balhara, 2011, p. 210).

In relation to a critique of the DSM-IV, Kleinman (1996) objected to a conception of the DSM system as an "anchor" against which cultural syndromes are determined and writes:

> … one could argue that because 90% of DSM categories are culture bound to North America and western Europe, the very idea of culture bound as "exotic" syndromes outside Euro-American culture itself is flawed; therefore, the use of this concept to label only non-Western or ethnic syndromes is biased and inappropriate. This could be dealt with by including Euro-American culture bound disorders such as anorexia nervosa (p. 23).

Current Concessions to Cultural Influences in the DSM-5

In the current fifth edition of the DSM (American Psychiatric Association, 2013a), concessions to cultural influences are incorporated in the following ways:

In the beginning section on DSM-5 Basics, a section on cultural issues (pp. 14–15) discusses three concepts which replace the concept of a "culture-bound syndrome" in the DSM-IV. These are the following:

1. The "cultural syndrome" defined as a cluster or group of co-occurring, relatively invariant symptoms found in a specific cultural group, community, or context;
2. The "cultural idiom of distress" defined as a linguistic term, phrase, or way of talking about suffering, pathology, and/or distress features among individuals of a cultural group; and
3. The "cultural explanation or perceived cause" defined as a label, attribution, or feature of an explanatory model that provides a culturally conceived etiology or cause for symptoms, illness, or distress.

Within most sections describing a specific disorder, a subsection entitled "Culture-Related Diagnostic Issues" discusses cultural variations in the expression, diagnostic features, and differential interpretations of the disorder in different cultural contexts.

In Section III entitled *Emerging Measures and Models*, the Cultural Formulation Interview (CFI) is described. The CFI consists of a 16-item questionnaire "that clinicians may use to obtain information during a mental health assessment about the impact of culture on key aspects of an individual's clinical presentation and care" (p. 750). Four subdomains of assessment are emphasized in the CFI: cultural definition of the problem; cultural perceptions of cause, context, and support; cultural factors affecting self-coping and past help-seeking; and cultural factors affecting current help-seeking.

Finally, the Appendix includes a Glossary of nine *Cultural Concepts of Distress* that have been documented and written about in international psychiatry. Each concept includes a discussion of the extent to which the concept is related to existing DSM-5 diagnoses, as well as a discussion of the concept's presence in other cultural contexts.

The Western Conundrum

Although nuanced differences can be discerned across the particulars of the previous four narratives, they nevertheless share a common thread. When cultural differences are noted, they are often framed as belonging to a "Western" vs. "Non-Western" cultural tradition. According to Kleinman (1996), for example, the "category fallacy" is the unwarranted assumption that "a Western psychiatric diagnosis carries the same meaning when extended to another cultural context" (Cheung & Mak, 2018, p. 132). In their recent chapter (at the time of this writing) on sociocultural factors in psychopathology, Cheung and Mak (2018) state:

> … Western diagnostic systems have begun to pay attention to indigeneous illness categories and to recognize cultural limitations of some of the existing diagnostic nosologies that aim to provide a common language for mental health professionals to communicate across cultural and social contexts … some researchers have challenged whether culture-bound syndromes can be seen as variants of Western disorders contextualized in non-Western cultures and not as special categories indigenous to specific cultures (pp. 128, 131).

This chapter addresses the central question: To what extent does the Western/Non-Western distinction represent a clear template for understanding key conditions under which DSM categories are reliable and applicable to mental health diagnosis/treatment? The first step in properly addressing this question is to survey the literature to sample a wide variety of statements where the Western/Non-Western distinction is used to either criticize the DSM, specifically, or diagnostic categories, generally. These statements are listed in Table 1 and are numbered for convenient referencing in subsequent sections.

This chapter argues that the Western/Non-Western distinction may appear initially persuasive at first blush but is deficient for communicating accurate information to be useful absent additional and more precise analyses. The overwhelming majority of DSM-5 content related to the cultural features of specific mental disorders makes liberal references to specific continents and countries. Therefore, to aid in the reanalysis of the Western/Non-Western distinction, key information related to 197 countries are shown in Table 2. Each country is described along five variables:

1. The extent to which each country is located in one or both of the Western or Eastern hemispheres,
2. The breakdown of racial and ethnic groups living within each country,
3. The religious diversity of the country as indicated by survey data,
4. Each country's ordinal ranking in a summary measure of average achievement in key dimensions of human development, and
5. The percentage of persons within each country suffering from multidimensional poverty.

Table 1 Published commentaries about “Western vs. Non-Western” influences related to the *Diagnostic and Statistical Manual (DSM) Editions*

1.	“[Anorexia nervosa] exists in contemporary Western societies that regard slim female bodies a beautiful, sexually desirable, and commercially significant. Except among the Westernized upper middle class of Japan, Taiwan, and Hong Kong, there is no anorexia nervosa in Asia” (Kleinman, 1996, p. 18)
2.	“… the members of many non-Western societies and traditionally oriented ethnic groups regard the person as more sociocentric than egocentric; the boundaries of the ego as permeable, and the self (or soul) is fluid and capable of leaving the body, entering altered states, and becoming possessed …. These alternative ideas are basic to the mental health categories of traditional Chinese, Indians, Southeast Asians, and members of African and South American groups, who together constitute more than three fourths of the world’s population” (Kleinman, 1996, p. 20)
3.	“The sharp contrasts in the cultural values and orientations between Asian and Western populations provide an excellent opportunity to search for a common language in psychiatric classification and diagnosis across cultures that will likely lead to significant insights in the field of psychiatric nosology” (Lin, 1996a, p. 35)
4.	“… cross-ethnic differences may contribute to difficulties for Western-trained psychiatric clinicians in accurately evaluating Asian patients, especially if they are not familiar with Asian cultures and … detect more subtle, often nonverbal expressions of mood and attitudes” (Lin, 1996a, p. 36)
5.	“… Asian cultures are predominantly group oriented. This is in sharp contrast to the heavy emphasis on individualism commonly seen in contemporary Western societies” (Lin, 1996a, p. 36)
6.	“Differences between Asian and Western peoples … in the concept of self and interpersonal relationships should be expected to significantly influence personality structures and the manifestation of [pre-DSM5] Axis II disorders” (Lin, 1996a, p. 36)
7.	“Looking through this Western prism of mind-body dichotomy, Asian and other non-Western patients who fail to make [the mind/body] distinction run the risk of being labeled as more primitive, not psychologically minded, somatizing, and alexithymic” (Lin, 1996a, p. 37)
8.	“Concepts and phrases used in standardized diagnostic instruments, such as the Composite International Diagnostic Interview, to describe psychiatric symptoms, are less consistent with cultural concepts in many developing countries of Asia, Africa, and Latin America than in developed Western countries” (Kohn et al., 2009, p. 743)
9.	“Clinicians working with Native American people may erroneously assume that mental disorder in Native Americans is identical to that in whites, requiring no deviation at all from Western conceptualizations of psychopathology” (Thompson, 1996, p. 31)
10.	“Western societies are becoming more complex with the growth of immigrant populations who bring cultural beliefs and practices that often differ in critical ways from their host cultures” (Jackson et al., 2011, p. 268)
11.	“[Anorexia nervosa and bulimia disorders] do occur in non-Western immigrants to the United States, Canada, and Europe – that is, among those who might have been expected to be immune from them in their native country … because American psychiatrists expect to find these eating disorders only in affluent populations of European descent, the diagnosis may be missed in some of their non-Western immigrant patients” (Prince, 1996, p. 187)
12.	“Non-Western notions of disease causality that are not understood by Western professionals may contribute to the appearance of treatment nonadherence on the part of immigrant or refugee patients” (Paniagua & Yamada, 2013, p. 8)
13.	“[the revision process of the DSM] must be extended beyond the middle and upper classes of American and European society to the remaining, non-Western world that constitutes the vast majority of humankind” (Manson, 1996, p. 108)
14.	“… it is not clear to what extent nosologic systems to classify mental disorders, which were developed mainly in Western and developed nations, reflect the disorders present in other countries” (Wang, 2011, p. 234)
15.	“In the United States and other developed countries, where health care and mental health care are embedded in Western medical systems, mental illness retains a stigma that makes people reluctant to seek treatment. This problem is often compounded in non-Western nations, where these conditions can be interpreted as punishment for past behavior” (Jackson et al., 2011, p. 268)
16.	“The central role played by the state and the psychiatric profession in the contemporary Western approach to psychiatric illness, as symbolized in protocols such as DSM-IV, is a result of the demographic, social, and political economic transformations that took place in the early modern and modern periods in western Europe” (Fabrega, 1996, p. 6)

(continued)

Table 1 (continued)

17.	"Although trance and possession states are common and normal components of religious and other ceremonies in many cultures, trance and possession disorder (leading to distress and dysfunction) is also the most common dissociative disorder reported in non-Western cultures" (Spiegel & Cardeňa, 1996, p. 166)
18.	"Anorexia nervosa and bulimia nervosa have been considered the prototypical 'culture-bound syndromes' of Western society …. If this fear and other assumedly typical disorder characteristics are not fully transcultural, cases of anorexia and bulimia having somewhat different presentations may be consistently underdiagnosed among minority or non-Western populations" (Ritenbaugh, Shisslak, Teufel, & Leonard-Green, 1996, p. 171)
19.	"Among heavier women, the development of [bulimia nervosa] disorders may represent the negative value placed on fatness by Western society …. This ideation is shared by many nonanorexic Western women, raising the possibility that … it may be a presenting condition descriptive of Western culture, rather than a requirement for the diagnosis of anorexia" (Ritenbaugh et al., 1996, p. 182)
20.	"Although previously [eating disorders] had only been described in exotic or non-Western cultures, in 1969 [it had been suggested] that the Western world might harbor culture-bound syndromes as well and specifically referred to anorexia nervosa as one possibility …. Since that time, a considerable literature has emerged supporting the view that anorexia nervosa and bulimia are found primarily in Western cultures or in cultures undergoing rapid and significant Westernization" (Prince, 1996, p. 188)
21.	"Cultural constructionists insist that to develop culturally sensitive understandings of human sexuality and sexual behavior, we must move beyond the simple assessment of how select features of the sexuality of other cultural or ethnic groups fit into or vary from those of Western society (particularly of Western medicine) … many authors have critiqued the paraphilias … as culture-bound, out-dated constructs of Western medicine – the zeitgeist of a former era. [For example, some scholars have] stated that the concept of pedophilia has no relevance to man-boy sexual relations in New Guinea" (Davis, 1996, p. 198)
22.	"[One writer] critiqued the DSM paraphilias as a culture-bound moral hierarchy that reflects Western cultural views of sex as a matter of personal responsibility; as biologically ordained; and as a negative, dangerous, and disruptive force. [According to some scholars], Western sexualities are structured with an extremely punitive social framework, where an excess of significance is associated with differences in sexual acts and 'unfit' forms of sexual desire (especially those that deviate from practices with reproductive potential)" (Davis, 1996, p. 198)
23.	"Anthropological sources show that intersexes may or may not be discomforted by issues of sex and gender identity, however … their identity may not necessarily coincide with the Western binary mode of gender assignment (male vs. female)" (Davis, 1996, p. 200)
24.	"One major difference … between the diagnostic and evaluation process found in Western psychiatry … and that in many other groups is in the cultural construction of 'cause,' for example, spirits or a broken taboo on the one hand, and the psychodynamics of repression or stress-related coping responses on the other. The latter is a Western science mode, one in which the premises of the belief differ from those in a typical 'folk' conceptual system" (Hughes, 1996, p. 298)
25.	"… Western models [are] based on *naturalistic* views of disease causation including infection, stress, organic deterioration, accidents, and acts of overt human aggression. In contrast, among many non-Western societies, disease models were based on *supernatural* views (i.e., any disease that accounts for impairment of health as a consequence of some intangible force) including (a) theories of mystical causation because of impersonal forces such as fate, ominous sensations, contagion, mystical retribution; (b) theories of animistic causation because of personalized forces such as soul loss and spirit aggression; and (c) theories of magical causation or actions of evil forces including sorcery and witchcraft" (Paniagua & Yamada, 2013, pp. 7–8)
26.	"… [N]on-Western supernatural views approach disease as disharmony … that is manifest in an ever-widening circle of systems, from the psychosocial to the psychospiritual realms of existence, where fate, sympathetic magic, spirits, evil forces, and such loom large" (Paniagua & Yamada, 2013, pp. 74–75)
27.	"The biomedically oriented Western health system is rooted in a fundamental separation of body and mind as advanced by Rene Descartes …. By contrast, the therapeutic process of indigenous healing is inclusive in its use of multiple techniques and strategies to restore harmony and balance of the body, mind, and spirit, both within the individual as well as between the individual and the environment" (Paniagua & Yamada, 2013, p. 78)
28.	"Does not the language of DSM-IV reflect culturally particularistic assumptions about the nature of mind, behavior, and personhood drawn from Western European culture?" (Fabrega, 1996, p. 8)
29.	"Critics using a cultural framework … argue that the DSM's nosological system is based on Western American beliefs (e.g., individualism, emphasis on biology) and practices (e.g., standardization) that limit their usefulness among different cultural groups" (La Roche, Fuentes, & Hinton, 2015, p. 183)

(continued)

Table 1 (continued)

30.	“Numerous authors … define the prevalent Western American individualistic self-orientation, which is diametrically opposed to that of many cultural minorities who tend to define themselves through a collectivistic self-orientation or in relationship to others” (La Roche et al., 2015, p. 187)
31.	“Probably none of us living in Western societies would be surprised to be asked by a mental health worker if we felt ‘blue’ or ‘down’…. Most of the 80% of our planet’s people who live in non-Western societies would be baffled by this.” (Kleinman, 1996, p. 17)
32.	“The explicit assumption in DSM should be that a patient’s condition almost always can be understood with a culturally sensitive application of Western concepts of psychopathology, until this assumption is proved incorrect by treatment failure or other evidence” (Thompson, 1996, p. 33)
33.	“… as a product of the Western intellectual legacy, modern psychiatric nosology has been heavily imprinted by European and North American cultural characteristics …. One of such unique Western beliefs is the artificial separation between the mind (psychological processes) and the body (physiological processes)” (Lin, 1996a, p. 37)
34.	“Because the concept and diagnostic criteria of psychotic and organic conditions have derived predominantly from clinical experiences with European and North American patients and have been formulated by Western psychiatric thinkers …, issues related to their applicability to and utility with non-Western patients have remained controversial …” (Lin, 1996b, p. 49)
35.	“… ‘being controlled by a dead person’ would be readily regarded as a ‘bizarre delusion’ by most clinicians trained in Western settings. This, however, may not be universally appropriate, because in many traditional, non-Western societies, the spirits of the deceased are regarded as capable of interacting with and possessing those still alive” (Lin, 1996b, p. 53)
36.	“The most salient feature of mood disorders is a distinction between psyche and soma that reflects a long Western intellectual history of mind-body dualism …. The greatest difficulty lies in determining the presence of dysphoria, as defined by Western experience, largely because of the attendant assumptions about emotion and its phenomenology” (Manson, 1996, p. 100)
37.	“[Egocentric definitions of the self], best exemplified in Western, industrialized populations, characterize the person as unique, separate, and autonomous. [Sociocentric definitions of the self] found in many non-Western cultural traditions, depict the person in relational terms, as part of an interdependent collective, defined by kinship and myth” (Manson, 1996, p. 101)
38.	“… guilt, shame, and sinfulness, which often are closely linked in Western experience … can be translated into Hopi but are conceptualized quite differently and evoke attributions that are distinct from one another as well as from those implied by their English counterparts within the Judeo-Christian framework …. Chinese [language] offers a wealth of terms that convey sadness and despair …. However, … this mood is treated and reported quite differently by the Chinese than by their Western counterparts” (Manson, 1996, p. 102)
39.	“Some critics regard the sexual dysfunctions as based on culture-bound, masculinist, middle-class, Western values and standards … [T]o what degree is the high prevalence for or vulnerability to sexual problems in Western society related to cultural inhibitions or restrictiveness … and unrealistic expectations or ignorance and anxiety about performance that characterize the Euro-American tradition?” (Davis, 1996, p. 197)
40.	“Western biomedical knowledge is defined, communicated, and modified through a nerve-ending process of disease classification. It would be well for us to remember that in an increasingly international world, 80% of the world population does not share in Western culture” (Kraus, 1996, p. 260)
41.	“Most research to date has been limited in ability to examine national differences – particularly between Western and non-Western diagnostic approaches – in perceptions of mental illness or in approaches to treatment” (Jackson et al., 2011, p. 268)
42.	“Early non-Western psychiatric pioneers … often were trained in Western medical schools and residency programs, and their assumptions and methods were deeply rooted within Western cultural traditions. Today, within the field of indigenous psychology, there is increasingly the voice of non-Western scholars … who are critical of the bias inherent in much of our prior mental health knowledge and practice” (Paniagua & Yamada, 2013, p. 13)
43.	“Western biomedical medicine itself represents a culture into which medical students are acculturated” (Paniagua & Yamada, 2013, p. 56)
44.	“… in the West people differentiate between the mind and the body in how they talk about symptoms. In the United States we feel ‘stressed’ or ‘depressed’ or ‘anxious’ and we attribute nonphysical causes to these feelings. Other cultures do not differentiate between the psychological and the somatic in quite so clear a manner” (Paniagua & Yamada, 2013)

(continued)

Table 1 (continued)

45.	"Western thinking of the science of psychology in its prototypical form … assumes a global relevance and is treated as universal of generating knowledge. Its dominant voice subscribes to a decontextualized vision with an extraordinary emphasis on individualism, mechanism, and objectivity. This peculiarly Western mode of thinking is fabricated, projected, and institutionalized through representation technologies and scientific rituals and transported on a large scale to the non-Western societies under political-economic domination … Mapping reality through Western constructs has a pseudo-understanding of the people of alien cultures and has debilitating effects in terms of misconstruing the special realities of other people …. Consequently, when people from other cultures are exposed to Western psychology, they find their identities placed in question and their conceptual repertories rendered obsolete" (Gergen, Gulrerce, Lock, & Misra, 1996, pp. 497–498)

Western/Non-Western distinctions are derived from criteria that typically are explicit, but can also be implicit. Five such criteria, and important exceptions related to each, are described below:

"Western" as Referring to World Hemispheric Location

A longitudinal circle divides the globe into the Eastern and Western Hemispheres. This circle is referenced by two Meridians. The *Prime Meridian* is 0° longitude. All countries located to the east of the Prime Meridian are collectively referred to as Eastern Hemisphere countries, and all countries west of the Prime Meridian are collectively referred to as Western Hemisphere countries. The second Meridian is called the *180th Meridian*, which is 180 degrees longitude. All countries located to the east of the 180th Meridian are in the Western Hemisphere, and countries located to the west of the 180th Meridian are in the Eastern Hemisphere.

Important Exceptions An obvious deviation from this template is that 12 countries share both hemispheres even though scholars speak of each of these countries as self-contained cultural entities (see Table 2).

The Prime Meridian intersects eight countries (i.e., Algeria, Burkina Faso, Ghana, France, Mali, Spain, Togo, and the United Kingdom), which places them in both the Eastern and Western hemispheres (Worldatlas, 2015; see Table 2). The 180th Meridian runs through four countries: Fiji, Kiribati, Russia, and the United States – hence, these also belong to both the Eastern and Western hemispheres (Worldatlas, 2015; see Table 2).

When giving examples of countries that characterize the "the Western way of doing things" vs. "the Eastern way of doing things," the exemplars, more often than not, geographically match their respective hemispheres. For example, the continent of Asia (in whole or in part) is often characterized as "Non-Western" (see statements 1–8 in Table 1). Unfortunately, a common error would be overlooking scientific/philosophical movements characterized as "Western" vs. "Eastern" that do not match their respective hemispheric locations. For example, Canada, the United States, Germany, Australia, and the United Kingdom are often depicted as "Western" countries due to historical, cultural, political, and economic similarities. Geographically, however, Australia is situated in the Eastern Hemisphere (see Table 2). Many countries in South America are situated in the Western Hemisphere, yet there is considerable debate and disagreement as to whether these countries are fully part of the "Western world" (Huntington, 1996).

"Western" as Referring to White People

Particularly within the United States, the term "White" is colloquially used as a descriptor of persons who are more formally labeled as being "Caucasian." This label is derived from the word "Caucasus," – which refers to either a mountain range or a regional area situated between the Black Sea and the Caspian Sea. As a descriptive term for a regional area, the Caucasus region is occupied by the countries of Russia, Georgia,

Table 2 Countries around the globe: hemispheric location, race/ethnicity breakdown, religious diversity, human development/economic, and percent of population in poverty

Country	Hemisphere (WH, Western; EH, Eastern)	Race/ethnic groups (NationMaster, 2019)	Religious diversity (Pew Research Center, 2014a)[a]	Human Development Index (HDI) ranking for 2017[b]	Percent of population in severe multidimensional poverty[c]
Afghanistan	EH	Pashtun 42%, Tajik 27%, Hazara 9%, Uzbek 9%, Aimak 4%, Turkmen 3%, Baloch 2%, other 4%	*RDI*: 0.1 Muslim: 99.7%	168	25.13
Albania	EH	Albanian 95%, Greek 3%, other 2% (Vlach, Roma [Gypsy], Serb, Macedonian, Bulgarian)	*RDI*: 3.7 Muslim: 80.3% Christian: 18.0% Unaffiliated: 1.4%	68	0.16
Algeria	WH/ EH	Arab-Berber 99%, European less than 1%	*RDI*: 0.5 Muslim: 97.9% Unaffiliated: 1.8%	85	0.28
Andorra	EH	Spanish 43%, Andorran 33%, Portuguese 11%, French 7%, other 6%	*RDI*: 2.2 Christian: 89.5% Unaffiliated: 8.8%	35	ND
Angola	EH	Ovimbundu 37%, Kimbundu 25%, Bakongo 13%, mestico (mixed European and native African) 2%, European 1%, other 22%	*RDI*: 2.0 Christian: 90.5% Unaffiliated: 5.1%	147	32.46
Antigua and Barbuda	WH	Black 91%, mixed 4.4%, White 1.7%, other 2.9%	*RDI*: 1.5 Christian: 93.0% Folk religion: 3.6% Unaffiliated: 1.7%	70	ND
Argentina	WH	White (mostly Spanish and Italian) 97%, mestizo (mixed White and Amerindian ancestry), Amerindian, or other non-White groups 3%	*RDI*: 3.0 Christian: 85.2% Unaffiliated: 12.2%	47	ND
Armenia	EH	Armenian 93%, Azeri 1%, Russian 2%, other (mostly Yezidi Kurds) 4%;	*RDI*: 0.3 Christian: 98.5% Unaffiliated: 1.3%	83	0.00
Aruba	WH	Mixed White/Caribbean Amerindian 80%, other 20%	*RDI*: 1.7 Christian: 91.9% Unaffiliated: 6.0% Folk religion: 1.3%		ND

(continued)

Table 2 (continued)

Country	Hemisphere (WH, Western; EH, Eastern)	Race/ethnic groups (NationMaster, 2019)	Religious diversity (Pew Research Center, 2014a)[a]	Human Development Index (HDI) ranking for 2017[b]	Percent of population in severe multidimensional poverty[c]
Australia	EH	White 92%, Asian 7%, aboriginal and other 1%	*RDI*: 5.6 Christian: 67.3% Unaffiliated: 24.2% Buddhist: 2.7% Muslin: 2.4% Hindu: 1.4%	3	ND
Austria	EH	German 88.5%, indigenous minorities 1.5% (includes Croatians, Slovenes, Hungarians, Czechs, Slovaks, Roma), recent immigrant groups 10% (includes Turks, Bosnians, Serbians, Croatians)	*RDI*: 3.8 Christian: 80.4% Unaffiliated: 13.5% Muslim: 5.4%	20	ND
Azerbaijan	EH	Azeri 90.6%, Dagestan 2.2%, Russian 1.8%, Armenian 1.5%, other 3.9%	*RDI*: 0.7 Muslim: 96.9% Christian: 3.0%	80	0.52
Bahamas	WH	Black 91%, White 5%, mixed 2% (Black/White; Study.com, 2019)	*RDI*: 0.9 Christian: 96.0% Unaffiliated: 3.1%	54	ND
Bahrain	EH	Bahraini 46%, non-Bahraini 54%	*RDI*: 5.4 Muslin: 70.3% Christian: 14.5% Hindu: 9.8% Buddhist: 2.5% Unaffiliated: 1.9%	43	ND
Bangladesh	EH	Bengali 98%, other 2% (includes tribal groups, non-Bengali Muslims)	*RDI*: 2.1 Muslim: 89.8% Hindu: 9.1%	136	16.21
Barbados	WH	Black 90%, White 4%, Asian and mixed 6%	*RDI*: 1.1 Christian: 95.2% Unaffiliated: 1.9% Other religion: 1.4%	58	0.00
Belarus	EH	Belarusian 83.7%, Russian 8.3%, Polish 3.1%, Ukrainian 1.7%, other 3.2%	*RDI*: 4.7 Christian: 71.2% Unaffiliated: 28.6%	53	ND

Belgium	EH	Fleming 58%, Walloon 31%, mixed or other 11%	*RDI*: 5.7 Christian: 64.2% Muslim: 5.9% Unaffiliated: 29%	17	ND
Belize	WH	Mestizo 48.7%, Creole 24.9%, Maya 10.6%, Garifuna 6.1%, other 9.7%	*RDI*: 2.6 Christian: 87.6% Unaffiliated: 8.9% Folk religion: 1.5%	106	0.65
Benin	EH	Fon and related 39.2%, Adja and related 15.2%, Yoruba and related 12.3%, Bariba and related 9.2%, Peulh and related 7%, Ottamari and related 6.1%, Yoa-Lokpa and related 4%, Dendi and related 2.5%, other 1.6% (includes Europeans), unspecified 2.9%	*RDI*: 7.2 Christian: 53% Muslim: 23.8% Folk religion: 18.1% Unaffiliated: 5%	163	38.05
Bermuda	WH	Black 53.8%, White 31%, mixed 7.5%, other races 7.1%, unspecified 0.6%	*RDI*: 4.6 Christian: 75% Unaffiliated: 19.4% Folk religion: 3% Muslim: 1.1%	ND	ND
Bhutan	EH	Bhote 50%, ethnic Nepalese 35%, indigenous or migrant tribes 15%	*RDI*: 4.5 Buddhist: 74.7% Hindu: 22.6% Folk religion: 1.9%	134	14.68
Bolivia	WH	Quechua 30%, mestizo (mixed White and Amerindian ancestry) 30%, Aymara 25%, White 15%	*RDI*: 1.3 Christian: 93.9% Unaffiliated: 4.1%	118	7.11
Bosnia and Herzegovina	EH	Bosniak 48%, Serb 37.1%, Croat 14.3%, other 0.6%	*RDI*: 6.0 Christian: 52.3% Muslim: 45.2% Unaffiliated: 2.5%	77	0.06
Botswana	EH	Tswana (or Setswana) 79%, Kalanga 11%, Basarwa 3%, other, including Kgalagadi and White 7%	*RDI*: 5.0 Christian: 72.1% Unaffiliated: 20.6% Folk religion: 6%	101	ND
Brazil	WH	White 53.7%, mulatto (mixed White and Black) 38.5%, Black 6.2%, other (includes Japanese, Arab, Amerindian) 0.9%, unspecified 0.7%	*RDI*: 2.3 Christian: 88.9% Unaffiliated: 7.9% Folk religion: 2.8%	79	0.939

(continued)

Table 2 (continued)

Country	Hemisphere (WH, Western; EH, Eastern)	Race/ethnic groups (NationMaster, 2019)	Religious diversity (Pew Research Center, 2014a)[a]	Human Development Index (HDI) ranking for 2017[b]	Percent of population in severe multidimensional poverty[c]
Brunei	EH	Malay 66.3%, Chinese 11.2%, indigenous 3.4%, other 19.1%	*RDI*: 4.8 Muslim: 75.1% Christian: 9.4% Buddhist: 8.6% Folk religion: 6.2%	39	ND
Bulgaria	EH	Bulgarian 76.9%, Turk 8%, Roma 4.4%, other 0.7% (including Macedonian, Armenian, Tatar, Circassian), other (unknown) 10%	*RDI*: 3.5 Christian: 82.1% Muslim: 13.7% Unaffiliated: 4.2%	51	ND
Burkina Faso	WH/EH	Mossi over 40%, other approximately 60% (includes Gurunsi, Senufo, Lobi, Bobo, Mande, and Fulani)	*RDI*: 6.2 Muslim: 61.6% Christian: 22.5% Folk religion: 15.4	183	64.84
Burundi	EH	Hutu (Bantu) 85%, Tutsi (Hamitic) 14%, Twa (Pygmy) 1%, Europeans 3000, South Asians 2000	*RDI*: 1.8 Christian: 91.5% Folk religion: 5.7% Muslim: 2.8%	185	45.37
Cambodia	EH	Khmer 90%, Vietnamese 5%, Chinese 1%, other 4%	*RDI*: 0.7 Buddhist: 96.9% Muslim: 2.0%	146	12.03
Cameroon	EH	Cameroon Highlanders 31%, Equatorial Bantu 19%, Kirdi 11%, Fulani 10%, Northwestern Bantu 8%, Eastern Nigritic 7%, other African 13%, non-African less than 1%	*RDI*: 5.3 Christian: 70.3% Muslim: 18.3% Unaffiliated: 5.3% Folk religion: 3.3% Other religion: 2.7%	151	25.81
Canada	WH	British Isles origin 28%, French origin 23%, other European 15%, Amerindian 2%, other, mostly Asian, African, Arab 6%, mixed background 26%	*RDI*: 5.3 Christian: 69.0% Unaffiliated: 23.7% Muslim: 2.1% Hindu: 1.4% Folk religion: 1.2%	12	ND

Cape Verde	WH	Creole (mulatto) 71%, African 28%, European 1%	*RDI*: 2.3 Christian: 89.1% Unaffiliated: 9.1% Folk religion: 1.5%	125	ND
Cayman Islands	WH	Mixed 40%, White 20%, Black 20%, expatriates of various ethnic groups 20%	*RDI*: 3.3 Christian: 83.5% Unaffiliated: 9.4% Folk religion: 4.5%	ND	ND
Central African Republic	EH	Baya 33%, Banda 27%, Mandjia 13%, Sara 10%, Mboum 7%, M'Baka 4%, Yakoma 4%, other 2%	*RDI*: 2.2 Christian: 89.5% Muslim: 8.5%	188	54.72
Chad	EH	Two hundred distinct groups; North and center, mostly Muslim: Arabs, Gorane (Toubou, Daza, Kreda), Zaghawa, Kanembou, Ouaddai, Baguirmi, Hadjerai, Fulbe, Kotoko, Hausa, Boulala, and Maba. South, mostly Christian or animist: Sara (Ngambaye, Mbaye, Goulaye), Moundang, Moussei, Massa	*RDI*: 6.0 Muslim: 55.3% Christian: 40.6% Unaffiliated: 2.5% Folk religion: 1.4%	186	66.16
Chile	WH	White and White-Amerindian 95%, Amerindian 3%, other 2%	*RDI*: 2.2 Christian: 89.4% Unaffiliated: 8.6%	44	ND
China	EH	Han Chinese 91.9%, Zhuang, Uygur, Hui, Yi, Tibetan, Miao, Manchu, Mongol, Buyi, Korean, and other nationalities 8.1%	*RDI*: 7.3 Unaffiliated: 52.2% Folk religion: 21.9% Buddhist: 18.2% Christian: 5.1% Muslim: 1.8%	86	0.35
Colombia	WH	Mestizo 58%, White 20%, mulatto 14%, Black 4%, mixed Black-Amerindian 3%, Amerindian 1%	*RDI*: 1.6 Christian: 92.5% Unaffiliated: 6.6%	90	0.90
Comoros	EH	Antalote, Cafre, Makoa, Oimatsaha, Sakalava	*RDI*: 0.4 Muslim: 98.3%	165	16.21
Congo, Democratic Republic of the	EH	With over 200 African ethnic groups, the majority are Bantu; the four largest tribes – Mongo, Luba, Kongo (all Bantu), and the Mangbetu-Azande (Hamitic) – make up about 45% of the population	*RDI*: 0.9 Christian: 95.8% Unaffiliated: 1.8% Muslim: 1.5%	176	42.24
Costa Rica	WH	White (including mestizo) 94%, Black 3%, Amerindian 1%, Chinese 1%, other 1%	*RDI*: 1.9 Christian: 90.9% Unaffiliated: 7.9%	63	ND

(continued)

Table 2 (continued)

Country	Hemisphere (WH, Western; EH, Eastern)	Race/ethnic groups (NationMaster, 2019)	Religious diversity (Pew Research Center, 2014a)[a]	Human Development Index (HDI) ranking for 2017[b]	Percent of population in severe multidimensional poverty[c]
Croatia	EH	Croat 89.6%, Serb 4.5%, Bosniak 0.5%, Hungarian 0.4%, Slovene 0.3%, Czech 0.2%, Roma 0.2%, Albanian 0.1%, Montenegrin 0.1%, others 4.1%	*RDI*: 1.4 Christian: 93.4% Unaffiliated: 5.1% Muslim: 1.4%	46	ND
Cuba	WH	Mulatto 51%, White 37%, Black 11%, Chinese 1%	*RDI*: 6.5 Christian: 59.2% Unaffiliated: 23.0% Folk religion: 17.4%	73	ND
Cyprus	EH	Greek 77%, Turkish 18% (each concentrated almost exclusively in separate areas), other 5%	*RDI*: 4.6 Christian: 73.2% Muslim: 25.3% Unaffiliated: 1.2%	32	ND
Czech Republic	EH	Czech 90.4%, Moravian 3.7%, Slovak 1.9%, other 4%	*RDI*: 4.1 Unaffiliated: 76.4% Christian: 23.3%	27	ND
Denmark	EH	Scandinavian (approx. 86% Danish descent), Inuit, Faroese, German, Turkish, Iranian, and Somali (approx. 13%)	*RDI*: 3.3 Christian: 83.5% Unaffiliated: 11.8% Muslim: 4.1%	11	ND
Djibouti	EH	Somali 60%, Afar 35%, French, Arab, Ethiopian, and Italian 5%	*RDI*: 0.7 Muslim: 96.9% Christian: 2.3%	172	15.68
Dominica	WH	Black (75%), mixed Black and European (19%), European (0.8%), Syrian, Carib Amerindian (0.1%)	*RDI*: 1.2 Christian: 94.4% Folk religion: 3.0%	103	ND
Dominican Republic	WH	White 16%, Black 11%, mixed 73%	*RDI*: 2.4 Christian: 88.0% Unaffiliated: 10.9%	94	0.49
Ecuador	WH	Mestizo (mixed Amerindian and White) 65%, Amerindian 25%, Spanish and others 7%, Black 3%	*RDI*: 1.3 Christian: 94.1% Unaffiliated: 5.5%	86	0.83
Egypt	EH	Egyptian 98%, Berber, Nubian, Bedouin, and Beja 1%, Greek, Armenian, other European (primarily Italian and French) 1%	*RDI*: 1.1 Muslim: 94.9% Christian: 5.1%	115	0.58

El Salvador	WH	Mestizo 90%, White 9%, Amerindian 1%	*RDI*: 2.4 Christian: 88.2% Unaffiliated: 11.0%	121	1.69
Equatorial Guinea	EH	Fang 57%; rest are Bubi, Seke, Yoruba, Igbo; less than 1000 Europeans, mostly Spanish	*RDI*: 2.4 Christian: 88.7% Unaffiliated: 5.0% Muslim: 4.0% Folk religion: 1.7%	141	ND
Eritrea	EH	Ethnic Tigrinya 50%, Tigre and Kunama 40%, Afar 4%, Saho (Red Sea coast dwellers) 3%, other 3%	*RDI*: 5.4 Christian: 62.9% Muslim: 36.6%	179	ND
Estonia	EH	Estonian 67.9%, Russian 25.6%, Ukrainian 2.1%, Belorussian 1.3%, Finn 0.9%, other 2.2%	*RDI*: 5.5 Unaffiliated: 59.6% Christian: 39.9%	30	ND
Eswatini (formerly Swaziland)	EH	Swazi 82%, Zulu 9%, Tsonga, Afrikaner, mixed (Black/White)	RDI: 2.4 Christian: 88.1% Unaffiliated: 10.1%	144	4.43
Ethiopia	EH	Oromo 40%, Amhara and Tigrean 32%, Sidamo 9%, Shankella 6%, Somali 6%, Afar 4%, Gurage 2%, other 1%	*RDI*: 5.6 Christian: 62.8% Muslim: 34.6% Folk religion: 2.6%	173	61.84
Fiji	WH/ EH	Fijian 51%, Indian 44%, European, other Pacific Islanders, overseas Chinese, and other 5%	*RDI*: 5.8 Christian: 64.4% Hindu: 27.9% Muslim: 6.3%	92	ND
Finland	EH	Finn 93.4%, Swede 5.7%, Sami (Lapp) 0.1%, Roma 0.2%, Estonian 0.2%	*RDI*: 3.5 Christian: 81.6% Unaffiliated: 17.6%	15	ND
France	WH/ EH	French 77%, Fleming, Algerian, Moroccan Berber, Moroccan Arab, Algerian Arab, Italian, Basque, Portuguese, Jewish	*RDI*: 5.9 Christian: 63.0% Unaffiliated: 28.0% Muslim: 7.5%	24	ND
Gabon	EH	Bantu tribes, including four major tribal groupings: Fang, Punu, Nzeiby, Mbede (Obamba/Bateke); other Africans and Europeans 10.8%, including 0.8% French and 0.8% persons of dual nationality	*RDI*: 4.5 Christian: 76.5% Muslim: 11.2% Folk religion: 6.0% Unaffiliated: 5.6%	110	4.81

(continued)

Table 2 (continued)

Country	Hemisphere (WH, Western; EH, Eastern)	Race/ethnic groups (NationMaster, 2019)	Religious diversity (Pew Research Center, 2014a)[a]	Human Development Index (HDI) ranking for 2017[b]	Percent of population in severe multidimensional poverty[c]
Gambia	WH	African 99% (Mandinka 42%, Fula 18%, Wolof 16%, Jola 10%, Serahuli 9%, other 4%), non-African 1%	*RDI*: 1.1 Muslim: 95.1% Christian: 4.5%	174	32.04
Georgia	EH	Georgian 83.8%, Azeri 6.5%, Armenian 5.7%, Russian 1.5%, other 2.5%	*RDI*: 2.3 Christian: 88.5% Muslim: 10.7%	70	ND
Germany	EH	German 91.5%, Turkish 2.4%, Italian 0.7%, Greek 0.4%, Polish 0.4%, other 4.6%	*RDI*: 5.3 Christian: 68.7% Unaffiliated: 24.7% Muslim: 5.8%	5	ND
Ghana	WH/ EH	Black African 98.5% (major tribes, Akan 44%, Moshi-Dagomba 16%, Ewe 13%, Ga 8%, Gurma 3%, Yoruba 1%), European and other 1.5% (1998)	*RDI*: 4.7 Christian: 74.9% Muslim: 15.8% Folk religion: 4.9% Unaffiliated: 4.2%	140	9.60
Greece	EH	Greek 98%, other (Turks, Macedonian Slavs, Albanians, Armenians, Bulgarians, Jews, Vlachs) 2%	*RDI*: 2.5 Christian: 88.1% Unaffiliated: 6.1% Muslim: 5.3%	31	ND
Grenada	WH	Black 82%, mixed Black and European 13%, European and East Indian 5%, and trace of Arawak/Carib Amerindian	*RDI*: 0.8 Christian: 96.6% Folk religion: 1.3%	75	ND
Guatemala	WH	Mestizo (Ladino) – mixed Amerindian-Spanish ancestry – and European 59.4%, K'iche 9.1%, Kaqchikel 8.4%, Mam 7.9%, Q'eqchi 6.3%, other Mayan 8.6%, indigenous non-Mayan 0.2%, other 0.1%	*RDI*: 1.1 Christian: 95.2% Unaffiliated: 4.1%	127	11.29
Guinea	EH	Peuhl 40%, Malinke 30%, Susu 20%, smaller tribes 10%	*RDI*: 3.1 Muslim: 84.4% Christian: 10.9% Folk religion: 2.7% Unaffiliated: 1.8%	175	38.12
Guinea-Bissau	WH	African 99% (Balanta 30%, Fula 20%, Manjaca 14%, Mandinga 13%, Papel 7%), European and mulatto less than 1%	*RDI*: 7.5 Muslim: 45.1% Folk religion: 30.9% Christian: 19.7% Unaffiliated: 4.3%	177	40.47

Guyana	WH	East Indian 50%; Black 36%; Amerindian 7%; White, Chinese, and mixed 7%	*RDI*: 5.7 Christian: 66.0% Hindu: 24.9% Muslim: 6.4% Unaffiliated: 2.0%	125	0.69
Haiti	WH	Black 95%, mulatto and White 5%	*RDI*: 2.7 Christian: 86.9% Unaffiliated: 10.6% Folk religion: 2.2%	168	22.52
Honduras	WH	Mestizo 90%, Amerindian 7%, Black 2%, White 1%	*RDI*: 2.5 Christian: 87.6% Unaffiliated: 10.5% Folk religion: 1.1%	133	6.60
Hungary	EH	Hungarian 92.3%, Roma 1.9%, other or unknown 5.8%	*RDI*: 3.5 Christian: 81.0% Unaffiliated: 18.6%	45	ND
Iceland	WH	Homogeneous mixture of Norse/Celtic descendants 94%, population of foreign origin 6%	*RDI*: 1.1 Christian: 95.0% Unaffiliated: 3.5%	6	ND
India	EH	Indo-Aryan 72%, Dravidian 25%, Mongoloid and other 3%	*RDI*: 4.0 Hindu: 79.5% Muslim: 14.4% Christian: 2.5% Other religion: 2.3%	130	8.59
Indonesia	EH	Javanese 45%, Sundanese 14%, Madurese 7.5%, coastal Malays 7.5%, other 26%	*RDI*: 2.6 Muslim: 87.2% Christian: 9.9% Hindu: 1.7%	116	1.24
Iran	EH	Persian 51%, Azerbaijani 24%, Gilaki and Mazandarani 8%, Kurd 7%, Arab 3%, Lur 2%, Baloch 2%, Turkmen 2%, other 1%	*RDI*: 0.1 Muslim: 99.5%	60	ND
Iraq	EH	Arab 75%–80%; Kurdish 15%–20%; Turkoman, Assyrian, or other 5%	*RDI*: 0.2 Muslim: 99.0%	120	3.00
Ireland	WH	Celtic, English, Black Irish	*RDI*: 1.7 Christian: 92.0% Unaffiliated: 6.2% Muslim: 1.1%	4	ND

(continued)

Table 2 (continued)

Country	Hemisphere (WH, Western; EH, Eastern)	Race/ethnic groups (NationMaster, 2019)	Religious diversity (Pew Research Center, 2014a)[a]	Human Development Index (HDI) ranking for 2017[b]	Percent of population in severe multidimensional poverty[c]
Israel	EH	Jewish 80.1% (Europe/Americas/Oceania born 32.1%, Israel born 20.8%, Africa born 14.6%, Asia born 12.6%), non-Jewish 19.9% (mostly Arab)	*RDI*: 4.5 Jewish: 75.6% Muslim: 18.6% Unaffiliated: 3.1% Christian: 2.0%	22	ND
Italy	EH	Italian (includes small clusters of German-, French-, and Slovene-Italians in the north and Albanian- and Greek-Italians in the south)	*RDI*: 3.3 Christian: 83.3% Unaffiliated: 12.4% Muslim: 3.7%	28	ND
Ivory Coast	WH	Akan 42.1%, Voltaiques (Gur) 17.6%, Northern Mandes 16.5%, Krous 11%, Southern Mandes 10%, other 2.8% (includes 130,000 Lebanese and 14,000 French)	*RDI*: 7.4 Christian: 44.1% Muslim: 37.5% Folk religion: 10.2% Unaffiliated: 8.0%	170	24.51
Jamaica	WH	Black 90.9%, East Indian 1.3%, White 0.2%, Chinese 0.2%, mixed 7.3%, other 0.1%	*RDI*: 4.3 Christian: 77.2% Unaffiliated: 17.2% Folk religion: 4.5%	97	0.81
Japan	EH	Japanese 99%; Korean, Chinese, Brazilian, Filipino, other 1%	*RDI*: 6.2 Buddhist: 36.2% Unaffiliated: 57.0% Other: 4.7% Christian: 1.6%	19	ND
Jordan	EH	Arab 98%, Circassian 1%, Armenian 1%	*RDI*: 0.6 Muslim: 97.2% Christian: 2.2%	95	0.09
Kazakhstan	EH	Kazak (Qazaq) 53.4%, Russian 30%, Ukrainian 3.7%, Uzbek 2.5%, German 2.4%, Tatar 1.4%, Uygur 1.4%, other 4.9%	*RDI*: 5.0 Muslim: 70.4% Christian: 24.8% Unaffiliated: 4.2%	58	0.00

Kenya	EH	Kikuyu 22%; Luhya 14%; Luo 13%; Kalenjin 12%; Kamba 11%; Kisii 6%; Meru 6%; other African 15%; Asian, European, and Arab 1%	*RDI*: 3.1 Christian: 84.8% Muslim: 9.7% Unaffiliated: 2.5% Folk religion: 1.7% Other: 1.2%	142	13.45
Kiribati	WH/ EH	Micronesian 98.8%, other 1.2%	*RDI*: 0.7 Christian: 97.0% Other: 2.2%	134	ND
Kuwait	EH	Kuwaiti 45%, other Arab 35%, South Asian 9%, Iranian 4%, other 7%	*RDI*: 4.8 Muslim: 74.1% Christian: 14.3% Hindu: 8.5% Buddhist: 2.8%	56	ND
Kyrgyzstan	EH	Kyrgyz 64.9%, Uzbek 13.8%, Russian 12.5%, Dungan 1.1%, Ukrainian 1%, Uygur 1%, other 5.7% (1999)	*RDI*: 5.0 Muslim: 70.4% Christian: 24.8% Unaffiliated: 4.0%	122	0.04
Laos	EH	Lao Loum (lowland) 68%, Lao Theung (upland) 22%, Lao Soung (highland) including the Hmong (“Meo”) and the Yao (Mien) 9%, ethnic Vietnamese/ Chinese 1%	*RDI*: 5.4 Buddhist: 66.0% Folk religion: 30.7% Christian: 1.5%	139	22.00
Latvia	EH	Latvian 57.7%, Russian 29.6%, Belorussian 4.1%, Ukrainian 2.7%, Polish 2.5%, Lithuanian 1.4%, other 2%	*RDI*: 5.7 Christian: 55.8% Unaffiliated: 43.8%	41	ND
Lebanon	EH	Arab 95%, Armenian 4%, other 1%	*RDI*: 5.5 Muslim: 61.3% Christian: 38.3%	80	ND
Lesotho	EH	Sotho 99.7%; Europeans, Asians, and other 0.3%	*RDI*: 0.7 Christian: 96.8% Unaffiliated: 3.1%	159	8.60
Liberia	WH	Berber and Arab 97%, Greeks, Maltese, Italians, Egyptians, Pakistanis, Turks, Indians, Tunisians	*RDI*: 2.8 Christian: 85.9% Muslim: 12.0% Unaffiliated: 1.4%	181	33.15
Libya	EH	Berber and Arab 97%, Greeks, Maltese, Italians, Egyptians, Pakistanis, Turks, Indians, Tunisians	*RDI*: 0.7 Muslim: 96.6% Christian: 2.7%	108	0.08

(continued)

Table 2 (continued)

Country	Hemisphere (WH, Western; EH, Eastern)	Race/ethnic groups (NationMaster, 2019)	Religious diversity (Pew Research Center, 2014a)[a]	Human Development Index (HDI) ranking for 2017[b]	Percent of population in severe multidimensional poverty[c]
Liechtenstein	EH	Alemannic 86%; Italian, Turkish, and other 14%	*RDI*: 1.7 Christian: 91.9% Muslim: 5.0% Unaffiliated: 2.9%	17	ND
Lithuania	EH	Lithuanian 83.4%, Polish 6.7%, Russian 6.3%, other or unspecified 3.6%	*RDI*: 2.1 Christian: 89.8% Unaffiliated: 10.0%	35	ND
Luxembourg	EH	Celtic base (with French and German blend), Portuguese, Italian, Slavs (from Montenegro, Albania, and Kosovo), and European	*RDI*: 4.9 Christian: 70.4% Unaffiliated: 26.8% Muslim: 2.3%	21	ND
Macedonia	EH	Macedonian 64.2%, Albanian 25.2%, Turkish 3.8%, Roma (Gypsy) 2.7%, Serb 1.8%, other 2.2%	*RDI*: ND	80	ND
Madagascar	EH	Malayo-Indonesian (Merina and related Betsileo), Côtiers (mixed African, Malayo-Indonesian, and Arab ancestry, Betsimisaraka, Tsimihety, Antaisaka, Sakalava), French, Indian, Creole, Comoran	*RDI*: 3.0 Christian: 85.3% Unaffiliated: 6.9% Folk religion: 4.5% Muslim: 3.0%	161	57.25
Malawi	EH	Chewa, Nyanja, Tumbuko, Yao, Lomwe, Sena, Tonga, Ngoni, Ngonde, Asian, European	*RDI*: 3.4 Christian: 82.7% Muslim: 13.0% Unaffiliated: 2.5% Folk religion: 1.7%	171	18.51
Malaysia	EH	Malay 50.4%, Chinese 23.7%, indigenous 11%, Indian 7.1%, others 7.8%	*RDI*: 6.3 Muslim: 63.7% Buddhist: 17.7% Christian: 9.4% Hindu: 6.0% Folk religion: 2.3%	57	ND
Maldives	EH	South Indians, Sinhalese, Arabs	*RDI*: 0.4 Muslim: 98.4%	101	0.07

Mali	WH/ EH	Mande 50% (Bambara, Malinke, Sarakole), Peul 17%, Voltaic 12%, Tuareg and Moor 10%, Songhai 6%, other 5%	*RDI*: 1.6 Muslim: 92.4% Christian: 3.2% Unaffiliated: 2.7% Folk religion: 1.6%	182	56.67
Malta	EH	Maltese (descendants of ancient Carthaginians and Phoenicians; strong elements of Italian stock), very small British minority	*RDI*: 0.7 Christian: 97.0% Unaffiliated: 2.5%	29	ND
Marshall Islands	EH	Micronesian	*RDI*: 0.6 Christian: 97.5% Unaffiliated: 1.5%	106	ND
Mauritania		Mixed Maur/Black 40%, Maur 30%, Black 30%	*RDI*: 0.2 Muslim: 99.1%	159	26.44
Mauritius	EH	Indo-Mauritian 68%, Creole 27%, Sino-Mauritian 3%, Franco-Mauritian 2%	*RDI*: 6.7 Hindu: 56.4% Christian: 25.3% Muslim: 16.7%	65	ND
Mexico	WH	Mestizo (Amerindian-Spanish) 60%, Amerindian or predominantly Amerindian 30%, White 9%, other 1%	*RDI*: 1.1 Christian: 95.1% Unaffiliated: 4.7%	74	1.02
Micronesia	EH	Nine ethnic Micronesian and Polynesian groups	*RDI*: ND	131	ND
Moldova	EH	Moldavian/Romanian 78.2%, Ukrainian 8.4%, Russian 5.8%, Gagauz 4.4%, Bulgarian 1.9%, other 1.3%	*RDI*: 0.6 Christian: 97.4% Unaffiliated: 1.4%	112	0.06
Monaco	EH	French 47%, Monegasque 16%, Italian 16%, other 21%	*RDI*: 2.8 Christian: 86% Unaffiliated: 11.7%	ND	ND
Mongolia	EH	Mongol (predominantly Khalkha) 94.9%, Turkic (of which Kazak is the largest group) 5%, other (including Chinese and Russian) 0.1%	*RDI*: 6.5 Buddhist: 55.1% Unaffiliated: 35.9% Folk religion: 3.5% Muslim: 3.2% Christian: 2.3%	92	1.58
Montenegro	EH	Montenegrin 43%, Serbian 32%, Bosniak 8%, Albanian 5%, other (Muslims, Croats, Roma) 12%	*RDI*: 4.0 Christian: 78.1% Muslim: 18.7% Unaffiliated: 3.2%	50	0.14

(continued)

Table 2 (continued)

Country	Hemisphere (WH, Western; EH, Eastern)	Race/ethnic groups (NationMaster, 2019)	Religious diversity (Pew Research Center, 2014a)[a]	Human Development Index (HDI) ranking for 2017[b]	Percent of population in severe multidimensional poverty[c]
Morocco		Arab-Berber 99.1%, Jewish 0.2%, other 0.7%	*RDI*: 0.0 Muslim: 99.9%	123	6.49
Mozambique	EH	Indigenous tribal groups 99.66% (Shangaan, Chokwe, Manyika, Sena, Makua, and others), Europeans 0.06%, Euro-Africans 0.2%, Indians 0.08%	*RDI*: 7.0 Christian: 56.7% Muslim: 18.0% Unaffiliated: 17.9%	180	49.24
Myanmar (Burma)	EH	Burman 68%, Shan 9%, Karen 7%, Rakhine 4%, Chinese 3%, Indian 2%, Mon 2%, other 5%	*RDI*: 4.0 Buddhist: 80.1% Christian: 7.8% Folk religion: 5.8% Muslim: 4.0% Hindu: 1.7%	148	13.89
Namibia	EH	Black 87.5%, White 6%, mixed 6.5%. Note: about 50% of the population belong to the Ovambo tribe and 9% to the Kavangos tribe; other ethnic groups are Herero 7%, Damara 7%, Nama 5%, Caprivian 4%, Bushmen 3%, Baster 2%, Tswana 0.5%	*RDI*: 0.6 Christian: 97.5% Unaffiliated: 1.9%	129	12.88
Nauru	EH	Nauruan 58%, other Pacific Islander 26%, Chinese 8%, European 8%	*RDI*: 4.1 Christian: 79.0% Folk religion: 8.1% Other religion: 7.4% Unaffiliated: 4.5%	ND	ND
Nepal	EH	Brahman-Hill 12.5%, Chetri 15.5%, Magar 7%, Tharu 6.6%, Tamang 5.5%, Newar 5.4%, Muslim 4.2%, Kami 3.9%, Yadav 3.9%, other 32.7%, unspecified 2.8%	*RDI*: 3.8 Hindu: 80.7% Buddhist: 10.3% Muslim: 4.6% Folk religion: 3.7%	149	11.99
Netherlands	WH/EH	Dutch 83%, other 17% (9% of non-Western origin, mainly Turks, Moroccans, Antilleans, Surinamese, and Indonesians)	*RDI*: 6.4 Christian: 50.6% Unaffiliated: 42.1% Muslim: 6.0%	10	ND

New Zealand	EH	European 69.8%, Maori 7.9%, Pacific Islander 4.4%, Asian 5.7%, other 0.5%, mixed 7.8%, unspecified 3.8%	*RDI*: 6.2 Christian: 57.0% Unaffiliated: 36.6% Hindu: 2.1% Buddhist: 1.6% Muslim: 1.2%	16	ND
Nicaragua	WH	Mestizo 69%, White 17%, Black 9%, Amerindian 5%	*RDI*: 2.8 Christian: 85.8% Unaffiliated: 12.5% Folk religion: 1.4%	124	5.51
Niger	EH	Hausa 56%, Djerma 22%, Fula 8.5%, Tuareg 8%, Beri Beri (Kanouri) 4.3%, Arab, Toubou, and Gourmantche 1.2%, about 1200 French expatriates	*RDI*: 0.4 Muslim: 98.4%	189	74.88
Nigeria	EH	More than 250 ethnic groups, including Hausa and Fulani 29%, Yoruba 21%, Ibo 18%, Ijaw 10%, Kanuri 4%, Ibibio 3.5%, Tiv 2.5%	*RDI*: 5.9 Christian: 49.3% Muslim: 48.8% Folk religion: 1.4%	157	32.67
North Korea	EH	Racially homogeneous; small Chinese community, a few ethnic Japanese	*RDI*: 5.3 Unaffiliated: 71.3% Other religion: 12.9% Folk religion: 12.3% Christian: 2.0% Buddhist: 1.5%	22	ND
Norway	EH	Norwegian 80%, Swedes, Poles, Lithuanians, migrant communities (Somalis, Turks, Iraqis, Russions, Vietnamese, Bosnians), Sami people <1%	*RDI*: 3.1 Christian: 84.7% Unaffiliated: 10.1% Muslim: 3.7%	1	ND
Oman	EH	Arab, Baluchi, South Asian (Indian, Pakistani, Sri Lankan, Bangladeshi), African	*RDI*: 2.9 Muslim: 85.9% Christian: 6.5% Hindu: 5.5%	48	ND
Pakistan	EH	Punjabi, Sindhi, Pashtun (Pathan), Baloch, Muhajir (immigrants from India and their descendants)	*RDI*: 0.8 Muslim: 96.4% Hindu: 1.9% Christian: 1.6%	150	24.74
Palau	EH	Palauan (Micronesian with Malayan and Melanesian admixtures) 69.9%, Filipino 15.3%, Chinese 4.9%, other Asian 2.4%, White 1.9%, Carolinian 1.4%, other Micronesian 1.1%, other or unspecified 3.2%	*RDI*: 2.7 Christian: 86.7% Other religion: 10.4% Unaffiliated: 1.2%	60	ND

(continued)

Table 2 (continued)

Country	Hemisphere (WH, Western; EH, Eastern)	Race/ethnic groups (NationMaster, 2019)	Religious diversity (Pew Research Center, 2014a)[a]	Human Development Index (HDI) ranking for 2017[b]	Percent of population in severe multidimensional poverty[c]
Panama	WH	Mestizo 70%, Amerindian and mixed (West Indian) 14%, White 10%, Indian 6%	*RDI*: 1.5 Christian: 93.0% Unaffiliated: 4.8%	66	ND
Papua New Guinea	EH	Melanesian, Papuan, Negrito, Micronesian, Polynesian	*RDI*: 0.2 Christian: 99.2%	153	ND
Paraguay	WH	Mestizo 95%	*RDI*: 0.7 Christian: 96.9% Folk religion: 1.7% Unaffiliated: 1.1%	110	1.02
Peru	WH	Amerindian 45%, mestizo 37%, White 15%, Black, Japanese, Chinese, and other 3%	*RDI*: 1.0 Christian: 95.5% Unaffiliated: 3.0%	89	2.72
Philippines	EH	Tagalog 28.1%, Cebuano 13.1%, Ilocano 9%, Bisaya/Binisaya 7.6%, Hiligaynon Ilonggo 7.5%, Bikol 6%, Waray 3.4%, other 25.3%	*RDI: 1.6* Christian: 92.6% Muslim: 5.5% Folk religion: 1.5%	113	4.74
Poland	EH	Polish 96.7%, German 0.4%, Belorussian 0.1% Ukrainian 0.1%, other 2.7%	*RDI*: 1.2 Christian: 94.3% Unaffiliated: 5.6%	33	ND
Portugal		Portuguese 95%, Africans, Brazilians, Chinese, Gypsies 5%	*RDI*: 1.4 Christian: 93.8% Unaffiliated: 4.4%	41	ND
Qatar	EH	Arab 40%, Pakistani 18%, Indian 18%, Iranian 10%, other 14%	*RDI: 5.7* Muslim: 67.7% Christian: 13.8% Hindu: 13.8% Buddhist: 3.1%	37	ND
Republic of the Congo	EH	Kongo 48%, Sangha 20%, M'Bochi 12%, Teke 17%, Europeans and other 3%	*RDI*: 2.9 Christian: 85.9% Unaffiliated: 9.0% Folk religion: 2.8% Muslim: 1.2% Other religion: 1.1%	ND	ND

Romania	EH	Romanian 89.5%, Hungarian 6.6%, Roma (Gyspy) 2.5%, Ukrainian 0.3%, German 0.3%, Russian 0.2%, Turkish 0.2%, other 0.4%	*RDI*: 0.1 Christian: 99.5%	52	ND
Russia	WH/ EH	Russian 79.8%, Tatar 3.8%, Ukrainian 2%, Bashkir 1.2%, Chuvash 1.1%, other or unspecified 12.1%	*RDI*: 4.9 Christian: 73.3% Unaffiliated: 16.2% Muslim: 10.0%	49	ND
Rwanda	EH	Hutu 84%, Tutsi 15%, Twa (Pygmoid) 1%	*RDI*: 1.4 Christian: 93.4% Unaffiliated: 3.6% Muslim: 1.8%	158	22.95
Saint Kitts and Nevis	WH	Predominantly Black; some British, Portuguese, and Lebanese	*RDI*: 1.2 Christian: 94.6% Unaffiliated: 1.6% Hindu: 1.5% Folk religion: 1.3%	72	ND
Saint Lucia	WH	Black 90%, mixed 6%, East Indian 3%, White 1%	*RDI*: 1.9 Christian: 91.1% Unaffiliated: 6.0% Other religion: 2.0%	90	0.00
Saint Vincent and the Grenadines	WH	Black 66%, mixed 19%, East Indian 6%, Carib Amerindian 2%, other 7%	*RDI*: 2.4 Christian: 88.7% Hindu: 3.4% Unaffiliated: 2.5% Folk religion: 2.0% Muslim: 1.5%	99	ND
Samoa	WH	Native Pacific Islander 91.6%, Asian 2.8%, White 1.1%, mixed 4.2%, other 0.3%	*RDI*: 0.4 Christian: 98.3%	104	ND
San Marino	EH	Sammarinese, Italians	*RDI*: 1.8 Christian: 91.6% Unaffiliated: 7.2%	ND	ND
Sao Tome and Principe	EH	Mestico (mixed European and native African), Angolares (descendants of Angolan slaves), Forros (descendants of freed slaves), Servicais (contract laborers from Angola, Mozambique, and Cape Verde), Tongas (children of Servicais born on the islands), Europeans (primarily Portuguese	*RDI*: 3.5 Christian: 82.2% Unaffiliated: 12.6% Folk religion: 2.9% Other religion: 2.4%	143	4.40

(continued)

Table 2 (continued)

Country	Hemisphere (WH, Western; EH, Eastern)	Race/ethnic groups (NationMaster, 2019)	Religious diversity (Pew Research Center, 2014a)[a]	Human Development Index (HDI) ranking for 2017[b]	Percent of population in severe multidimensional poverty[c]
Saudi Arabia	EH	Arab 90%, Afro-Asian 10%	*RDI*: 1.5 Muslim: 93.0% Christian: 4.4% Hindu: 1.1%	39	ND
Senegal	WH	Wolof 43.3%, Fulani 23.8%, Serer 14.7%, Diola 3.7%, Mandingo 3%, Soninke 1.1%, European and Lebanese 1%, other 9.4%	*RDI*: 0.8 Muslim: 96.4% Christian: 3.6%	164	32.05
Serbia	EH	Serb 66%, Albanian 17%, Hungarian 3.5%, other 13.5%	*RDI*: 1.6 Christian: 92.5% Muslim: 4.2% Unaffiliated: 3.3%	67	0.10
Seychelles	EH	Creoles (African, Asian, European blends) 93.2%, British 3.0%, French 1.8%, Chinese 0.4%, Indian 0.4%, others 1.2% (Wikipedia, 2019)	*RDI*: 1.3 Christian: 94.0% Unaffiliated: 2.1% Hindu: 2.1% Muslim: 1.1%	62	ND
Sierra Leone	WH	Twenty native African tribes 90% (Temne 30%, Mende 30%, other 30%); Creole (Krio) 10%; refugees from Liberia's recent civil war, small numbers of Europeans, Lebanese, Pakistanis, and Indians	*RDI*: 4.0 Muslim: 78.0% Christian: 20.9%	184	48.41
Singapore	EH	Chinese 76.8%, Malay 13.9%, Indian 7.9%, other 1.4%	*RDI*: 9.0 Buddhist: 33.9% Christian: 18.2% Unaffiliated: 16.4% Muslim: 14.3% Other religion: 9.7% Hindu: 5.2% Folk religion: 2.3%	9	ND
Slovakia	EH	Slovak 85.8%, Hungarian 9.7%, Roma 1.7%, Ruthenian/Ukrainian 1%, other and unspecified 1.8%	*RDI*: 2.9 Christian: 85.3% Unaffiliated: 14.3%	38	ND
Slovenia	EH	Slovene 93.1%, Croat 1.8%, Serb 2%, Bosniak 1.1%, other or unspecified 12%	*RDI*: 4.0 Christian: 78.4% Unaffiliated: 18.0% Muslim: 3.6%	25	ND

Solomon Islands	EH	Melanesian 94.5%, Polynesian 3%, Micronesian 1.2%, other 1.1%, unspecified 0.2%	*RDI*: 0.6 Christian: 97.4% Folk religion: 1.3%	152	ND
Somalia	EH	Somali 85%, Bantu and others 15% (including Arabs 30,000)	*RDI*: 0.1 Muslim: 99.8%	ND	67.47
South Africa	EH	Black African 79%, White 9.6%, colored 8.9%, Indian/Asian 2.5%	*RDI*: 3.6 Christian: 81.2% Unaffiliated: 14.9% Muslim: 1.7% Hindu: 1.1%	113	1.12
South Korea	EH	Homogeneous (except for about 20,000 Chinese)	*RDI*: 7.4 Unaffiliated: 46.4% Christian: 29.4% Buddhist: 22.9%	22	ND
Spain	WH/ EH		*RDI*: 3.9 Christian: 78.6% Unaffiliated: 19.0% Muslim: 2.1%	26	ND
Sri Lanka	EH		*RDI*: 5.6 Buddhist: 69.3% Hindu: 13.6% Muslim: 9.8% Christian: 7.3%	76	ND
Sudan	EH	Black 52%, Arab 39%, Beja 6%, foreigners 2%, other 1%	*RDI*: 2.0 Muslim: 90.7% Christian: 5.4% Folk religion: 2.8%	167	30.89
Suriname	WH	East Indians (Hindustanis) 37%, Creole (mixed White and Black) 31%, Javanese 15%, "Bush Negroes" (also known as Maroons) 10%, Amerindian 2%, Chinese 2%, White 1%, other 2%	*RDI*: 7.6 Christian: 51.6% Hindu: 19.8% Muslim: 15.2% Unaffiliated: 5.4% Folk religion: 5.3% Other religion: 1.8%	100	2.51
Sweden	EH	Indigenous population: Swedes with Finnish and Sami minorities; foreign-born or first-generation immigrants: Finns, Yugoslavs, Danes, Norwegians, Greeks, Turks	*RDI*: 5.4 Christian: 67.2% Unaffiliated: 27.0% Muslim: 4.6%	7	ND

(continued)

Table 2 (continued)

Country	Hemisphere (WH, Western; EH, Eastern)	Race/ethnic groups (NationMaster, 2019)	Religious diversity (Pew Research Center, 2014a)[a]	Human Development Index (HDI) ranking for 2017[b]	Percent of population in severe multidimensional poverty[c]
Switzerland	EH	German 65%, French 18%, Italian 10%, Romansch 1%, other 6%	*RDI*: 3.7 Christian: 81.3% Unaffiliated: 11.9% Muslim: 5.5%	2	ND
Syria	EH	Arab 90.3%, Kurds, Armenians, and other 9.7%	*RDI*: 1.6 Muslim: 92.8% Christian: 5.2% Unaffiliated: 2.0%	155	1.23
Taiwan	EH	Taiwanese (including Hakka) 84%, mainland Chinese 14%, aborigine 2%	*RDI*: 8.2 Folk religion: 44.2% Buddhist: 21.3% Unaffiliated: 12.7% Other religion: 16.2% Christian: 5.5%	ND	ND
Tajikistan	EH	Tajik 79%, Uzbek 15.3%, Russian 1.1%, Kyrgyz 1.1%, other 2.6%	*RDI*: 0.7 Muslim: 96.7% Christian: 1.6% Unaffiliated: 1.5%	127	2.32
Tanzania	EH	Mainland, native African 99% (includes 95% Bantu, consisting of well over 100 tribes); Asian, European, and Arab 1%; Zanzibar, Arab, native African, mixed	*RDI*: 5.7 Christian: 61.4% Muslim: 35.2% Folk religion: 1.8% Unaffiliated: 1.4%	154	26.13
Thailand	EH	Thai 75%, Chinese 14%, other 11%	*RDI*: 1.5 Buddhist: 93.2% Muslim: 5.5%	83	0.13
Togo	WH/ EH	Native African (37 tribes; largest and most important are Ewe, Mina, and Kabre) 99%, European and Syrian-Lebanese less than 1%	*RDI*: 7.5 Christian: 43.7% Folk religion: 35.6% Muslim: 14.0% Unaffiliated: 6.2%	165	24.41

Tonga	EH	Polynesian, European	*RDI*: 0.3 Christian: 98.9%	98	ND
Trinidad and Tobago	WH	Indian (South Asian) 40%, African 37.5%, mixed 20.5%, other 1.2%, unspecified 0.8%	*RDI*: 5.8 Christian: 65.9% Hindu: 22.7% Muslim: 5.9% Folk religion: 1.9% Unaffiliated: 1.9%	69	0.10
Tunisia	EH	Arab-Berber 98%, European 1%, Jewish and other 1%	*RDI*: 0.1 Muslim: 99.5%	95	0.19
Turkey	EH	Turkish 80%, Kurdish 20%	*RDI*: 0.4 Muslim: 98.0%	64	ND
Turkmenistan	EH	Turkmen 85%, Uzbek 5%, Russian 4%, other 6%	*RDI*: 1.5 Muslim: 93.0% Christian: 6.4%	108	0.00
Tuvalu	EH	Polynesian 96%, Micronesian 4%	*RDI*: 0.7 Christian: 96.7% Other religion: 1.9% Unaffiliated: 1.3%	ND	ND
Uganda	EH	Baganda 17%, Ankole 8%, Basoga 8%, Iteso 8%, Bakiga 7%, Langi 6%, Rwanda 6%, Bagisu 5%, Acholi 4%, Lugbara 4%, Batoro 3%, Bunyoro 3%, Alur 2%, Bagwere 2%, Bakonjo 2%, Jopodhola 2%, Karamojong 2%, Rundi 2%, non-African (European, Asian, Arab) 1%, other 8%	*RDI*: 2.7 Christian: 86.7% Muslim: 11.5%	162	25.42
Ukraine	EH	Ukrainian 77.8%, Russian 17.3%, Belorussian 0.6%, Moldovan 0.5%, Crimean Tatar 0.5%, Bulgarian 0.4%, Hungarian 0.3%, Romanian 0.3%, Polish 0.3%, Jewish 0.2%, other 1.8%	*RDI*: 3.1 Christian: 83.8% Unaffiliated: 14.7% Muslim: 1.2%	88	0.00
United Arab Emirates	EH	Emiri 19%, other Arab and Iranian 23%, South Asian 50%, other expatriates (includes Westerners and East Asians) 8%	*RDI*: 4.4 Muslim: 76.9% Christian: 12.6% Hindu: 6.6% Buddhist: 2.0% Unaffiliated: 1.1%	34	ND

(continued)

Table 2 (continued)

Country	Hemisphere (WH, Western; EH, Eastern)	Race/ethnic groups (NationMaster, 2019)	Religious diversity (Pew Research Center, 2014a)[a]	Human Development Index (HDI) ranking for 2017[b]	Percent of population in severe multidimensional poverty[c]
United Kingdom	WH/ EH	English 83.6%, Scottish 8.6%, Welsh 4.9%; Northern Irish 2.9%, Black 2%, Indian 1.8%, Pakistani 1.3%, mixed 1.2%, other 1.6%	*RDI*: 5.1 Christian: 71.1% Unaffiliated: 21.3% Muslim: 4.4% Hindu: 1.3%	14	ND
United States	WH/ EH	White 75.1%; Black 12.3%; Asian 3.6%; American Indian and Alaska Native 0.9%; Native Hawaiian and other Pacific Islander 0.1%; other race 5.5%; Hispanic origin 12.5%	*RDI*: 4.1 Christian: 78.3% Unaffiliated: 16.4% Jewish: 1.8% Buddhist: 1.2%	13	ND
Uruguay	WH	White 88%, mestizo 8%, Black 4%	*RDI*: 5.7 Christian: 57.9% Unaffiliated: 40.7%	55	ND
Uzbekistan	EH	Uzbek 80%, Russian 5.5%, Tajik 5%, Kazak 3%, Karakalpak 2.5%, Tatar 1.5%, other 2.5%	*RDI*: 0.7 Muslim: 96.7% Christian: 2.3%	105	0.32
Vanuatu	EH	Ni-Vanuatu 98.5%, other 1.5%	*RDI*: 1.5 Christian: 93.3% Folk religion: 4.1% Other religion: 1.4% Unaffiliated: 1.2%	138	10.16
Vatican City	EH	Italian, Swiss, other	*RDI*: 0.0 Christian: 99.0%	ND	ND
Venezuela	WH	Spanish, Italian, Portuguese, Arab, German, African, indigenous people	*RDI*: 2.2 Christian: 89.3% Unaffiliated: 10.0%	78	ND
Vietnam	EH	Kinh (Viet) 86.2%, Tay 1.9%, Thai 1.7%, Muong 1.5%, Khome 1.4%, Hoa 1.1%, Nun 1.1%, Hmong 1%, others 4.1%	*RDI*: 7.7 Folk religion: 45.3% Unaffiliated: 29.6% Buddhist: 16.4% Christian: 8.2%	116	0.74

Virgin Islands	WH	Black 82%, White 6.8%, other 11.2% (includes Indian and mixed)	*RDI*: ND	ND	ND
Yemen	EH	Predominantly Arab, but also Afro-Arab, South Asians, Europeans	*RDI*: 0.2 Muslim: 99.1%	178	23.90
Zambia	EH	African 98.7%, European 1.1%, other 0.2%	*RDI*: 0.5 Christian: 97.6%	144	24.35
Zimbabwe	EH	African 98% (Shona 82%, Ndebele 14%, other 2%), mixed and Asian 1%, White less than 1%	*RDI*: 2.7 Christian: 87.0% Unaffiliated: 7.9% Folk religion: 3.8%	156	8.76

Note: Religious categories are shown only if percentages >1.0%

[a] Religious Diversity Index (RDI): Countries with scores of 7.0 or higher are categorized as having a "very high" degree of religious diversity; scores from 5.3 to 6.9 are categorized as having a "high" level of diversity; scores from 3.1 to 5.2 are categorized as having "moderate" diversity; scores at 3.0 or lower are categorized as having "low" diversity according to 2010 population estimates (Pew Research Center, 2014b)

[b] Human Development Index (HDI): A summary measure of average achievement in key dimensions of human development: life expectancy at birth (UNDESA, 2017), school enrollment (mean years of schooling for adults aged 25 years or more and expected years of schooling for children of school entering age; UNESCO Institute for Statistics, 2018; Barro & Lee, 2016; OECD, 2017), and gross national income per capita (ILO, 2018; UNDESA, 2017; World Bank, 2018; IMF, 2018). For technical details, see Human Development Indices and Indicators (2018). An HDI rank of 1 = country with highest HDI rank, and 189 = country with lowest HDI rank. Cells with a "ND" indicate that no data was available for that country

[c] Multidimensional Poverty Index (MPI): A summary measure that reflects how people living within a country experience poverty in multiple and simultaneous ways along ten indicators (e.g., nutrition, child mortality, years of schooling, school attendance, cooking fuel, sanitation, drinking water, electricity, housing, and assets) across three dimensions: health, education, and standard of living. For additional details, see Alkire and Jahan (2018). Percentage of the population in severe multidimensional poverty is defined as the percentage of persons living within a country with a deprivation score of 50% or more. Cells with a "ND" indicate that no data was available for that country

Azerbaijan, and Armenia. Despite similarities in superficial racial appearance, the Caucasus region is home to more than 50 different ethnic groups who speak Indo-European and Turkic languages (Encyclopedia Britannica, 2019). According to the most recent information (at the time of this writing) from the US Census Bureau (2018), "White" as a racial category is defined as "[any] person having origins in any of the original peoples of Europe, the Middle East, or North Africa."

Some writers portray "Western" influences as synonymous with behaviors, beliefs, and cultural influences that are associated with people having white (pink) skin, whose distant descendants originated from the continent of Europe. According to this logic, any person (regardless of where in the world they live) whose distant ancestors did not originate from Europe is automatically considered to be "Non-Western." As such, some argue that any conclusions developed by "Western (White) science" is inapplicable (or perhaps harmful) to "Non-Western (non-White)" persons. For example, in the forward to a book celebrating the culture and learning styles of African-American school children (Hale, 1986), Hilliard states:

> Psychology, sociology, anthropology, sociolinguistics, and other related disciplines developed at the same time that Europe was in its ascendancy and was beginning to extend its political control throughout the world. Therefore, while Western behavioral science has developed in this environment, it has also served, frequently, as the handmaiden of colonial expansion and exploitation … Current difficulty in understanding Black children and how they develop in America is really only a part of the fallout from the historical pattern of development of Western behavioral science … in its investigation of all the world's people, one of the chief characteristics of Western behavioral science has been a rigid ethnocentrism. The obvious problem created by this ethnocentrism is that information about human behavior becomes distorted. The problem becomes compounded as behavioral scientists examine the growth and development of African-American children. … the overwhelming predisposition of those who have been trained in the Western behavioral science tradition is to attempt to view the behavior of others through Western eyes (pp. xxi, xxii).

In a recent commentary on a political controversy caused by a congressman's public comments about "Western civilization," Hood (2019) writes:

> Western civilization is white civilization. No one can credibly claim to "defend Western Civilization" without defending the people that created it.

Important Exceptions Some critics of the DSM will characterize majority non-White countries as automatically "Non-Western," even if they are geographically located in the Western Hemisphere (see Bahamas, Barbados, Bermuda, and Cape Verde in Table 2). As in the previous Hilliard quote, non-White peoples will be considered "Non-Western" even if they are born and raised in a majority White "Western" country (see comment 9, Table 1). Others have suggested that the descriptor "White" should be abandoned in scientific writing (Bhopal & Donaldson, 1998), due to its inability to effectively communicate the wide ethnic heterogeneity that is encompassed by the term. Even contemporary "White advocacy" groups in the United States recognize the difficulty in a characterization of "White" as meaning "homogeneous." One such group defines the demographics of what they characterize as the "true" White population in the world, which in their view excludes American Hispanics who self-identify as "White," Latin Americans, mestizos, Arabs, large percentages of Mediterranean people living in Europe (e.g., persons from Spain, Italy), or anyone who is of racially mixed parentage but nevertheless "looks White" (White Date, 2017).

"Non-Western" as Referring to Immigrants/Refugees

Some criticize the DSM as not being applicable for immigrants to Western countries, who are automatically considered to be so culturally exotic that they cannot be accurately understood using Western psychological service traditions or standard DSM nosologies (see comments 10–12, Table 1).

Important Exceptions For starters, differences between some immigrant groups who arrive in Western countries under adverse conditions vs. native populations are *quantitative (not qualitative) in nature*. That is, certain immigrant groups experience an accumulation of stressors related to language differences, fear of deportation (for the non-documented), fear of crime from living in resettled immigrant communities, economic strain, and occasional prejudices from the surrounding community (Bailey, Venta, Crosby, Varela, & Boccaccini, 2019). The degree to which immigrant status results in significant qualitative differences from native groups in the interpretation of DSM mental disorders is a function of the complex interplay of differences between the source and host countries, the recency of initial immigration, and the degree of acculturation to the host culture (Balidemaj, 2016; Sam & Berry, 2016; Wolf et al., 2017). In addition, a variety of additional factors confounds the clear isolation and understanding of simple immigration effects on mental health (e.g., social support, poverty, low educational and/or job skills, language barriers, preexisting mental health disorders, criminality, and age of initial immigration; see Alegría, Álvarez, & DiMarzio, 2017; Bekteshi & Kang, 2018; Berry, Phinney, Sam, & Vedder, 2006). Sometimes, the mental health profiles of foreign-born persons are healthier compared to US-born persons from the same ethnic group – despite worse socioeconomic conditions in the source country (i.e., "the immigrant paradox"; Escobar, Nervi, & Gara, 2000). Finally, the ethnic mix in many traditionally "Non-Western" non-White, underdeveloped, or "Third-World" locations are characterized by immigrants from more affluent "Western" countries (e.g., see Burundi, Egypt, Equatorial Guinea, Gabon, and Mozambique in Table 2).

"Western" as Referring to the Influence of Christianity

The origin, spread, and cultural influence of Christianity is generally considered to be a fundamental factor in the formation of what is commonly referred to as "Western civilizations" around the world (e.g., see Backholer, 2016; Brooke, 2011; Chilton, 2006; Harrison & Lindberg, 2011; Schmidt, 2004).

Christian religious values that emphasize the study of God's influence on the natural world have provided religious justification for experimental science and scientific research beginning in antiquity and up to the seventeenth and eighteenth centuries. For example, Roger Bacon (born in 1219), who is often credited with formalizing the scientific method, was a Franciscan friar (Gillispie, Holmes, Koertge, & Gale, 2008).

The influence of Christianity on education has been profound, as both the Catholic and Protestant Churches founded the Western world's first major universities and schools attached to monasteries and cathedrals. In addition, the Christian church has always incorporated the education of evangelized people groups as an integral part of its social ministry. In some communities within countries, the Christian church is either the main provider of education or at least supplements government-run school systems.

The basic tenets of Christianity are generally credited with igniting moral passions in societies that led to the eventual overturning of legally sanctioned slavery and racial discrimination. The Christian church has been a major source of public social welfare services for orphans, the homeless, and the poor. Numerous social welfare organizations such as parishes, hospitals, orphanages, and homes for the elderly or the handicapped are under the administrative leadership of the Catholic church.

The world's most prolific classical music composers (e.g., Bach, Haydn, Mozart, Beethoven, Schubert) have contributed timeless works that are heavily influenced by Christian worship of God. Some of the most well-known and valuable works of art (to this day) incorporate Christian themes (e.g., The Creation of Adam, Christ Crucified, The Last Supper, The Pietà, Sistine Madonna, The Last Judgment, The Angelus, the Sistine Chapel ceiling).

Christian theology has also strongly influenced Western philosophers, legal reasoning, and political activism, as the teachings of Jesus and the Bible are crucial sources for modern ideas about government and human rights, legal jurisprudence, property rights, law enforcement, and notions of fairness and equality under the law.

Christian teachings on sexual morality, marriage, and family life are profoundly influential in shaping societies. When these teachings are challenged by movements seeking to overturn these principles (on topics such as birth control, divorce, abortion, homosexuality, and polygamy), the sometimes violent political conflicts that ensue threaten to tear apart societies.

Finally, Christianity has contributed major holidays such as Christmas and Easter to popular culture worldwide. The history of time itself is numbered according to whether or not years occurred before or after the birth of Christ (i.e., BC or AD).

Important Exceptions When understanding the intersection of mental health and psychopathology with Christian influences within Western societies, several caveats must be kept in mind. First, using the United States as an example, the extent to which the United States is considered to be a Christian nation is a matter of considerable debate (even among Christian writers; see Hall, 2011). Barton (2017) writes:

> … a Christian nation is not one in which all of its citizens are Christians, or the laws require everyone to adhere to Christian theology, or all leaders are Christians, or any such superficial measurement.

Barton opines that the United States is a Christian nation because Christianity has significantly influenced and shaped the good things that it has become known for in modern times. In contrast, Kelly (2018) argues that the United States is not a Christian nation and never has been, primarily because the text of the US Constitution makes no mention of Jesus or Christianity and that the personal lives of the founding fathers did not show clear and unequivocal evidence of a deep Christian faith.

Second, Christianity is not practiced nor understood in a consistent manner across countries that differ considerably with respect to prior religious traditions, living standards, educational levels, or contact with more advanced, technological societies. Although Christian religious traditions practiced by some primitive groups may incorporate well-known Christian symbols (e.g., crosses, communion ceremonies, statues of Jesus or the Virgin Mary) – their interpretation of Christianity is often indistinguishable from primitive pagan/animistic practices that incorporate beliefs in magic, ancient arcane superstitions, multiple deities, or the worship of inanimate objects (called "syncretism"; e.g., see Nehrbass, 2012; Thornton, 2018; WSJ Staff Reporter, 2015).

Third, there is no necessary relationship between the high proportion of persons within a country who identify as Christian and a lower frequency of crime and violence. In some countries in which the majority of its citizens identify as Christians, the constant presence and social mayhem caused by organized crime severely lowers the quality of life of its citizens (e.g., see Colombia, Table 2). In other countries, competing sects of Christianity generate long-standing traditions of violence and intergroup hatreds that contradict the fundamental nonviolent tenets of biblical Christianity (e.g., see Ireland in Table 2; Cochrane, 2013).

Fourth, researchers have long recognized the important distinction between "cultural Christianity" and "born-again Christianity." A country can be saturated with Christian symbols that, over time, have become routine and familiar features of the popular cultural landscape. Yet, the biblical tenets of the faith may have little to no influence on personal convictions and behavior, or they are confused with political/social conservatism (Inserra, 2019). Here, the lives of persons who profess to be Christians are virtually indistinguishable in key areas from those who do not identify as Christians (particularly on surveys; see Barrick, 2007). According to Christian doctrine, in contrast, a "born-again" Christian is one who has personally received the risen Jesus Christ as his/her Lord and Savior. This is followed by the indwelling of the Holy Spirit (see John 3:16, Ephesians 1:13) and leading to a profoundly changed life (see Sproul & Bailey, 2010).

"Western" as Referring to Highly Developed Culture (i.e., Technology, Economics, Art, Medicine, Music, Philosophy, Literature, Law)

Countries differ profoundly with respect to the quality of life of its citizens. Large areas within some countries are characterized by a largely rural/agricultural mode of living, low literacy rates, high rates of preventable diseases, extremely high birth rates, high infant mortality rates, low life expectancy rates, poor sanitation (i.e., poor or nonexistent sewer or trash removal systems, contaminated water supplies), little to no adequate infrastructure, and low levels of industrial development. In these countries, the business and governmental systems are characterized by high levels of corruption (e.g., bribery, rigged elections, political dictatorships, rampant political favoritism). These are societies that are generally considered to be "Non-Western" (see comments 13–27, Table 1).

According to Stein, Kawakami, de Girolamo, and Lépine (2018), "[h]igh-income countries tend to be Westernized, educated, industrialized, rich, and democratic" (WEIRD, p. 120). In these countries, citizens have a higher level of literacy and educational attainment and enjoy the highest levels of per capita income (relative to other countries). These countries have highly advanced railroad, subway, and airline systems that are the envy of the world and have high levels of industrialization that can adequately serve the food/energy consumption, sanitation, and computer/communication needs of its citizens. These countries are hosts to the greatest universities and hospitals, most artistically advanced symphonies, movie industries, and art galleries in the world. Although there will always be some level of crime and corruption in these countries, for the most part, business and government is overseen by an extensive system of checks and balances written into law.

Some writers credit the French demographer Alfred Sauvy with first coining the terms "First-," "Second-," and "Third-World" countries back in 1952 when referring to the United States and its capitalist allies as "First-World" countries (e.g., Canada, Western Europe, Japan, Australia), communist Soviet Union and its Eastern European satellites as "Second-World" countries, and all other countries that were not actively aligned with these other two groups during the "Cold War" years (i.e., between 1947 and 1991) as "Third-World" countries. While the term "First World" continues to be used only occasionally today (and the term "Second World" ceasing to be used at all), the term "Third World" has endured and has come to mean backward, economically poor countries with a low per capita real income, a lower standard of living, high rates of infant mortality, and colonial domination from First- and Second-World powers. This term has been roughly applied to all of the nations in Asia (except China and Japan), Africa (except South Africa), Latin America, the Caribbean, and some Oceania countries (Leonard, 2006). As of the time of this writing, the term "developing countries" is beginning to replace the term "Third-World" countries (e.g., see Hu, 2018).

Important Exceptions Complicating matters is the simple observation that countries within the same continent are not homogeneous with respect to the standard of living of their inhabitants (and regions within countries are not homogeneous as well). The continent of Africa is a prime example of these extremes.

Over half of the nations in Africa are considered to be among the poorest countries in the world, due entirely or in part to a pervasive lack of economic growth, entrenched political instability, and long-standing internal civil wars and strife (e.g., see Somalia, Central African Republic, and Burundi in Table 2).

In the African nation of Gabon, in contrast, 20% of the population earns over 90% of the country's income, while approximately one-third of the population lives below the poverty line (Seterra, 2018). The island nation of Seychelles (an African country situated in the Indian Ocean) has the highest nominal per capita gross domestic product (GDP) of all countries on the African continent. Although the country is characterized by widespread poverty and economic inequality that favors the upper and ruling classes, its gross domestic product (GDP) output has increased nearly sevenfold between 1976 and 2015. Mauritius is also an island nation of Africa located in the Indian Ocean. As of 2015, it boasts a 92.7% adult literacy rate (Knoema, 2015). Built on a free market economy, Mauritius was ranked in 2019 as having the 25th freest economy in the world, which ranks 1st among 47 countries in sub-Saharan Africa and above regional and world averages (Heritage Foundation, 2019). Its tropical climate, clear sea waters, beaches, and tropical fauna and flora make it a major tourist destination and received a host of annual tourism awards for the world's best beach, honeymoon, and cruise destination (World Travel Awards, 2019). Algeria, Tunisia, South Africa, and Gabon are additional African countries with high living standards, due to their oil and gas-based economies, tourism industry, energy exports, ability to attract international business and investment opportunities, and/or high value placed on education (Udodiong, 2018).

"Western" as a Foil Against Which to Contrast "Eastern" Psychology, Values, and Worldviews

From the previous discussion (i.e., "Western" as descriptive of technologically advanced societies), it would be quite understandable to equate Westernization with a country's "modernization." However, some writers challenge this assumption with the argument that modernization does not necessary denote Westernization in all cases – as some countries are thoroughly modernized yet do not fully embrace "Western" values (e.g., see Ggrwlknl, 2016). The strongest counterpart to a country's "Western" values are "Eastern" values – so named due to a country's geographical location in the Eastern Hemisphere, as well as its home to Mongoloid racial/ethnic groups (e.g., Chinese, Korean, Japanese, Taiwanese, Vietnamese, Laotians).

One popular theory asserts that Western societies are "individualistic" while Eastern societies are "collectivistic" (i.e., the individualism/collectivism (I-C) distinction; Kim, Triandis, Kagitcibasi, Choi, & Yoon, 1994). In individualistic societies, persons are expected to look after themselves and their immediate family only, while individuals in collectivist societies are socialized from birth to be integrated into strong and cohesive in-groups that protect them in exchange for unquestioning loyalty (Hofstede, 1991).

In a landmark text entitled *The Geography of Thought* (Nisbet, 2003), social psychologist Richard Nisbett argued that profound differences between Western and Asian peoples in their social ecologies and structures, philosophies, and educational systems predispose them to different ways of seeing and thinking about the world and further that these differences are rooted in ancient Grecian philosophical systems (i.e., based on Socrates, Aristotle, and Plato) and Chinese philosophical systems (i.e., based on Confucius). For example, the role of lawyers in Western law is primarily confrontational and adversarial – resulting in winners and losers (Nisbet, 2003). In contrast, Chinese law seeks to reduce hostilities and look for areas of mutual compromise. In the West, each individual is a separate unit which naturally confers certain human rights. In contrast, East Asians view societies as whole organisms in which individuals are seen as contributing to the well-being of the whole, and as such there is little conception of individual rights. Finally, the Western view of religion (rooted in Christianity) is rooted in allegiance to one God who is the ultimate author of "right vs. wrong." In contrast, Eastern religions are seen as more tolerant and accommodating toward a plurality or religious beliefs and ideas – which reflects a "both/and" mentality as opposed to an "either/or" mentality. Thus, the East/West distinction ultimately views human behavior itself as not "hardwired," but profoundly shaped by culture.

Some scholars will typically use the adjectives "Western" vs. "Eastern" in referring to two mutually exclusive categories of basic philosophical principles that undergird their respective disciplines (e.g., philosophy, Gupta & Mohanty, 2000; medicine, Unschuld, 2009; ethics, Williams, 2017; Zeuschner, 2014).

Applications to Mental Health Cross-cultural researchers criticize the DSM for its presumed theoretical grounding in Western principles of psychiatric science. Any psychological practices that are an outgrowth of this perspective are deemed to be incompatible, irrelevant, or invalid when applied to clients from countries that are rooted in Eastern psychology, personal values, or life worldview (see comments 28–45 in Table 1).

Matsumoto and Juang (2017) cite cultural differences in the construct of "emotional complexity" between individuals from Western as opposed to East Asian cultures. They cite research showing that European Americans tend to experience positive emotions more frequently and intensely but experience negative emotions less frequently or intensely. In contrast, East Asians were more likely to experience the co-occurrence of positive and negative emotions.

There are studies which suggest persuasive evidence for cultural variation in somatic awareness. Eastern (particularly Chinese) cultures perceive bodily and psychological states as closely intertwined (see reviews by Ma-Kellams, 2014). That is, Eastern cultural groups (even those living in Western countries) appear to demonstrate a greater emphasis on their bodily states when describing themselves and their emotional experiences in the context of caregiver/client mental health and medical interventions. In Chinese holistic medicine, for example, the body is a powerful psychological force where decision-making and thought reside primarily in the liver, gallbladder, and heart (see Ye, 2002).

Lin (1996a) argues that the Western tendency to clearly separate the mind (i.e., psychological processes) from the body (physiological processes) is artificial, and this would lead Western psychiatrists to treat the somatic representations of depression and anxiety as secondary in importance. Lin further argues that Asian patients would run the risk of being misdiagnosed by Western psychiatrists. She writes:

> Looking through this Western prism of mind-body dichotomy, Asian and other non-Western patients who fail to make such a distinction run the risk of being labeled as more primitive, not psychologically minded, somatizing, and alexithymic (p. 37).

Important Exceptions The pigeonholing of entire societies on the basis of simplistic dichotomies glosses over important distinctions. This creates cardboard caricatures instead of a careful, nuanced understanding of complex cultures. This complexity manifests in three important controversies, described below:

Challenging the Mutual Exclusivity of Western Versus Eastern Thought Mark (2016) challenges the mutual exclusivity of the East/West dichotomy on purely philosophical grounds. She argues that the similarities between Eastern and Western philosophies are far greater than any differences typically emphasized by scholars. She asserts that there is no significant division between the two philosophies when it comes to the most basic question as to what it means to be a human being (i.e., the existence of innate knowledge of right vs. wrong and good vs. bad). In addition, she argues that no major differences exist as to each philosophy's fundamental purpose – which is to find meaning in one's life and purpose to one's path. In short, her criticism asserts that East/West differences in philosophy are relatively superficial, but similarities in each system's essential life questions are strikingly similar (i.e., "universal").

An interesting illustration of this criticism, as it relates to comparative systems of logic, comes from an interchange between a famous Christian apologist and a university professor concerning the universal nature of the *law of noncontradiction* in formal logic (see Zacharias, 2012). The law of noncontradiction states, in essence, that "A" and "Not-A" cannot both be true. The university professor argued that the apologist's defense of Christianity against other world religions was illustrative of a purely Western frame of thinking (i.e., "either/or"). His argument was that the apologist's defense ignored the Eastern system of "both/and" thought. This way of thinking essentially allows for the condition of "A" and "Not-A" coexisting. The apologist confronted the professor with the irony that arguing for the validity of "either/or" or "both/and" frames of thought was *in itself* an implicit validation of the primacy and universality of "either/or" thinking (as thinking must be *either* "either/or" thinking *or* "both/and" thinking; i.e., the law of noncontradiction). The point here is that it is impossible to avoid "either/or" thinking in human beings, as the law of noncontradiction is *universal*. Hence, Westerners and Easterners (however defined) are not as fundamentally different in thinking as psychologists and psychiatrists are led to believe.

Challenging the Validity and Application of the Individualism/Collectivism Construct

There are a number of constructs studied by psychologists that are thought to discriminate between cultural groups (see review by Taras, Rowney, & Steel, 2009). The Individualism/collectivism (I-C) has arguably generated the most research of all of the theories of East/West differences in human psychological behavior. Voronov and Singer (2002) argue that the I-C framework has been grossly overused or used improperly. They outline a variety of criticisms of this theory, which are briefly summarized next.

The I-C construct is based on Hofstede's (1980) seminal factor analytic study in which questionnaires were given to 117, 000 employees of a high-technology multinational corporation who were highly educated and skilled managers, technicians, and white-collar professionals. Fourteen work-goal items were factor analyzed to derive four dimensions, one of which was the I-C dimension. This data is criticized for not being representative of their respective countries, particularly the poorer countries. In addition, the Hofstede study has been criticized on the lack of correspondence between operational definitions of collectivism and individualism and the items designated to measure the construct. Finally, Bond (2002) argues that in their enthusiasm to quickly embrace the I-C distinction (which reflects, in his words, "a growing academic hunger for structure concerning culture," p. 74), psychologists overlooked the fact that Hofstede subdivided the first extracted factor and ignored the other subfactor (called "power distance"; Bond, 2002). Bond opines:

> … this closer inspection of Hofstede's results suggests that had [he] left his first factor intact, Japan and the United States would have been cultural neighbors, not distant contrasts (p. 74).

On this point, Bond (2002) cites other studies that suggest that the Japanese have been found to be "more individualistic, not less, than Americans" (p. 74).

Another criticism of I-C theory stems from the failure of its most ardent supporters to acknowledge within-country variability. Voronov and Singer (2002) cite studies with subjects from China and India, suggesting *both* collectivist and individualist attitudes in popular cultural sayings and social attitudes.

At the most basic level, they argued that their review of 15 empirical studies that directly compared Japan and the United States on the I-C dimension (up to 2002; using questionnaire and behavioral data as dependent variables) was not supportive of I-C theory. In some studies reviewed, data from Japan did not show extreme collectivist scores and data from the United States did not show extreme individualism scores.

They also criticize the I-C construct by offering a different interpretation of data outcomes. Voronov and Singer cite a series of experiments with both Japanese and American subjects leading to the conclusion that collectivist behavior "is explainable not in terms of a fundamentally different cognitive organization of the self, but because it is advantageous to the self in the long run" (p. 464). Said differently, individuals from collectivist societies are motivated to display collectivist views from the expectation of rewards or fear of punishment from the group – which is fundamentally an individualistically oriented motivation.

Finally, there is the error of misconstruing findings from I-C research on nations as reflecting individualized psychological traits (i.e., the ecological fallacy, Bond, 2002). This explains why these constructs have been renamed “idiocentrism vs. allocentrism” when studied at the level of the individual (e.g., see Schimmack, Oishi, & Diener, 2005).

Even when researchers study the I-C construct at the level of the individual, Kitayama (2002) argues that the cross-cultural validity of attitude surveys (the method that is most frequently used to measure variations in individualism-collectivism in individuals) cannot be taken for granted due to basic psychometric problems that give rise to various forms of measurement bias.

Most Countries Experience Westernization to Some Degree The depiction of Western vs. Eastern countries as static, mutually exclusive entities is not entirely accurate, as all Non-Western countries (however defined) experience Westernization (however defined) to varying degrees. This process can be as small as hosting a chain of McDonald’s stores where none would be expected to adopting Western customs only up to a certain point, while other important Non-Western traditions remain intact, to a full and headlong rush toward complete Westernization (however defined). This Westernization occurs in countries as diverse as Japan (Hoffman, 2016), Nigeria (Wahab, Odunsi, & Ajiboye, 2012), India (Kapur, 2012), Korea (Frost, 2018; Zakaria, 2003), the Middle East (Lewis, 1996), and Latin America (Llosa, 2008). While Westernization is a global phenomenon, “Easternization” (based on the philosophical principles of Confucius) is not. Westernization is aided by a number of dynamic processes, which have included colonialization, education, industrialization, free-market competition, the worldwide expansion of media technology, the increasing ease of intercontinental transportation, the influence of religious missions, and internal political changes – as well as the resulting changes in national legislation.

The most obvious manifestation of Westernization within any country is in its observable products such as constitutional, legislative, and/or parliamentary governments, architecture, popular music and fashion, food choices, day-care centers for working women, advanced medical treatments, the choice of which holidays and festivals to celebrate, and the choice of languages spoken. Less obvious are intangible factors that eventually influence customs and practices within a society that slowly change over time, such as the manner in which large business deals are negotiated, the extent to which traditional values and customs are held in esteem or contempt, the degree of respect/care given to elders, upgrades in sanitation and public health, or the degree to which popular entertainment (movies and music) influence popular culture.

Western influences in and of themselves are not always equally dominant in changing societies, as some Western influences that may seem profound at first glance actually are not entirely successful in changing deep-rooted non-Western traditions and societal characteristics. On this point, one blogger noted for his extensive global travels opines:

> Westernization is a complicated phenomenon. At the core it’s simply a set of ideals and values that are battling against another set of ideals and values. And for it to conquer the ideals of another country and its indigenous culture, the latter needs to be weaker and less resilient. But here’s the thing that most people don’t realize: for Westernization to take hold, not only does the target country need to be weaker and less resilient, it also must want to adopt a new culture. It must yearn for change …. A poor ex-Communist country like Lithuania … and Ukraine … has its reasons for looking to the West; they’ve suffered enough under Soviet rule. But a country like Brazil with one of the most amazing and well-known cultures in the world doesn’t really need the West. (Maverick, 2015)

Further complicating matters is the truism that, within any one country, Westernization (whatever its impact) may only influence only certain parts of a country, when significant portions of a country remain untouched by Westernization.

DSM Revisions: Implications for Cultural Critiques

Updating the DSM regularly as a result of new scholarship on the intersection of psychopathology and cultural issues is both important and necessary. Given the tremendous diversity across the globe in languages, races and ethnicities, economic living conditions, political histories, and medical sophistication, it cannot be assumed that the processes of understanding, diagnosing, and alleviating mental illness are the same in all geographical regions. The challenge rests in figuring out whether or not the evidence on which such an understanding is based is indeed compelling. Unfortunately, these issues are extremely complex (both conceptually and empirically). Bond (2002) argues that "cultural contrasts in the social sciences … often [seems] tendentious, Procrustean, and ideological (p. 74)". Furthermore, he argues that social psychologists [are] mesmerized by the "fearful symmetry" of [dichotomous bipolar categories in describing countries] and "all too willingly ignored anomalies and the fine print" (p. 75).

At the outset, it needs to be acknowledged that cross-cultural research, no matter how well-intentioned, is vulnerable to being influenced by hidden assumptions and ideologically based narratives that are sometimes explicitly stated but more often than not remain implicit. When these assumptions and narratives are made explicit, they can be challenged with reasoned counterarguments. The previous discussion has shown that the "Western/Non-Western" distinction is perhaps the most popular beachhead from which scholars have launched cultural criticisms of the DSM system. However, this discussion has also revealed significant conceptual problems with this critical framework. This gives rise to the following challenges:

The Western/Non-Western Distinction (as a Means for Categorizing Countries) Is a Shaky Foundation for Evaluating Mental Health Diagnostic Models

Fundamentally, all countries commonly referred to as "Western" are not necessarily located in the Western Hemisphere, and many heavily Westernized nations (however defined) are located in the Eastern Hemisphere (e.g., Australia, Japan, South Africa, Lithuania; see Table 2).

Another difficulty in nailing down a clear understanding of "Western" vs. "Non-Western" influences comes from a confusion of historical events and influences vs. present-day realities. For example, the Protestant Reformation (which marked a major split within Christianity from the Roman Catholic church) is generally considered to inaugurate "Western" influences in Europe. However, the major influences of the Protestant Reformation were in northern European countries (e.g., Denmark, Estonia, Finland, Iceland, Ireland, Norway, Sweden), but not in southern European countries (e.g., Spain, Italy, Greece, Romania). Yet Europe as a whole is often referred to as "Western" (see comments 11, 13, 28, and 34 from Table 1).

The concepts of liberal democracy and freedom of speech are generally considered to be "core" values of Westernization. Historically, however, certain parts of Europe have been ruled by absolute monarchies and fascist dictatorships which forcefully squashed the "will of the people" from above (e.g., see Berman, 2019; Lee, 2008).

It is also problematic to categorically state that "Western" countries are the most developed or the wealthiest. Although the African continent tends to be the home of countries with the highest percentages of persons in extreme poverty (see Multidimensional Poverty Index (MPI), Table 2), European countries have experienced devastating economic setbacks in their histories (e.g., potato famine in Ireland, devastation from WWII in Germany). Many Middle Eastern countries are rich in oil and have the world's wealthiest businessmen – while a large percentage of their general population is underdeveloped (e.g., see Human Development Index (HDI) of Iraq, Jordan, Libya, Morocco, and Yemen in Table 2).

Finally, the glib attribution of Westernization as being the sole characteristic of Caucasians is wholly inaccurate (e.g., Hilliard foreword to Hale, 1986). Many eastern European countries (e.g., Russia, Ukraine, Armenia, Georgia) have vast Caucasian majorities but are not considered to be remotely "Western" in their political histories (see Jankowski, 2013). Technology, business, and commerce in countries like Japan and China are the envy of "Westernized" United

States (e.g., see Appelbaum, Cao, Han, Parker, & Simon, 2018; Wittner & Brown, 2016), yet the Japanese and Chinese are obviously not Caucasian. There are many wealthy non-White millionaires living in the United States, whose upbringing, outlook, and lifestyles are unabashedly "Western" (e.g., see Kimbro, 2014).

Cultural critics of the DSM commit an egregious error when they focus on only one personal characteristic of individuals and erroneously assume that this characteristic is highly correlated with unnamed characteristics that are presumed to invalidate DSM diagnoses. In her comments on the applicability of the DSM to Asian peoples (including Asian Americans), Lin (1996a) writes:

> Asians represent more than half of the population on Earth. Any diagnostic system or portion of the system that cannot be meaningfully applied to the majority of the human race deserves careful scrutiny as to its validity and clinical utility (p. 37).

In making this comment on the primacy of racial group membership, no acknowledgment is made as to the particular mental illness from which the person is suffering, where the person is born and socialized, their ethnicity, their educational or social class status, what language is spoken, the degree of acculturation (if any) experienced in the country of residence, or how "Westernized" the person is.

The Influence of Cultural Variation on Mental Health Diagnoses Is Complex and Nuanced and Cannot Always Be Assumed to Be Similar for All Syndromes

There are approximately 297 mental disorders listed in the DSM-5, which are classified into approximately 16 clinically relevant categories. Given the tremendous diversity in the etiology, understanding (i.e., categorical vs. dimensional), boundaries (i.e., thresholds distinguishing between abnormal and normal), comorbidity, and treatment of these disorders – broad-brushed criticisms that the DSM is too narrow, invalid, or irrelevant for large portions of the global population are misleading.

Kluckhohn and Murray (1948) articulated a fundamental principle that fully explains – at a conceptual level – the primary sources of variation among all human beings. This principle states that human variation is influenced by three factors:

1. All persons share characteristics in common with every other human being.
2. All persons share characteristics in common with only certain subsets of other human beings (e.g., subsets based on age, gender, sexual orientation, race, ethnicity, developmental stage, language, religion, nationality).
3. Each person is *totally unique* and has characteristics which are not shared with any other human being.

Social scientists and researchers who devote their careers to the study of multicultural and cross-cultural issues are prone to exaggerate the importance of cultural influences on human behavior (factor #2). As an example, consider the following quote that opens the *DSM-5 Handbook on the Cultural Formulation Interview* (Lewis-Fernández, Aggarwal, Hinton, Hinton, & Kirmayer, 2016):

> Culture shapes every aspect of patient care in psychiatry, influencing when, where, how, and to whom patients narrate their experiences of illness and distress … the patterning of symptoms …, and the models clinicians use to interpret and understand symptoms in terms of psychiatric diagnoses …. Culture also shapes patients' perceptions of care, including what types of treatment are acceptable and for how long …. Even when patients and clinicians share similar cultural, ethnic, or linguistic backgrounds, culture impacts care through other influences on identity, such as gender, age, class, race, occupation, sexual orientation, and religion …. Cultural contexts and expectations frame the clinical encounter for every patient …. (Lewis-Fernández, Aggarwal, & Kirmayer, 2016, p. xxvii)

The proper evaluation of this expansive statement depends on a careful weighing and subsequent evaluation of a number of nuanced variables. The Lewis-Fernández et al. statement is vulnerable to severe criticism when certain biological and genetic factors that influence mental illness are considered. There are biologically and genetically based factors influencing mental health shared by all human beings (the first factor of Kluckhohn and Murray's tripartite principle of human variation), regardless of where on the globe they were born.

The Universal Influence of Genetics For starters, the study of families using population genetic methods over the past 50 years has consistently supported a genetic, heritable component to mental disorders – and advanced molecular biological techniques have identified specific chromosomal regions and genes that have been associated with particular diseases. Research on normal humans generally has found that approximately 40–70% of various aspects of cognition, temperament, and personality are attributable to genetic factors (Grebb & Carlsson, 2009).

Furthermore, as much as 70–80% of the tens of thousands genes in the human body (see Saey, 2018) are expressed in the brain (Grebb & Carlsson, 2009). Fundamentally, the brain is responsible for human cognitive abilities, emotions, and behaviors and is the organ that integrates epigenetic, environmental, and psychosocial experiences. According to Dicicco-Bloom and Falluel-Morel (2009), an increasing number of neuropsychiatric conditions are considered to originate during brain development, including schizophrenia, depression, autism, and attention-deficit/hyperactivity disorder (p. 59).

The Universal Influence of Brain and Central Nervous System Functions The general central nervous system interacts with the body's immune system to influence bodily homeostasis and the development of diseases, including psychiatric diseases. The neuropsychiatric disorder that best characterizes the nature of this interaction are major depressive disorders (Raison, Cowles, & Miller, 2009).

Because of these relationships, many neuropsychologists and neuropsychiatrists advocate for building the classification of patients with mental illnesses directly from an understanding of brain-based biology, rather than solely from the assessment of symptoms gleaned from the patient's own subjective interpretations of their thoughts and feelings (e.g., see Grebb & Carlsson, 2009).

The Universal Experience of Pain Other bodily functions are universal and can influence mental functioning to a significant degree. All human beings experience physical pain. Unremitting pain, despite persons' best attempts to avoid the offending stimulus, can lead to affective disorders such as depression and anxiety (Breder & Conway, 2009, p. 341).

The Universal Experience of Sleep Sleeping is a fundamental behavior of all human beings, occupying approximately one-third of human existence. If human beings experience significant difficulties in regulating their amounts and cycles of sleeping and wakefulness, various degrees of mental disturbances will likely result. Conversely, patients with psychiatric disorders also report abnormalities in sleeping patterns, and a majority of commonly used psychiatric medications have effects on sleep (Benca, Cirelli, & Tononi, 2009, p. 361).

The point here is that human beings, who may be born and raised in a completely different cultural milieu separated by continents, do not have strange and exotic bodily functions that have unknown effects on the brain and nervous system. Said differently, there are no such animals as "Western" brain functions vs. "Non-Western" brain functions. Biological features of the brain and central nervous system are universal across all human beings, and cross-cultural psychiatry should integrate this knowledge into their understanding of mental illnesses throughout the world.

Disentangling Cultural Effects: Proceed With Caution! When scholars criticize the DSM for cultural reasons, the challenge for audiences begins with clarifying the overall objective(s) of such efforts. These objectives more often than not are muddled and fail to be clearly distinguished by DSM cultural critics. When rudimentary efforts are made to do so, these criticisms range from the blatantly ideological to the superficial (i.e., criticisms that are relatively easy to fix given appropriate improvements in clinical training), to the most profound (i.e., criticisms that require a fundamental rethinking of the meaning of psychopathology).

At the blatantly ideological end of this continuum, for example, La Roche (2013) argues that psychotherapists are obligated to present themselves to culturally different clients in a manner that maintains solidarity with their sociopolitical struggles. La Roche (2013) writes:

> Cultural psychotherapy is not neutral. In the face of injustice, cultural psychotherapists do not remain silent. Comments that affirm therapists' commitment to diversity, against discrimination, and in favor of social or economic justice are required from the onset of psychotherapy (p. 8).

According to La Roche, sensitivity is demonstrated when the therapist makes an effort to understand the client's cultural values, demonstrate awareness of racism, understand undocumented immigrants' fear of deportation, or engage in empathetic conversations about how social services can be accessed or paid for.

Another concern of DSM critics is that cultural differences between the client and the assumptions of the DSM system (relevant to problem formulation) will be "misconstrued," "overlooked," or "underappreciated" (La Roche et al., 2015, p. 183). Later on, the authors opine that a lack of attention to cultural factors leads to an "inadequate or incomplete" understanding, which in turn interferes with accurate clinical inferences (p. 188). They conclude with the following argument:

> … that much work still remains ahead of us if it is truly to become a more inclusive description of the range of psychopathology for all individuals in the United States and beyond. The DSM-5 contains many Western American assumptions (e.g., universalism, individualism) that limit its applicability with cultural minorities. (La Roche et al., 2015, p. 188)

This criticism boils down to the argument that the DSM's disease classification system is rooted in "Western" American beliefs (e.g., individualism, emphasis on biology) and practices (e.g., standardization) that limit their diagnostic usefulness among different racial, ethnic, language, sexual, and cultural groups (La Roche, 2013; Sue & Sue, 2016). The phrase "diagnostic usefulness" must be further unpacked to elucidate the nature of specific concerns. For example, embedded in these criticisms is the unspoken assumption that a client from one cultural group will be assessed by a diagnostician from a significantly different cultural group (or at least one that has been trained under "Western" psychiatric/psychological methods) and that this is the source for subsequent diagnostic missteps or errors. One such fear is that psychological or behavioral traits presumed to be "normal" in one cultural milieu will be misinterpreted as pathology (e.g., see Bird et al., 1988).

Where Cultural Variation Influences Are Strongest If cultural variation does affect the process of diagnosing and treating mental illnesses, its effects are most influential in areas that are peripheral to brain and bodily functions. These include, but certainly are not limited to, differences in the quality of training that mental health professionals receive across geographical settings, the cultural knowledge and clinical experience that the caregiver brings to bear on the interpretation of client thoughts and feelings, cultural features of a clients' willingness to receive professional help, cultural variations in the comfort levels in which problems are discussed in a therapeutic interaction, differences in the language and dialects spoken by clients/patients (and the extent to which caregivers can also speak these), regionally and culturally specific idioms that clients use to understand and describe symptoms (and the extent to which caregivers understand these), cultural differences in the social stigma that may surround certain presenting problems, and cultural features involved in the willingness of patients to accept diagnoses and adhere to treatment regimens.

Within-Country Variability In drawing conclusions from cross-cultural investigations, scholars must be sensitive to the "analysis of variance problem," where the size of between-group differences (however defined) must be carefully weighed against the size of "within-group" differences when using cultural knowledge to make diagnostic interpretations. That is, many cultural differences that are hastily attributed to "between-country" differences may be just as robust within countries (see also Taras et al., 2009). A reasonable argument can be made that the continuum of poverty/wealth and/or high/low educational levels within any country – rather than the Western/Non-Western framework in distinguishing between countries – better explains important differences in what patients bring to sessions with psychiatrists and psychologists.

The Influence of IQ and SES The link between lower IQ and lower socioeconomic status (SES) levels is well-established (Jensen, 1998; Strenze, 2007). General cognitive ability, or intelligence, is perhaps the most stable of all psychological traits across the lifespan and predicts educational, occupational, and health outcomes better than any other psychological trait (see reviews in Plomin & von Stumm, 2018).

Poorer persons tend to have lower IQs and lower levels of formal education. Lower measured IQs have been shown to have a significant relationship to various types of psychopathology and behavior problems (Dietz, Lavigne, Arend, & Rosenbaum, 1997; Korous, Causadias, Bradley, & Luthar, 2018; Wadsworth & Achenbach, 2005). Health disparities that vary by socioeconomic status within countries are ubiquitous across the globe and occur regardless of country, health system, disease, or organ system involved (Gottfredson, 2005). Lower levels of IQ are significantly associated with lower levels of functional literacy (defined as the ability to use printed and written information to function in society). In industrialized societies, low levels of functional literacy are associated with weaker attachments to the labor force, higher rates of reliance on food stamps and welfare benefits, and living in poverty (Gottfredson, 2004). Countries with a critical mass of low IQ citizens, such as those found in African countries (e.g., see Lynn, 2008; Lynn & Vanhanen, 2006), generally suffer from greater rates of preventable communicable diseases, parasitic diseases, respiratory infections, perinatal/prenatal fatalities, and poor nutritional conditions (World Health Organization, 2018).

To the extent that mental health services are not linked with medical services, lower SES persons are less likely to seek out mental health services for felt problems (Hodgkinson, Godoy, Beers, & Lewin, 2017). When they do, they are less likely to receive evidence-based interventions compared to more affluent persons and are also more likely to prematurely terminate mental health services (Kim & Cardemil, 2012). In primarily agricultural and technologically backward areas within countries, low SES persons are more likely to consult indigenous healers with little or no formal training in psychology, psychiatry, or medicine.

In contrast, more affluent persons tend to have higher IQs and levels of formal education. Higher IQ scores tend to be associated with better behavioral, cognitive, and emotion control, better academic performance in learning settings, and generally better outcomes with respect to education, occupational attainment, mental/physical health, and mortality rates (Plomin & Deary, 2015). However, high IQ can also be associated with a higher prevalence of other psychological problems (e.g., see Karpinski, Kolb, Tetreault, & Borowski, 2018; Rommelse et al., 2017).

Higher IQ persons with better jobs have more financial resources to pay for private therapist fees, and their higher educational levels and more expansive vocabularies allow them to be better candidates for accurately describing their symptoms to diagnosticians.

There Are Serious Difficulties in Generalizing from National Characteristics to Individual Behavior

There are huge differences between the broad characteristics of entire countries and the day-to-day normal living conditions of its citizens. Similarly, there are huge differences between the day-to-day normal living conditions of citizens and the factors which facilitate the onset and maintenance of mental illnesses. As a result, cross-cultural scholars are sometimes quite sloppy in drawing implications from research findings. This can be manifested in a variety of ways.

First, cultural critics of the DSM are prone to commit the *ecologic inference fallacy*, defined as a misinterpretation of statistical data that occurs whenever inferences about the nature of individuals are deduced from inferences about the group to which those individuals belong (Babbie, 2017). As discussed earlier, nowhere is this more evident than in opinions on the relationship between countries and their citizens with respect to the individualism/collectivism construct (Bond, 2002; see also item #31, Table 2).

The same problem occurs when discussing religious affiliation. Just because a majority of a nation's citizens are classified as identifying with a particular religion, this says little or nothing about the extent to which the tenets of the religion are deeply internalized to the extent that it has a significant influence on everyday attitudes, habits, and interpersonal relationships.

Characteristics about residents living within a country cannot always be reliably inferred from whatever political leader rules the country at any given point in time. As mentioned previously, some countries are ruled by oppressive dictators who themselves have psychological problems (e.g., see Pettman, 2012) and whose political/philosophical policies are not widely shared by the country's residents (to put it mildly). In the United States, for example, a new president is elected every 4 or 8 years. Nearly half of the country did not vote for whomever occupies the White House at any given point in time. As a result, some go so far as to say that they will leave the country if the opposing candidate for whom they did not vote is elected (e.g., see Kaysen, 2018).

Some Countries Are *Better* than Other Countries with Respect to Mental Healthcare Services

In their zeal to acknowledge cultural features of mental illnesses that have been previously overlooked by DSM manuals, cross-cultural psychologists and psychiatrists are prone to commit the *egalitarian/false equivalence fallacy*. This fallacy is based on the unspoken assumption that the reasoning of good, fair, and moral people should always begin with the foundational assumption that normative or frequent practices of all cultural groups are equally desirable, valid, and/or deserving of equal respect. Therefore, cultures (however defined) are not to be evaluated (either implicitly or explicitly) as good or bad or ranked along a continuum of better to worse. To do this would be considered "unscholarly" at best or "ethnocentric" at worst (see also Bredström, 2019).

In the context of cross-cultural psychiatry/psychology, therefore, a culture that attributes all physical symptoms and mental disturbances to the unseen work of invisible spirits, curses, and hexes (e.g., see Simons & Hughes, 1985) is deserving of equal scientific respect as cultures who incorporate latest scientific advances in the biological, neurological, genetic, and chemical effects on brain/behavior relationships. This is a false equivalence. The bottom line is that antipsychotic medications will have the same effect on the schizophrenic brain regardless of differences in cultural explanations for this condition.

The provision of high-quality mental health services exists within the context of the quality of general healthcare, which varies considerably from country to country. According to one recent study (Healthcare Access and Quality Collaborators, 2017), the small country of Andorra (located between Spain and France; see Table 2) topped the list of having the best healthcare system in the world, with approximately 3.6 physicians per 1000 residents (see Andorra Guides, n.d.). Although the tiny country has only one hospital, it has a national health service that is responsible for the administration and management of all public healthcare resources in the country. Ninety-two percent of the country's residents are covered under its social health insurance system, as enrollment is mandatory for salaried workers. Hospital visits are typically covered up to 90%; dental, general practitioner, and physiotherapy are covered up to 75%; and birth expenses and work-related accidents are covered up to 100% (Andorra Guides, n.d.). Andorra consistently ranks as being among the top ten countries in the world for having the highest life expectancy due to its locally grown food, prevalence of opportunities for exercising (in the forms of hiking and skiing), a generally slower pace of life, clean water, and fresh air.

Andorra has a social security system that covers up to 100% of medical expenses. For a brief overview of how mental health disorders are served by professionals in Andorra, readers are encourage to consult All Andorra (2019).

The next nine top-ranked countries for healthcare were Iceland, Switzerland, Sweden, Norway, Australia, Finland, Spain, the Netherlands, and Luxembourg. Major developed and Westernized countries such as Japan (11th place), Canada (17th place), the United Kingdom (30th place), and the United States (35th place) did not rank as well as would be expected. Of the top 20 ranked countries, all but Australia and Japan are located in Western Europe.

Many countries demonstrated worse rankings than would be expected given their levels of wealth (e.g., Indonesia, the Philippines, and India). With the exceptions of Afghanistan, Haiti, and Yemen, the 30 countries at the bottom of the ranking were all located in sub-Saharan Africa. The Central African Republic is at the very bottom of the list.

Countries differ in the extent to which they prioritize mental healthcare at the primary, secondary, and tertiary levels. This is operationalized as a country's policies and legislation which ensures that persons with disabilities are entitled to the full spectrum of human rights and basic freedoms without discrimination (Cronin, Gouda, McDonald, & Hallahan, 2017; Davidson, 2016; Rodriguez-Cayro, 2017). There are considerable differences (both between and within countries) in the extent to which persons suffering from mental illness face stigma, persecution, and denial of basic human rights and have convenient access to mental healthcare (Hanlon, Wondimagegn, & Alem, 2010; McGeorge, 2012; Semrau, Barley, Law, & Thornicroft, 2011; Wainberg et al., 2017).

Proposed Advantages of a Supplementary DSM Text

The essential complaint of DSM cultural critics is effectively summarized by Morrison (2014), who writes:

> [The] DSM-5 may not be uniformly applicable to all cultures. These criteria are derived largely from studies of North American and European cultures. Although the DSMs have been widely used with great success throughout the world, it is not assured that mental disorders largely described by North American and European clinicians will translate to other languages and other cultures (p. 14).

This author believes that such insecurities are grossly exaggerated, as there is considerable research that has translated and documented DSM disorders throughout many regions of the globe (e.g., see Scott et al., 2018). In addition, research suggests that existing published research tends to reflect a palpable bias in highlighting differences between groups of people, while neglecting similarities between groups that are equally as interesting and important (e.g., see Hanel, Maio, & Manstead, 2018).

This chapter brings many different lines of argument to bear on the assertion that the "Western/Non-Western" framework for criticizing the DSM revisions – though common – is often vague, exaggerated, ill-defined, lacking in sufficient precision and specificity, and lacking in conceptual and empirical development to significantly advance an understanding of similarities and differences in mental illnesses throughout different regions of the globe.

Even though the terms "cultures" and "Westernization" are constructs that are frequently used in discussions about DSM revisions, it must never be forgotten that constructs are ultimately mental abstractions (Laerd Dissertation, 2012). Abstract constructs are also multidimensional, meaning that a wide variety of factors can enter into the conceptualization of a construct. Thus, a person, group, or country's standing on one dimension does not necessarily predict similar standing on another dimension. Just because the majority of citizens in two countries use modern cell phones, it does not mean that citizens within these countries share the same convictions about marriage and child-rearing. Just because citizens of two countries share similar convictions about marriage and child-rearing, it does not mean that they are exposed to the same preventative resources on how to deal effectively with stress. Conversely, just because citizens of two countries have different convictions about marriage and child-rearing, it does not mean that they both cannot benefit from the same resources on how to deal effectively with stress. Ultimately, these relationships must be determined and understood *empirically* (First, 2017b).

It is also problematic to use individual countries as the primary unit of analysis for differentiating cultures (i.e., Country 1 = Culture 1; Country 2 = Culture 2; Country 3 = Culture 3, etc.). Countries overlap considerably in their major religions, languages, cultural influences, ethnicities, and health/health-related problems. Unfortunately, "culture" is often treated like a categorical variable, with non-permeable and mutually exclusive boundaries presumed to separate one culture from another culture. A moment's reflection reveals the problems with this characterization. A wealthy Bosnian businessman may be "culturally different" from a Bosnian peasant, but both are considered to be "culturally different" from typical Americans. However, there are huge "cultural differences" between a wealthy American businessman and a poor Native American farmer living on a reservation. In fact, the American businessman may share more culturally in common with the Bosnian businessman than with the Native American farmer. The problem here is that the same nondescript and bland phrase "cultural differences" is used in vastly different contexts, with no array of different words that can communicate subtle nuances in meaning.

It must never be forgotten that usage of the DSM to understand mental illness is ultimately applied in clinical practice to *individuals*, not groups (Satel, 2000; Stuart, 2004). Wariness of the *ecologic fallacy* (i.e., the gratuitous assumption that individuals who belong to the same ethnic/racial group are influenced in the same way by their reference culture or to assume that all individuals in a specific group adopt the same cultural norms in all environments in the same manner; see Frisby & O'Donohue, 2018, p. 693) must be uppermost in the minds of applied mental health professionals.

Suggestions for a Cultural Supplement to the DSM

At the time of this writing, the process for updating the DSM-5 is in full swing (e.g., see First, 2017a; Moran, 2017). Writers who are professionally attached (either indirectly or directly) to work groups on cultural revisions/additions to the DSM have been tactful in articulating their concerns with the process and its eventual outcome (e.g., see La Roche et al., 2015; Lewis-Fernández & Aggarwal, 2013; Mezzich, Kleinman, Fabrega, & Parron, 1996; Mezzich et al., 1999). These concerns include the perception that important content (which is the product of many hours of committee work) is either excluded from the final DSM revision or severely edited.

Numerous texts are published that are designed to supplement the understanding and effective use of the DSM-5 (e.g., see Barnhill, 2014, First, 2014, Morrison, 2014; Reichenberg, 2014), in general, and the *DSM-5 Handbook on the Cultural Formulation Interview*, in particular (Lewis-Fernández, Aggarwal, Hinton, et al., 2016). There is no reason why a series of supplemental texts dealing with mental health diagnoses around the world cannot also be used with current DSM revisions. The proposed supplement can be used in harmony with the

International Statistical Classification of Diseases and Related Health Problems, now in its tenth revision (World Health Organization, 2016).

Five Guiding Principles

Listed below are five principles to be considered and debated for a cultural supplement to the DSM, based on the various principles discussed in this chapter:

1. There is an urgent need for interdisciplinary collaboration between cross-cultural psychologists and psychiatrists, medical doctors, sociologists, epidemiologists, cross-cultural political scientists, and medical anthropologists who work in various parts of the globe. This would prevent DSM criticisms written by American psychologists and psychiatrists from relying solely on broad stereotypes and sweeping generalizations (e.g., "all Asians are guided by Eastern philosophy") that are not informed by closely related disciplines.

   Preference would be given to empirical field research studies actually conducted on persons suffering from mental illnesses within specific countries, rather than broad speculations about entire countries based on social psychological research with nonrepresentative samples (e.g., the collectivism/individualism distinction; see Bond, 2002).
2. The *Cultural Formulation Interview* (CFI; Lewis-Fernández, Aggarwal, & Kirmayer, 2016) is a much-needed tool for cross-cultural research whose future potential for data-based cultural comparisons has only just begun to be realized (see description earlier in the chapter). The CFI is a more standardized version of the Outline of the Cultural Formulation (OCF) first described in the DSM-IV (American Psychiatric Association, 1994). Before the DSM-5 was published, the CFI was translated into a variety of languages and was empirically evaluated for its feasibility, acceptability, and perceived clinical utility among clinicians and patients across 11 research sites in the United States, Canada, India, Peru, Kenya, and the Netherlands (Aggarwal et al., 2014).

   The underlying assumption of the CFI is that culture (however defined) shapes a patient's perspective and approach to clinical care, influencing when, where, how, and to whom patients narrate their experiences of illness and distress (La Roche & Bloom, 2018). Although this is an interesting hypothesis, the influence of cultural differences (however defined) on CFI content from clients must be defined empirically (First, 2017b).

   Some research suggests that use of the CFI or its predecessor (the Outline of the Cultural Formulation or OCF) increases the accuracy and/or acceptability of DSM diagnoses (Bäärnhielm, Wistedt, & Rosso, 2015; Kirmayer, Thomb, Jurcik, Jarvis, & Guzder, 2008; Lewis-Fernández et al., 2016; Lewis-Fernández et al., 2017), and use of the CFI has been shown to enhance medical communication in positive directions (Aggarwal, Desilva, Nicasio, Boiler, & Lewis-Fernández, 2015). Published studies report promising inter-rater reliability data on instruments designed to assess clinicians' fidelity to the *DSM-5 Handbook on the Cultural Formulation Interview* (Aggarwal et al., 2014).

   Although use of the CFI is a promising step toward helping clinicians to be more sensitive in understanding cultural issues, there are some areas needing improvement. The *DSM-5 Handbook on the Cultural Formulation Interview* is the DSM supplement that illustrates how the core CFI (and the tool for collecting collateral information) is used, how to use 12 supplementary modules, and how to meaningfully interpret video case vignettes that illustrate the use of the CFI with actors posing as clients.

   This author watched several of these videos (accessed from https://www.appi.org/Lewis-Fernandez), which are explicitly designed to reinforce whatever points the authors are trying to get across in the supplement. In the videos, there was little to no depiction of interviewer deviation from the interview script. The actors playing the interviewees came off as reasonably bright, articulate, and verbal – however, not all clients in the real world fit this description. Further CFI research is needed from video and/or interview transcription studies which can provide data on real-life clients (representing a variety of economic and occupational backgrounds) from different countries who were eventually diagnosed with DSM conditions.

3. It bears repeating that the all-purpose "Western/Non-Western" distinction may be well-intentioned but is wholly inadequate (as a basis for criticizing the DSM) at best or grossly misleading at worst. This chapter proposes a categorization scheme that would match the one used by the World Health Organization when publishing its Global Health Estimates (World Health Organization, 2016). Here, the globe is divided into six regions: the *African Region* (e.g., Algeria, Ethiopia, Kenya, Nigeria, Senegal, Uganda), the *Region of the Americas* (e.g., the Bahamas, Brazil, Canada, Guatemala, Haiti, the United States, Venezuela), the *Southeast Asia Region* (e.g., Bangladesh, India, Indonesia, Sri Lanka, Thailand), the *European Region* (e.g., Austria, Belgium, France, Germany, the Netherlands, Portugal, Spain, Sweden), the *Eastern Mediterranean Region* (e.g., Egypt, Iran, Kuwait, Pakistan, Saudi Arabia, Tunisia), and the *Western Pacific Region* (e.g., Australia, China, New Zealand, Korea, Japan, the Philippines).This scheme is based purely on geographical subdivisions and obviates the need to artificially shoehorn countries into a somewhat tenuous and artificial "Western/Non-Western" framework.

   The proposed DSM supplement could be published in six volumes, with each volume corresponding to these six regions. Although the countries represented within a region are diverse across many dimensions, there is ample room within each volume to expand on mental health scholarship related to the countries represented within each of these regions.

   Within each global region, a preliminary section that can classify/categorize countries (such as what is shown in Table 2) would be helpful for readers. The only difference is that country charts in DSM supplement volumes would include additional variables that discriminate between countries (i.e., information that specifies the variety of major languages spoken within each country). Helpful sections would discuss the extent to which each country is similar to other countries within the region, with respect to prevalence research on DSM categories.

4. Debates over whether or not the DSM categories have construct validity in different cultural situations are an appropriate topic for discussion but would not invalidate the DSM categories in the proposed supplements. A proposed DSM supplement should retain the main DSM categories (since a tremendous amount of hard work has gone into their retention with each revision), and cultural variations relevant to the diagnostic issues (from the source countries within each volume) should be provided with the latest research. Currently, the DSM-5 devotes only one paragraph on "Culture-Related Diagnostic Issues" to each mental illness category, which is woefully insufficient. In contrast, the entire *raison d'être* of the supplements is to devote exclusive and much-needed attention to these important issues.

5. When critics evaluate the cross-cultural validity of the DSM revisions, inordinate attention is given to abstract distal factors (e.g., references to Western vs. Eastern philosophy) that are often far removed from the types of concrete "everyday" problems that require mental health intervention in different regions of the globe. There is persuasive evidence that there is a constellation of common mental disorders that are responsible for the major burden of mental health problems worldwide, which can be treated with evidence-based interventions delivered by trained mental health doctoral and subdoctoral caregivers (Wainberg et al., 2017). As examples, natural disasters, acts of terrorism, genocidal conflicts, and the presence of war – and related mass migration issues related to all of these – have common

> physical and psychological effects on all human beings. However, these conditions do not happen with equal frequency throughout the world (Ursano, Fullerton, Weisaeth, & Raphael, 2017). Sections within the proposed cultural supplement would include current research on the often devastating mental health effects (e.g., trauma- and stressor-related disorders, sleep-wake disorders) of these conditions on the lives of those most affected.

Even in the absence of these conditions, there are significant differences between and within countries in access to high-quality mental health services and the cultural stigma that is attached to various diagnostic categories. Due to a variety of factors, countries differ in the human resources that can be brought to bear on the suffering of its citizens, as well as a lack of research capacity for service implementation and mental health policy changes (Wainberg et al., 2017).

Conclusion

This author is inclined to agree with the general sentiment voiced by Michels (2009), who writes:

> Health and mental health are global issues…. Medical and psychiatric journals have contributors and readers from around the world. Scientific meetings have multinational audiences. International research collaboration is common. Psychiatry is a global profession; we can learn a great deal from each other and our patients can benefit. Many American psychiatrists come from other cultures and other countries. Many American patients come from other cultures and other countries … the globalization of psychiatry and mental health is a powerful trend that promises to develop further in the future. (Michels, 2009, p. vii)

If globalization of psychiatry, psychology, and mental health represents a powerful trend, then it is indeed appropriate to recognize that the power of this trend seems proportional to rapid advances in communication, technology, biogenetic research, and the sharing of international resources to help a country's most vulnerable citizens. Western/Non-Western distinctions are becoming increasingly blurred with each passing decade, and some psychiatric conditions are much more universal than previously imagined. It is high time that the DSM, its revisions, and its supplementary materials adequately reflect these trends.

Acknowledgments This author wishes to thank Dr. Sally Satel for her helpful comments on an earlier draft of this chapter.

References

Aggarwal, N. K., Desilva, R., Nicasio, A. V., Boiler, M., & Lewis-Fernández, R. (2015). Does the Cultural Formulation Interview for the fifth revision of the diagnostic and statistical manual of mental disorders (DSM-5) affect medical communication? A qualitative exploratory study from the New York site. *Ethnicity and Health, 20*(1), 1–28.

Aggarwal, N. K., Glass, A., Tirado, A., Boiler, M., Nicasio, A., Alegria, M., … Lewis-Fernández, R. (2014). The development of the DSM-5 Cultural Formulation Interview-Fidelity Instrument (CFI-FI): A pilot study. *Journal of Health Care for the Poor and Underserved, 25*(3), 1397–1417.

Alegría, M., Álvarez, K., & DiMarzio, K. (2017). Immigration and mental health. *Current Epidemiology Reports, 4*(2), 145–155.

Alkire, S., & Jahan, S. (2018). *The new global MPI 2018: Aligning with the sustainable development goals*. HDRO Occasional Paper, United Nations Development Programme (UNDP). Accessed March 2019 from http://hdr.undp.org/sites/default/files/2018_mpi_jahan_alkire.pdf

All Andorra. (2019). *Interview with Oscar Fernàndez*. Accessed April 2019 from https://all-andorra.com/the-consultation-of-a-psychologist-in-andorra-costs-from-50-to-60-euros-and-next-year-we-hope-that-this-cost-will-be-partially-covered-by-the-state-insurance-cass-explains-the-president-of-the-asso/

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association Publishing.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th edition text revision ed.). Washington, DC: American Psychiatric Association Publishing.

American Psychiatric Association. (2013a). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

American Psychiatric Association. (2013b). *From planning to publication: Developing the DSM-5*. Accessed March 2019 from https://www.psychiatry.org/.../Practice/DSM/APA_DSM-Development-of-DSM-5.pdf

American Psychiatric Association. (2013c). *The people behind the DSM-5*. Accessed March 2019 from https://www.psychiatry.org/.../Practice/DSM/APA_DSM_People-Behind-DSM-5.pdf

American Psychiatric Association. (2018). *DSM history*. Accessed March 2019 from https://www.psychiatry.org/psychiatrists/practice/dsm/history-of-the-dsm

Andorra Guides. (n.d.). *Andorra's healthcare system*. Accessed April 2019 from https://andorraguides.com/healthcare/system/

Appelbaum, R. P., Cao, C., Han, X., Parker, R., & Simon, D. (2018). *Innovation in China*. Medford, MA: Polity Press.

Arehart-Treichel, J. (2010). *DSM-5 work groups assess thousands of comments*. Accessed March 2019 from https://psychnews.psychiatryonline.org/doi/full/10.1176/pn.45.16.psychnews_45_16_023

Bäärnhielm, S., Wistedt, A., & Rosso, M. (2015). Revising psychiatric diagnostic categorization of immigrant patients after using the Cultural Formulation in the DSM-IV. *Transcultural Psychiatry, 52*(3), 287–310.

Babbie, E. (2017). *The basics of social research* (7th ed.). Boston, MA: Cengage Learning.

Backholer, P. (2016). *How Christianity made the modern world*. ByFaith Media.

Bailey, C. A., Venta, A., Crosby, J., Varela, J., & Boccaccini, M. (2019). The effect of unpreparedness for immigration court on psychopathology. *Journal of International Migration and Integration, 20*(2), 419–435. https://doi.org/10.1007/s12134-018-0614-9

Balhara, Y. (2011). Culture-bound syndrome: Has it found its right niche? *Indian Journal of Psychological Medicine, 33*(2), 210–215.

Balidemaj, A. (2016). *Acculturation, ethnic identity, and psychological well-being of Albanian-American immigrants in the United States* (Doctoral dissertation). Accessed March 2019 from https://tigerprints.clemson.edu/cgi/viewcontent.cgi?article=2636&context=all_dissertations

Barnhill, J. W. (Ed.). (2014). *DSM-5 clinical cases*. Washington, DC: American Psychiatric Publishing.

Barrick, A. (2007). Study compares Christian and non-Christian lifestyles. *Christian Today*. Accessed March 2019 from https://www.christiantoday.com/article/american.study.reveals.indulgent.lifestyle.christians.no.different/9439.htm

Barro, R. J., & Lee, J. W. (2016). *Dataset of educational attainment*. February 2016 revision. www.barrolee.com. Accessed 8 June 2018.

Barton, D. (2017). Is America a Christian nation? *Wallbuilders*. Accessed March 2019 from https://wallbuilders.com/america-christian-nation/

Bekteshi, V., & Kang, S. (2018). Contextualizing acculturative stress among Latino immigrants in the United States: A systematic review. *Ethnicity & Health*, 1–18. https://doi.org/10.1080/13557858.2018.1469733

Benca, R. M., Cirelli, C., & Tononi, G. (2009). Basic science of sleep. In B. J. Sadock, V. A. Sadock, & P. Ruiz (Eds.), *Comprehensive textbook of psychiatry* (Vol. 1, 9th ed., pp. 361–375). Philadelphia, PA: Wolters Kluwer.

Berman, S. (2019). *Democracy and dictatorship in Europe: From the ancient régime to the present day*. New York, NY: Oxford University Press.

Berry, J. W., Phinney, J. S., Sam, D. L., & Vedder, P. (Eds.). (2006). *Immigrant youth in cultural transition: Acculturation, identity, and adaptation across national contexts*. Mahwah, NJ: Lawrence Erlbaum.

Bhopal, R. & Donaldson, L. (1998). White, European, Western, Caucasian, or what? inappropriate labeling in research on race, ethnicity, and health. *American Journal of Public Health, 88*(9), 1303–1307.

Bird, H. R., Camino, G., Rubio-Stipec, M., Gould, M. S., Ribera, J., Sesman, M., … Moscoso, M. (1988). Estimates of the prevalence of childhood maladjustment in a community survey in Puerto Rico. *Archives of General Psychiatry, 45*, 1120–1126.

Bond, M. H. (2002). Reclaiming the individual from Hofstede's ecological analysis – A 20-year odyssey: Comment on Oyserman et al. (2002). *Psychological Bulletin, 128*(1), 73–77.

Breder, C. D., & Conway, C. M. (2009). Pain systems: Interface with the affective brain. In B. J. Sadock, V. A. Sadock, & P. Ruiz (Eds.), *Comprehensive textbook of psychiatry* (Vol. 1, 9th ed., pp. 341–361). Philadelphia, PA: Wolters Kluwer.

Bredström, A. (2019). Culture and context in mental health diagnosing: Scrutinizing the DSM-5 revision. *Journal of Medical Humanities, 40*(3), 347–363. Accessed April 2019 from https://link.springer.com/content/pdf/10.1007%2Fs10912-017-9501-1.pdf

Brooke, J. H. (2011). Modern Christianity. In J. H. Brooke & R. L. Numbers (Eds.), *Science & religion around the world* (pp. 92–119). New York, NY: Oxford University Press.

Brown, D. (1991). *Human universals*. New York, NY: McGraw-Hill.

Brown, D. (2000). Human universals and their implications. In N. Roughley (Ed.), *Being humans: Anthropological universality and particularity in transdisciplinary perspectives* (pp. 136–174). Berlin, Germany: Walter de Gruyter.

Bryant-Davis, T., Ellis, M. U., & Edwards, N. (2013). Therapeutic treatment approaches for ethnically diverse survivors of interpersonal trauma. In F. A. Paniagua & A. Yamada (Eds.), *Handbook of multicultural mental health: Assessment and treatment of diverse populations* (2nd ed., pp. 505–526). San Diego, CA: Academic Press.

Canino, G., & Alegria, M. (2008). Psychiatric diagnosis – Is it universal or relative to culture? *Journal of Child Psychology and Psychiatry, 49*(3), 237–250.

Charlson, F. J., Ferrari, A. J., Santomauro, D. F., Diminic, S., Stockings, E., Scott, J. G., … Whiteford, H. A. (2018). Global epidemiology and burden of schizophrenia: Findings from the global burden of disease study 2016. *Schizophrenia Bulletin, 44*(6), 1195–1203.

Cheung, F. M., & Mak, W. (2018). Sociocultural factors in psychopathology. In J. N. Butcher & J. M. Hooley (Eds.), *APA handbook of psychopathology volume 1: Understanding, assessing, and treating adult mental disorders* (pp. 127–147). Washington, DC: American Psychological Association.

Chilton, B. (2006). Christianity: What it is and how it defines Western civilization. In J. Neusner (Ed.), *Religious foundations of Western civilization: Judaism, Christianity and Islam* (pp. 71–104). Nashville, TN: Abingdon Press.

Clay, R. A. (2011). Revising the DSM. *APA Monitor, 42*(1), 54.

Cochrane, F. (2013). *Northern Ireland: The reluctant peace*. New Haven, CT: Yale University Press.

Cockerham, W. C. (2015). *Medical sociology* (13th ed.). New York, NY: Routledge.

Cronin, T., Gouda, P., McDonald, C., & Hallahan, B. (2017). A comparison of mental health legislation in five developed countries: A narrative review. *Irish Journal of Psychological Medicine, 34*(4), 261–269.

Davidson, L. (2016, April 26). Mental health laws would diminish stigma and improve the lives of millions. *The Guardian*. Accessed April 2019 from https://www.theguardian.com/global-development-professionals-network/2016/apr/26/mental-health-law-diminish-stigma-improve-lives

Davis, D. L. (1996). Cultural sensitivity and the sexual disorders of DSM-IV: Review and assessment. In J. E. Mezzich, A. Kleinman, H. Fabrega, & D. L. Parron (Eds.), *Culture and psychiatric diagnosis: A DSM-IV perspective* (pp. 191–208). Washington, DC: American Psychiatric Press.

DeSilva, R., Aggarwal, N. K., & Lewis-Fernández, R. (2015). The DSM-5 Cultural Formulation Interview and the evolution of cultural assessment in psychiatry. *Psychiatric Times, 32*(6). Accessed March 2019 from https://www.psychiatrictimes.com/special-reports/dsm-5-cultural-formulation-interview-and-evolution-cultural-assessment-psychiatry

DiCicco-Bloom, E., & Falluel-Morel, A. (2009). Neural development and neurogenesis. In B. J. Sadock, V. A. Sadock, & P. Ruiz (Eds.), *Comprehensive textbook of psychiatry* (Vol. 1, 9th ed., pp. 42–64). Philadelphia, PA: Wolters Kluwer.

Dietz, K. R., Lavigne, J. V., Arend, R., & Rosenbaum, D. (1997). Relation between intelligence and psychopathology among preschoolers. *Journal of Clinical Child Psychology, 26*(1), 99–107.

Encyclopedia Britannica. (2019). *Caucasian peoples*. Accessed February 2019 from https://www.britannica.com/topic/Caucasian-peoples#accordion-article-history

Escobar, J. I., Nervi, C. H., & Gara, M. A. (2000). Immigration and mental health: Mexican Americans in the United States. *Harvard Review of Psychiatry, 8*(2), 64–72.

Fabrega, H. (1996). Cultural and historical foundations of psychiatric diagnosis. In J. E. Mezzich, A. Kleinman, H. Fabrega, & D. L. Parron (Eds.), *Culture and psychiatric diagnosis: A DSM-IV perspective* (pp. 3–14). Washington, DC: American Psychiatric Press.

First, M. B. (2017a). Public comment period opens for first set of new proposals to update DSM-5. *Psychiatric Times*. Accessed April 2019 from https://www.psychiatrictimes.com/dsm-5/public-comment-period-opens-first-set-new-proposals-update-dsm-5

First, M. B. (2017b). The DSM revision process: Needing to keep an eye on the empirical ball: A commentary on “expert consensus v. evidence-based approaches in the revision of the DSM” by Kendler & Solomon (2016). *Psychological Medicine, 47*(1), 19–22.

First, M. G. (2014). *DSM-5 handbook of differential diagnosis*. Washington, DC: American Psychiatric Publishing.

Foulks, E. F. (1996). Culture and personality disorders. In J. E. Mezzich, A. Kleinman, H. Fabrega, & D. L. Parron (Eds.), *Culture and psychiatric diagnosis: A DSM-IV perspective* (pp. 243–252). Washington, DC: American Psychiatric Press.

Frisby, C. L. & O’Donohue, W. (Eds.). (2018). Cultural competence in applied psychology. New York: Springer

Frost, P. (2018). *South Korea: The ugly side of Westernization*. Accessed April 2019 from http://evoandproud.blogspot.com/2018/07/south-korea-ugly-side-of-westernization.html

Gergen, K. J., Gulrerce, A., Lock, A., & Misra, G. (1996). Psychological science in cultural context. *American Psychologist, 51*, 496–503.

Ggrwlknl. (2016). *Modernisation is not westernization*. Accessed March 2019 from https://ggrwlknl.wordpress.com/2016/11/28/modernisation-is-not-westernisation/

Gillispie, C., Holmes, F., Koertge, N., & Gale, T. (2008). *Complete dictionary of scientific biography*. Detroit, MI: Charles Scribner’s Sons.

González, C. A., & Griffith, E. (1996). Culture and the diagnosis of somatoform and dissociative disorders. In J. E. Mezzich, A. Kleinman, H. Fabrega, & D. L. Parron (Eds.), *Culture and psychiatric diagnosis: A DSM-IV perspective* (pp. 137–149). Washington, DC: American Psychiatric Press.

Gottfredson, L. S. (2004). Intelligence: Is it the epidemiologists’ elusive “fundamental cause” of social class inequalities in health? *Journal of Personality and Social Psychology, 86*(1), 174–199.

Gottfredson, L. S. (2005). *Thinking more deeply about health disparities*. Accessed July 2017 from http://www1.udel.edu/educ/gottfredson/reprints/2005BMJrapidresponse.pdf

Grebb, J. A., & Carlsson, A. (2009). Introduction and considerations for brain-based diagnostic system in psychiatry. In B. J. Sadock, V. A. Sadock, & P. Ruiz (Eds.), *Comprehensive textbook of psychiatry* (Vol. 1, 9th ed., pp. 1–5). Philadelphia, PA: Wolters Kluwer.

Gupta, B., & Mohanty, J. N. (Eds.). (2000). *Philosophical questions: East and West*. Lanham, MD: Rowman & Littlefield.

Hale, J. (1986). *Black children: Their roots, culture, and learning styles* (Revised ed.). Baltimore, MD: Johns Hopkins University Press.

Hall, M. D. (2011, June 7). *Did America have a Christian founding?* The Heritage Foundation. Accessed March 2019 from https://www.heritage.org/political-process/report/did-america-have-christian-founding

Hanel, P., Maio, G. R., & Manstead, A. (2018). A new way to look at the data: Similarities between groups of people are large and important. *Journal of Personality and Social Psychology: Interpersonal Relations and Group Processes, 116*(4), 1–22.

Hanlon, C., Wondimagegn, D., & Alem, A. (2010). Lessons learned in developing community mental health care in Africa. *World Psychiatry, 9*(3), 185–189.

Harrison, P., & Lindberg, D. C. (2011). Early Christianity. In J. H. Brooke & R. L. Numbers (Eds.), *Science & religion around the world* (pp. 67–91). New York, NY: Oxford University Press.

Healthcare Access and Quality Collaborators. (2017). Healthcare access and quality index based on mortality from causes amenable to personal health care in 195 countries and territories, 1990-2015: A novel analysis from the Global Burden of Disease Study 2015. *Lancet, 390*, 231–266.

Heritage Foundation. (2019). *2019 Index of economic freedom: Mauritius*. Accessed March 2019 from https://www.heritage.org/index/country/mauritius

Hodgkinson, S., Godoy, L., Beers, L. S., & Lewin, A. (2017). Improving mental health access for low-income children and families in the primary care setting. *Pediatrics, 139*(1), pii: e20151175. Accessed June 2019 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5192088/

Hoffman, M. (2016, December 17). Western culture and the end of Japanese "harmony". *The Japan Times*. Accessed April 2019 from https://www.japantimes.co.jp/news/2016/12/17/national/media-national/western-culture-end-japanese-harmony/#.XKJXO4WcGUl

Hofstede, G. (1980). Motivation, leadership, and organization: Do American theories apply abroad? Organizational Dynamics. Accessed December 2019 from www.cultureready.org/sites/default/files/publications/Motivation%20Leadership%20and%20Organization_Hofstede_1980%5b1%5d.pdf

Hofstede, G. (1991). *Cultures and organizations: Software of the mind*. London, UK: McGraw-Hill.

Hood, G. (2019, January 21). *Western civilization is White civilization*. Accessed February 2019 from https://www.amren.com/commentary/2019/01/western-civilization-is-white-civilization/

Hu, K. (2018, September 19). *China's premier reminds the world: "China remains a developing country"*. Yahoo Finance. Accessed February 2019 from https://finance.yahoo.com/news/chinas-premier-reminds-world-china-remains-developing-country-145413881.html

Hughes, C. C. (1985). Glossary of "culture-bound" or folk psychiatric syndromes. In R. C. Simons & C. C. Hughes (Eds.), *The culture-bound syndromes: Folk illnesses of psychiatric and anthropological interest* (pp. 469–505). Dordrecht, The Netherlands: D. Reidel.

Hughes, C. C. (1996). The culture-bound syndromes and psychiatric diagnosis. In J. E. Mezzich, A. Kleinman, H. Fabrega, & D. L. Parron (Eds.), *Culture and psychiatric diagnosis: A DSM-IV perspective* (pp. 289–307). Washington, DC: American Psychiatric Press.

Human Development Indices and Indicators 2018 Statistical Update. (2018). *Technical notes*. Accessed February 2019 from http://hdr.undp.org/sites/default/files/hdr2018_technical_notes.pdf

Huntington, S. P. (1996). *The clash of civilizations and the remaking of world order*. New York, NY: Simon & Schuster.

ILO (International Labour Organization). (2018). *ILOSTAT database*. Accessed 13 April 2018 at Geneva. www.ilo.org/ilostat

IMF (International Monetary Fund). (2018). *World economic outlook database*. Washington, DC. Accessed 15 June 2018 at www.imf.org/en/data

Inserra, D. (2019). *The unsaved Christian: Reaching cultural Christianity with the gospel*. Chicago, IL: Moody Publishers.

Jackson, J. S., Abelson, J. M., Berglund, P. A., Mezuk, B., Torres, M., & Zhang, R. (2011). The intersection of race, ethnicity, immigration, and cultural influences on the nature and distribution of mental disorders. In D. A. Regier, W. E. Narrow, E. A. Kuhl, & D. J. Kupfer (Eds.), *The conceptual evolution of DSM-5* (pp. 267–285). Washington, DC: American Psychiatric Publishing.

Jankowski, T. (2013). *Eastern Europe! Everything you need to know about the history (and more!) of a region that shaped our world and still does*. Williamstown, MA: New Europe Books.

Jensen, A. R. (1998). *The g factor: The science of mental ability*. Westport, CT: Praeger.

Kapur, A. (2012, March 9). How India became America. *The New York Times*. Accessed April 2019 from https://www.nytimes.com/2012/03/11/opinion/sunday/how-india-became-america.html

Karpinski, R. I., Kolb, A. M., Tetreault, N. A., & Borowski, T. B. (2018). High intelligence: A risk factor for psychological and physiological overexcitabilities. *Intelligence, 66*, 8–23.

Kaysen, R. (2018, April 14). Some said they'd flee Trump's America. These people actually did. *The New York Times*. Accessed April 2019 from https://www.nytimes.com/2018/04/14/style/moving-to-canada-jk-traveling-until-2020.html

Kelly, E. (2018, February 4). *America is not a Christian nation and never has been*. Accessed March 2019 from https://allthatsinteresting.com/founding-fathers-religion

Kim, S., & Cardemil, E. (2012). Effective psychotherapy with low-income clients: The importance of attending to social class. *Journal of Contemporary Psychotherapy, 42*(1), 27–35.

Kim, U., Triandis, H. C., Kagitcibasi, C., Choi, S., & Yoon, G. (Eds.). (1994). *Individualism and collectivism: Theory, method, and applications*. Thousand Oaks, CA: Sage.

Kimbro, D. (2014). *The wealth choice: Success secrets of black millionaires*. New York, NY: St. Martin's Griffin.

Kirmayer, L., Thomb, B., Jurcik, T., Jarvis, G., & Guzder, J. (2008). Use of an expanded version of the DSM-IV outline of the cultural formulation on a cultural consultation service. *Psychiatric Services, 59*(6), 683–686.

Kitayama, S. (2002). Culture and basic psychological processes – toward a system view of culture: Comment on Oyserman et al. (2002). *Psychological Bulletin, 128*(1), 89–96.

Kleinman, A. (1996). How is culture important for DSM-IV? In J. E. Mezzich, A. Kleinman, H. Fabrega, & D. L. Parron (Eds.), *Culture and psychiatric diagnosis: A DSM-IV perspective* (pp. 15–25). Washington, DC: American Psychiatric Press.

Kluckhohn, D. M., & Murray, H. A. (1948). *Personality in nature, society, and culture*. New York, NY: Knopf.

Knoema. (2015). *World Atlas Data: Mauritius*. Accessed March 2019 from https://knoema.com/atlas/Mauritius/topics/Education/Literacy/Adult-literacy-rate

Kohn, R., Wintrob, R. M., & Alarcón, R. D. (2009). Transcultural psychiatry. In B. J. Sadock, V. A. Sadock, & P. Ruiz (Eds.), *Comprehensive textbook of psychiatry: Volume 1* (pp. 734–753). Philadelphia, PA: Wolters Kluwer.

Korous, K. M., Causadias, J. M., Bradley, R. H., & Luthar, S. S. (2018). Unpacking the link between socioeconomic status and behavior problems: A second-order meta-analysis. *Cultural Development and Psychopathology, 30*(5), 1889–1906.

Kraus, R. F. (1996). Cultural comments on personality disorders: II. In J. E. Mezzich, A. Kleinman, H. Fabrega, & D. L. Parron (Eds.), *Culture and psychiatric diagnosis: A DSM-IV perspective* (pp. 259–261). Washington, DC: American Psychiatric Press.

Kupfer, D. J., First, M. B., & Regier, D. A. (Eds.). (2002). *A research agenda for DSM-V*. Washington, DC: American Psychiatric Association.

La Roche, M. (2013). *Cultural psychotherapy: Theory, methods and practice*. Los Angeles, CA: Sage.

La Roche, M. J., Fuentes, M. A., & Hinton, D. (2015). A cultural examination of the DSM-5: Research and clinical implications for cultural minorities. *Professional Psychology: Research and Practice, 46*(3), 183–189.

La Roche, M. & Bloom, J. B. (2018). Examining the effectiveness of the cultural formulation interview with young children: A clinical illustration. *Transcultural Psychiatry.*

Laerd Dissertation. (2012). *Constructs in quantitative research*. Accessed April 2019 from http://dissertation.laerd.com/constructs-in-quantitative-research.php

Lee, S. J. (2008). *European dictatorships 1918–1945*. New York, NY: Routledge.

Leonard, T. M. (2006). *Third world*. In T. M. Leonard (Ed.), *Encyclopedia of the developing world: Vol. 3* (pp. 1542–1543). New York, NY: Routledge.

Lewis, B. (1996). The Middle East, Westernized despite itself. *Middle East Quarterly, 3*(1), 53–61.

Lewis-Fernández, R., & Aggarwal, N. (2013). Culture and psychiatric diagnosis. *Advances in Psychosomatic Medicine, 33*, 15–30.

Lewis-Fernández, R., Aggarwal, N., Hinton, L., Hinton, D., & Kirmayer, L. (Eds.). (2016). *DSM-5 handbook on the Cultural Formulation Interview*. Washington, DC: American Psychiatric Association Publishing.

Lewis-Fernández, R., Aggarwal, N., & Kirmayer, L. (2016). Introduction. In R. Lewis-Fernández, N. Aggarwal, L. Hinton, D. Hinton, & L. Kirmayer (Eds.), *DSM-5 handbook on the Cultural Formulation Interview* (pp. xxvii–xxxiv). Washington, DC: American Psychiatric Association Publishing.

Lewis-Fernández, R., Aggarwal, N. K., Lam, P. C., Galfalvy, H., Weiss, M. G., Kirmayer, L. J., … Vega-Dienstmaier, J. M. (2017). Feasibility, acceptability and clinical utility of the Cultural Formulation Interview: Mixed methods results from the DSM-5 international field trial. *The British Journal of Psychiatry, 210*, 290–297.

Lin, K. (1996a). Asian American perspectives. In J. E. Mezzich, A. Kleinman, H. Fabrega, & D. L. Parron (Eds.), *Culture and psychiatric diagnosis: A DSM-IV perspective* (pp. 35–37). Washington, DC: American Psychiatric Press.

Lin, K. (1996b). Cultural influences on the diagnosis of psychotic and organic disorders. In J. E. Mezzich, A. Kleinman, H. Fabrega, & D. L. Parron (Eds.), *Culture and psychiatric diagnosis: A DSM-IV perspective* (pp. 49–57). Washington, DC: American Psychiatric Press.

Littlewood, R., & Lipsedge, M. (1985). Culture-bound syndromes. In K. Granville (Ed.), *Recent advances in clinical psychiatry* (pp. 105–142). New York, NY: Livingstone.

Llosa, M. V. (2008, January 1). The paradoxes of Latin America. *The American Interest, 3*(3), 7–11.

Lynn, R. (2008). *The global bell curve: Race, IQ, and inequality worldwide*. Augusta, GA: Washington Summit Publishers.

Lynn, R., & Vanhanen, T. (2006). *IQ and global inequality*. Augusta, GA: Washington Summit Publishers.

Ma-Kellams, C. (2014). Cross-cultural differences in somatic awareness and interoceptive accuracy: A review of the literature and directions for future research. *Frontiers in Psychology, 5*, 1–9. Accessed March 2019 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4253951/

Manderson, L., Cartwright, E., & Hardon, A. (Eds.). (2016). *The Routledge handbook of medical anthropology*. New York, NY: Routledge.

Manson, S. M. (1996). Culture and DSM-IV: Implications for the diagnosis of mood and anxiety disorders. In

J. E. Mezzich, A. Kleinman, H. Fabrega, & D. L. Parron (Eds.), *Culture and psychiatric diagnosis: A DSM-IV perspective* (pp. 99–113). Washington, DC: American Psychiatric Press.

Mark, E. (2016, January 17). *Similarities between Eastern & Western philosophy*. Ancient History Encyclopedia. Retrieved March 2019 from https://www.ancient.eu/article/855/

Martinez, C. (2013). Conducting the cross-cultural clinical interview. In F. A. Paniagua & A. Yamada (Eds.), *Handbook of multicultural mental health: Assessment and treatment of diverse populations* (pp. 191–204). Boston, MA: Academic Press.

Matsumoto, D., & Juang, L. (2017). *Culture and psychology* (6th ed.). Boston, MA: Cengage Learning.

Maverick, J. (2015). *Why Brazil will not be Westernized anytime soon*. Maverick Traveler. Accessed April 2019 from https://mavericktraveler.com/brazil-will-not-westernized-anytime-soon/

McGeorge, P. (2012). Lessons learned in developing community mental health care in Australia and the South Pacific. *World Psychiatry, 11*(2), 129–132.

McNally, R. J. (2012). *What is mental illness?* Cambridge, MA: Harvard University Press.

Mezzich, J. E., Kirmayer, L. J., Kleinman, A., Fabrega, H., Parron, D. L., Good, B. J., … Manson, S. M. (1999). The place of culture in DSM-IV. *The Journal of Nervous & Mental Disease, 187*(8), 457–464.

Mezzich, J. E., Kleinman, A., Fabrega, H., & Parron, D. L. (1996). *Culture and psychiatric diagnosis: A DSM-IV perspective*. Washington, DC: American Psychiatric Press.

Michels, R. (2009). Foreward: The future of psychiatry. In B. J. Sadock, V. A. Sadock, & P. Ruiz (Eds.), *Comprehensive textbook of psychiatry* (Vol. 1, 9th ed.). Philadelphia, PA: Wolters Kluwer.

Moran, M. (2017, August 14). Process for updating DSM-5 is up and running. *Psychiatric News*. Accessed April 2019 from https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2017.9a4

Morrison, J. (2014). *DSM-5 made easy: The clinician's guide to diagnosis*. New York, NY: Guilford Press.

NationMaster. (2019). *People/Ethnic groups: Countries compared*. Accessed February 2019 from https://www.nationmaster.com/country-info/stats/People/Ethnic-groups

Nehrbass, K. (2012). *Christianity and animism in Melanesia: Four approaches to gospel and culture*. Pasadena, CA: William Carey Library.

Nisbet, R. (2003). *The geography of thought: How Asians and Westerners think differently … and why*. New York, NY: The Free Press.

OECD (Organization for Economic Co-operation and Development). (2017). *Education at a glance 2017: OECD indicators*. Paris. www.oecd-ilibrary.org/education/education-at-a-glance-2017_eag-2017-en. Accessed 15 June 2018.

Paniagua, F. A. (2013). Culture-bound syndromes, cultural variations, and psychopathology. In F. A. Paniagua & A. Yamada (Eds.), *Handbook of multicultural mental health: Assessment and treatment of diverse populations* (2nd ed., pp. 25–47). San Diego, CA: Academic Press.

Paniagua, F. A., & Yamada, A. (2013). *Handbook of multicultural mental health: Assessment and treatment of diverse populations* (2nd ed.). San Diego, CA: Academic Press.

Patel, V. (2016). Universal health coverage for schizophrenia: A global mental health priority. *Schizophrenia Bulletin, 42*(4), 885–890.

Pettman, R. (2012). *Psychopathology and world politics*. Hackensack, NJ: World Scientific Publishing.

Pew Research Center. (2014a, April 4). *Religious diversity index scores by country*. Accessed February 2019 from http://www.pewforum.org/2014/04/04/religious-diversity-index-scores-by-country/

Pew Research Center. (2014b, April 4). *Global religious diversity*. Accessed February 2019 from http://www.pewforum.org/2014/04/04/global-religious-diversity/

Pinker, S. (2003). *The blank slate: The modern denial of human nature*. New York, NY: Penguin Books.

Plomin, R., & Deary, U. (2015). Genetics and intelligence differences: Five special findings. *Molecular Psychiatry, 20*, 98–108.

Plomin, R., & von Stumm, S. (2018). The new genetics of intelligence. *Nature Reviews Genetics, 19*, 148–159.

Prince, R. (1996). Cultural comments on eating disorders. In J. E. Mezzich, A. Kleinman, H. Fabrega, & D. L. Parron (Eds.), *Culture and psychiatric diagnosis: A DSM-IV perspective* (pp. 187–190). Washington, DC: American Psychiatric Press.

Prince, R., & Tcheng-Laroche, F. (1987). Culture-bond syndromes and international disease classifications. *Cultural Medicine Psychiatry, 11*, 3–19.

Raison, C. L., Cowles, M. K., & Miller, A. H. (2009). Immune system and central nervous system interactions. In B. J. Sadock, V. A. Sadock, & P. Ruiz (Eds.), *Comprehensive textbook of psychiatry* (Vol. 1, 9th ed., pp. 175–198). Philadelphia, PA: Wolters Kluwer.

Reichenberg, L. W. (2014). *DSM-5 essentials: The savvy clinician's guide to the changes in criteria*. Hoboken, NJ: Wiley.

Ritenbaugh, C., Shisslak, C., Teufel, N., & Leonard-Green, T. (1996). A cross-cultural review of eating disorders in regard to DSM-IV. In J. E. Mezzich, A. Kleinman, H. Fabrega, & D. L. Parron (Eds.), *Culture and psychiatric diagnosis: A DSM-IV perspective* (pp. 171–185). Washington, DC: American Psychiatric Press.

Rodriguez-Cayro, K. (2017, October 11). What does mental health care look like abroad? This is how 9 countries treat mental illness. *Bustle*. Accessed April 2019 from https://www.bustle.com/p/what-does-mental-health-care-look-like-abroad-this-is-how-9-countries-treat-mental-illness-2885010

Rommelse, N., Antshel, K., Smeets, S., Greven, C., Hoogeveen, L., Faraone, S. V., & Hartman, C. A. (2017). High intelligence and the risk of ADHD and other psychopathology. *The British Journal of Psychiatry, 211*, 359–364.

Saey, T. (2018, September 17). A recount of human genes ups the number to at least 46,831. *Science News*. Accessed April 2019 from https://www.sciencenews.org/article/recount-human-genes-ups-number-least-46831

Sam, D. L., & Berry, J. W. (Eds.). (2016). *The Cambridge handbook of acculturation psychology*. New York, NY: Cambridge University Press.

Satel, S. (2000). *P.C., MD.: How political correctness is corrupting medicine*. New York, NY: Basic Books.

Schimmack, U., Oishi, S., & Diener, E. (2005). Individualism: A valid and important dimension of cultural differences between nations. *Personality and Social Psychology Review, 9*(1), 17–31.

Schmidt, A. J. (2004). *How Christianity changed the world*. Grand Rapids, MI: Zondervan.

Scott, K. M., de Jonge, P., Stein, D. J., & Kessler, R. C. (2018). *Mental disorders around the world: Facts and figures from the WHO World Mental Health surveys*. Cambridge, UK: Cambridge University Press.

Semrau, M., Barley, E. A., Law, A., & Thornicroft, G. (2011). Lessons learned in developing community mental health care in Europe. *World Psychiatry, 10*(3), 217–225.

Seterra. (2018, October 3). *The five richest countries in Africa*. Accessed March 2019 from https://online.seterra.com/en/p/africa-richest

Shiraev, E. B., & Levy, D. A. (2017). *Cross-cultural psychology: Critical thinking and contemporary applications* (6th ed.). New York, NY: Routledge.

Simons, R. C., & Hughes, C. C. (1985). *The culture-bound syndromes: Folk illnesses of psychiatric and anthropological interest*. Dordrecht, Holland: D. Reidel Publishing.

Spiegel, D., & Cardeña, E. (1996). Nosological comments on cultural diversity of dissociative and somatoform disorders. In J. E. Mezzich, A. Kleinman, H. Fabrega, & D. L. Parron (Eds.), *Culture and psychiatric diagnosis: A DSM-IV perspective* (pp. 163–167). Washington, DC: American Psychiatric Press.

Sproul, R. C., & Bailey, G. (2010). *What does it mean to be born again?* Lake Mary, FL: Reformation Trust Publishing.

Stein, D. J., Kawakami, N., de Girolamo, G., & Lépine, J. (2018). Social anxiety disorder. In K. M. Scott, P. de Jonge, D. J. Stein, & R. C. Kessler (Eds.), *Mental disorders around the world: Facts and figures from the WHO World Mental Health surveys* (pp. 120–133). Cambridge, UK: Cambridge University Press.

Strenze, T. (2007). Intelligence and socioeconomic success: A meta-analytic review of longitudinal research. *Intelligence, 35*, 401–426.

Stuart, R. B. (2004). Twelve practical suggestions for achieving multicultural competence. *Professional Psychology: Research and Practice, 35*(1), 3–9.

Sue, D. W., & Sue, D. (2016). *Counseling the culturally diverse: Theory and practice* (7th ed.). New York, NY: John Wiley.

Taras, V., Rowney, J., & Steel, P. (2009). Half a century of measuring culture: Review of approaches, challenges, and limitations based on the analysis of 121 instruments for quantifying culture. *Journal of International Management, 15*, 357–373.

Thompson, J. W. (1996). Native American perspectives. In J. E. Mezzich, A. Kleinman, H. Fabrega, & D. L. Parron (Eds.), *Culture and psychiatric diagnosis: A DSM-IV perspective* (pp. 31–33). Washington, DC: American Psychiatric Press.

Thornton, B. J. (2018). Changing landscapes of faith: Latin American religions in the twenty-first century. *Latin American Research Review, 53*(4), 857–862.

Udodiong, I. (2018). Here are Africa's most developed countries in 2018. *Business Insider*. Accessed March 2019 at https://www.pulse.ng/bi/lifestyle/lifestyle-here-are-africas-most-developed-countries-in-2018/p9snd8r

UNDESA (United Nations Department of Economic and Social Affairs). (2017). *World population prospects: The 2017 revision*. New York. http://esa.un.org/unpd/wpp. Accessed 10 May 2018.

UNESCO (United Nations Educational, Scientific and Cultural Organization) Institute for Statistics. (2018). Data Centre. http://data.uis.unesco.org. Accessed 15 June 2018.

United States Census Bureau. (2018). *Race*. Accessed February 2018 from https://www.census.gov/topics/population/race/about.html

Unschuld, P. U. (2009). *What is medicine? Western and eastern approaches to healing*. Berkeley, CA: University of California Press.

Ursano, R. J., Fullerton, C. S., Weisaeth, L., & Raphael, B. (2017). *Textbook of disaster psychiatry* (2nd ed.). Cambridge, UK: Cambridge University Press.

Voronov, M., & Singer, J. A. (2002). The myth of individualism-collectivism: A critical review. *Journal of Social Psychology, 142*(4), 461–480.

Wadsworth, M. E., & Achenbach, T. M. (2005). Explaining the link between low socioeconomic status and psychopathology: Testing two mechanisms of the social causation hypothesis. *Journal of Consulting and Clinical Psychology, 73*(6), 1146–1153.

Wahab, E. O., Odunsi, S. O., & Ajiboye, O. E. (2012). Causes and consequences of rapid erosion of cultural values in a traditional African society. *Journal of Anthropology, 2012*, 1–7. Accessed April 2019 from https://www.hindawi.com/journals/janthro/2012/327061/

Wainberg, M. L., Scorza, P., Shultz, J. M., Helpman, L., Mootz, J. J., Johnson, K. A., … Arbuckle, M. R. (2017). Challenges and opportunities in global mental health: A research-to-practice perspective. *Current Psychiatry Reports, 19*(5), 28. Accessed April, 2019 from https://link.springer.com/content/pdf/10.1007%2Fs11920–017-0780-z.pdf

Wang, P. S. (2011). Assessing mental disorders and service use across countries. In D. A. Regier, W. E. Narrow, E. A. Kuhl, & D. J. Kupfer (Eds.), *The conceptual evolution of DSM-5* (pp. 231–266). Washington, DC: American Psychiatric Publishing.

Westermeyer, J. (1996). Culture and the diagnostic classification of substance-related disorders. In J. E. Mezzich, A. Kleinman, H. Fabrega, & D. L. Parron (Eds.), *Culture and psychiatric diagnosis: A DSM-IV perspective* (pp. 49–57). Washington, DC: American Psychiatric Press.

White Date. (2017). *How many white people are there in the world?* Accessed February 2019 from https://www.whitedate.net/how-many-white-people-are-there-in-the-world/

Wikipedia. (2019). *Seychelles*. Accessed March 2019 from https://en.wikipedia.org/wiki/Seychelles

Williams, E. J. (2017). *Aesthetics and ethics in eastern and western philosophy*. Independently Published.

Wittner, D. G., & Brown, P. C. (Eds.). (2016). *Science, technology, and medicine in the modern Japanese empire*. New York, NY: Routledge.

Wolf, S., Hahn, E., Dettling, M., Nguyen, M., Wingenfeld, K., Stingl, M., … Ta, T. (2017). Migration-related stressors and their effect on the severity level and symptom pattern of depression among Vietnamese in Germany. *Depression Research and Treatment, 2017*, 1–9. https://doi.org/10.1155/2017/8930432

World Bank. (2018). *World development indicators database*. Washington, DC. Accessed 28 July 2018 at http://data.worldbank.org

World Health Organization. (2016). *International statistical classification of diseases and related health problems (10th revision)* (5th ed.). Geneva, Switzerland: WHO Press.

World Health Organization. (2018). *Global health estimates 2016: Disease burden by cause, age, sex, by country and region, 2000–2016*. Accessed April 2019 from https://www.who.int/healthinfo/global_burden_disease/estimates/en/index1.html

World Travel Awards. (2019). *Mauritius Tourism Promotion Authority*. Accessed March 2019 from https://www.worldtravelawards.com/profile-1725-mauritius-tourism-promotion-authority

Worldatlas. (2015). *Countries in both the Eastern and Western Hemispheres*. Accessed January 2019 from https://www.worldatlas.com/aatlas/infopage/eastwestco.htm

WSJ Staff Reporter. (2015, September 21). Catholic and African religious traditions meld in Cuba. *The Wall Street Journal*. Accessed March 2019 from https://www.wsj.com/articles/catholic-and-african-religious-traditions-meld-in-cuba-1442881959

Yamada, A., Atuel, H. R., & Weiss, E. L. (2013). Military culture and multicultural diversity among military service members: Implications for mental health providers. In F. A. Paniagua & A. Yamada (Eds.), *Handbook of multicultural mental health: Assessment and treatment of diverse populations* (2nd ed., pp. 389–446). San Diego, CA: Academic Press.

Ye, Z. (2002). Different modes of describing emotions in Chinese: Bodily changes, sensations, and bodily images. *Pragmatics & Cognition, 10*, 307–339.

Zacharias, R. (2012). *The law of non-contradiction vs. the dialectical system*. Accessed March 2019 from https://www.youtube.com/watch?v=TVsNEIOXTQc

Zakaria, F. (2003, August 17). Young arabs and fear of westernization. *The Globalist*. Accessed April, 2019 from https://www.theglobalist.com/young-arabs-and-fear-of-westernization/

Zeuschner, R. B. (2014). *Classical ethics east and west: Ethics from a comparative perspective*. Brattleboro, VT: Echo Point Books.

Preventing Prejudice and Promoting Intergroup Relations

Andreas Beelmann and Sebastian Lutterbach

Abstract

The chapter reviews results from systematic reviews and meta-analyses of research on preventing prejudice and discrimination and promoting intergroup relations. It classifies prevention approaches according to the intervention content (intergroup contact, knowledge-based programs, individual skill acquisition) and the intervention method (educational measures, standardized programs, media-based approaches, and cultural events). Contact approaches encompass direct encounters such as youth exchange programs or inclusive school classes or indirect contact experiences via television spots or storybook reading with social out-group members. Interventions providing knowledge about social out-groups, democratic values, and positive intergroup norms are realized in citizenship education programs, diversity trainings, antiracism programs, or implicit bias trainings. Fundamental approaches on individual skill promotion center on the acquisition of interpersonal competencies such as empathy or conflict resolution. Especially, intergroup contact interventions and programs facilitating both encounters with social out-group members and individual skill acquisition (empathy and perspective taking in particular) yield most promising effects on preventing prejudice and discrimination. More research is needed to systematically evaluate the effectiveness of civic and citizenship education programs on preventing prejudice and promoting pro-diversity attitudes as well as social cohesion. Finally, we discuss limitations (such as the lack of long-term evaluations) and methodological caveats (such as their implementation in real-world contexts) of prejudice prevention programs.

Keywords

Prevention · prejudice · discrimination · efficacy · intergroup relations

Introduction

Prejudice and discrimination against social out-group members are ubiquitous phenomena in society. Feelings of being threatened by refugees,

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L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_16

migrants, and other minorities; the successful election of individuals and political parties promoting more or less overt devaluation and discrimination of specific social groups; disadvantages and social exclusion based on religion or sexual orientation; new and old forms of anti-Semitism; overt or covert violence toward people who look different or have different cultural lifestyles; and new forms of terrorist threat—these are all well-known examples of the social realities to be found in probably every society in the world (see, e.g., Dovidio, Hewstone, Glick, & Esses, 2010).

Currently, these problems have to be faced at a time when there is an increasing need for individuals and social groups to cooperate in dealing with the realities of multicultural and diverse societies and rapidly progressing economic globalization. Basically, these problems call for a promotion of personal competencies along with an understanding of which conditions need to be encouraged to promote nonviolent and tolerant social progress and which conditions are optimal for successfully living within plural societies. The following sections present interventions designed to prevent prejudice and discrimination and to promote tolerance and social relations between different social groups in order to exert a positive influence on the aforementioned problems and bring about significant change in our societies.

Prejudice is a multifaceted construct that includes negative intergroup feelings, attitudes, and behavior (Brown, 2010) that can already be observed in children from preschool age onward (see Aboud, 1988; Raabe & Beelmann, 2011). The emergence of prejudice thereby can be viewed as a result of a complex interplay between societal, social, and individual variables (Levy & Killen, 2008). Accordingly, several social-developmental theories of prejudice have been formulated that address the role in the formation of prejudice during childhood and adolescence of, for example, cognitive and social-cognitive development (Aboud, 1988; Bigler & Liben, 2007), identity development (Nesdale, 2004), moral development (Killen & Rutland, 2011), intergroup contact and friendships (Davies, Tropp, Aron, Pettigrew, & Wright, 2011), social norms (Rutland, 2004), or intergroup threat (Bar-Tal & Teichman, 2005). Hence, this diversity of models is also reflected in a large number of different intergroup interventions, programs, and initiatives aiming to reduce prejudice and discrimination and to promote intergroup relations (Aboud et al., 2012; Beelmann & Heinemann, 2014; Oskamp, 2000; Paluck & Green, 2009; Ponterotto, Utsey, & Petersen, 2006; Stephan & Stephan, 2001; Stephan & Vogt, 2004). These approaches originate from a range of different disciplines such as social psychology and the educational, developmental, political, and media sciences to mention just a few. We limit this chapter mainly to the prevention of ethnic, racial, and national prejudice, although the approaches may generalize to other domains such as gender, disability, and sexual orientation. We categorize the measures of prejudice prevention and reduction along two dimensions addressing the intervention content and the intervention strategy (see Table 1). The content dimension (A) refers to the "what" or the theoretical background where contact interventions (A1), knowledge-based interventions (A2), and individual skills promotion (A3) can be distinguished. The strategic dimension (B) refers to the intervention methods applied and therefore to the "how" of the measures. We differentiate between educational measures (B1), standardized structured learning programs (B2), and media-based interventions and cultural events (B3). It should be noted here that the use of the term prevention in the sense of absolutely avoiding any negative evaluation of social out-groups is—as in other prevention fields (e.g., aggression)—unrealistic, at least on a population basis (in contrast to an individual level of prejudice). For prejudice, however, there is no clear threshold regarding whether a certain level of prejudice is normal, dysfunctional, or a threat to members of the social out-groups exposed to it (in contrast to, e.g., clinical definitions of behavioral disorders). In addition, there are numerous assessment methods for prejudice with unknown normative distributions and no universal definition of prejudice. Therefore, it is difficult or even impossible to make a clear conceptual distinction

Table 1 Classification of anti-prejudice interventions to promote intergroup relations with examples

	Intervention strategy (B)		
Intervention content (A)	Educational measures (B1)	Standardized programs (B2)	Media-based interventions and cultural events (B3)
Contact interventions (A1)	Integrative schooling, cooperative learning	"Extended-contact" programs, coexistence programs	Media campaigns with celebrities, cultural festivals
Knowledge-based interventions (A2)	Political education (civic/citizen education)	Multicultural programs, antiracism programs	Information on cultures and cultural diversity within films and documentaries
Individual skills promotion (A3)	All measures within the educational system	Cognitive and social trainings	Films, books, etc. for promoting individual abilities

between the prevention (avoiding any level of prejudice ever occurring) and the reduction/remediation of prejudice (changing people with a more or less severe level of prejudice). However, from a pragmatic perspective, we use the term prevention throughout this article and restrict our presentation to any intervention aiming to reduce prejudice or (positively formulated) promote intergroup relations and do not apply it to interventions that try to remediate people with severe levels of prejudice such as political or religious extremists. Nonetheless, it has to be noted that this distinction is continuous and not categorical with a clear determination point.

Types of Intergroup Interventions: Concepts and Evaluation

Contact Interventions (A1)

Intervention Concepts

A major group of interventions has either been developed in the context of the contact hypothesis or can be assigned to the theory's core assumptions (see Allport, 1954; Pettigrew, 1997). These assume that contact experiences between members of different social groups lead not only to reduced levels of prejudice and discrimination against social out-group members but also to improved intergroup relationships in general. Contact interventions are based on the seminal work of Allport (1954) who also emphasized key conditions for intergroup contact: the possibility to establish personal relationships with out-group members (e.g., close friendships); equal status between groups; common goals; cooperation between groups; and support by authorities, law, or norms.

Numerous interventions based on the assumptions drawn from the contact hypothesis have been developed. These range from integrated schools and specific educational learning strategies to youth exchange programs and media campaigns. The first implementations of contact interventions in the 1950s were integrative school systems in the race-segregated United States designed to prevent prejudice and discrimination in childhood and adolescence (Brown v. Board of Education, 1954; Schofield, 1995). Inclusive classes composed of different social group members (typically different ethnic groups but also other social groups such as disabled and nondisabled) aimed to increase the frequency of cross-group interactions, thereby leading to a sustained improvement in intergroup relations.

One variation of contact interventions does not rely on direct but on indirect (or extended) intergroup contact (Wright, Aron, McLaughlin-Volpe, & Ropp, 1997). Indirect contact interventions attempt to extend the contact principle to situations in which a direct personal encounter or the necessary and supportive conditions of direct contact are difficult to establish, because, for example, relevant out-group members are not living in the local context. Mediators of such extended contacts are parents, teachers, peers, or media celebrities. Accordingly, indirect intergroup contact interventions seek, for example, to bring about extended contact experiences via interactions between in-group friends and potential out-group members or via prominent advocates of social groups (e.g., television spots with prominent soccer players from two different ethnic groups). One example of indirect contact was presented and evaluated by Cameron and colleagues (Cameron & Rutland, 2006; Cameron, Rutland, & Brown, 2007; Cameron, Rutland, Brown, & Douch, 2006). They developed comic adventure stories in which a child belonging to the ethnic majority (in this case, English children) makes friends with a refugee child, and both children share as well as solve social problems in their everyday lives. The principle—as in other extended contact interventions—is for participants to experience successful and satisfying social interactions that prevent or decrease negative out-group evaluations between salient groups. At the same time, social interactions with out-group members and the development of cross-group friendships are supposed to be promoted by in-group role models. Another contact intervention using the principle of indirect intergroup contact is the so-called coexistence programs (see, e.g., Stephan, Hertz-Lazarowitz, Zelniker, & Stephan, 2004). This term characterizes a large and diverse group of intervention programs used in the contexts of historically grown and existential conflicts between social groups (e.g., the conflict between Arabs and Jews in Israel or Catholics and Protestants in Northern Ireland). The basic idea behind such programs is to reconcile intergroup conflicts via the intermediation of reciprocal respect and the fundamental acceptance of out-group rights. For this purpose, intervention participants process and reflect on, for example, written descriptions of individual victim biographies (e.g., parents who have lost a child in a military attack). Other programs in this group also use supplementary information about the cultural history of the out-group.

The most recent form of indirect intergroup contact is to be found in the conception of imagined intergroup contact (Crisp & Turner, 2009). Imagined contact describes the mental simulation of a social interaction with one or more out-group members (Crisp, Stathi, Turner, & Husnu, 2009). These mental simulations of positive contact experiences are designed to activate the cognitive concepts associated with successful interactions with out-group members (e.g., meeting a Muslim stranger for the first time at a party or cooperating with a foreign colleague at the workplace). Thus, imagined intergroup contact should have a positive emotional impact on future expectations of positive, relaxed, and comfortable direct contacts, thereby reducing the fear of negative encounters with out-group members as well as negative attitudes toward the social out-group.

Evaluation

Interventions based on the contact hypothesis have a long tradition in social psychology and have been evaluated extensively. For example, Pettigrew and Tropp (2006) synthesized data from more than 500 studies with a total of about 200,000 participants that focused on the effects of intergroup contact on attitudes toward ethnic and other social groups such as the elderly or disabled. Overall, the authors found that intergroup contact had a significant positive intervention effect on prejudice reduction. Effect sizes ranged between $d = -0.42$ and -0.49, thereby indicating a 20–25% reduction of prejudice via intergroup contact interventions.[1,2] These effects remained stable even after controlling for methodological limitations. Furthermore, Pettigrew and Tropp

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[1] Pettigrew and Tropp (2006) used correlations as effect sizes. We calculated *Cohen's d* for better comparability with other meta-analytical evidence within this text. A negative d index indicates a reduction of prejudice and hence a positive intervention effect.

[2] The interpretation of effect sizes is a matter of ongoing controversial discussions. For example, Cohen (1988) established the rule of thumb of small ($d = 0.2$), medium ($d = 0.5$), and high ($d = 0.8$) effect sizes. However, other authors have argued that the magnitude depends largely on the context of an intervention and that small effects may well be impressive if, for example, interventions are of low intensity (Ellis, 2010). In the area of prejudice prevention, we currently do not have the normative data and universal scales available—at least in part—in other prevention fields (e.g., in the prevention of crime with offences) from which to draw really practical conclusions (e.g., reduction of extremism, rates of new cross-group friendships, etc., see above). However, if we compare the reported effect size with other prevention effects (e.g., Sandler et al., 2014), we could cautiously state that these are of practical importance.

(2006) found that contact interventions under Allport's (1954) optimal contact conditions (see above) have a significantly stronger effect on prejudice (d = −0.60) than interventions with unstructured contacts between groups (d = −0.42). Additionally, the authors found different contact effects depending on the salient out-group as well as age effects (contact effects appear to be stronger for children and adolescents), but no moderation by participants' gender. In a supplementary meta-analysis, Pettigrew and Tropp (2008) examined the processing variables between intergroup contact and attitudes toward social out-groups and found that positive contact effects are mediated via reduced levels of intergroup anxiety and by increased empathy. On the other hand, increments in knowledge about the relevant out-group affected the relation between cross-group contact and prejudice to a significantly lesser extent.

Positive effects of direct intergroup contact have also been confirmed in a meta-analysis on cross-group friendships (Davies et al., 2011). These authors integrated 135 studies with 208 individual samples and found that cross-group friendships improved attitudes toward the social out-group with a medium effect of d = 0.53. This effect appeared to be independent from participants' age, gender, or social group status. Cross-group friendships elicited smaller effects when friendships were between ethnic or racial groups and stronger effects between groups that differed in sexual orientation or religious affiliation. Furthermore, by analyzing longitudinal studies, Davies et al. (2011) confirmed a medium-sized long-term effect (d = 0.48) and showed that cross-group friendships improve out-group evaluations and attitudes especially via heightened values of time spent and self-disclosure with out-group friends, thereby indicating the significance of such behavioral engagement.

The effects of extended intergroup contact interventions have been summarized in a recent meta-analysis by Zhou, Page-Gould, Aron, Moyer, and Hewstone (2018). These authors covered 20 years of research on the extended contact hypothesis and summarized the results of 115 studies to analyze its effects on intergroup attitudes. Again, the mean effect between extended cross-group contact and intergroup attitudes was medium (d = 0.52), indicating improvements in out-group evaluations via extended intergroup encounters. Furthermore, the authors confirmed the existence of extended contact effects on improved out-group attitudes independent from direct contact experiences. Although the effect sizes decreased after controlling for direct cross-group friendships, there was still a significant extended contact-attitudes relation (d = 0.35). Regarding potential moderation, Zhou et al. (2018) found no effect of the country of study conduct, participants' mean age, or gender, indicating that the extended contact effect holds for a wide range of applications. Another meta-analysis by Miles and Crisp (2014) focused on imagined intergroup contact in which imagining a positive interaction with an out-group member should reduce prejudice and encourage positive intergroup behavior. This meta-analysis summarized 70 studies and found a small-to-medium overall effect (d = 0.35) on intergroup bias. The interrelation between imagined contact with out-group members and intergroup attitudes was stronger the more that participants had been instructed to elaborate on the situation in which the imagined intergroup interaction was set (e.g., workplace, school, leisure activity). Imagined intergroup contact effects were also stronger for children than for adults, indicating that imagined contact may be particularly able to promote social change in educational settings.

A final meta-analysis by Lemmer and Wagner (2015) integrated studies testing the impact of direct and indirect contact programs on ethnic prejudice in real-world settings. Outcomes were assessed directly after the termination of the intervention (k = 123 comparisons with N = 11,371 participants) and in follow-up tests at least 1 month later (k = 25 with N = 1650 participants). Results indicated that direct contact interventions led to a stronger decrease in ethnic prejudice than indirect contact interventions (effect sizes between *d* = 0.29 and 0.41 vs. between *d* = 0.23 and 0.33, respectively). Furthermore, follow-up studies indicated that intergroup contact intervention effects persisted over time (follow-up effect sizes ranged from *d* = 0.23 to 0.35). In addition, the authors found a slightly higher mean effect size when studies were conducted in countries with severe societal conflicts such as Israel (*d* = 0.31) compared to other regions (*d* = 0.27). Finally, Lemmer and Wagner (2015) found evidence that contact interventions work better for majority group members (*d* = 0.38) than for low-status group members (*d* = 0.20).

In summary, there is convincing evidence from intensive empirical research and meta-analytical results that interventions based on the assumptions of Allport's (1954) contact hypothesis clearly reduce prejudice toward social out-group members and improve intergroup relations. Intergroup contact effects appear to operate regardless of participants' gender, age, social context, social status, or the duration of contact experiences. The latter finding is quite surprising, because contact interventions range between some days up to 12 months (Lemmer & Wagner, 2015). However, the intensity of interventions is at least confounded with the level of directness of contact, with direct contact interventions usually being more intensive than imagined contact (which lasts for only a few minutes; see Miles & Crisp, 2014) and eliciting stronger effects on intergroup attitudes. In addition, positive outcomes also require the realization of Allport's (1954) contact conditions, and these can probably be implemented better within direct encounter. Independent from intensity and level of directness, intergroup contact interventions reduce prejudice more efficiently among majority group members than among minority groups and show higher effects for children and adolescents than adults. In addition, contact interventions reduce prejudice over time in different social contexts and for different social groups and therefore yield the best prospects for future implementations designed to promote intergroup relations and improve social cohesion in diversified societies.

Knowledge-Based Intergroup Interventions (A2)

Intervention Concepts

A second group of interventions is based on the idea that providing information about social out-groups and imparting positive intergroup norms and values associated with democracy, cultural diversity, tolerance, and human rights will theoretically reduce prejudice and promote intergroup relations. These approaches use social identity theory (Tajfel & Turner, 1979) to describe the impact of social categorization processes on negative intergroup evaluations. Interventions then aim to reduce prejudice by deemphasizing social categories (i.e., group members become individuated) or applying decategorization (i.e., the use of social categories is terminated or at least qualified), cross-categorization (i.e., in-groups and out-groups are formed according to orthogonal combinations of two simple categorizations such as race and nationality that lead to mixed social categorizations), and multiple classification (i.e., simultaneous identification with multiple social categories) or by creating an inclusive, superordinate social category such as a European identity compared to a national identity construction (cf. Brewer, 2000; Brown & Hewstone, 2005; Cameron et al., 2006; Gaertner & Dovidio, 2000; Mummendey & Wenzel, 1999).

Again, this group of interventions relates to a variety of different interventions and programs. One more general strategy is that taken by civic or citizen education programs such as the Active Citizenship through Technology (ACT) program (Bers & Chau, 2010) which facilitates participation in constructing a "Virtual Campus of the Future" together with other students, campus administers, and academic departments. These programs usually aim to promote citizenship experiences or normative political participation and engagement (e.g., voting, joining political parties)—naturally with a clear orientation toward principles of democracy and human rights (Manning & Edwards, 2014). Clearly, such an orientation seems to be incompatible with prejudice and discrimination of ethnic or other social out-groups. Programs are often not just information based (e.g., addressing democracy, citizenship, and other concepts); but these also try to apply democratic principles through behavioral exercises. For example, service learning programs (Celio, Durlak, & Dymnicki, 2011) combine a community service with an academic curriculum, thereby aiming to teach youth to take responsibility for the community and encourage insight into the need for participation in a democratic society.

Other more focused approaches using information-based strategies are diversity or multicultural training programs (see Garcia, 1995; Paluck, 2006; Paluck & Green, 2009). These programs seek to increase an understanding of differentness and to promote tolerance between members of different social, cultural, or religious groups by imparting information on the diversity of human cultures. This greater intercultural knowledge then is hypothesized to lead to a reduction in prejudice, resentments, and discrimination. One example is the "A World of Differences" anti-bias curriculum developed by the *A World of Differences Institute* of the Anti-Defamation League in New York (see www.adl.org). One version of this curriculum for children from kindergarten to grade 5 contains five units with 25 lessons and addresses issues such as "understanding my strengths, skills and identity," "understanding and appreciating differences," and "understanding bias and discrimination." Other diversity programs focus on communication-related aspects, aiming primarily at persons who have to adapt to another culture for professional reasons (see Kulik & Robertson, 2008).

In contrast to diversity programs that try to establish more tolerance, antiracism programs aim to reduce and avoid severe forms of social devaluation of out-group members. In most cases, these measures provide historical information on serious violations against human rights such as the Holocaust and try to inform about the political and social backgrounds of such crimes against humanity. In addition, this type of program deals particularly with the intermediation of social values and norms such as democracy or general human rights that facilitate an understanding of the significance of a shared social value system and should decrease any motivation toward negative out-group attitudes and discriminatory behavior.

Another group of training programs focuses on unconscious or implicit biases. Implicit biases are learned stereotypes that affect automatic forms of cognitive information processing and are able to influence behavior (Dovidio & Gaertner, 1986; Fazio, 1995; Noon, 2018). Implicit bias trainings confront participants with their own biases, provide knowledge about the social functions of prejudices and discrimination, and discuss tools that can be used to adjust automatic patterns of cognitive processes and eliminate discriminatory behavior. These programs use the implicit association test (IAT; Greenwald, McGhee, & Schwartz, 1998) to assess participants' baseline implicit bias levels before giving them unconscious bias training tasks to change or control individual implicit biases or presentations on automatic information processing and finally reevaluating their bias levels in long-term posttests (Devine, Forscher, Austin, & Cox, 2012). Training techniques cover counterstereotyping (e.g., imagining powerful women to decrease gender bias), negation trainings that encourage participants to actively reject cognitions that reinforce their biases, perspective-taking trainings, and meditation approaches especially loving-kindness meditation (LKM), which is a "Buddhist technique for cultivating unconditional kindness toward all living things" (Aspy & Proeve, 2017, p. 104).

Evaluation

When evaluating the effectiveness of inter- and multicultural intervention programs, Stephan and Stephan (1984) concluded that the majority have positive effects and reduce prejudice. An updated meta-analysis (Stephan, Renfro, & Stephan, 2004) synthesized 35 studies and found small-to-medium effects on attitudinal measures (e.g., prejudice, negative stereotypes, and sympathy toward out-group members, $d = 0.25$) as well as on behavioral measures (e.g., behavioral preferences and intentions such as to interact with members of the social out-group, $d = 0.38$).

Interestingly, these effects were more than twice as large at follow-up assessments (8–64 weeks after the intervention) although only a few studies provided such follow-up data. However, increased follow-up effects are not uncommon in prevention research, and it can be assumed that certain contents require a given period of time to deliver sizable effects. Apart from this, the systematic review by Stephan, Renfro, et al. (2004) illustrates a familiar pattern: Programs were more effective when implemented in combination with real direct contacts with social out-group members.

A recent meta-analytical integration of over 40 years of empirical research on diversity trainings by Bezrukova, Spell, Perry, and Jehn (2016) addressed gaps in the previously conducted systematic reviews on the effectiveness of diversity training programs (e.g., Kalinoski et al., 2013; Smith, Constantine, Dunn, Dinehart, & Montoya, 2006). It assessed the effects of diversity training programs on four outcome dimensions over time and across different characteristics of training context, design, and participants. The four outcome dimensions were the following:

(a) Cognitive learning (referring to how far participants acquire knowledge about cultural diversity);
(b) Behavioral learning (the development of participants' skills in, e.g., situational judgment or objective behavior);
(c) Attitudinal/affective learning (changes in participants' attitudes toward diversity); and
(d) Reactions of participants (feelings toward an instructor or toward the training overall).

The analysis integrated 260 studies of 29,407 participants reported in 236 research articles. The largest effects of diversity trainings were on participants' reactions toward training instructors (e.g., their competence, credibility, and experience) or the likelihood of content transfer in daily routines ($d = 0.61$) followed by cognitive learning ($d = 0.57$), behavioral learning ($d = 0.48$), and attitudinal/affective learning ($d = 0.30$). The authors also calculated effect sizes for delayed posttest effects (up to 24 months after diversity training) showing that only cognitive learning outcomes were maintained over time. Furthermore, results revealed that diversity training effects were larger when accompanied by other diversity initiatives (e.g., diversity training within integrative educational contexts) targeting both awareness and skills development as well as when they were conducted over a sustained period of time and training groups contained a greater proportion of women. In sum, diversity trainings contribute to the reduction of prejudice and discrimination against out-group members by providing information (and sometimes skills) with which to adjust to and cope with increasing diversity of societies.

Quite similar evidence has been obtained for antiracism programs (McGregor, 1993). Albeit the scarcity of research in this field, this meta-analysis of seven controlled studies found a moderate effect size ($d = 0.48$) on the reduction of racist attitudes. Besides the scarcity of evaluations, reviews on antiracism programs fail to demonstrate whether and how such programs can be applied to and influence members of risk groups (e.g., adolescents who already have contacts with extreme right-wing groups).

This criticism also applies to the large number of civic/citizen education and service learning programs, although recently conducted systematic reviews found some evidence of their efficacy. Nonetheless, these reviews focus mainly on effects on civic engagement such as voluntary services in the community and political participation such as voting (Geboers, Geijsel, Admiraal, & ten Dam, 2013; Lin, 2013; Manning & Edwards, 2014) or on attitudes toward the self, school, and learning and on social skills and academic performance (Celio et al., 2011), but not on intergroup attitudes and relations. Accordingly, it is difficult to draw conclusions on the efficacy of such programs in terms of prejudice reduction and decreased levels of discrimination. However, Lösel, King, Bender, and Jugl (2018) confirmed an orientation toward democratic values as a protective factor against political and religious ideologies and violent radicalization. Hence, it can be assumed that civic or citizen education is probably an efficacious measure for reducing prejudice and discrimination as well.

Regarding the effectiveness of implicit bias trainings, Lai et al. (2014) investigated 17 intervention studies on implicit prejudice (total $N = 17{,}021$). Interventions used a broad variety of training techniques, such as counterstereotyping, perspective-taking, empathy training, or evaluative conditioning methods. Non-Black US participants were evaluated on their preferences for Whites compared to Blacks via IAT pre-posttests and self-reported racial attitudes. The average effect of implicit bias trainings was $d = 0.36$, whereas trainings using counterstereotypical methods ($d = 0.38$), intentional strategies to overcome bias ($d = 0.38$), or evaluative conditioning ($d = 0.27$) were especially effective in reducing implicit preferences. Interventions applying perspective-taking methods ($d = -0.01$), approaches to egalitarian values ($d = 0.05$), or emotion induction ($d = 0.06$) tended to be ineffective in altering implicit prejudices. However, these effects account exclusively for change in implicit bias values. No intervention was able to reduce explicit forms of racial prejudice. Furthermore, it is questionable whether IAT-measured implicit prejudice reveals small (Greenwald, Poehlman, Uhlmann, & Banaji, 2009) or even any effects at all (Oswald, Mitchell, Blanton, Jaccard, & Tetlock, 2013) on explicit attitudes or behavior.

Individual Skill Promotion (A3)

Intervention Concepts

A third heterogeneous group of interventions to prevent or reduce prejudice places more emphasis on training and promoting individual competencies such as multiple classification (see above), perspective taking, empathy, conflict resolution, or social competencies in general. Approaches are based on social-cognitive developmental theories on the origins of prejudice and discrimination (Aboud, 1988; Raabe & Beelmann, 2011) as well as on social learning theory (McKown, 2005). These concepts assume that individual deficits in the aforementioned cognitive or social-cognitive competencies encourage prejudice and discriminatory behaviors, whereas tolerant attitudes, in contrast, are strengthened by the promotion of these competencies (Beelmann & Heinemann, 2014).

A series of interventions can be differentiated on the basis of these assumptions (Aboud & Levy, 2000). One fundamental approach refers to Aboud's (1988) contribution on the development of prejudice that focuses on multiple classification skills. Children are trained by delivering social information (e.g., characteristics of minority group children) in order to learn that individuals have multiple affiliations to different or varying social groups (Aboud & Fenwick, 1999). Other authors have tried to promote empathy and perspective-taking skills as significant correlates of intergroup-related attitudes (Miklikowska, 2018; Stephan & Finlay, 1999). These approaches range from simple perspective-taking and empathy exercises (e.g., describing discriminated persons and imagining their feelings; see Finlay & Stephan, 2000) to simulations of one's own discrimination experiences. The latter uses, for example, the relatively prominent social psychological "blue eyes-brown eyes" simulation (see, e.g., Steward, LaDuke, Bracht, Sweet, & Gamarel, 2003). This method works with arbitrary group divisions (originally based on eye color—hence the name of the technique—but other attributes can be used instead) and the simulation of group advantages or disadvantages (e.g., the devaluation of out-group members). It allows children, adolescents, and even adults to experience the feeling of being discriminated against and should lead to favorable attitudes and own behavior when engaging in social relations with members of different groups. Nonetheless, from an ethical point of view, the experience of discrimination is not completely unproblematic, because fake discrimination events may have negative psychological consequences in participants (e.g., increased feeling of anxiety about future encounters with out-group members or anger reactions).

A relatively unspecific approach to the prevention of prejudice is the promotion of social competencies, especially by training problem-solving and conflict resolution skills. Contrary to the aforementioned interventions, these programs train general social behavior without a specific focus on the reduction of prejudice and discrimination. However, social skills in problem solving and conflict resolution facilitate nonviolent behavior in conflict situations and enhance the capacity to solve social problems between groups in diversified societies. Training in conflict resolution skills, for example, is used in adult mediation training programs and in elementary schools to train coping with peer conflicts (see, e.g., Johnson, Johnson, Dudley, & Acikgoz, 1994; Johnson, Johnson, Dudley, & Magnuson, 1995; Sandy & Cochran, 2000).

The same mechanism works for a vast number of social training programs (see Durlak, Domitrovich, Weissberg, & Gulotta, 2015) and programs to prevent antisocial behavior (e.g., aggression, violence, delinquency, or crime). However, the focus of these approaches is seldom on preventing *group-based* aggression (see, for reviews, Beelmann & Raabe, 2009; Farrington, Gaffney, Lösel, & Ttofi, 2017). Current publications deal with hate crimes and crimes in the context of extremism (see Beelmann, 2014; Borum, 2014) and highlight how pejorative attitudes, prejudice, and discrimination influence violence and delinquency. In this area, however, prevention research is scarce (International Center for the Prevention of Crime, 2015).

Evaluation

Measures related to skills acquisition have proven to reduce prejudice and discrimination or foster tolerance toward human diversity. Numerous empirical evaluations reveal the effectiveness of cognitive and social cognitive programs especially among children, adolescents, and adults (Aboud & Levy, 2000). However, most of the effects of these diverse approaches and programs do not address biased out-group attitudes, beliefs, and discrimination tendencies but focus mainly on improving cognitive skills (e.g., Bigler & Liben, 1992; Katz & Zalk, 1978; Schaller, Asp, Rosell, & Heim, 1996); perspective taking and empathy (e.g., Feddes, Mann, & Doosje, 2015; Stephan & Finlay, 1999; Steward et al., 2003; Weiner & Wright, 1973); or moral development, problem-solving, social and conflict resolution skills (see Beelmann & Lösel, 2006; Garrard & Lipsey, 2007; Johnson & Johnson, 1996; Lösel & Beelmann, 2005).

However, one meta-analytical review by Beelmann and Heinemann (2014) summarized the effectiveness of a variety of structured programs designed to promote individual competencies in reducing prejudice and improving intergroup attitudes in children and adolescents. The overall effect size for 45 studies on cognitive and social-cognitive training programs was moderate ($d = 0.40$). Trainings in perspective taking and empathy as well as in social skills yielded the strongest effects in terms of reduced levels of prejudice or improved attitudes toward out-groups (both $d = 0.50$), followed by trainings on moral development ($d = 0.36$), interventions promoting problem-solving skills ($d = 0.20$), and trainings in classification/social categorization ($d = 0.16$). Hence, individual training in perspective-taking, empathy, and social skills seems to offer one of the best ways of reducing prejudice and discrimination—at least in childhood and adolescence.

Educational Measures (B1)

Concepts

A number of interventions have been designed for the educational context. Two particularly well-known concepts are integrative schooling (see above) and bilingual education. The latter later should lead to enhanced knowledge of other languages and cultures and finally to more acceptance of the respective social out-groups (see Stephan & Stephan, 2001). However, cooperative learning techniques are used more frequently to promote intergroup attitudes. These techniques are applied when students work together on tasks within heterogeneous groups (e.g., in terms of race), and their work assignment is arranged in such a way that all group members have to cooperate to achieve a high overall performance. This arrangement is hypothesized to promote not only group cohesion (and finally intergroup relations) but also academic performance.

Different forms of cooperative learning techniques have been developed such as the *Student Teams-Achievement Divisions* (Slavin, 1990), the *Learning Together Techniques* (Johnson & Johnson, 1994), or the *Jigsaw-Technik* (Aronson & Patnoe, 1997). These differ in whether, for example, the individual performance of each student can be evaluated afterward or whether these establish a competition between the small groups within the classroom. However, independent from the different methods and from possible implementation problems (e.g., strain on underachievers), these cooperative learning techniques do meet the conditions for successful intergroup contact (i.e., mutual task, same status within the contact situation, support by authorities).

Evaluation

Reviews have reported mostly positive evaluations of the effectiveness of educational measures although simultaneously identifying some critical aspects. For example, Schofield's (1995) review of the effects of integrative schooling found that interethnic contacts within schools lead to positive intergroup attitudes only when programs succeeded in initiating personal relationships and friendships between group members (Aboud & Levy, 2000). This has led to modifications of concepts of integrative schooling over the years (see Pfeifer, Brown, & Juvonen, 2007; Schofield, 2006; Schofield & Hausmann, 2004) by, for example, combining them with additional methods or advanced training for teachers.

Only a few studies have evaluated the effects of bilingual education systematically and then mostly in the context of ethnically integrated schools. Although these also revealed some positive effects on prejudice reduction (see, e.g., Genesee & Gándara, 1999), it is difficult to see how their effects could be generalized to other intergroup constellations such as the relation between handicapped and nonhandicapped people. In contrast, the outcome of cooperative learning techniques has been subject to intensive evaluation research (Johnson & Johnson, 1989, 2000; Slavin, 1995). For example, Slavin and Cooper (1999) confirmed a significant reduction in prejudice in elementary and secondary school children independent from the type of cooperative learning techniques applied. After summarizing over 180 studies, Johnson and Johnson (1989, 2000) concluded that—compared to individual and competition-oriented techniques—cooperative learning techniques not only reduce prejudice but also promote interpersonal attraction between members of different social groups in the classroom. The effect sizes for cooperative learning techniques were large (e.g., $d = 0.66$) and especially pronounced for intergroup contexts with handicapped children. Independent from these differential outcomes, cooperative learning techniques had positive effects on academic achievement and the students' general satisfaction with their school.

Standardized Training Programs (B2)

Concepts

A second intervention strategy encompasses more or less standardized or manualized training programs. These concepts are mostly highly structured, consecutive, and designed to teach and practice concrete cognitive or social competencies. For example, Beelmann, Saur, and Ziegler (2010) developed a 15-session multimodal training program for elementary school children based on developmental risk factors and processes of prejudice and other forms of negative intergroup attitudes (see Beelmann, 2011; Raabe & Beelmann, 2011). The program covers three domains: (a) reading and discussing indirect contact stories as proposed by Cameron et al. (2006), (b) imparting intercultural knowledge (e.g., by taking a fictitious world trip), and (c) promoting those cognitive and social-cognitive competencies that correlate negatively with prejudice and discrimination (e.g., empathy, perspective taking, multiple classification, social-problem solving).

Evaluation

A meta-analytical review conducted by Beelmann and Heinemann (2014) provides some insights into the effectiveness of a variety of standardized training programs for reducing prejudice and improving intergroup attitudes. The authors summarized the results of 81 international research reports with 122 intervention-control comparisons of structured programs designed to reduce prejudice or promote positive out-group evaluations in children and adolescents. They analyzed contact programs (direct, indirect), knowledge acquisition trainings (on out-groups, values, and norms), and—as mentioned above—social-cognitive trainings or combinations of these three types of program. The overall effect on reducing prejudice was small to medium ($d = 0.30$). In comparison with knowledge acquisition programs and social-cognitive skill programs, intergroup contact interventions yielded the strongest effects in terms of decreasing the level of prejudice ($d = 0.43$). However, the effect size for social-cognitive trainings was only slightly lower ($d = 0.40$). In particular, the targeted out-group moderated the effects of trainings on intergroup attitudes, with programs addressing attitudes toward persons with disabilities eliciting the highest effect sizes and proving to be even more effective than interventions addressing attitudes toward ethnic out-group members. No further characteristics of trainings (e.g., duration, intensity rating) or characteristics of participants (e.g., age group, gender, in-group) accounted for further effect-size variability, indicating that the programs are suitable for a broad range of applications. However, in line with Pettigrew and Tropp (2008), the authors (Beelmann & Heinemann, 2014) found that contact interventions showed the strongest effects when combined with social cognitive trainings on, for example, empathy and perspective-taking skills. The advantages of multimodal or combined prevention strategies could be confirmed by follow-up data from the aforementioned program by Beelmann et al. (2010). Follow-up assessments made 1 and almost 5 years after the termination of the program revealed high effects on the children's intercultural knowledge and medium effects on their prejudice and tolerance toward ethnic out-groups compared to an equivalent control group (Beelmann, 2018; Beelmann & Karing, 2015).

Media-Based Interventions and Cultural Events (B3)

Concepts

A final intervention strategy is based on the media (print and visual) or cultural events. Once again, this covers a broad variety of provisions such as public campaigns or festivals. Such interventions are used widely and seem to be among the most popular practical approaches for lowering prejudice and discrimination. Their popularity is based on the assumption that the reasons for prejudice and discrimination are information deficits or low problem awareness and that such broadband and cost-effective strategies are a good way to tackle these problems. Therefore, the aims of media-based interventions and cultural events are twofold: on the one hand, a broad distribution of information on, for example, discriminative social groups or social or political grievances such as injustice and, on the other hand, films, television series, and spots as well as cultural events to promote responsiveness in target groups and enhance problem awareness within the general public and society. Examples for media-based interventions are public awareness campaigns with celebrities from sport or entertainment as conducted, for example, during the soccer World Cup to counteract racism at sport events. Other examples are films or television series that impart information on social out-groups and apply forms of indirect or extended contact (e.g., contact between children of different ethnicities in *Sesame Street*; see Cole, Labin, & del Rocio Galarza, 2008). More recently, Bilali and colleagues applied an audio-based intervention (so-called radio drama) in different countries in Africa (see, e.g., Bilali & Vollhardt, 2013; Bilali, Vollhardt,

& Rarick, 2016). This intervention contains entertaining stories on fictional interethnic conflicts that try to enhance the understanding about the development of intergroup conflicts and give role models to learn about avoiding prejudice and violence and opportunities for reconciliation.

Evaluation

The relative shortage of systematic evaluations also applies to media-based interventions, public campaigns, and cultural events—despite their relatively high popularity. However, some analyses of public campaigns indicate not only some positive effects but also negative side effects such as sensitivity effects (e.g., participants become worried about a topic that they did not know about before) and increased feelings of threat (see, e.g., Vrij & Smith, 1999). These are important findings, because public campaigns are disseminated broadly by definition, and could therefore also have broad negative effects. For example, it is conceivable that the large-scale dissemination of campaigns with multicultural content may lead to increased feelings of being threatened by foreigners in certain population groups. Therefore, differential and further deliberations are necessary to avoid negative side effects of media and public campaigns—at least in the area of prejudice prevention (Winkel, 1997). Evaluations of television series are also difficult to summarize, although these measures are widely used, at least in the United States (Persson & Musher-Eizenman, 2003). An older narrative review by Graves (1999) did reveal some cautious positive evidence. The main problem was uncertainty about the intensity of the intervention (i.e., who has viewed, for example, a certain television film or series) and whether or not this does indeed lead to more interethnic contact and less prejudice. However, in recent studies, Bilali and colleagues showed that a radio drama intervention in African countries was able to reach a high proportion of the population and had a significantly positive effect on several intergroup attitude measures (Bilali & Vollhardt, 2013; Bilali et al., 2016).

Summary and Conclusions

Various interventions have been designed to reduce prejudice and promote intergroup relations. They take the form of either direct or indirect (extended) contacts between members of different social groups; are based on information about these groups; or aim to promote social, cognitive, or social-cognitive competencies that correlate empirically with intergroup attitudes and behavior. Some have been evaluated extensively; others still lack convincing evidence (see Aboud et al., 2012; Oskamp, 2000; Paluck & Green, 2009; Stephan & Stephan, 2001). Especially positive are the effects of contact interventions in general along with cooperative learning methods and prevention programs that foster empathy and perspective taking. Results on other programs such as multicultural trainings and civic or citizen education or value education are also promising. However, despite these positive conclusions, there are also limitations and methodological caveats. The most challenging is the lack of long-term evaluations showing stable and long-lasting effects on prejudice and intergroup relations. In addition, most evaluations measure assessed effects on intergroup knowledge and attitudes or behavioral intentions but not on intergroup behavior or further outcomes such as intergroup friendships. Further problems concern the need to go beyond pilot projects in order to implement and disseminate programs in routine social settings such as schools or communities (Beelmann, Malti, Noam, & Sommer, 2018; Malti, Noam, Beelmann, & Sommer, 2016). The last 20 years of prevention research confirm impressively that it is not just the content and methods of interventions that lead to the intended outcomes but also the context and implementation conditions (Durlak & DuPre, 2008). Hence, more intensive intervention research is needed to develop programs that are effective in real-world settings. Finally, there are still insufficient links between programs addressing intergroup relations and research in related fields such as crime prevention or the prevention of radicalization and violent extremism (Beelmann, 2014). More integrative research combining results from diverse research fields should lead to more promising concepts and approaches. For example, programs are still insufficiently linked to developmental knowledge and on the risk factors involved in prejudice, discriminative behavior, and more general problems such as antisocial behavior and crimes (Farrington, Gaffney, & Ttofi, 2017; Nivette, Eisner, & Ribeaud, 2017; Rutland & Killen, 2015). Such synergies will be necessary to exploit the full potential of the programs and interventions described here and may significantly reduce the real societal problems reported in the introduction.

References

Aboud, F. E. (1988). *Children and prejudice*. Oxford, UK: Blackwell.

Aboud, F. E., & Fenwick, V. (1999). Exploring and evaluating school-based interventions to reduce prejudice. *Journal of Social Issues, 55*, 767–786. https://doi.org/10.1111/0022-4537.00146

Aboud, F. E., & Levy, S. R. (2000). Interventions to reduce prejudice and discrimination in children and adolescents. In S. Oskamp (Ed.), *Reducing prejudice and discrimination* (pp. 269–293). Mahwah, NJ: Lawrence Erlbaum.

Aboud, F. E., Tredoux, C., Tropp, L. R., Brown, C. S., Niens, U., Noor, N. M., & The Una Global Evaluation Group. (2012). Interventions to reduce prejudice and enhance inclusion and respect for ethnic differences in early childhood: A systematic review. *Developmental Review, 32*, 307–336. https://doi.org/10.1016/j.dr.2012.05.001

Allport, G. W. (1954). *The nature of prejudice*. Cambridge, UK: Addison-Wesley.

Aronson, E., & Patnoe, S. (1997). *The Jigsaw classroom*. New York, NY: Longman.

Aspy, D. J., & Proeve, M. (2017). Mindfulness and loving-kindness meditation: Effects on connectedness to humanity and to the natural world. *Psychological Reports, 120*, 102–117. https://doi.org/10.1177/0033294116685867

Bar-Tal, D., & Teichman, Y. (2005). *Stereotypes and prejudice in conflict: Representations of Arabs in Israeli Jewish society*. New York, NY: Cambridge University Press.

Beelmann, A. (2011). The scientific foundation of prevention. The status quo and future challenges of developmental crime prevention. In T. Bliesener, A. Beelmann, & M. Stemmler (Eds.), *Antisocial behavior and crime. Contributions of developmental and evaluation research to prevention and intervention* (pp. 137–164). Cambridge, MA: Hogrefe Publishing.

Beelmann, A. (2014). Preventing right-wing extremism: European and international research. In C. Mudde (Ed.), *Youth and the extreme right* (pp. 164–177). New York, NY: The International Debate Education Association.

Beelmann, A. (2018). Toleranzförderung und Vorurteilsprävention bei Kindern. Ergebnisse des Grundschulprogramms PARTS. In A. Beelmann (Ed.), *Toleranz und Radikalisierung in Zeiten sozialer Diversität. Beiträge aus den Sozialwissenschaften* [Tolerance and radicalization in times of social diversity. Contributions from social sciences] (pp. 9–27). Schwalbach/Ts, Germany: Wochenschau Verlag.

Beelmann, A., & Heinemann, K. S. (2014). Preventing prejudice and improving intergroup attitudes: A meta-analysis of child and adolescent training programs. *Journal of Applied Developmental Psychology, 35*, 10–24. https://doi.org/10.1016/j.appdev.2013.11.002

Beelmann, A., & Karing, C. (2015). Förderung toleranter Einstellungen und die Prävention von Vorurteilen. Langzeitwirkungen des Programms zur Förderung von Akzeptanz, Respekt, Toleranz und sozialer Kompetenz (PARTS) [Promotion of tolerant attitudes and the prevention of prejudice. Long-term effects of the program for the promotion of acceptance, respect, tolerance, and social competence (PARTS)]. *Forum Kriminalprävention, 1/2015*, 51–58.

Beelmann, A., & Lösel, F. (2006). Child social skills training in developmental crime prevention: Effects on antisocial behavior and social competence. *Psicothema, 18*, 602–609.

Beelmann, A., Malti, T., Noam, G., & Sommer, S. (2018). Innovation and integrity: Desiderata and future directions for prevention and intervention science. *Prevention Science, 19*, 358–365. https://doi.org/10.1007/s11121-018-0869-6

Beelmann, A., & Raabe, T. (2009). The effects of preventing antisocial behavior and crime in childhood and adolescence. Results and implications of research reviews and meta-analyses. *European Journal of Developmental Science, 3*, 260–281. https://doi.org/10.3233/DEV-2009-3305

Beelmann, A., Saur, M., & Ziegler, P. (2010). *PARTS – Programm zur Förderung von Akzeptanz, Respekt, Toleranz & Sozialer Kompetenz* [PARTS – Program for the promotion of acceptance, respect, tolerance, and social competence]. Jena, Germany: Institut für Psychologie.

Bers, M., & Chau, C. (2010). The virtual campus of the future: Stimulating and simulating civic action in a virtual world. *Journal of Computing in Higher Education, 22*, 1–23. https://doi.org/10.1007/s12528-009-9026-3

Bezrukova, K., Spell, C. S., Perry, J. L., & Jehn, K. A. (2016). A meta-analytical integration of over 40 years of research on diversity training evaluation. *Psychological Bulletin, 142*(11), 1227–1274. https://doi.org/10.1037/bul0000067

Bigler, R. S., & Liben, L. S. (1992). A cognitive-developmental approach to racial stereotyping and reconstructive memory in Euro-American children. *Child Development, 64*, 1507–1518. https://doi.org/10.1111/j.1467-8624.1993.tb02967.x

Bigler, R. S., & Liben, L. S. (2007). Developmental intergroup theory: Explaining and reducing children's social stereotyping and prejudice. *Current Directions in Psychological Science, 16*, 162–166. https://doi.org/10.1111/j.1467-8721.2007.00496.x

Bilali, R., & Vollhardt, J. R. (2013). Priming effects of a reconciliation radio drama on historical perspective-taking in the aftermath of mass violence in Rwanda. *Journal of Experimental Social Psychology, 49*, 144–151. https://doi.org/10.1016/j.jesp.2012.08.011

Bilali, R., Vollhardt, J. R., & Rarick, J. R. D. (2016). Assessing the impact of a media-based intervention to prevent intergroup violence and promote positive intergroup relations in Burundi. *Journal of Community & Applied Social Psychology, 26*, 221–235. https://doi.org/10.1002/casp.2246

Borum, R. (2014). Psychological vulnerabilities and propensities for involvement in violent extremism. *Behavioral Sciences & the Law, 32*, 286–305. https://doi.org/10.1002/bsl.2110

Brewer, M. B. (2000). Reducing prejudice through cross-categorization: Effects of multiple social identities. In S. Oskamp (Ed.), *Reducing prejudice and discrimination* (pp. 165–183). Mahwah, NJ: Lawrence Erlbaum.

Brown, R. (2010). *Prejudice: Its social psychology* (2nd ed.). Chichester, UK: Wiley.

Brown, R., & Hewstone, M. (2005). An integrative theory of intergroup contact. *Advances in Experimental Social Psychology, 37*, 255–343. https://doi.org/10.1016/S0065-2601(05)37005-5

Brown v. Board of Education, 347 U.S. 483 (1954).

Cameron, L., & Rutland, A. (2006). Extended contact through story reading in school: Reducing children's prejudice toward the disabled. *Journal of Social Issues, 62*(3), 469–488. https://doi.org/10.1111/j.1540-4560.2006.00469.x

Cameron, L., Rutland, A., & Brown, R. (2007). Promoting children's positive intergroup attitudes towards stigmatized groups: Extended contact and multiple classification skills training. *International Journal of Behavioral Development, 31*(5), 454–466. https://doi.org/10.1177/0165025407081474

Cameron, L., Rutland, A., Brown, R., & Douch, R. (2006). Changing children's intergroup attitudes toward refugees: Testing different models of extended contact. *Child Development, 77*(5), 1208–1219. https://doi.org/10.1111/j.1467-8624.2006.00929.x

Celio, C. I., Durlak, J., & Dymnicki, A. (2011). A meta-analysis of the impact of service-learning on students. *Journal of Experimental Education, 34*(2), 164–181. https://doi.org/10.1177/105382591103400205

Cohen, J. (1988). *Statistical power analysis for the behavioral science* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum.

Cole, C. F., Labin, D. B., & del Rocio Galarza, M. (2008). Begin with the children: What research on Sesame Street's international co-productions reveals about using media to promote a new more peaceful world. *International Journal of Behavioral Development, 32*, 355–361. https://doi.org/10.1177/0165025408090977

Crisp, R. J., Stathi, S., Turner, R. N., & Husnu, S. (2009). Imagined intergroup contact: Theory, paradigm and practice. *Social and Personality Psychology Compass, 3*(1), 1–18. https://doi.org/10.1111/j.1751-9004.2008.00155.x

Crisp, R. J., & Turner, R. N. (2009). Can imagined interactions produce positive perceptions? Reducing prejudice through simulated social contact. *American Psychologist, 64*(4), 231–240. https://doi.org/10.1037/a0014718

Davies, K., Tropp, L. R., Aron, A., Pettigrew, T. F., & Wright, S. C. (2011). Cross-group friendships and intergroup attitudes: A meta-analytic review. *Personality and Social Psychology Review, 15*(4), 332–351. https://doi.org/10.1177/1088868311411103

Devine, P. G., Forscher, P. S., Austin, A. J., & Cox, W. T. L. (2012). Long-term reduction in implicit bias: A prejudice habit-breaking intervention. *Journal of Experimental Social Psychology, 48*(6), 1267–1278. https://doi.org/10.1016/j.jesp.2012.06.003

Dovidio, J. F., & Gaertner, S. (1986). *Prejudice, discrimination, and racism: Historical trends and contemporary approaches*. San Diego, CA: Academic Press.

Dovidio, J. F., Hewstone, M., Glick, P., & Esses, V. M. (Eds.). (2010). *The Sage handbook of prejudice, stereotyping and discrimination*. Los Angeles, CA: Sage.

Durlak, J. A., Domitrovich, C. E., Weissberg, R. P., & Gulotta, T. P. (Eds.). (2015). *Handbook of social and emotional learning: Research and practice*. New York, NY: Guilford.

Durlak, J. A., & DuPre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology, 41*, 327–350. https://doi.org/10.1007/s10464-008-9165-0

Ellis, P. D. (2010). *The essential guide to effect sizes. Statistical power, meta-analysis, and the interpretation of research results*. Cambridge, UK: Cambridge University Press.

Farrington, D. P., Gaffney, H., Lösel, F., & Ttofi, M. M. (2017). Systematic reviews of the effectiveness of developmental prevention programs in reducing delinquency, aggression, and bullying. *Aggression and Violent Behavior, 33*, 91–106. https://doi.org/10.1016/j.avb.2016.11.003

Farrington, D. P., Gaffney, H., & Ttofi, M. M. (2017). Systematic reviews of explanatory risk factors for violence, offending, and delinquency. *Aggression and Violent Behavior, 33*, 24–36. https://doi.org/10.1016/j.avb.2016.11.004

Fazio, R. H. (1995). Attitudes as object-evaluation associations: Determinants, consequences and correlations of attitude accessibility. In R. Petty & J. Krosnick

(Eds.), *Attitude strength: Antecedents and consequences* (pp. 247–282). Hillsdale, NJ: Lawrence Erlbaum Associates.

Feddes, A. R., Mann, L., & Doosje, B. (2015). Increasing self-esteem and empathy to prevent violent radicalization: A longitudinal quantitative evaluation of a resilience training focused on adolescents with a dual identity. *Journal of Applied Social Psychology, 45*, 400–411. https://doi.org/10.1111/jasp.12307

Finlay, K. A., & Stephan, W. G. (2000). Improving intergroup relations: The effects of empathy on racial attitudes. *Journal of Applied Social Psychology, 30*(8), 1720–1737. https://doi.org/10.1111/j.1559-1816.2000.tb02464.x

Gaertner, S., & Dovidio, J. (2000). *Reducing intergroup bias: The common ingroup identity model*. Hove, UK: Psychology Press.

Garcia, M. H. (1995). An anthropological approach to multicultural diversity training. *Journal of Applied Behavioral Science, 31*, 490–500. https://doi.org/10.1177/0021886395314013

Garrard, W. M., & Lipsey, M. W. (2007). Conflict resolution education and antisocial behavior in U.S. schools: A meta-analysis. *Conflict Resolution Quarterly, 25*, 9–38. https://doi.org/10.1002/crq.188

Geboers, E., Geijsel, F., Admiraal, W., & ten Dam, G. (2013). Review of the effects of citizenship education. *Educational Research Review, 9*, 158–173. https://doi.org/10.1016/j.edurev.2012.02.001

Genesee, F., & Gándara, P. (1999). Bilingual education programs: A cross-national perspective. *Journal of Social Issues, 55*, 665–685. https://doi.org/10.1111/0022-4537.00141

Graves, S. B. (1999). Television and prejudice reduction: When does television as a vicarious experience make a difference? *Journal of Social Issues, 55*, 707–727. https://doi.org/10.1111/0022-4537.00143

Greenwald, A. G., McGhee, D. E., & Schwartz, J. L. K. (1998). Measuring individual differences in implicit cognition: The implicit association test. *Journal of Personality and Social Psychology, 74*, 1464–1480. https://doi.org/10.1037/0022-3514.74.6.1464

Greenwald, A. G., Poehlman, T. A., Uhlmann, E. L., & Banaji, M. R. (2009). Understanding and using the implicit association test: III. Meta-analysis of predictive validity. *Journal of Personality and Social Psychology, 97*, 17–41. https://doi.org/10.1037/a0015575

International Center for the Prevention of Crime. (2015). *Preventing radicalization: A systematic review*. Montreal, QC: International Center for the Prevention of Crime. www.cipc-icpc.org

Johnson, D. W., Johnson, R., Dudley, B., & Acikgoz, K. (1994). Effects of conflict resolution training on elementary school students. *The Journal of Social Psychology, 134*(6), 803–817. https://doi.org/10.1080/00224545.1994.9923015

Johnson, D. W., & Johnson, R. T. (1989). *Cooperation and competition: Theory and research*. Edina, MN: Interaction.

Johnson, D. W., & Johnson, R. T. (1994). Learning together. In S. Sharan (Ed.), *Handbook of cooperative learning methods* (pp. 51–65). Westport, CT: Greenwood.

Johnson, D. W., & Johnson, R. T. (1996). Conflict resolution and peer mediation programs in elementary and second schools: A review of research. *Review of Educational Research, 66*, 459–506. https://doi.org/10.2307/1170651

Johnson, D. W., & Johnson, R. T. (2000). The three Cs of reducing prejudice and discrimination. In S. Oskamp (Ed.), *Reducing prejudice and discrimination* (pp. 239–268). Mahwah, NJ: Lawrence Erlbaum.

Johnson, D. W., Johnson, R. T., Dudley, B., & Magnuson, D. (1995). Training elementary school students to manage conflict. *The Journal of Social Psychology, 135*(6), 673–686. https://doi.org/10.1080/00224545.1995.9713971

Kalinoski, Z. T., Steele-Johnson, D., Peyton, E. J., Leas, K. A., Steinke, J., & Bowling, N. A. (2013). A meta-analytic evaluation of diversity training outcomes. *Journal of Organizational Behavior, 34*(8), 1076–1104. https://doi.org/10.1002/job.1839

Katz, P., & Zalk, S. R. (1978). Modification of children's racial attitudes. *Developmental Psychology, 14*, 447–461. https://doi.org/10.1037/0012-1649.14.5.447

Killen, M., & Rutland, A. (2011). *Children and social exclusion: Morality, prejudice, and group identity*. Chichester, UK: Wiley-Blackwell.

Kulik, C. T., & Robertson, L. (2008). Common goals and golden opportunities: Evaluations of diversity education in academic and organizational settings. *Academy of Management Learning & Education, 7*, 309–331. https://doi.org/10.5465/AMLE.2008.34251670

Lai, C. K., Marini, M., Lehr, S. A., Cerruti, C., Shin, J. C., Joy-Gaba, J. A., … Nosek, B. A. (2014). Reducing implicit racial preferences: I A comparative investigation of 17 interventions. *Journal of Experimental Psychology: General, 143*, 1765–1785. https://doi.org/10.1037/a0036260

Lemmer, G., & Wagner, U. (2015). Can we really reduce ethnic prejudice outside the lab? A meta-analysis of direct and indirect contact interventions: Meta-analysis of contact interventions. *European Journal of Social Psychology, 45*(2), 152–168. https://doi.org/10.1002/ejsp.2079

Levy, S. R., & Killen, M. (2008). *Intergroup attitudes and relations in childhood through adulthood*. Oxford, UK: Oxford University Press.

Lin, A. R. (2013). Citizenship education in American schools and its role in developing civic engagement: A review of the research. *Educational Review, 67*(1), 35–63. https://doi.org/10.1080/00131911.2013.813440

Lösel, F., & Beelmann, A. (2005). Social problem solving programs for preventing antisocial behavior in children and youth. In M. McMurran & J. McGuire (Eds.), *Social problem solving and offenders: Evidence, evaluation and evolution* (pp. 127–143). New York, NY: Wiley.

Lösel, F., King, S., Bender, D., & Jugl, I. (2018). Protective factors against extremism and violent radicalization: A systematic review of research. *International Journal of Developmental Science, 12*, 89–102. https://doi.org/10.3233/DEV-170241

Malti, T., Noam, G. G., Beelmann, A., & Sommer, S. (2016). Toward dynamic adaptation of psychological interventions for child and adolescent development and mental health. *Journal of Clinical Child & Adolescent Psychology, 45*(6), 827–836. https://doi.org/10.1080/15374416.2016.1239539

Manning, N., & Edwards, K. (2014). Does civic education for young people increase political participation? A systematic review. *Educational Review, 66*(1), 25–45. https://doi.org/10.1080/00131911.2013.763767

McGregor, J. (1993). Effectiveness of role playing and antiracist teaching in reducing student prejudice. *Journal of Educational Research, 86*, 215–226. https://doi.org/10.1080/00220671.1993.9941833

McKown, C. (2005). Applying ecological theory to advance the science and practice of school-based prejudice reduction interventions. *Educational Psychologist, 40*(3), 177–189. https://doi.org/10.1207/s15326985ep4003_4

Miklikowska, M. (2018). Empathy trumps prejudice: The longitudinal relation between empathy and anti-immigrant attitudes in adolescence. *Developmental Psychology, 54*(4), 703–717. https://doi.org/10.1037/dev0000474

Miles, E., & Crisp, R. J. (2014). A meta-analytic test of the imagined contact hypothesis. *Group Processes & Intergroup Relations, 17*(1), 3–26. https://doi.org/10.1177/1368430213510573

Mummendey, A., & Wenzel, M. (1999). Social discrimination and tolerance in intergroup relations: Reactions to intergroup difference. *Personality and Social Psychology Review, 3*, 158–174. https://doi.org/10.1207/s15327957pspr0302_4

Nesdale, D. (2004). Social identity processes and children's ethnic prejudice. In M. Bennett & F. Sani (Eds.), *The development of the social self* (pp. 219–246). New York, NY: Psychology Press.

Nivette, A., Eisner, M., & Ribeaud, D. (2017). Developmental predictors of violent extremist attitudes: A test of general strain theory. *Journal of Research in Crime and Delinquency, 54*(6), 755–790. https://doi.org/10.1177/0022427817699035

Noon, M. (2018). Pointless diversity training: Unconscious bias, new racism and agency. *Work, Employment and Society, 32*, 198–209. https://doi.org/10.1177/0950017017719841

Oskamp, S. (Ed.). (2000). *Reducing prejudice and discrimination*. Mahwah, NJ: Lawrence Erlbaum.

Oswald, F. L., Mitchell, G., Blanton, H., Jaccard, J., & Tetlock, P. E. (2013). Predicting ethnic and racial discrimination: A meta-analysis of IAT criterion studies. *Journal of Personality and Social Psychology, 105*(2), 171–192. https://doi.org/10.1037/a003273

Paluck, E. L. (2006). Diversity training and intergroup contact: A call to action research. *Journal of Social Issues, 62*(3), 577–595. https://doi.org/10.1111/j.1540-4560.2006.00474.x

Paluck, E. L., & Green, D. P. (2009). Prejudice reduction: What works? A review and assessment of research and practice. *Annual Review of Psychology, 60*(1), 339–367. https://doi.org/10.1146/annurev.psych.60.110707.163607

Persson, A., & Musher-Eizenman, D. R. (2003). The impact of a prejudice-prevention television program on young children's ideas about race. *Early Childhood Research Quarterly, 18*, 530–546. https://doi.org/10.1016/j.ecresq.2003.09.010

Pettigrew, T. F. (1997). Generalized intergroup contact effects on prejudice. *Personality and Social Psychology Bulletin, 23*, 173–185. https://doi.org/10.1177/0146167297232006

Pettigrew, T. F., & Tropp, L. R. (2006). A meta-analytic test of intergroup contact theory. *Journal of Personality and Social Psychology, 90*(5), 751–783. https://doi.org/10.1037/0022-3514.90.5.751

Pettigrew, T. F., & Tropp, L. R. (2008). How does intergroup contact reduce prejudice? Meta-analytic tests of three mediators. *European Journal of Social Psychology, 38*(6), 922–934. https://doi.org/10.1002/ejsp.504

Pfeifer, J. H., Brown, C. S., & Juvonen, J. (2007). Prejudice reduction in schools. Teaching tolerance in schools: Lessons learned since Brown v. Board of Education about the development and reduction of children's prejudice. *Social Policy Report, 21*, 1–24. https://doi.org/10.1002/j.2379-3988.2007.tb00051.x

Ponterotto, J. G., Utsey, S. O., & Petersen, P. B. (2006). *Preventing prejudice. A guide for counselors, educators, and parents*. Thousand Oaks, CA: Sage.

Raabe, T., & Beelmann, A. (2011). Development of ethnic, racial, and national prejudice in childhood and adolescence: A multinational meta-analysis of age differences. *Child Development, 82*, 1715–1737. https://doi.org/10.1111/j.1467-8624.2011.01668.x

Rutland, A. (2004). The development and self-regulation of intergroup attitudes in children. In M. Bennett & F. Sani (Eds.), *The development of the social self* (pp. 247–265). New York, NY: Psychology Press. https://doi.org/10.4324/9780203391099

Rutland, A., & Killen, M. (2015). A developmental science approach to reducing prejudice and social exclusion: Intergroup processes, social-cognitive development, and moral reasoning. *Social Issues and Policy Review, 9*, 125–154. https://doi.org/10.1111/sipr.12012

Sandler, I., Wolchik, S. A., Cruden, G., Mahrer, N. E., Ahn, S., Brincks, A., & Brown, C. H. (2014). Overview of meta-analyses of the prevention of mental health, substance use, and conduct problems. *Annual Review of Clinical Psychology, 10*, 243–273. https://doi.org/10.1146/annrev-clinpsy-050212-185524

Sandy, S. V., & Cochran, K. M. (2000). The development of conflict resolution skills in children. In M. Deutsch & P. T. Coleman (Eds.), *The handbook of conflict resolution* (pp. 317–342). San Francisco, CA: Jossey-Bass Publishers.

Schaller, M., Asp, C. H., Rosell, M. C., & Heim, S. J. (1996). Training in statistical reasoning inhibits the formation of erroneous group stereotypes. *Personality and Social Psychology Bulletin, 22*, 829–844. https://doi.org/10.1177/0146167296228006

Schofield, J. W. (1995). Review of research on school desegregation's impact on elementary and secondary school students. In J. A. Banks & C. A. Mc Gee (Eds.), *Handbook of research on multicultural education* (pp. 597–616). New York, NY: MacMillan.

Schofield, J. W. (2006). *Migration background, minority-group membership and academic achievement. Research evidence from social, educational, and developmental psychology*. Berlin, Germany: Arbeitsstelle Interkulturelle Konflikte und gesellschaftliche Integration, Wissenschaftszentrum Berlin für Sozialforschung (AKI Research Review 5).

Schofield, J. W., & Hausmann, L. R. M. (2004). School desegregation and social science research. *American Psychologist, 59*, 538–546. https://doi.org/10.1037/0003-066X.59.6.538

Slavin, R. E. (1990). *Cooperative learning: Theory, research, and practice*. Englewood Cliffs, NJ: Prentice Hall.

Slavin, R. E. (1995). When and why does cooperative learning increase achievement? Theoretical and empirical perspectives. In R. Hertz-Lazarowitz & N. Miller (Eds.), *Interaction in cooperative groups: The theoretical anatomy of group learning* (pp. 145–173). Cambridge, MA: Cambridge University Press.

Slavin, R. E., & Cooper, R. (1999). Improving intergroup relations: Lessons learned from cooperative learning programs. *Journal of Social Issues, 55*, 647–663. https://doi.org/10.1111/0022-4537.00140

Smith, T., Constantine, M., Dunn, T., Dinehart, J., & Montoya, J. (2006). Multicultural education in the mental health professions: A meta-analytic review. *Journal of Counseling Psychology, 53*, 132–145. https://doi.org/10.1037/0022-0167.53.1.132

Stephan, C. W., Hertz-Lazarowitz, R., Zelniker, T., & Stephan, W. G. (2004). Introduction to improving Arab–Jewish relations in Israel: Theory and practice in coexistence educational programs. *Journal of Social Issues, 60*(2), 237–252. https://doi.org/10.1111/j.0022-4537.2004.00109.x

Stephan, C. W., Renfro, L., & Stephan, W. G. (2004). The evaluation of multicultural education programs: Techniques and meta-analysis. In W. G. Stephan & W. P. Vogt (Eds.), *Multicultural education programs* (pp. 227–242). New York, NY: Teacher College Press.

Stephan, W. G., & Finlay, K. (1999). The role of empathy in improving intergroup relations. *Journal of Social Issues, 55*(4), 729–743. https://doi.org/10.1111/0022-4537.00144

Stephan, W. G., & Stephan, C. W. (1984). The role of ignorance in multicultural education. In N. Miller & M. B. Brewer (Eds.), *Groups in contact: The psychology of desegregation* (pp. 229–257). New York, NY: Academic Press.

Stephan, W. G., & Stephan, C. W. (2001). *Improving intergroup relations*. Thousand Oaks, CA: Sage. https://doi.org/10.4135/9781452229225

Stephan, W. G., & Vogt, W. P. (Eds.). (2004). *Education programs for improving intergroup relations*. New York, NY: Teacher College Press.

Steward, T. L., LaDuke, J. R., Bracht, C., Sweet, B. A. M., & Gamarel, K. E. (2003). Do the "Eyes" have it? A program evaluation of Jane Elliot's "Blue Eyes/Brown Eyes" diversity training exercise. *Journal of Applied Social Psychology, 33*, 1898–1921. https://doi.org/10.1111/j.1559-1816.2003.tb02086.x

Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. In W. G. Austin & S. Worchel (Eds.), *The social psychology of intergroup relation* (pp. 33–47). Monterey, CA: Brooks & Cole.

Vrij, A., & Smith, B. J. (1999). Reducing ethnic prejudice by public campaigns: An evaluation of a present and a new campaign. *Journal of Community and Applied Social Psychology, 9*, 195–215. https://doi.org/10.1002/(SICI)1099-1298(199905/06)9:3<195::AID-CASP504>3.0.CO;2-#

Weiner, M. J., & Wright, F. E. (1973). Effects of undergoing arbitrary discrimination upon subsequent attitudes toward a minority group. *Journal of Applied Psychology, 3*, 94–102.

Winkel, F. W. (1997). Hate crime and anti-racism campaigning: Testing the approach of portraying stereotypical information-processing. *Issues in Criminological & Legal Psychology, 29*, 14–19.

Wright, S. C., Aron, A., McLaughlin-Volpe, T., & Ropp, S. A. (1997). The extended contact effect: Knowledge of cross-group friendships and prejudice. *Journal of Personality and Social Psychology, 73*(1), 73–90. https://doi.org/10.1037/0022-3514.73.1.73

Zhou, S., Page-Gould, E., Aron, A., Moyer, A., & Hewstone, M. (2018). The extended contact hypothesis: A meta-analysis on 20 years of research. *Personality and Social Psychology Review, 23*(2), 132–160. Published online first April 19. https://doi.org/10.1177/1088868318762647

Prejudice and the Ethical Code

Zarus E. P. Watson and Kimberly N. Frazier

Abstract

This chapter focuses on mental health practitioner cultural competence and how it impacts the clinician's ability to make sound ethical decisions. Authors use case studies to illuminate various ethical dilemmas and outline ethical code standards from various mental health professions to show what is outlined by the code and what barriers can impede mental health professional's ethical decision-making. Authors provide definitions to ethical practice, discuss barriers to ethical practice, and make the argument linking cultural competence to ethical practice and decision-making A discussion regarding key issues practitioners must be aware is also provided.

Keywords

Bias · Prejudice · Ethics · Psychotherapy · Countertransference

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Introduction

"Cathy, a 54-year-old Caucasian female, is a mental health practitioner within an employee assistance program firm contracted by a state's hospital system to supply mental health and related services to all levels of the public entity's employee population. A new client has been added to Cathy's caseload, Rick, a 25-year-old, Latino-American male nurse at a large suburban site state hospital. The client has been referred to her because of increasing levels of absenteeism, poor work performance, and increasingly disruptive behavior on site with fellow nursing professionals.

Upon meeting with Rick for the first time, Cathy goes over the intake report and notes that Rick states that he has become increasingly depressed and dissatisfied with his job. Cathy notes this and asks Rick if his depression and dissatisfaction might be due to a mismatch between himself and the job he has chosen; after all, nursing is a traditional female occupation because of a woman's greater capacity for nurturance. Rick responds that he did not believe that this aspect of the nursing profession had ever occurred to him. Cathy notes that it would not be uncommon for such thoughts to be at the unconscious level. She goes on to point out to Rick that his own Hispanic lineage and conditioning would probably have difficulty reconciling itself in his mind with a career that is lacking in recognized 'machismo.'

© Springer Nature Switzerland AG 2020
L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_17

Rick slumps back into his chair and muses that this is indeed information that he has not considered. He thought that it was all about being overworked with a family to support but maybe it's more than that."

Diagnostically, the aforementioned case is fraught with possible threats to therapeutic competence along multiple cultural dimensions, including but not limited to intersectional influences of socio-race, ethnicity, gender, and age. The counselor in this case is operating from a stance of cultural incompetence, meaning she is acting unconsciously from a perceptual viewpoint that she inherently knows the client as well as the client's social group. This "unconscious knowing" on the therapist's part is a conditioned identity state of unvetted descriptors that often denote, monolithically, what certain group's values are as well as their operational norms. From this type of perceptual stance toward a client, known as transference, the therapist is provided with a comfortable yet illegitimate base from which to interpret and diagnose on sight or with very little information.

The client in this case is now beginning to take onto himself what the therapist feels the issues are, even before a thorough exploration of his own thoughts and feelings regarding causation could commence. The failure of this therapist to take into account cultural dimensions and other conditioned elements from both sides of the therapeutic dyad will often set the stage for a faulty and unethical experience with poor outcome likely (Herlihy & Watson, 2003; Sciarra, 1999; Staemmler, 2012; Young, 2013).

Social and behavioral scientists have recognized such socially laden interactions, even external to the therapeutic dynamic, have revived the idea of "intersectionality," as originally put forward by Kimberle Crenshaw in the 1980s (Bartlett, 2017). Within the original definition, Crenshaw used "intersectionality as a means of describing the overlapping effects of multiple dimensions of cultural prejudice imbedded in human interaction." Though her original research was formed in the arena of public policy and related to African-American women, Crenshaw noted that the phenomenon contextually could apply to all member groups with a given society.

In parallel, racial, gender, and ethnic identity development theorists (Clark, Swim, & Cross Jr., 1996; Helms, 1990, 1993; Helms & Cook, 1999) have long recognized such socially conditioned human interaction at both the group and individual level. They maintain that there is proven variability in perceived viewpoints of self, others, and the environment, not just between socially ascribed groups but within them as well. They further note that such variability of perception is brokered by systemically conditioned cognitions operating at both the conscious and unconscious levels.

These cognitions, the fruit of unconscious social messaging, are received, formed, and shaped over time as an ever-evolving amalgamation of an individual's personal life experiences (as well as their extended experiences as part of a socially ascribed group) and will orientate the individual's perceptual viewpoint regarding their own place within society. This perceptual viewpoint will in turn influence resultant cognitions and behaviors. This encompasses all those behaviors and cognitions imported as preconditions into the therapeutic process itself by both clientele and therapist alike (Helms, 1993; Lee, 2013; Herlihy & Watson, 2007). In recognition of this phenomena within the mental health domain, theorists, researchers, and practitioners (Lee, 2007) have increasingly cited central issues of cultural competence and ethical practice in supervision, therapeutic practice and training, testing, research and consultation, and, by extension, the possible effects on social influence factors such as policy (Boysen & Vogel, 2008; Chao, 2013; Durodoye, 2006; Hays, 2008; Watson, Herlihy, & Pierce, 2006; Woidneck, Pratt, Gundy, Nelson, & Twohig, 2012).

For more than four decades, mental health clinicians have questioned their role within and beyond the therapeutic dynamic. Johnson (1972), Barnes (1972), and others specifically questioned the role of Black psychologists and therapists who work with a largely Black clientele, especially when considering the larger social backdrop of discrimination, oppression, and the overall comparison of minority group behaviors to the then accepted "White" and/or dominant norms of behavior (Cross, Smith, & Payne, 2002). Such questioning only intensified in the 1990s with researchers exploring and questioning training and testing bias concerns of minority populations (Azibo, 1992; Wyche & Novick, 1992). Theorists and clinicians continue to question and grapple with a field that, at times, still refuses to see itself as being susceptible to the larger social influences that surround it (Barrett, 2010; Pedersen, 2004; Thompson, 2004).

Increasingly, examples of incidents and practices concerning mental health professionals in such areas as clinical practice, outreach, testing, and research have and are garnering headlines as well as concerns within the professional ranks of all mental health fields. Take into account the real case that follows.

Interrogational Real Case

The fairly recent issue surrounding the role of two clinical psychologists in the Central Intelligence Agency and United States military's development, design, and use of "enhanced" interrogation methods (including waterboarding) of jailed enemy combatants is but one, though notably clear, example of probable clashes between the professional ethical codes in which we operate and the separate target processes and goals of other social entities and agencies, within which we may professionally engage (Fink & Risen, 2017). The psychologists in question, employed by the CIA, did participate in the design of enhanced interrogation techniques that many other agencies (including the Geneva Convention) has defined as torture and, in several cases, did participate in the interrogational techniques when applied to clientele (identified by the CIA as enemy combatants).

In this case, as well as others, the central question is how do we as practitioners and researchers justify, as one of the involved CIA employed psychologists have done (Mitchell & Harlow, 2016), behaviors that are seemingly in conflict with the various codes of conduct (American Counseling Association, 2014). Further, in the case of this "enhanced interrogation" episode, a repudiation of the episode and a prohibition of any present and future use of the techniques subsequently issued by the American Psychological Association (Fink & Risen, 2017).

Questions

1. What elements, including our codes of conduct, should drive our professional activities across the multiple settings of clinical practice and consultancy?
2. In the wake of the recent mental health-wide professional development of consciousness, especially in terms of social justice for the marginalized within society, how can we, as clinicians, become more professionally congruent with our various codes of conduct, especially in the face of what are sometimes strong counterforces of influence (Herlihy & Watson, 2003; Herlihy & Watson, 2007; Lee, 2007; Pakman, 2007)?

Defining Cultural Competence

Cultural competence is being aware that there are personal dynamics mental health professionals and their clients bring into the working alliance and the overall relationship. Possessing cultural competence means that the mental health professional is keenly aware of the cultural experiences that they and their clients bring to the therapeutic working alliance and overall therapy experience (Lee, 2013). Being culturally competent assumes that all mental health professionals adopt a nonjudgmental and culturally aware perspective that is cognizant of within-group differences as well as between-group differences to ensure that relevant and appropriate assessments, techniques, and case conceptualization of client issues are being considered at all times (Woidneck et al., 2012).

To be a culturally competent professional you lead with the following assumptions with every client, every intervention and strategy, and every time you are conceptualizing client issues: (1) both the client and the mental health professional bring a multitude of cultural variables that are encompassed and intersect in regard to age, sex, gender, sexual orientation, religion, education, ethnicity, economic status, and many others and (2) cultural diversity is present in all counseling relationships, remembering that all counseling is multicultural in nature. Being culturally competent means that as a mental health professional you acknowledge the following (Lee, 2013):

- Becoming culturally diverse requires mental health professionals to become self-aware.
- Mental health professionals must be willing to modify strategies to fit the needs of the individuals they counsel and understand their client's worldview.
- Mental health professionals recognize personal beliefs, values, biases, assumptions, and attitudes (both positive and negative) about other ethnic groups and cultures.
- Mental health professionals understand the dynamics of oppression, racism, discrimination, stereotyping, and institutional barriers that prevent some potential clients from accessing mental health services.
- Mental health professionals must actively acquire knowledge and skills to effectively work with diverse populations through supervision, consultation, training, and education.
- Mental health professionals should be aware of their own cultural background, attitudes, values, beliefs, and biases.
- Mental health professionals are cognizant of their limitations and are aware that they cannot know everything about the cultural background, attitudes, values, and beliefs of various ethnic groups.
- Mental health professionals respect the role that family and community holds within each ethnic group and how that may impact clients.
- Mental health professionals are aware of the impact of social, environmental, and political factors that impact various cultural groups and use those factors to help assess problems and selecting interventions and strategies for clients.
- Mental health professionals should use interventions, strategies, and goals that are consistent with the life experiences and cultural values of clients.

Defining Ethical Practice

Practicing ethically means that you are operating how a mental health professional should behave per the guidelines that have been adoptive by your respective professional organization. Ethical practice allows for security in the profession (i.e., the general public has a baseline idea of how a professional from a specific discipline will behave ethically) and allows professionals to know the depth of their ethical scope of practice. Having sound ethical practice also means that one is operating with sound ethical decision-making skills. Ethical decision-making is composed of the following components: (1) ethical commitment, deciding what is ethical and acting on that decision appropriately; (2) ethical sensitivity, being able to recognize various ethical issues in a given situation; and (3) ethical reasoning, figuring out what the right thing to do based on our ethical commitment and sensitivity (Robert J. Rutland Institute for Ethics, 2007).

Barriers to Sound Ethical Practice

To practice in an ethically sound manner, mental health clinicians must remember that the professional code of ethics functions as the rule and standard of practice; the adopted ethical code functions as the guideline of what is expected of all clinicians. When making ethical decisions clinicians must ensure that the decision made withstands ethical scrutiny and does not defend what is accepted based on a client's group membership, values, or specific belief. Sound ethical practice means that the decision made has a common currency that is independent of any cultural variables such a religion, sex, gender, or beliefs. To ensure sound ethical practice the following conditions must be considered: (1) overall consequences, sound ethical decisions must be based on the greatest good for the greatest number of people overall; (2) overall rights, sound ethical decisions consider and have an appreciation of individual rights and rights for the minority; and, finally, character, sound ethical decisions consider the reaching excellence in life, institution, or profession.

Thus, we are striving to be excellent human beings and excellent professionals (Cottone & Claus, 2000; Robert J. Rutland Institute for Ethics, 2007).

Barriers to Cultural Competence

Clinicians must overcome collective barriers and engage themselves therapeutically in a way that promotes cultural competence within thier clinical practice. To overcome barriers to cultural competence four elements must be addressed (Lee, 2013):

1. The clinician must adopt a stance of being a continual learner not in just the techniques used in therapy but in the individual persons they serve.
2. The clinician must realize that the content surrounding the situational aspects, both historical and psychological, of any identified socially ascribed group should not be regarded as concrete rules but more as informed guidelines that are not monolithic across the entire group's membership.
3. The clinician should become introspective of their own subject and influenced cognitions in order for them not to become a liability within the therapeutic domain.
4. At the core of the clinician's approach to be culturally competent should be a stance of being actively non-assumptive. In short to assume that there are always elements regarding your client which are unknown to you and that hypothesizing should remain unacted upon by the clinician until content from the client enforces the aforementioned hypothesis.

Linking Cultural Competence and Ethical Practice

Non-assumptiveness and Nonjudgmentality

When considering the linkages between cultural competence and ethical practice, the aspects of non-assumptiveness and nonjudgmentality must be taken into account. Both are hallmarks of clinical practice within the mental health sphere (Seligman & Reichenberg, 2014). Classic therapeutic approaches, including but not limited to person centered, rationale emotive, gestalt, and cognitive behavioral, all hail from a position that therapist should regard their clients from a position that does not assume the person's motivations or meanings. Likewise, the therapist must refrain from judging the client's past and/or behaviors or cognitions. Failing to adhere to these two basic foundational aspects can result in therapist-generated errors and misalignments regarding therapeutic case conceptualization, effective treatment planning, and the quality of outcomes.

In the area of cultural competence and multicultural counseling, the therapist's position is one of acknowledging that the client(s) in session is a unique entity, no matter what their socially ascribed group may be. There is no monolithic viewpoint from which persons, even within an acknowledged group, will perceive the world and themselves in a unified manner. Seeing this uniqueness in all human beings is, at its foundation, a keystone of cultural competent practice. Here again, it is important for the therapist to be able to gain awareness of their own socially conditioned thoughts regarding themselves and others. Often operating at an unconscious level, such self-examination should be at the center of a purposeful plan for being an effective practitioner.

Within the ethical practitioner, controlling positions of judgmentality is, again, central to one's ability to operate as an effective clinician. The ethically grounded therapist does not allow "popular" external content regarding behaviors and/or actions that may be espoused by those persons similar to the client, to become a precondition that sways decisions regarding key elements such as diagnosis and treatment planning.

Regarding the previously mentioned real case, in which psychologists were employed by the CIA in the role of enhanced interrogation designers and, eventually, participants, having a client(s) labeled as “a terrorist or enemy combatant” could very well have resulted in unethical therapist behaviors (i.e., waterboarding) that are contextually deemed “acceptable” and later rationalized by the therapist reasoning. Such reasoning can exist through the therapist’s own failure to recognize that certain socially conditioned value judgments were a precondition to the therapeutic engagement (Hays, 2001; Watson et al., 2006). In this case, failures on the dimensions of cultural competence and ethical practice were allowed to take place and a dysfunctional precondition was subsequently allowed to develop and exist within the therapeutic dynamic. Within the precondition, the therapist’s clients were labeled in ways that were, by western standards, socially and subjectively undesirable within the categories of socio-race (Arab and/or African descent) and occupation (accused enemy combatant). This unfettered precondition, socially conditioned and often operating unconsciously, formed the groundwork that made certain practices in the therapeutic setting acceptable (Lee, 2013; Pope-Davis & Coleman, 2001), even though, on their face, such practices are incongruent to professional mental health ethical codes.

Professional Associations Stance on Cultural Competence and Ethical Practice

Many of the professional associations that mental health professionals belong have adopted guidelines that outline how each association expects their members to incorporate and practice cultural competence and ethical sound interventions and practices. The adaptation of guidelines outlines the expectation of using a cultural lens and being ethically sound when working with clients and strengthens the idea of having a non-biased attitude regarding clients and the cultural experiences and the beliefs the bring into session. Further, having biased attitudes can create a possible influence on the interventions, strategies, assessments, and conceptualization given to that client and the issues that client brings to session. It also strengthens the idea that clinicians too bring their own cultural experiences and beliefs to the clinical process and not being aware of both the clinician and client cultural beliefs and cultural experiences and how they can impact and influence the overall mental health experience can have potentially negative outcomes (Boysen & Vogel, 2008).

Despite the adaptation of guidelines and ongoing recommendations by professional organizations, there is still a stigma attached to seeking out mental health services and higher rates of dropping out of mental health services for minority clients persist. The lower rates of engagement and continuation suggest that minority clients are feeling a disconnection between what has been adapted and what clinicians are actually executing during the therapy sessions (Gonzalez et al., 2010; Woidneck et al., 2012). Another disconnect is that current research regarding the implementation of culturally competent strategies and interventions are widely self-report studies; thus many clinicians are not aware of their own cultural bias and attitudes about cultural competence and when self-reporting many respondents are not always honest about their level of cultural bias and attitudes toward cultural competence (Katz & Hoyt, 2014). Below are a few notable professional organizations and how they have adopted guidelines regarding cultural competence and ethical practice:

- The American Counseling Association (ACA) has sections within the 2014 adopted code of ethics which outlines professional counselor’s requirement to be culturally competent to better aid their clients and students.
- The Association of Multicultural Counseling and Development (AMCD) has revised the organization’s multicultural competencies (1991, 2015) which have been adopted and recognized by the American Counseling

Association. The competencies outline attitudes, beliefs, knowledge, skills, and action culturally competent counselors acknowledge and develop.
- The American Psychological Association (APA) speaks generally in their Ethical Principles and Code of Conduct (2010, 2016) about respect for people's rights and dignity in their general principle section of the code of conduct as it relates to cultural competence and ethical principle.
- The National Association of Social Workers (NASW) Code of Ethics (1999) outline score values and ethical standards for social workers, including the vital importance of multicultural competence, advocacy, empowerment, and social justice. NASW additionally supports the Standards for Cultural Competence along with the indicators for the achievement of such standards (NASW, 2007).

Clinician Awareness

It is important to note that having professional orgranizations adopt guidelines which states how imperative it is to practice through the lens of looking at cultural competence and ethical practice as going hand in hand, one cannot be practiced without operating with the other. Clinicians will always have to lead with being aware in order to provide the most effective care for their clients. Not being assumptive wards mental health professionals against being culturally incompetent and ethically unsound. To practice effectively clinicians must be cognizant of the following (Lee, 2013):

- The health professionals must make an effort to highlight the importance of social influence in order to overcome what little is done to address cultural issues and practice (autopilot).
- Ethical breaches will continue because one's being is couched in cultural incompetence, hence stressing a non-assumption and judgmental mentality.
- Health professionals need to be cognizant that the cultural training received in graduate school should only be viewed as a primer and to be competent there must be constant self-exploration and education.
- Remember there are variances within any and all the ascribed groups even if there is a common thread.
- Being culturally competent is a fluid process and where you are today does not mean you will be at the same level of cultural competence tomorrow.

Summary

The importance of the twin phenomena of cultural competence and ethical practice cannot be overstated. The growing literature, regarding both phenomena, shows that both are essential to clinical practice that serves the client well. Further, the literature also shows that without adherence to both, effective clinical practice is at risk. The literature has also shown that both of these aspects are so intertwined within the foundational concepts of counseling and psychotherapy that a practitioner cannot effectively possess the traits of one without having to purposely engage the other.

To be a culturally competent practitioner is at the foundation for being an ethical practitioner. The risk of unethical practice is largely seen as a clinical experience that has given itself over to assumptive conditioned cognitions, which in turn typically can lead behaviors that will put both the client and practitioner at risk of poor outcomes and, especially in the clinician's case, ethical breaches. Adherence to the field's code of ethical practice should be seen as being a nonnegotiable screen for acceptable ethical behavior in the mental health profession. Having a stance of non-assumption regarding one's clientele will result in the use of the code as a logical, natural, and necessary activity that would not be overlooked by the clinician. From training to practice, the concepts of cultural competence and ethics in practice must form the foundation of mental health practice regardless of setting, clientele type, or practitioner approach. In only this way can we provide a service to the larger community that is an asset to functional development rather than as an unknowing contributor to dysfunction.

References

American Counseling Association. (2014). *ACA code of ethics*. Alexandria, VA: Author.

Azibo, D. A. (1992). Understanding the proper and improper usage of the comparative research framework. In A. Burlew, W. Banks, H. McAdoo, & D. Azibo (Eds.), *African-American psychology: Theory, research, and practice* (pp. 18–27). Newbury Park, CA: Sage.

Barnes, E. J. (1972). The black community as the source of positive self-concept for black children: A theoretical perspective. In R.L. Jones (Ed.). *Black Psychology* (pp. 166–192). Harper & Row.

Barrett, J. A. (2010). Multicultural social justice and human rights: Strategic professional development for social work and counseling practitioners. *Journal for Social Action in Counseling & Psychology, 3*(1), 117–123.

Bartlett, T. (2017, May 26). “Intersectionality” goes viral: But what does it mean? *The Chronicle of Higher Education: The Chronicle Review, Section B.*, B6–B7.

Boysen, G., & Vogel, D. (2008). The relationship between level of training, implicit bias, and multicultural competency among counselor trainees. *Training and Education in Professional Psychology, 2*(2), 103–109.

Chao, R. C. (2013). Race/ethnicity and multicultural competence among school counselors: Multicultural training, racial/ethnic identity, and color-blind racial attitudes. *Journal of Counseling & Development, 91*, 140–151.

Clark, L., Swim, J., & Cross, W. E., Jr. (1996). *Functions of racial identity in everyday life: A daily diary study*. Unpublished manuscript.

Cottone, R. R., & Claus, R. (2000). Ethical decision-making models: A review of the literature. *Journal of Counseling & Development, 78*, 275–283.

Durodoye, B. A. (2006). Ethical issues in multicultural counseling. In C. C. Lee (Ed.), *Multicultural issues in counseling: New approaches to diversity* (pp. 295–306). Alexandria, VA: American Counseling Association.

Fink, S., & Risen, J. (2017, June). *Psychologists open a window on brutal C.I.A. interrogations*. New York, NY: New York Times.

Hays, D. G. (2008). Assessing multicultural competence in counselor trainees: A review of instrumentation and future directions. *Journal of Counseling & Development, 86*, 95–101.

Hays, P. (2001). *Addressing cultural complexities in practice: A framework for clinicians and counselors*. Washington, DC: American Psychological Association.

Helms, J. E. (1990). *Black and white racial identity: Theory, research, and practice*. Westport, CT: Greenwood.

Helms, J. E. (1993). I also said, a White racial identity influences White researchers. *The Counseling Psychologist, 21*, 240–243.

Helms, J. E., & Cook, D. E. (1999). *Using race and culture in counseling and psychotherapy: Theory and process*. New York, NY: Allyn & Bacon.

Herlihy, B. R., & Watson, Z. E. (2003). Ethical issues and multicultural competence in counseling. In F. D. Harper & J. McFadden (Eds.), *Culture and counseling: New approaches* (pp. 363–378). Boston, MA: Allyn & Bacon.

Herlihy, B. R., & Watson, Z. E. (2007). Social justice and counseling ethics. In C. Lee (Ed.), *Counseling for social justice* (2nd ed., pp. 181–199). Alexandria, VA: ACA.

Johnson, J. L. (1972). Special education and the inner city: A challenge for the future or another means for cooling the mark out? In R.L. Jones (Ed.). *Black Psychology* (pp. 295–307). Harper & Row.

Katz, A., & Hoyt, W. (2014). The influence of multicultural counseling competence and anti-black prejudice on therapists’ outcome expectancies. *Journal of Counseling Psychology, 61*(2), 299–305.

Lee, C. (2013). *Multicultural issues in counseling: New approaches to diversity*. Alexandria, VA: American Counseling Association.

Lee, C. C. (2007). *Counseling for social justice* (2nd ed.). Alexandria, VA: American Counseling Association.

Mitchell, J., & Harlow, B. (2016). *Enhanced interrogation: Inside the minds and motives of the Islamic terrorists trying to destroy America*. New York, NY: Crown Publishing Group.

Pakman, M. G. (2007). Risk reduction and the micropolitics of social justice in mental health care. In E. Aldarondo (Ed.), *Advancing social justice through clinical practice* (pp. 151–173). London, UK: Erlbaum Publishers.

Pedersen, P. B. (2004). The multicultural context of mental health. In T. Smith (Ed.), *Practicing multiculturalism: Affirming diversity in counseling and psychology* (pp. 35–56). Boston, MA: Pearson Publishing.

Pope-Davis, D. B., & Coleman, H. L. K. (Eds.). (2001). *The intersection of race, class, and gender in multicultural counseling*. Thousand Oaks, CA: Sage.

Robert J. Rutland Institute for Ethics. (2007, August). *Ethics across the curriculum no. 8*. Clemson, SC: Clemson University.

Sciarra, D. T. (1999). *Multiculturalism in counseling*. Peacock.

Seligman, L., & Reichenberg, L. W. (2014). *Theories of counseling & psychotherapy: Systems, strategies & skills* (4th ed.). Boston, MA: Pearson Publishing.

Staemmler, F. M. (2012). *Empathy in psychotherapy: How therapists and clients understand each other*. New York, NY: Springer Publishing Co..

Thompson, C. E. (2004). Awareness and identity: Foundational principles of multicultural practice. In T. Smith (Ed.), *Practicing multiculturalism: Affirming diversity in counseling and psychology* (pp. 17–31). Boston, MA: Pearson Publishing.

Watson, Z. E., Herlihy, B. R., & Pierce, L. A. (2006). Forging the link between multicultural competence and ethical counseling practice: A historical perspective. *Counseling & Values, 50*, 99–107.

Woidneck, M., Pratt, K., Gundy, J., Nelson, C., & Twohig, M. (2012). Exploring cultural competence in acceptance and commitment therapy outcomes. *Professional Psychology: Research and Practice, 43*(3), 227–233.

Wyche, L. G., & Novick, M. R. (1992). Standards for educational and psychological testing: The issue of testing bias from the perspective of school psychology and psychometrics. In A. Burlew, W. Banks, H. McAdoo, & D. Azibo (Eds.), *African-American psychology: Theory, research, and practice* (pp. 229–235). Newbury Park, CA: Sage.

Young, M. (2013). *Learning the art of helping: Building blocks and techniques* (5th ed.). New York, NY: Pearson.

Prejudice in the Health Care System: Remediation Strategies

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Abstract

A growing evidence base suggests health care professionals are subject to the same biases as the general public, and these biases can unintentionally influence the quantity and quality of health care. Specifically, it highlights the ways in which physician biases impact decision-making, potentially leading to health care disparities. Many studies have investigated how awareness, through introspection and formal measures of bias, might impact behavior; however, few have offered empirically supported training packages that teach physicians behavioral skills they can use to manage bias. This chapter provides a critical review of the most common recommendations for mitigating bias and suggests that an existing approach, acceptance and commitment training (ACT), can address some of the limitations and inconsistencies prevalent in the literature. We conclude with an outline of the ongoing research at one school of medicine, in hopes of inspiring others to consider similar approaches to the management of bias.

Keywords

Prejudice · Implicit bias · Physician bias · Acceptance and commitment training · Implicit bias training

> Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death.
> – Martin Luther King, Jr.

The above words were proclaimed by Martin Luther King, Junior in 1966, at a press conference, before his speech at the Medical Committee for Human Rights. As powerful and humbling as these words may be, they still ring true; prejudice in the health care system remains, and the effects are just as deadly for patients today as they were decades ago. A myriad of evidence suggests there are substantial racial and ethnic differences in both quantity (how much access) and quality of care that may contribute to health care disparities, which then influences health outcomes (Smedley, Stith, & Nelson, 2002). For instance, limited and inadequate access to health care contributes to the premature death of approximately 260 African Americans every day (Smedley et al., 2002), and delayed health care is associated with worse

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© Springer Nature Switzerland AG 2020
L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_18

health outcomes and higher costs (Kraft et al., 2009). These findings have encouraged the formation of numerous organizations and research institutions, whose missions place emphasis on improving minority health. For example, the Department of Health and Human Services (HHS) Office of Minority Health (OMH) was created in 1986 to reduce health disparities among racial and ethnic minorities and to create policies and programs that would improve patient care. Since its inception, there has been an interdisciplinary investigation into the many factors that contribute to health care inequality. One compounding and amplifying factor of systemic health inequality is prejudice.

The purpose of this chapter is to discuss how prejudice and bias influences the quality of health care and to discuss remediation strategies that combat their effects. To do so, we will need to briefly review the relation between health care disparities and implicit bias. It is important to mention that it is outside of the scope of this chapter to address other contributors to systemic health care disparities, such as the operation of health care systems and the legal and regulatory climate in which the health care system operates. However, we will briefly discuss how quantity of care relates to quality of care and can, therefore, contribute to prejudice and bias. This chapter concludes with a review and critique of remediation strategies currently described in the literature and offers a more comprehensive and theoretically coherent approach to mitigating bias among health care providers.

Prejudice, Implicit Bias, and Stigma as it Relates to Health Care Disparities

The Institute of Medicine (IOM; Smedley et al., 2002) defines health care disparities as “differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention” (Smedley et al., 2002, pp. 3–4). They go on to define discrimination as “differences in care that result from biases, prejudices, stereotyping, and uncertainty in clinical communication and decision-making” (Smedley et al., 2002, p. 4). Health care disparities are multivariable and intertwined, and this can appear overwhelming for the sole practitioner to address. However, awareness about the automatic processes that contribute to these disparities, such as prejudice and the implicit bias involved in prejudice, can draw attention to their detrimental effects.

Implicit bias, also known as unconscious bias or implicit social cognition, refers to the “attitudes or stereotypes that affect our understanding, actions, and decisions” in a manner that is outside of our awareness (Staats, Capatosta, Tenney, & Mamo, 2017, p. 10).This phenomenon encompasses favorable and unfavorable assessments of oneself and others that are generated automatically, based on our learning history. Simply stated, implicit bias is influenced by learned associations we acquire over the course of our lifetime through direct and indirect experiences. Although implicit biases are said to be automatic and inaccessible through introspection, they are also malleable (Staats et al., 2017), a point we will return to later in the chapter. It is foundational for us to understand implicit bias and prejudice in the health care system because it contributes to some of the greatest health care disparities. Moreover, it is critical that we understand that long-established beliefs and attitudes about minorities, and negative stereotypes and implicit biases we learn, are deeply embedded in our culture. This can contribute to discriminatory behavior, which, then, can unfold in complex ways, giving rise to an array of adverse health outcomes.

Socioeconomic Status

Research on the social determinants of health highlights ways in which socioeconomic status—specifically, stigma related to Medicaid—plays a role in physician discrimination. Allen, Wright, Harding, and Broffman (2014) suggest Medicaid- and Medicare-funded patients face increasing stigma, which impacts their immediate as well as long-term health. This stigma potentially affects millions of low-income citizens. In the United States, approximately 50% of births are financed by Medicaid (Markus, Andres, West, Garro, & Pellegrini, 2013). A 2014 report published by the Bureau of Labor Statistics suggests that 20% of White children, 19% of Asian children, 37% of Black children, and 35% of Hispanic children are covered by Medicaid. It is disheartening that before these children are even grown, we have disenfranchised their health with our judgments. Insurance-based discrimination leads to suboptimal care that occurs less frequently and is often delayed. For instance, in a study examining reports of insurance-based discrimination and its association with quality and quantity of care (access to care), researchers found that participants who reported insurance-based discrimination were more likely to (1) lack confidence in the health care system, (2) "[forgo] care because of cost," and (3) "experience provider level barriers when seeking care" (Han, Call, Pintor, Alarcon-Espinoza, & Simon, 2015, p. 519).

Children covered by Medicaid face prejudice and inadequate care that often begins with the form of insurance used at their birth and continues into adulthood as other aspects of their lives are judged by the medical community. Chetty et al. (2016) analyzed the relation between income and life expectancy and found that, since the 1950s, there has been an increase in early mortality in low-income populations. Men with income in the top 1% have a life expectancy that is 15 years longer than the average man with an income in the bottom 1% of the income bracket and greater than any man living in any country worldwide. American men living in poverty have life expectancies akin to men in Sudan and Pakistan. Their analyses highlighted that the greatest differences in life expectancy are likely influenced by income. These findings suggest poverty affects access to health care greater than any other single factor, and the effect of the systemic bias creating disparities in health outcomes is inherently unethical.

Race and Ethnicity

Strong evidence also suggests racial and ethnic minorities experience lower quality of care. Smedley et al. (2002) found that minority patients faced unequal treatment due to prejudice, and this led to worse medical outcomes across conditions including cancer, cardiovascular disease, diabetes management, pain management, and mental health. Xu, Murphy, Kochanek, & Arias (2016) report that the age-adjusted, all-cause mortality rate for non-Hispanic Black males is 1.2 times greater than White males and twice that of Hispanic males. Black men have the highest health risk in the United States, with their incidence of cardiovascular disease, cancer, obesity, and stroke being significantly higher than any other population. Additionally, Xu and colleagues compared the age-adjusted mortality rate for malignant neoplasms (i.e., cancerous tumors or abnormal cells) for White versus Black males and found that there was a 1.7-fold increase in mortality for Black men from 1950 to 2004. Health disparities for Black males are increasing every year and because racism shapes all facets of one's life, patients experiencing prejudice have an even greater need for preventative care, wellness resources, and access to care.

The most significant increase in health care disparities is seen at the intersection of sex, age, race, income, and geographical site of care. Intersectionality includes the way that a combination of patients' social factors, such as age, sex, and race, has a multiplicative effect on physician bias. Geronimus (1996) studied health deterioration faced by African American women in early adulthood—specifically in pregnancy—and coined the term "weathering" to describe the effects of social inequality. The weathering hypothesis posited that the cumulative effects of constant exposure to racism and socioeconomic disadvantage contributed to the poor health outcomes experienced by African American women. This study found that African American women in low-income areas in Michigan experienced worse health profiles, which led to a threefold increased risk of low birth weight and fourfold increased risk of very low birth weight. Further it has been reported that:

> compared to other racial and ethnic groups, African-American women tended to be younger, more likely to have a Cesarean section, to stay longer in the hospital, and to incur higher Medicaid costs. African-American women were also more likely to experience preeclampsia, placental abruption, preterm birth, small birth size for gestational age, and fetal death/stillbirth. (Zhang et al., 2013, p. 1519)

One of the most astounding claims, however, is the estimated cost reduction, if racial disparities associated with adverse pregnancy outcomes were eliminated. Zhang et al. (2013) calculated that Medicaid could save $114–$214 million per year. This suggests that the intersectionality of these social factors contributed to exponentially worse health outcomes seen in African American births. Thus, our personal biases can cause patient suffering and unnecessary health care costs.

Despite the clear demonstration of racial health inequity in the literature, it can also be seen that improvements in health outcomes are possible under certain circumstances. In a field experiment, researchers found that patient-doctor communication and health outcomes improve when the provider is the same race and gender as their patient (Alsan, Garrick, & Graziani, 2018). There is a stronger patient preference for a provider that resembles the patient when the patient already believes that the medical system is untrustworthy or if they have very limited experience within the health care system. They also found that when cooperative physician-patient communication allowed for increased health screening, there was a 19% decrease in the difference between Black and White male cardiovascular mortality.

In addition to racial concordance, improvements in health care disparities can also be seen when there is a focus on the disparity. For example, the literature suggests the presence of significant racial disparities in kidney transplantation. Between 2010 and 2014, of the 44,678 African Americans on a waitlist for a kidney transplant, only 2,412 (5.4%) received a kidney; however, of the 66,429 Caucasian Americans on the waitlist for a kidney, 12,648 (19%) received a kidney (Purnell et al., 2018). In most areas, prejudice and health care disparities appear to be on the rise; however, due to extensive research and interdisciplinary collaboration on prejudice affecting health care outcomes, positive changes are also being realized. For example, the United Network for Organ Sharing (UNOS) published its data for 2016 showing equality in organ transplant. This shows that organizational focus on mitigating an area of health disparity can have a positive impact.

Sexual Orientation

The history of how we have come to conceptualize sexual orientation in health care illuminates how influential cultural bias can be on defining our characterization of patients. Until 1973, the American Psychiatric Association (APA) defined “homosexuality” in the Diagnostic and Statistical Manual (DSM) as a medical pathology (Greener, 2013). This characterization of homosexuality as a pathology undermined equality in health care for a whole cohort of patients. Although the characterization of homosexuality changed in the DSM-5 (APA, 2013), the effects of the original conceptualization still reverberate today.

Health care disparities have a direct and indirect impact on patients based on their sexual orientation. One direct impact, as measured by the Association of American Medical Colleges (AAMC), is that the lesbian, bisexual, gay, transgender, queer/questioning (LBGTQ) community is 50% less likely to receive needed medical and behavioral health care (AAMC; Fisher, 2017). This survey of health care access found that gay, lesbian, and bisexual respondents were consistently less likely to receive needed medical care when compared to heterosexual respondents. They also noted that the largest barrier to care was that the patient was unable to find a provider. An indirect impact of this is that there may be an increased risk of disability, mental health challenges, and harmful behaviors such as smoking and drinking for LGBTQ patients who are unable to access care. Due to health disparities experienced by older members of this community, “lesbians and bisexual women have a higher risk of cardiovascular disease and obesity, and bisexual men have a higher risk of poor physical health and living alone than did heterosexuals” (Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013, p. 1802).

The Effects of Stigma on Health Care

The medical community maintains many pervasive and harmful narratives that blame the patient for their condition—as is often the case with mental illness, obesity, type 2 diabetes, and cardiovascular disease. As mentioned with sexual orientation, physicians have erred in their characterization of many patient populations. The assertion of blame in these situations has contributed to the harmful social acceptance of these biases. Individuals that are characterized with blame also lack in-group protection due to internalization of stigmatization. For example, McHugh and Kasardo (2012) examined the research of anti-fat bias, which found that anti-fat bias is held by people of all weight groups, demonstrating lack of in-group protection. In the case of obesity, the medical community has contributed to this internalization of blame and stigma with the body mass index which has associated weight/height with health (Burgard, 2009).

Weiner, Perry, and Magnusson (1988) studied the cause of stigma in medical students, as it related to diseases perceived to be self-inflicted (low vs high personal responsibility). Low responsibility diseases (e.g., cancer) were received with sympathy and increased attention to the patient, whereas high responsibility diseases (e.g., obesity, type 2 diabetes, and addiction) were received with disgust and anger. In a meta-analysis, Phelan et al. (2015) suggest “negative feelings such as disgust, anger, blame, and dislike” are common reactions (p. 322). They also report that some medical providers prefer not to treat obesity and express their concern about patients’ willingness to make lifestyle changes (p. 322). Irrespective of the volume of literature indicating how little control we have over our weight, patients affected by obesity are often disrespected by their providers and, thus, are reluctant to discuss their weight (Brown, Thompson, Tod, & Jones, 2006). Phelan and colleagues demonstrated that three important differences occur when providers care for patients with obesity: “First, primary care providers engage in less patient-centered communication with patients they believe are not likely to be adherent;…. Second, primary care providers have reported less respect for patients with obesity compared with those without…. Third, primary health care providers may allocate time differently, spending less time educating patients with obesity about their health” (p. 321). Finally, research shows that because of stigma and discrimination, patients with obesity are more likely to experience substandard health care, which then impacts health care utilization (Puhl & Heuer, 2010).

As outlined above, health care disparities can be seen in many populations and are pronounced in minority patient populations. As the landmark IOM study (Smedley et al., 2002) concluded, many of these disparities are attributable to provider stigma and bias. Below we will review the literature documenting the presence of bias in physicians and discuss how that bias can affect medical decision-making and contribute to health care disparities.

Physician Bias

Upon graduation, all physicians recite an oath, widely believed to be written in the fourteenth century BC, by Hippocrates, the father of Western medicine:

> I solemnly pledge to consecrate my life to the service of humanity; I will give to my teachers the respect and gratitude that is their due; I will practice my profession with conscience and dignity; The health of my patient will be my first consideration; I will respect the secrets that are confided in me, even after the patient has died; I will maintain by all the means in my power, the honor and the noble traditions of the medical profession; My

> colleagues will be my sisters and brothers; I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient; I will maintain the utmost respect for human life; I will not use my medical knowledge to violate human rights and civil liberties, even under threat; I make these promises solemnly, freely and upon my honor.
> (Hippocrates, c 400 bc)

Physicians pledge to do no harm to patients and to provide the best possible care regardless of the patient's background. However, despite public declaration of these egalitarian values, it is also known that physicians' implicit biases may betray their explicitly held values in ways that cause them to discriminate against patients, oftentimes, without even knowing that they are doing so.

Implicit biases may be especially problematic in health care settings, because they host the perfect combination of conditions under which bias can become manifest. Health care settings are stressful, there are time pressures, and doctors are often called upon to multitask; these conditions can serve as a breeding ground for use of cognitive heuristics, such as implicit bias (White, 2011). This produces a significant cognitive load for doctors, which can set the occasion for them to rely on implicit bias to guide their patient interactions and even decision-making (Burgess, 2010).

There is a sizeable body of literature that documents the presence of bias in physicians. A 2004 report by the Sullivan Commission on Diversity in Healthcare Workforce (Sullivan, 2004) noted that health care professionals are subject to the same cultural biases and attitudes as the general public. The report stated, "At the personally mediated level, racism in health care can operate in the personalized form of prejudice, stereotype, or bias and can result in discriminatory actions (or inactions; pp. 41–42)."

In addition to implicit bias, physicians have been noted to have more negative *explicit* biases toward Black patients than Whites, and patient characteristics have been shown to affect physicians' perspectives (van Ryn & Burke, 2000). Explicit bias refers to consciously held attitudes or beliefs about groups of people. For example, one study showed that physicians perceived Black patients with low and middle socioeconomic status more negatively than they perceived White and more affluent patients. Specifically, patients who were Black were perceived to be less intelligent, more likely to engage in risky behavior, and less likely to be adherent with treatment recommendations. Physicians also reported less feelings of affiliation, or connection, with patients who were Black. Additionally, patients who were low or middle SES were perceived to be less adherent with cardiac rehabilitation, to desire a physically active lifestyle, to have career demands, to have adequate social support, and to have responsibility for care of a family member (van Ryn & Burke, 2000). Other studies have documented negative explicit biases including stereotypes about nonadherence in Black patients (Bogart, Catz, Kelley, & Benotsch, 2001; Lutfey & Ketcham, 2005). Furthermore, these negative explicit biases have been associated with racial disparities and may mediate treatment decisions (Bogart et al., 2001; van Ryn, Burgess, Malat, & Griffin, 2006), as will be reviewed below.

In addition to explicit bias, a wide body of literature has also established that many health care providers hold pro-White and anti-Black implicit biases (Cooper et al., 2012; Green et al., 2007; Haider et al., 2011; Sabin, Nosek, Greenwald, & Rivara, 2009). For example, a study using vignette-based clinical assessments with first-year medical students asked students to take an assessment of implicit bias, the Implicit Association Test (IAT; Greenwald, McGhee, & Schwartz, 1998), and results showed that the majority of students had pro-White bias as well as implicit preference for those in the upper class (Haider et al., 2011). Sabin et al. (2009) gave the race attitude IAT to a sample of over 400,000 test takers, including over 2500 physicians. The researchers found that the physicians, similar to the general public, showed an implicit preference for Whites relative to Blacks. When race of the physician taking the test was analyzed, the researchers found that Black doctors did not show an implicit preference for Blacks or Whites, on average. Furthermore, an analysis of physician gender revealed that female doctors showed less implicit bias than did male doctors. As is the case with explicit biases, negative implicit biases have also been associated with stereotypes about patient nonadherence (Cooper et al., 2012; Green et al., 2007; Sabin, Rivara, & Greenwald, 2008).

The literature not only documents that physicians hold implicit biases, but that these biases can affect their behavior. Implicit attitudes are closely associated with physicians' nonverbal behavior, such as body language (Dovido, Kawakami, & Gaertner, 2002). A physician's implicit bias is likely to influence his or her facial expression, eye contact, warmth, and other nonverbal behaviors, which could impact communication and the doctor-patient relationship. These factors, in turn, could impact physician decision-making, quality of care, and patient outcomes (Sabin et al., 2009).

Bias and Medical Decision-Making

A physician's bias can result in poorer health outcomes for patients as a result of the way in which physicians interact with them and make medical decisions about them. Many research studies document the ways in which physician racial implicit biases have been shown to impact doctor-patient communication. Hagiwara, Dovido, Eggly, and Penner (2016) found that non-Black physicians with higher levels of implicit racial bias were more likely to use first-person plural pronouns (e.g., we, us, our) rather than first-person singular pronouns (e.g., I, me, my) as well as use anxiety-related words (e.g., nervous, worry), when interacting with Black patients. Studies examining the race of physicians and patients in medical interactions show that the makeup of the dyad can impact the quality of communication. For example, communication is poorer in racially discordant interactions, as when a non-Black physician talks with a Black patient, as compared with the quality of communication in racially concordant interactions (Dovido et al., 2008; Penner et al., 2010; Penner, Albrecht, Coleman, & Norton, 2007).

To make matters worse, studies show that patients perceive their doctor's biases and this perception can erode the trust that patients have in their doctors' treatment recommendations, which can lead to poor adherence and ultimately result in poor health outcomes. For example, Penner and colleagues (2016) studied interactions between non-Black oncologists, who were asked to take the race IAT, and Black cancer patients. These researchers found that oncologists with higher levels of implicit bias had shorter interactions, and patients of these physicians found them to be less patient-centered. Patients reported that this perception of physician bias made them less likely to remember the interaction and feel less confident about the doctors' recommendations regarding treatment. Researchers concluded that physician racial implicit bias is a likely contributor to health care disparities.

Specifically, Penner and colleagues (2010) found that a particular combination of physician bias resulted in negative patient interactions. Aversive racism is when a physician is low in explicit bias and high in implicit bias. Black patients responded more negatively to physicians who were classified as aversive racists than those with any other combination of implicit and explicit racism. The researchers hypothesized that "the inconsistency between positive overt expression and negative subtle displays may be particularly problematic because this kind of mismatch is generally perceived to reflect deceitfulness… which can be especially detrimental in interracial interactions that are often characterized by intergroup mistrust" (Penner et al., 2010, p. 437).

Physicians' implicit biases have been linked with medical decision-making using clinical vignettes (Green et al., 2007; Sabin et al., 2008, 2009). The literature also documents that clinicians demonstrate differences in clinical decision-making based on the patient's race, including in areas of patient joint replacement and procedures to save a patient's limbs (White, 2011), cardiovascular interventions (Green et al., 2007; Mezu, Ch, Halder, London, & Saba, 2012; Steiner & Miller, 2008), and pain management (Burgess, VanRyn, Crowley-Matoka, & Malat, 2006; Epps, Ware, & Packard, 2008; Heins, Homel, Sadfar, & Todd, 2010; Telfer, Bahal, Lo, & Challands, 2014; Todd, Samaroo, & Hoffman, 1993).

Doctors having to make decisions about cardiovascular interventions are particularly subject to allowing implicit bias to impact decision-making, as these decisions often have to be made quickly in emergency settings. It is thought that biased thinking is most likely to occur when the physician is under stress and time pressure (White, 2011) and is experiencing high levels of cognitive load (Burgess, 2010). In this vein, it had been demonstrated in the literature that physicians were less likely to refer women and Black patients for cardiac catheterization than patients who were male or White (Schulman et al., 1999). However, it was unclear whether those health care disparities were due to implicit bias until Green and colleagues (Green et al., 2007) conducted a study in which physician's implicit bias was shown to be predictive of medical decision-making. These researchers asked resident physicians to take a race IAT and then evaluate a vignette in which a 50-year-old male presents to an emergency department with chest pain suggestive of an acute myocardial infarction (i.e., heart attack). Residents were randomly assigned to see a photo of either a Black male or a White male. They were asked whether they would give thrombolysis (clot-breaking treatment) and the strength of their conviction as to whether they would offer the treatment. Although the residents did not endorse any explicit bias, their race IAT showed pro-White, anti-Black bias, and this implicit bias predicted thrombolysis decisions in linear regression analyses. Specifically, results showed that as the degree of anti-Black bias on the race IAT increased, recommendations for thrombolysis for Black patients decreased. There was an opposite effect for White patients, such that as the degree of physicians' pro-White bias increased, so did their likelihood of treating White patients with thrombolysis. The researchers concluded that physicians' unconscious biases influence medical decision-making, which, in turn, can contribute toward health care disparities.

Since this landmark study, a number of additional studies have linked physicians' implicit biases to medical decision-making. Many of these studies are in the area of pain management, where it has been shown that Black patients receive pain medications less frequently and in smaller quantities than White patients. A literature review performed by pain experts (Green et al., 2003) noted racial disparities in perception, assessment, and treatment of pain in all settings and across all types of pain. One study found that in emergency department settings, White patients with pain were significantly more likely to receive an opioid analgesic (31%) than Black (23%) or Hispanic (24%) patients, and shockingly, these racial differences were found to be even more pronounced with increasing severity of pain reported by patients (Fletcher, Kertesz, Kohn, & Gonzales, 2008). Similarly, racial disparities in provision of epidural analgesia have been found, with epidural analgesia being provided less often to Black women (49.5%) and Hispanic women (35.3%) than White women (59.6%; Rust et al., 2004). Racial disparities in opioid prescribing have even been detected for Black and Hispanic children (Fletcher et al., 2008). For example, Black children presenting with appendicitis in emergency departments were less likely to receive analgesia than White children (Goyal, Kuppermann, Cleary, Teach, & Chamberlain, 2015).

Noting the systemic undertreatment of pain in Black patients compared to White patients, Hoffman, Trawalter, Axt, and Oliver (2016) set out to determine whether the bias was related to beliefs about biological differences between Black and White patients, such as the perception that Blacks experience less pain than Whites. The researchers surveyed laypersons and students at various points in their medical training (first year, second year, third year, and residents) and found that a significant number of laypersons as well as individuals in medical training endorsed false beliefs about biological differences, such as "Blacks' nerve endings are less sensitive than whites'" and "Blacks' skin is thicker than Whites'." The researchers postulated that these false beliefs may have stemmed from ideologies championed by slave owners and scientists to justify slavery. Hoffman's data also indicated that participants who endorsed more false beliefs about biological differences showed a racial bias in the accuracy of their treatment recommendations for pain management. They concluded that doctors in training demonstrated racial bias in pain perception and that this bias could be contributing to health care disparities seen between Black and White patients in prescriptions around pain management.

The literature clearly demonstrates that physicians hold explicit and implicit biases and that these biases can impact the doctor-patient relationship and medical decision-making, which in turn can lead to health care disparities. The Association of American Medical Colleges acknowledges physician bias and so do many specialty associations, such as American Pediatric Association, calling for the need to educate doctors about bias and how to mitigate it. Next, we will review the literature on best practices to mitigate prejudice, including acceptance and commitment training (Hayes, Strosahl, & Wilson, 2012), and review how one school of medicine has implemented a curriculum to combat bias.

Remediation Strategies

Making the Case for Effective and Coherent Remediation Packages

As noted above, in both the literature and in clinical settings, it has become increasingly clear that despite publicly endorsed egalitarian values, health care professionals, like all human beings, unintentionally contribute to health care disparities. In order to effectively treat an increasingly diverse population, it is critical that all medical professionals not only understand the diverse cultures and backgrounds of their patients, but also their own well-established learning histories related to those cultures and backgrounds. Of even more importance is that they understand how their learning histories impact their evaluations and interactions, even when they do not intend this. This calls for more focus on learned prejudice, stereotypes, and bias. Although a number of studies have investigated how awareness, through introspection and formal measures of implicit bias might impact behavior change, few have offered well-rounded, empirically supported recommendations that teach providers what they can do to manage implicit bias. Moreover, even fewer studies have focused on changing the function of those thoughts (prejudicial thoughts) instead of the form or content of the thought alone. The remainder of this chapter will review current literature on remediation strategies and identify ways in which limitations might be addressed to ensure physicians learn skills that improve their interactions with patients and potentially eliminate health care disparities.

In light of the fact that an extensive literature now provides remediation strategies for prejudice and implicit bias, it is important to first consider the challenges some of those strategies and the conceptual or theoretical frameworks that support them, occasion. Stated more precisely, many of the pre-analytic assumptions and theories about implicit bias (or any other automatic cognitive process) appear to conflict with experimental outcomes. While theorists argue that implicit bias is unconscious, uncontrollable, and inflexible, empirical findings indicate that implicit bias is malleable and controllable. Accordingly, we will discuss the ramifications of incoherent conceptual, theoretical, and methodological approaches to treating automatic prejudice and implicit bias before turning our attention to specific remediation strategies (for a more detailed overview of these challenges, see Hughes, Barnes-Holmes, & Vahey, 2012).

In much of the literature regarding remediation strategies, automatic private experiences we are unaware of are termed unconscious. This is based on the premise that some bias is "activated involuntarily, without awareness or intentional control" (Staats et al., 2017, p. 10). This conceptualization has been proposed by both traditional and contemporary researchers who have long posited that regardless of conscious effort, automatic stereotypes and prejudice will often prevail over conscious intentions (Bargh, 1999; Devine, 1989; Greenwald & Banaji, 1995). Underlying this line of thinking is the presumption that unconscious bias (also called implicit bias) is inflexible and impervious to deliberate efforts to control its effects. Bargh (1994, 1999) asserts that the automaticity of the event appears to bypass awareness and attentional control. However, related and recent empirical findings have incited dialogue concerning conceptual discrepancies and now have researchers reconsidering some of the defining characteristics of automatic processes (Blair, 2002). For example, though unconscious biases are said to be activated automatically, determining criteria for automatic processes has proven difficult and most researchers consider a psychological event automatic if it has been consensually agreed upon by multiple observers (Blair, 2002). Theoretical gaps leave much to be desired and are likely responsible for many of the divergent definitions and explanations. This is problematic for several reasons; let us first consider conceptual discrepancies.

Contrary to initial—but still widely touted—theoretical underpinnings, implicit bias is also described as malleable, which suggests it is subject to change with enough training; this assertion is supported by growing evidence (see Blair, 2002; Devine, Forscher, Austin, and Cox 2012). Research also shows implicit bias can be influenced by context (i.e., it is more or less likely across different socially sensitive contexts and social instructions; Dasgupta & Greenwald, 2001; De Houwer, 2001, 2006; Hughes & Barnes-Holmes, 2011; Lowery, Hardin, & Sinclair, 2001; Nier, 2005). Specifically, findings suggest automatic processes are sensitive to contextual factors and stimuli (even those assumed to be the same) that evoke implicit bias in one context do not necessarily evoke that same type of response in another context. Therefore, the assumption that unconscious bias is inflexible, uncontrollable, and unconscious is challenged once again, drawing more attention to defining features of automatic processes. Moreover, it might be argued that automaticity does not equate to a lack of awareness. In fact, the aforementioned findings suggest otherwise, raising a number of empirical questions. For this reason, some researchers have abandoned the use of the term "unconscious bias" in favor of the term, "implicit bias." As such, implicit bias is the preferred term throughout this chapter.

As outlined above, the disconnect between empirical findings and traditional conceptualizations/defining features of implicit bias is becoming more apparent and, thus, problematic. Above all, a number of strategies and interventions are not supported by a coherent framework, leaving them to serve as stand-alone interventions. Even more problematic is the tendency to "mix and match" terminology, methodologies, and theories that do not serve the overarching goals of a research program (Hughes et al., 2012, p. 34). This brings us to our final point on the dangers of incoherence: investigatory practices and application should be influenced by scientific values and goals and should not become a "casserole" of conflicting, incoherent approaches. To illustrate, let us consider one of the most widely used and well-known measures of implicit cognition/bias, the Implicit Association Test (IAT; Greenwald et al., 1998).

Many researchers use the IAT to obtain an indirect measure of implicit bias because mental constructs cannot be observed directly. Therefore, the primary way of understanding implicit bias and how it is established is to study behavior and then infer automatic mental processes are what influence that behavior. The IAT relies on the assumption that behavioral outcomes (i.e., latency scores on IAT) can be used as proxies for mental associations (De Houwer, 2011) and, thus, "shape the theoretical understanding of mental constructs" (Barn-Anan, Nosek, & Vianello, 2009, p. 329). Though a more elaborate discussion is beyond the scope of this paper, it should be noted that this, too, leaves gaps in the literature because it rests on the idea that mental associations cannot be studied directly or manipulated. If these mental associations cannot be studied or manipulated, how do we know they are malleable or what we are doing actually results in a meaningful change?

Several systematic reviews of the literature on implicit bias in health care report that a large proportion of studies rely on the IAT, or related time sensitive tests, to determine the effects of various interventions (for an extensive review of the literature, see Fitzgerald & Hurst, 2017; Hall et al., 2015). While observed changes are commendable, what is of critical importance in clinical settings is a change in observable, patient-related behavior (e.g., physician-patient interactions, appropriate treatment recommendations, etc.) and few, if any studies, have been able to achieve this outcome. Equally important is the need to provide further evidence that changes in IAT scores also correlate with changes in prosocial, egalitarian behavior. Though a number of studies have demonstrated that the IAT is able to predict responding in some contexts, what is of critical importance is that those implicit responses and corresponding behavior (e.g., medical decision-making) are managed or changed. Moreover, they should generalize across settings, people, and behaviors, because, as we mentioned, mental constructs cannot readily (at this time) be manipulated. Unfortunately, for many researchers predicting and influencing behavior is not a scientific goal and prediction alone takes precedence (Hughes et al., 2012). One way of addressing the issue is to ensure both theoretical and methodological treatments of implicit bias align with their scientific goals, a point we will come back to later in the chapter.

A Broader Look at the Literature

If we take a moment to recall the effects of prejudice and implicit bias in health care that were outlined early in the chapter, it should come as no surprise that these well-documented, pervasive, and deleterious effects incited a clarion call for a solution: a solution that would address the problem directly and, in turn, reduce prejudice and discrimination. So, to this end, a number of researchers embarked on an empirical journey that would determine, contrary to traditional beliefs, implicit bias could be mitigated by a plethora of actions. The most recent and ubiquitous recommendations across the literature include mindfulness, perspective taking and empathy building, pursuit of values, and exposure to out-groups. While this list is not exhaustive, it does highlight strategies and skills that have been empirically tested across a number of conditions, both individually and collectively.

Treatment Packages Emphasizing Skills Training

In service of creating an effective intervention package, Devine, Forscher, Austin, and Cox (2012) developed a multipronged, habit-breaking intervention to reduce implicit bias. Culled from a list of empirically supported implicit bias reduction strategies, but slightly adapted to fit the needs of the study, the researchers tested five strategies across a 12-week period: selected strategies were stereotype replacement, counter-stereotypic imaging, individuation, perspective taking, and increasing opportunities for contact. Results showed that collectively, the aforementioned strategies reduced implicit bias, as measured by the IAT, and increased participants' self-reported concern about discrimination. Additionally, effects lasted up to 8 weeks, suggesting behavioral training has the potential to influence the long-term regulation of bias. This critical finding supports arguments put forth by many behavior scientists: a behavior-focused training, where implicit bias is treated as conditioned behavior, is most successful when it uses established principles of learning. Supporting this claim, in their analyses, Devine and colleagues compared implicit biases to habits, emphasizing their similarities. Furthermore, they argued that a better understanding of the contexts or conditions that occasion these implicit biases is required if one is to effectively "[break] the habit" (p. 2). They also stated, "the prejudice habit model could be strengthened through obtaining measures of the specific behavioral process (e.g., use of a particular strategy or set of strategies) required to produce change in implicit bias, concern, and personal awareness" (p. 13). In other words, to better understand how to effectively manage implicit bias, a behavioral approach should be considered. The benefits of this approach will be discussed later in the chapter.

Taking empirical findings and other ideas for reducing bias into account, Stone and Moskowitz (2011) offered recommendations specific to medical decision-making. They made the case that traditional approaches, such as cultural competence training, might unintentionally increase the likelihood that medical professionals categorize patients based on irrelevant assumptions about their social identities (e.g., gender). They go on to suggest that this approach only perpetuates stereotypes. By relying entirely on cultural knowledge, providers apply generalizations that may or may not be valid, which potentially affects their treatment recommendations. Therefore, Stone and Moskowitz discussed the benefits of implicit bias training over cultural competence training and outlined how trainings should be conducted for optimal results. It can be argued that their recommended training, which places an emphasis on teaching skills to reduce and manage implicit bias, might supplement medical professional's cultural competence training and, ultimately, result in better treatment outcomes.

Mindfulness

The call for skills-focused training is beginning to permeate the literature. Researchers are now making the argument that trainings focused solely on procedural knowledge should be abandoned in favor of skills-focused trainings that have a better chance of mitigating bias in the long run (Burgess, Beach, & Saha, 2017). For instance, mindfulness as a skill has proven useful across a plethora of conditions. It allows one to focus on the present moment: noticing thoughts, bodily sensations, and environmental cues in a nonjudgmental and compassionate way. Accordingly, it can be employed as a "mode of awareness," utilized across settings and situations (Burgess et al., 2017, p. 373). This is critical to managing implicit bias as it increases contact with thoughts and sensations that are often fleeting and unnoticed. Moreover, the nonjudgmental treatment of these thoughts can promote productive behavior (e.g., identifying how those thoughts came about and what can be done to ensure they are not harmful) and reduce less productive behavior (avoidance and negative thought suppression).

To speak to its effectiveness, Leuke and Gibson (2015) examined the effect of a 10-minute mindfulness meditation exercise on implicit biases, measured by the IAT. They found that participants who completed a 10-minute mindfulness exercise showed less implicit bias than participants who did not complete the mindfulness activity. In a follow-up study (Leuke & Gibson, 2016), the researchers applied the same intervention; however, they added a game condition in which the participants had to decide how much they trusted their partner. In this study, the researchers found that participants who completed the mindfulness activity were more likely to trust Black and White partners "almost identically" in an interracial game (p. 39). Similar conclusions have been reported by other researchers using comparable techniques (Burgess et al., 2017; Fabbro, Crescentini, Matiz, Clarici, & Fabbro, 2017; Leuke & Gibson, 2015).

Perspective Taking and Values

Another skill that is recommended frequently across disciplines is perspective taking (Benforado & Hanson, 2008; Galinsky & Moskowitz, 2000; Gutierrez et al., 2014; Todd & Galinsky, 2014). Defined more generally as having the ability to see the world from the perspective of a conceptualized "other," when taught effectively, this skill allows one to imagine the difficult situations stigmatized/marginalized people face daily. It has also reportedly increased the ability to empathize, a skill that seems to frequent a smaller proportion of the literature, but is central to change (Todd & Galinsky, 2014).

While perspective taking permits one to psychologically share identity of another person, this activity is pointless if the individual sees no value doing so. Stated more precisely, in order to increase the probability of one engaging in perspective taking, it is useful to target motivation related to that activity by helping that individual construct their personal values, thereby altering the reinforcing function of activities like perspective taking (Hayes, Strosahl, & Wilson, 2012). When an individual is taught to construct and state their values in a way that highlights the importance of egalitarian behavior (pro-diversity, equity, and inclusion), they will find that it is easier to understand and implement tactics for managing bias (such as perspective taking). To demonstrate, Byrne and Tanesini (2015) make the case that individuals can learn new associations through repeated opportunities to "act out their avowed commitment to [their] values" (p. 1259). They suggest this pursuit of goals becomes habitual and, thus, replaces old biased habits with new, egalitarian ones. Namely, it is through a program of habit formation (i.e., continuous practice and feedback) that goals acquire the ability to be activated automatically under certain conditions (e.g., in the presence of a minority group). Habit formation, they argue, promotes an ongoing engagement with goals, surpassing the limitations of "one-shot" trainings that focus solely on awareness. From Byrne and Tanesini's perspective, attending a lecture or presentation on strategies to reduce bias and being provided the opportunity to implement those strategies—through continuous practice, feedback, and reflection—are two very different activities. The latter needs to be implemented in conjunction with other strategies (i.e., lectures), if we want to effect change.

Although the assertion that egalitarian goals can reduce bias has been supported empirically (Moskowitz & Li, 2011), it proposes another issue: a theoretical flaw. As illustrated above, much of the research on egalitarian goals is supported by the idea that the continuous pursuit of goals, through practice, feedback, and reflection, results in the automatic activation of those goals in the future. Considering goals are nothing more than statements of desired action/outcomes, it seems more plausible that repeated opportunities to interact with individuals they might have biases against is what allows one to build new associations and relations that make negative biases less salient in the future. That is, through the presentation of multiple opportunities to interact positively with members of historically marginalized or stigmatized groups, those individuals come to acquire positive functions that automatically evoke positive associations or relations instead of negative ones. This is not to say egalitarian goals are unimportant, but rather it is through committed action associated with the goal, taken in the service of a larger value such as the Hippocratic Oath, individuals come to interact with others more often, establishing new functions, associations, and relations (for a detailed account of this process, see Hayes, Barnes-Holmes, & Roche, 2001, p. 202; for an overview of committed action and values, see Hayes, Strosahl, & Wilson, 2012). Once these new functions are acquired, the marginalized group member can evoke new associations and relations. This does not require the activation of goals.

It is worth noting that the same argument might also apply to the other empirically investigated strategies, such as approach-avoidance training (Kawakami, Phills, Steele, & Dovidio, 2007). That is, through repeated opportunities to interact (approach or avoid) with hypothetical members of marginalized groups, those members come to acquire new functions, evoking different automatic responses (i.e., associations or relations). However, given the contrived laboratory setting and the feasibility of this type of training for large groups with a vast array of established histories, it might be best to use a more pragmatic and easy-to-implement strategy, like goal setting, if it is just as effective. Goal setting also has the potential to generalize to other settings and social groups, as it does not limit its focus to one topic (e.g., race, sexual orientation, religion, etc.) or context. If this connection seems implausible since in-person interactions are formally different from online games, it might be helpful to consider how photos, words, and sounds have the ability to acquire the same functions people do. It is possible that the photos in the task Kawakami and colleagues use (pushing or pulling a joy stick toward or away from photos) have acquired the perceptual functions of the stimuli they represent (Hayes et al., 2001). Also worth noting is the complexity of language and the ability of repeated rules and instructions to influence behavior (see Hayes et al., 2001; Van Dessel, Gawronski, Smith, & De Houwer, 2017).

In this vein, it is important to revisit the benefits of using coherent theoretical and methodological approaches to manage bias. It would be remiss of us to not give credit to the researchers who have made great strides in identifying ways in which implicit bias could be mitigated; however, few studies have conducted a component analysis or thorough review on the additive effects each skill brings. Moreover, even fewer have developed comprehensive packages that have precision, scope, and depth (Hayes, Barnes-Holmes, & Wilson, 2012). Most approaches are developed from a wide range of philosophical and theoretical models, and when multiple skills are combined, they are sometimes supported by conflicting theories. One way of ameliorating this issue is to consider a far-reaching and empirically supported approach whose strategies and skills are grounded in a coherent philosophical and theoretical foundation: one like acceptance and commitment training (ACT; Hayes, Strosahl, & Wilson, 2012). Even more encouraging is it does so in a way that aligns with previously recommended strategies.

Using Acceptance and Commitment Training (ACT) to Address Prejudice

Based on relational frame theory (RFT), ACT treats prejudice as a "generalized verbal process that involves normal and useful language abilities gone awry" (Lillis & Levin, 2014, p. 182). It recognizes that as one of our greatest assets, language allows human beings to learn narratives, heuristics, rationalizations, and rules; but it is also our heaviest burden, influencing some of our greatest pain and misery (Hayes, Strosahl, & Wilson, 2012). This pain and misery may be experienced by the individual or by the people with whom they interact. That is, the associations and relations we learn influence how we respond to our own thoughts about ourselves, but also how we respond to others. Unfortunately, this sometimes includes discriminatory action and prejudice. As a verbal process, prejudice is defined as:

> The objectification and dehumanization of people as a result of their participation in verbal categories. This expansive definition includes bias and discrimination directed at any group that can be identified by a verbal label, such as "Black," "White," "gay," "Muslim," or "woman," as well as "poor," psychotic," "addict," "handicapped," "obese," and so on. (Lillis & Levin, 2014, p. 182)

From an RFT perspective, human beings learn to arbitrarily relate stimuli, people, and events early in childhood (Berens & Hayes, 2007) and acquire the ability to derive a vast network of complex relations[1] that permit automatic (brief and immediate; Hughes et al., 2012) verbal evaluations (Hayes et al., 2001). The ability to verbally evaluate people based on their participation in verbal categories (i.e., social groups) is central to our normal verbal processes (Hayes & Lillis, 2007). These categories, or the people participating within these categories, acquire functions and can transform the function of related stimuli (or people), contributing to what we call prejudice, stigma, and implicit bias. Given that verbal evaluations are often automatic, it is possible that individuals do not notice their evaluative responses and are limited in their ability to self-report (Hughes et al., 2012). This may subtly influence discrimination. It is for this reason that targeting the verbal processes (i.e., categorization and relational responding) that interfere with our ability to evaluate and interact appropriately with members of marginalized and underrepresented groups is of critical importance.

Changing established relations that we learned early in life is no easy feat (Hayes et al., 2001; Hayes & Lillis, 2007). This is not to say new relations cannot be learned or that we cannot elaborate on already established relations, but, rather, that another avenue should be considered. Instead of focusing on thought topography or frequency, our analyses should focus on function and what one does when negative thoughts are present. By

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[1] Although the term association is used widely throughout the literature to refer to learned associations between stimuli, RFT proposes human beings learn to derive relations between stimuli that share no formal properties. That is, human beings can relate stimuli (both arbitrarily and nonarbitrarily) "in the absence of any direct reinforcement for doing so" (Hughes et al., 2012, p. 23). This includes complex relating that captures more than "sameness" (Hayes et al., 2001). For this reason, the terms relation, relating, and relate will be used instead of association.

taking this approach, we can reduce the impact and believability of negative thoughts (e.g., prejudicial thoughts and implicit bias) without having to directly change automatic thought content (Lillis & Hayes, 2007; Lillis & Levin, 2014). This is achieved through the implementation of ACT.

Acceptance and commitment training (ACT), a non-psychotherapeutic variation of acceptance and commitment therapy, is an empirically based method that reduces the impact of verbal processes, such as negative or prejudicial thoughts (Hayes et al., 2004). With over 250 randomized controlled trials (RCTs; Hayes, 2018) that point to its effectiveness, ACT has been applied to a broad range of psychological issues. For example, studies have shown that ACT improves mental health and innovation (Bond & Bunce, 2000), physical and psychological well-being (Donaldson-Feilder & Bond, 2004; Noone & Hastings, 2011), absenteeism (Bond, Flaxman, & Bunce, 2008), college performance (Chase et al., 2013), and worksite distress (Flaxman & Bond, 2010). ACT has also been shown to reduce stress, burnout, stigma, and prejudice (Brinkborg, Michanek, Hesser, & Berglund, 2011; Hayes et al., 2004; Lillis & Hayes, 2007). Using the psychological flexibility model, ACT aims to teach skills that reduce psychological inflexibility (e.g., avoiding members of stigmatized groups in fear of saying something offensive) and increase psychological flexibility (Levin et al., 2016). Psychological flexibility is promoted through six core processes/skills: flexible attention to the present moment, which includes awareness of one's private thoughts; defusion from problematic or unwanted thoughts; willingness to experience or accept that those thoughts are present; the ability to relate to oneself and to others through perspective taking; the ability to construct, choose, and state values; and the ability to commit to valued action (Hayes, Strosahl, & Wilson, 2012). This is achieved experientially (e.g., through visualization exercises and metaphors), which helps promote self-management (Hayes, Strosahl, & Wilson, 2012). Therefore, by focusing on these skills, ACT has the potential to decrease harmful discriminatory behavior (e.g., outgroup avoidance and ingroup favoritism) and promote more pro-social, egalitarian behavior.

Table 1 Areas of application examining the effects of ACT as it pertains to prejudice and stigma

Article	Areas of application
Hayes et al. (2004)	Stigmatizing attitudes and burnout of substance use counselors
Levin, Luoma, Lillis, Hayes, and Viladarga (2014)	Developing a measure of psychological flexibility with stigmatizing thoughts
Lillis and Hayes (2007)	Applying components of ACT to reduce prejudice
Levin et al. (2016)	Examining the role of psychological inflexibility, perspective taking, and empathic concern in generalized prejudice
Luoma, Kohlenberg, Hayes, Bunting, and Rye (2008)	Using ACT to reduce self-stigma for substance use
Luoma, Kohlenberg, Hayes, and Fletcher (2012)	RCT of ACT to target shame in substance use disorders
Masuda et al. (2007)	Impact of ACT versus education on stigma toward people with psychological disorders
Masuda et al. (2009)	Relation between psychological flexibility and mental health stigma in ACT
Masuda, Hill, Morgan, and Cohen (2012)	Using ACT to modulate the impact of stigma and prejudice
Yadavaia and Hayes (2012)	ACT for self-stigma around sexual orientation

Note: Areas of application include either the entire title or a summarized variation of the title

As Table 1 indicates, a number of studies have provided some promising insight on how a functional approach (ACT) can effectively address private experiences such as stigma, prejudice, and bias. In a controlled study, Hayes et al. (2004) were the first to apply ACT as an intervention for substance use counselors' stigmatizing thoughts toward their clients and/or individuals who use substances. Counselors were randomly assigned to one of three workshops, so that their effects could be compared: a 1-day (6-hour) ACT workshop, a multicultural training, or a lecture on the biological basis for methamphetamine use. It was concluded that ACT exercises were effective at reducing the impact of stigmatizing thoughts and attitudes. Furthermore, even though multicultural training was found to be effective immediately following the training, those effects were not maintained over time, whereas the ACT training group showed a reduction in the believability of negative thoughts at follow-up. Related to the utility of a functional approach to managing stigma, these findings suggest it was the change in the function of those stigmatizing thoughts, and not the form, that made a difference. This indicates ACT has the potential to be most effective at managing complex, well-established verbal processes over time. These findings also support a statement made by Stone and Moskowitz (2011) about how skill-focused trainings can enhance cultural competence training. In a clinical setting, cultural competence training provides physicians with important information about the cultures and backgrounds of their patients. Supplementing that training with ACT can help change the function of stereotypic thoughts so they do not affect treatment recommendations.

In a similar study, Masuda et al. (2007) investigated the effects of an ACT workshop, compared to an educational workshop, in reducing stigma toward people with psychological disorders. Although both interventions were effective at reducing mental health stigma, one of the most interesting findings was that if the therapists demonstrated high psychological flexibility prior to attending the workshop, both the educational workshop and ACT training were effective; however, only the ACT training significantly reduced mental health stigma in those with lower levels of psychological flexibility. This finding suggests ACT interventions are likely to work for participants of varying backgrounds and perspectives. Additionally, ACT processes that promote psychological flexibility through acceptance and defusion may successfully reduce thought suppression or avoidant behavior. Ironically, suppression is a counterproductive tactic that has actually been shown to produce the thoughts one is trying to suppress (Galinsky & Moskowitz, 2000). The reduction of suppression, resistance, and avoidance is of critical importance to any organization trying to implement trainings and policies on diversity, equity, and inclusion.

Finally, to further investigate its effects on various forms of prejudice, specifically racial and ethnic attitudes, Lillis and Hayes (2007) compared a class session on ACT to a multicultural diversity lecture. Following the 75-minute ACT lecture, participants were more likely to use the skills learned in the lecture, and there was an increase in positive behavioral intentions. This not only exemplifies the potentiality of a functional approach to well-established verbal processes, but raises the question: What might we expect from comprehensive ACT interventions to which participants are exposed for longer periods of time?

Overall, research has demonstrated that ACT has the potential to combat prejudice while simultaneously addressing some of the concerns highlighted across fields. Even more encouraging is the fact that it is built on a coherent and parsimonious framework that aims to understand, predict, and influence behavior with precision, scope, and depth (Hughes et al., 2012). In particular, its analytic goals are conducive to addressing the gaps highlighted throughout this chapter. Additionally, many of the established and emerging ideas regarding remediation strategies support or closely mirror ACT processes (see Table 2 for an overview of recommendations that can be targeted through ACT).

To speak directly to this point, consider the detrimental effects of thought suppression highlighted earlier in this section (Galinsky & Moskowitz, 2000). A combination of ACT processes—present moment awareness, cognitive defusion, perspective taking, values, and committed action—is a promising alternative. For example, through the process of defusion, the individual learns to separate negative thoughts from reality by altering their function (Hayes, Strosahl, & Wilson, 2012). In particular, let us consider prejudicial thoughts and stereotypes like “Black people are criminals.” Instead of allowing these thoughts to influence their actions (both evaluative and even avoidance behaviors), one learns to change the function or believability of

Table 2 Common recommendations and ACT processes that address them

Recommendation	ACT process
Awareness of automatic biases and prejudice	Present moment awareness combined with perspective taking (self-as-context)[a]
Perspective taking	Perspective taking (self-as-context)
Increased contact	Committed action
Avoiding thought suppression	Acceptance, values, defusion
Stereotype replacement	Defusion (often combined with other processes)
Egalitarian values and enhanced internal motivation	Values

Note: Although these processes have been separated to provide examples of how ACT processes map onto distinct categories and/or recommendations throughout the literature, remember that ACT promotes a process-based, functional approach to treatment and intervention (i.e., one should always consider function over form)

[a] Some refer to self-as-context as perspective taking or flexible perspective taking. Given that this chapter focuses on managing bias, the authors chose to use the term perspective taking to emphasize skills that can be used to manage thoughts about oneself and about others

that thought (just because they have the thought does not mean it is true). Lillis and Hayes (2007) propose that defusion is “a kind of decategorization” that “loosens behavior regulatory power” (Lillis & Hayes, 2007, p. 406). However, it is important to remember that all six ACT skills are often used together. You can see this if we expand a bit on the most recent example. That is, instead of staying fused with negative thoughts and then avoiding interaction, one can learn to willingly notice their thoughts (acceptance and present moment awareness) as products of their learning history (perspective taking) that do not necessarily have any truth to them (defusion) and then act (committed action) in a way that moves them in the direction of their chosen and stated values. This highlights the importance of psychological flexibility, but most importantly, it demonstrates how ACT can support and augment other reduction models. There is also a growing body of empirical evidence that indicates increased awareness, perspective taking, and contact are effective remediation strategies (mentioned earlier in this chapter). ACT processes provide an avenue for these recommendations to be achieved functionally.

At the same time, ACT workshops can be easily adapted to fit the needs of health care institutions. For instance, if ACT was incorporated into a variety of professional development programs, physicians would learn to use all six core processes (skills) to address maladaptive thoughts throughout their workday. By way of illustration, we will consider the following example depicting how this might be accomplished in a medical setting. Through flexible attention to the present moment, physicians would acquire the ability to notice their private experiences throughout the day. Specifically, the biased and prejudicial thoughts that impact their interactions. Flexible attention also facilitates the process of defusion and acceptance—these three processes make up what is traditionally referred to as mindfulness. Thus, in addition to noticing unwanted thoughts, they are willing (acceptance) to make contact or acknowledge the thought in a nonjudgmental, but constructive way (defusion and perspective taking with regard to one’s own behavior). This teaches the physician to acknowledge the thought for what it is (just a thought) instead of trying to suppress or avoid the thought. Finally, they can choose to act or behave in ways that are consistent with chosen values regarding patient-centered care. This committed action brings the physician into contact—often, in more positive ways—with members of marginalized groups, providing opportunities to create new relations or to build on established and learned relational networks. These skills can be utilized for any unwanted thought and generalize across settings. Although much work still has to be done to bring this vision to fruition, we will end with a brief review of one of the first attempts to do so.

Incorporating ACT into the Curriculum at a US Medical School

Just as physicians can hold bias toward patients who are different from themselves, they can also have self-stigma related to their own mental health. Inspired by a number of successful interventions that improve psychological well-being, a medical school on the western coast of the

United States created an interdisciplinary team of professionals to incorporate ACT into their curriculum to address this self-stigma. The integration of ACT was part of the organizational response to a staggering number of studies suggesting physicians are significantly more likely to experience burnout, therefore affecting their professional and personal interactions.[2] Although wellness programs have been developed nationwide to address the needs of students' mental health, the environments these individuals occupy and the manner in which mental health conditions are stigmatized in the medical profession make it difficult for these professionals to seek assistance. Oftentimes, the fear of being judged or criticized overrides concerns about health. That being said, it is of the utmost importance that this stigma and fear is addressed early in their careers. By introducing medical students to a curriculum-based program that prevents burnout, normalizes stress, and teaches them skills to manage their stress, medical schools can help prevent the deleterious ramifications of physician burnout (e.g., poor patient care and reduced professionalism).

The abovementioned interdisciplinary team uses behavioral assessment tools (i.e., the Implicit Relational Assessment Procedures; IRAP, Barnes-Holmes, Hayden, Barnes-Holmes, & Stewart, 2008) to obtain longitudinal measures of implicit bias concerning obesity, socioeconomic status, sexual orientation, burnout, and cooperation. Additionally, students are provided implicit measures at the individual level and attend lectures on implicit bias to learn about how it contributes toward health care disparities. To teach medical students effective ways of coping and managing stress and implicit bias (toward self and patients), the interdisciplinary team[3] created online ACT modules. These modules are integrated into the medical curriculum in two phases. Within the first year of medical school, before students are engaged in patient care, they are taught ACT skills to manage their self-stigma and stress. In their third year, when medical students are more clinically active, they learn how to use these skills to manage their biases as it relates to patient care, thus reducing the potential for errors. Through repeated exposure to ACT and accompanying implicit bias measures, medical students are provided with multiple and tiered opportunities to learn about and apply these skills, as they pertain to the current focus of medical school. Although this work is still being developed, it is worth noting that in addition to obtaining implicit behavioral measures, a simulated patient encounter has been created to obtain behavioral measures of empathy. This approach carries important implications for those looking to address prejudice and bias in health care. As an intervention package, it incorporates several of the strategies and recommendations reviewed in this chapter (Byrne & Tanesini, 2015; Hayes et al., 2004; Hayes & Lillis, 2007): (1) it uses an empirically supported intervention based on a coherent framework, (2) it teaches skills, (3) it is incorporated into the curriculum to avoid "one-shot" training practices, (4) it provides multiple opportunities to practice skills, and (5) behavioral measures on patient encounters are being collected in addition to implicit measures.

Conclusion

As the bedrock of human suffering and misery, language has proven to be both a gift and a curse. The complex verbal processes that are central to problem-solving and decision-making are also capable of harm. As the population becomes increasingly diverse, it is crucial that physicians not only understand and respect cultural differences, but that they are aware of how their implicit biases may impact treatment recommendations so that these biases don't betray their explicitly held values of upholding the Hippocratic Oath. Most importantly,

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[2] For related work on implicit bias and interprofessional communication, see Baker et al. (2015) and Maraccini, Houmanfar, Kemmelmeier, Piasecki, and Slonim (2018).

[3] The interdisciplinary team includes leaders in medical education, members of the Performance Systems and Technology Lab in the Behavior Analysis program (faculty and students), faculty from the School of Journalism, and medical students.

organizations and institutions who educate and employ physicians need to supplement their lectures with behavioral skills training that teaches physicians important skills they can use across a variety of settings to manage their prejudicial thoughts. As demonstrated throughout this chapter, ACT is an effective, empirically supported method that can be implemented across multiple settings to achieve this goal and, in turn, alleviate human suffering.

References

Allen, H., Wright, B. J., Harding, K., & Broffman, L. (2014). The role of stigma in access to health care for the poor. *The Milbank Quarterly, 92*(2), 289–318.

Alsan, M., Garrick, O., & Graziani, G. C. (2018). Does diversity matter for health? Experimental evidence from Oakland. *Stanford Institute for Economic Policy Research (SIEPR)*, 18-030.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association.

Baker, T., Schwenk, T., Piasecki, M., Smith, G. S., Reimer, D., Jacobs, N., … Houmanfar, R. A. (2015). Change in a medical school: A data-driven management of entropy. *Journal of Organizational Behavior Management, 35*, 81–94.

Bargh, J. A. (1994). The four horsemen of automaticity: Awareness, intention, efficiency, and control in social cognition. In R. S. Wyer Jr. & T. K. Srull (Eds.), *Handbook of social cognition* (pp. 1–40). Hillsdale, NJ: Erlbaum.

Bargh, J. A. (1999). The cognitive monster: The case against the controllability of automatic stereotype effects. In S. Chaiken & Y. Trope (Eds.), *Dual-process theories in social psychology* (pp. 361–382). New York, NY: Guilford Press.

Barn-Anan, Y., Nosek, B., & Vianello, M. (2009). The sorting paired features task. *Experimental Psychology, 56*(5), 329–343.

Barnes-Holmes, D., Hayden, E., Barnes-Holmes, Y., & Stewart, I. (2008). The implicit relational assessment procedure (IRAP) as a response-time and event-related-potentials methodology for testing natural verbal relations: A preliminary study. *The Psychological Record, 58*, 497–516.

Benforado, A., & Hanson, J. (2008). The great attributional divide: How divergent views of human behavior are shaping legal policy. *Emory Law Journal, 57*(2), 311–408.

Berens, N. M., & Hayes, S. C. (2007). Arbitraily applicable comparative relations: Experimental evidence for a relational operant. *Journal of Applied Behavior Analysis, 40*(1), 45–71.

Blair, I. V. (2002). The malleability of automatic stereotypes and prejudice. *Personality and Social Psychology Review, 6*(3), 242–261.

Bogart, L. M., Catz, S. L., Kelley, J. A., & Benotsch, E. G. (2001). Factors influencing physicians' judgments of adherence and treatment decisions for patients with HIV disease. *Medical Decision Making, 21*(1), 28–36.

Bond, F. W., & Bunce, D. (2000). Mediators of change in emotion-focused and problem-focused worksite stress management interventions. *The Journal of Occupational Health Psychology, 5*(1), 156–163.

Bond, F. W., Flaxman, P. E., & Bunce, D. (2008). The influence of psychological flexibility on work redesign: Mediated moderation of a work reorganization intervention. *Journal of Applied Psychology, 93*(3), 645–654.

Brinkborg, H., Michanek, J., Hesser, H., & Berglund, G. (2011). Acceptance and commitment therapy for the treatment of stress among social workers: A randomized controlled trial. *Behavior Research and Therapy, 49*, 389–398.

Brown, I., Thompson, J., Tod, A., & Jones, G. (2006). Primary care support for tackling obesity: A qualitative study of the perceptions of obese patients. *The British Journal of General Practice: The Journal of the Royal College of General Practitioners, 56*(530), 666–672.

Burgard, D. (2009). What is health at every size? In E. Rothblum & S. Solovay (Eds.), *The fat studies reader* (pp. 42–53). New York, NY: New York University Press.

Burgess, D. J. (2010). Are providers more likely to contribute to health care disparities under high levels of cognitive load? How features of the health care setting may lead to biases in medical decision making. *Medical Decision Making, 30*(2), 246–257.

Burgess, D. J., Beach, M. C., & Saha, S. (2017). Mindfulness practice: A promising approach to reducing the effects of clinician implicit bias on patients. *Patient Education and Counseling, 200*, 372–376.

Burgess, D. J., VanRyn, M., Crowley-Matoka, M., & Malat, J. (2006). Understanding the provider contribution to race/ethnicity disparities in pain treatment: Insights from dual process models of stereotyping. *Pain Management, 7*(2), 119–134.

Byrne, A., & Tanesini, A. (2015). Instilling new habits: Addressing implicit bias in health care professionals. *Advances in Health Science Education, 20*, 1255–1262.

Chase, J. A., Houmanfar, R. A., Hayes, S. C., Ward, T. A., Vilardaga, J. P., & Follette, V. (2013). Values are not just goals: Online ACT-based values training adds to goal setting in improving undergraduate college student performance. *Journal of Contextual Behavioral Science, 2*(3–4), 70–84.

Chetty, R., Stepner, M., Abraham, S., Lin, S., Scuderi, B., Turner, N., … Cutler, D. (2016). Association between income and life expectancy in the United States 2001–2014. *JAMA, 315*(16), 1750–1766.

Cooper, L. A., Roter, D. L., Carson, K. A., Beach, M. C., Sabin, J. A., Greenwald, A. G., & Inui, T. S. (2012). The association of clinicians' implicit attitudes about race with medical visit communication and patient ratings of interpersonal care. *American Journal of Public Health, 102*(5), 979–987.

Dasgupta, N., & Greenwald, A. G. (2001). On the malleability of automatic attitudes: Combatting automatic prejudice with images of admired and disliked individuals. *Journal of Personality and Social Psychology, 81*, 800–814.

De Houwer, J. (2001). A structural and process analysis of the Implicit Association Test. *Journal of Experimental Social Psychology, 37*, 443–451.

De Houwer, J. (2006). Using the implicit association test does not rule out an impact of conscious propositional knowledge on evaluative conditioning. *Learning and Motivation, 37*, 176–187.

De Houwer, J. (2011). Why the cognitive approach in psychology would profit from a functional approach and vice versa. *Perspectives on Psychological Science, 6*(2), 202–209.

Devine, P. G. (1989). Stereotypes and prejudice: Their automatic and controlled components. *Journal of Personality and Social Psychology, 56*(1), 5–18.

Devine, P. G., Forscher, P. S., Austin, A. J., & Cox, W. T. (2012). Longer-term reduction in implicit race bias: A prejudice habit-breaking intervention. *Journal of Experimental Social Psychology, 48*(2), 1267–1278.

Donaldson-Feilder, E., & Bond, F. W. (2004). The relative importance of psychological acceptance and emotional intelligence to workplace well-being. *British Journal of Guidance Counseling, 32*(2), 187–203. https://doi.org/10.1080/08069880410001692210

Dovido, J. F., Kawakami, K., & Gaertner, S. L. (2002). Implicit and explicit prejudice and interracial interaction. *Journal of Personality and Social Psychology, 82*(1), 4–27.

Dovido, J. F., Penner, L. A., Albrecht, T. L., Norton, W. E., Gaertner, S. L., & Shenton, J. N. (2008). Disparities and distrust: The implications of psychological processes for understanding racial disparities in health and health care. *Social Science and Medicine, 67*(3), 478–486.

Epps, C. D., Ware, L. J., & Packard, A. (2008). Ethnic wait time differences in analgesic administration in the emergency department. *Pain Management in Nursing, 9*(1), 26–32.

Fabbro, A., Crescentini, C., Matiz, A., Clarici, A., & Fabbro, F. (2017). Effects of mindfulness meditation on conscious and non-conscious components of mind. *Applied Science, 7*(4), 349–361.

Fisher, K. (2017). Gay, lesbian, and bisexual health care. *AAMC, 44*(December), 1634–1640.

Fitzgerald, C., & Hurst, S. (2017). Implicit bias in health care professionals: A systematic review. *BMC Medical Ethics, 18*, 19.

Flaxman, P. E., & Bond, F. W. (2010). Worksite stress management training: Moderated effects and clinical significance. *Journal of Occupational Health Psychology, 15*(4), 347–358.

Fletcher, M. J., Kertesz, S. G., Kohn, M. A., & Gonzales, R. (2008). Trends in opioid prescribing by race/ethnicity for patients seeking care in US emergency departments. *Journal of the American Medical Association, 299*(1), 70–78.

Fredriksen-Goldsen, K. I., Kim, H.-J., Barkan, S. E., Muraco, A., & Hoy-Ellis, C. P. (2013). Health disparities among lesbian, gay, and bisexual older adults: Results from a population-based study. *American Journal of Public Health, 103*(10), 1802–1809.

Galinsky, A. D., & Moskowitz, G. B. (2000). Perspective-taking: Decreasing stereotype expression, stereotype accessibility, and in-group favoritism. *Journal of Personality and Social Psycology, 78*(4), 708724.

Geronimus, A. T. (1996). Black/white differences in the relationship of maternal age to birthweight: A population-based test of the weathering hypothesis. *Social Science & Medicine, 42*(4), 589–597.

Goyal, M. K., Kuppermann, N., Cleary, S. D., Teach, S. J., & Chamberlain, J. M. (2015). Racial disparities in pain management of children with appendicitis in emergency departments. *JAMA Pediatrics, 169*(11), 996–1002.

Green, A. R., Carney, D. R., Pallin, D. J., Ngo, L. H., Raymond, K. L., Lezzoni, L. I., & Banaji, M. R. (2007). Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. *Journal of General Internal Medicine, 22*(9), 1231–1238.

Green, C. R., Anderson, K. O., Baker, T. A., Campbell, L. C., Decker, S., Fillingim, R. B., … Vallerand, A. H. (2003). The unequal burden of pain: Confronting racial and ethnic disparities in pain. *Pain Medicine, 4*(3), 277–294.

Greener, M. (2013). DSM-5: Rewriting the 'bible'. *Progress in Neuro-Psychopharmacology & Biological Psychiatry, 17*(5), 24–26.

Greenwald, A. G., & Banaji, M. R. (1995). Implicit social cognition: Attitudes, self-esteem, and stereotypes. *Psychological Review, 102*, 4–27.

Greenwald, A. G., McGhee, D. E., & Schwartz, J. L. (1998). Measuring individual differences in implicit social cognition: The implicit association test. *Journal of Personality and Social Psychology, 74*(6), 1464–1480.

Gutierrez, B., Kaatz, A., Chu, S., Ramirez, D., Samson-Samuel, C., & Carnes, M. (2014). "Fair play": A videogame designed to address implicit race bias through active perspective taking. *Games for Health Journal, 3*(6), 371–377.

Hagiwara, N., Dovido, J. F., Eggly, S., & Penner, L. A. (2016). The effects of racial attitudes on affect and engagement in racially discordant medical interactions between non-Black physicians and Black patients. *Group Processes & Intergroup Relations, 19*(4), 509–527.

Haider, A. H., Sexton, J., Sriram, N., Cooper, L. A., Efron, D. T., Swoboda, S., … Cornwell, E. E. (2011).

Association of unconscious race and social class bias with vignette-based clinical assessments by medical students. *Journal of the American Medical Association, 306*(9), 942–951.

Hall, W. J., Chapman, M. V., Lee, K. M., Merino, Y. M., Thomas, T. W., Payne, B. K., … Coyne-Beasley, T. (2015). Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes. *American Journal of Public Health, 105*(12), 60–76.

Han, X., Call, K. T., Pintor, J. K., Alarcon-Espinoza, G., & Simon, A. B. (2015). Reports of insurance-based discrimination in health care and its association with access to care. *American Journal of Public Health, 105*(3), S517–S525.

Hayes, S. C. (2018). *ACT randomized controlled trials since 1986*. [Press release]. Retrieved from https://contextualscience.org/ACT_Randomized_Controlled_Trials

Hayes, S. C., Barnes-Holmes, D., & Roche, B. (2001). *Relational frame theory: A post Skinnerian account of human language and cognition*. New York, NY: Kluwer Academic/Plenum Publishers.

Hayes, S. C., Barnes-Holmes, D., & Wilson, K. G. (2012). Contextual behavioral science: Creating a science more adequate to the challenge of the human condition. *Journal of Contextual Behavioral Science, 1*, 1–16.

Hayes, S. C., Bissett, R., Roget, N., Padilla, M., Kohlenberg, B. S., Fisher, G., … Niccolls, R. (2004). The impact of acceptance and commitment training and multicultural training on the stigmatizing attitudes and professional burnout of substance abuse counselors. *Behavior Therapy, 35*, 821–835.

Hayes, S. C., & Lillis, J. (2007). Applying acceptance, mindfulness, and values to the reduction of prejudice. *Behavior Modification, 31*(4), 389–411.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2012). *Acceptance and commitment therapy: The process and practice of mindful change* (2nd ed.). New York, NY: The Guilford Press.

Heins, A., Homel, P., Sadfar, B., & Todd, K. (2010). Physician race/ethnicity predicts successful emergency department analgesia. *Journal of Pain, 11*(7), 692–697.

Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *PNAS, 113*(16), 4296–4301.

Hughes, S., & Barnes-Holmes, D. (2011). On the formation and persistence of implicit attitudes: New evidence from the Implicit Relational Assessment Procedure (IRAP). *The Psychological Record, 61*, 391–410.

Hughes, S., Barnes-Holmes, D., & Vahey, N. (2012). Holding on to our functional roots when exploring new intellectual islands: A voyage through implicit cognition research. *Journal of Contextual Behavioral Science, 1*, 17–38.

Kawakami, K., Phills, C. E., Steele, J. R., & Dovidio, J. F. (2007). Distance makes the heart grow fonder: Improving implicit racial attitudes and interracial interactions through approach behaviors. *Journal of Personality and Social Psychology, 92*, 957–971.

Kraft, A. D., Quimbo, S. A., Solon, O., Shimkhada, R., Florentino, J., & Peabody, J. W. (2009). The health and cost impact of care delay and the experimental impact of insurance on reducing delays. *The Journal of Pediatrics, 155*(2), 281–285.e1.

Leuke, A., & Gibson, B. (2015). Mindfulness meditation reduces implicit age and race bias: The role of reduced automaticity of responding. *Social Psychological and Personality Science, 6*(3), 284–291.

Leuke, A., & Gibson, B. (2016). Brief mindfulness meditation reduces discrimination. *Psychology of Consciousness: Theory, Research, and Practice, 3*(1), 34–44.

Levin, M. E., Luoma, J. B., Lillis, J., Hayes, S. C., & Viladarga, R. (2014). The acceptance and action questionnaire-stigma (AAQ-S): Developing a measure of psychological flexibility with stigmatizing thoughts. *Journal of Contextual Behavioral Science, 3*, 21–26.

Levin, M. E., Luoma, J. B., Viladarga, R., Lillis, J., Nobles, R., & Hayes, S. C. (2016). Examining the role of psychological inflexibility, perspective taking, and empathic concern in generalized prejudice. *Journal of Applied Social Psychology, 46*, 180–191.

Lillis, J., & Hayes, S. C. (2007). Applying acceptance, mindfulness, and values to the reduction of prejudice. A pilot study. *Behavior Modification, 31*(4), 389–411.

Lillis, J., & Levin, M. (2014). Acceptance and mindfulness for undermining prejudice. In A. Masuda (Ed.), *Mindfulness & acceptance in multicultural competency* (pp. 181–196). Oakland, CA: New Harbinger Publications.

Lowery, B.S., Hardin,C.D., & Sinclair, S. (2001). Social influence effects on automatic racial prejudice. *Journal of Personality and Social Psychology, 81*(5), 842–855.

Luoma, J. B., Kohlenberg, B. S., Hayes, S. C., Bunting, K., & Rye, A. K. (2008). Reducing self-stigma in substance abuse through acceptance and commitment therapy: Model, manual development, and pilot outcomes. *Addiction Research and Theory, 16*(2), 149–165.

Luoma, J. B., Kohlenberg, B. S., Hayes, S. C., & Fletcher, L. (2012). Slow and steady wins the race: A randomized clinical trial of acceptance and commitment therapy targeting shame in substance use disorders. *Journal of Consulting and Clinical Psychology, 80*(1), 43–53.

Lutfey, K. E., & Ketcham, J. D. (2005). Patient and provider assessments of adherence and the sources of disparities: Evidence from diabetes care. *Health Services Research, 40*(6), 1803–1817.

Maraccini, A. M., Houmanfar, R. A., Kemmelmeier, M., Piasecki, M., & Slonim, A. D. (2018). An interprofessional approach to train and evaluate communication accuracy and completeness during the delivery of nurse-physician student handoffs. *Journal of Interprofessional Education & Practice, 12*, 65–72.

Markus, A. R., Andres, E., West, K. D., Garro, N., & Pellegrini, C. (2013). Medicaid covered births, 2008 through 2010, in the context of the implementation of health reform. *Women's Health Issues, 23*(5), e273–e280.

Masuda, A., Hayes, S. C., Fletcher, L. B., Seignourel, P. J., Bunting, K., Herbst, S. A., … Lillis, J. (2007). Impact of acceptance and commitment therapy versus education on stigma toward people with psychological disorders. *Behaviour Research and Therapy, 45*, 2764–2772.

Masuda, A., Hayes, S. C., Lillis, J., Bunting, K., Herbst, S. A., & Fletcher, L. B. (2009). The relation between psychological flexibility and mental health stigma in acceptance and commitment therapy: A preliminary process investigation. *Behavior and Social Issues, 18*, 25–40.

Masuda, A., Hill, M. L., Morgan, J., & Cohen, L. L. (2012). A psychological flexibility-based intervention for modulating the impact of stigma and prejudice: A descriptive review of empirical evidence. *Psychology, Society, & Education, 4*(2), 211–223.

McHugh, M., & Kasardo, A. (2012). Sex roles. Anti-fat prejudice: The role of psychology in explication, education and eradication. *Sex Roles, 66*(9–10), 617–627.

Mezu, U., Ch, I., Halder, I., London, B., & Saba, S. (2012). Women and minorities are less likely to receive an implantable cardioverter defibrillator for primary prevention of sudden cardiac death. *Europace, 14*(3), 341–344.

Moskowitz, G. B., & Li, P. (2011). Egalitarian goals trigger stereotype inhibition: A proactive form of stereotype control. *Journal of Experimental Social Psychology, 47*, 103–116.

Nier, J. A. (2005). How dissociated are implicit and explicit racial attitudes? A bogus pipeline approach. *Group Processes and Intergroup Relations, 8*, 39–52.

Noone, S. J., & Hastings, R. P. (2011). Values and psychological acceptance as correlates of burnout in support staff working with adults with intellectual disabilities. *Journal of Mental Health Research in Intellectual Disabilities, 4*(2), 79–90.

Penner, L. A., Albrecht, T. L., Coleman, D. K., & Norton, W. E. (2007). Interpersonal perspectives on black-white health disparities: Social policy implications. *Social Issues and Policy Review, 1*, 63–98.

Penner, L. A., Dovidio, J. F., Gonzalez, R., Albrecht, T. L., Chapman, R., Foster, T., … Eggly, S. (2016). The effects of oncologist implicit racial bias in racially discordant oncology interactions. *Journal of Clinical Oncology, 34*(24), 2874–2880.

Penner, L. A., Dovido, J. F., West, T. V., Gaertner, S. L., Albrecht, T. L., Dailey, R. K., & Markova, T. (2010). Aversive racism and medical interactions with Black patients: A field study. *Journal of Experimental Social Psychology, 46*, 436–440.

Phelan, S. M., Burgess, D. J., Yeazel, M. W., Hellerstedt, W. L., Griffin, J. M., & van Ryn, M. (2015). Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obesity Reviews, 16*(4), 319–326.

Puhl, R. M., & Heuer, C. A. (2010). Obesity stigma: Important considerations for public health. *American Journal of Public Health, 100*(6), 1019–1028.

Purnell, T. S., Luo, X., Cooper, L. A., Massie, A. B., Kucirka, L. M., Henderson, M. L., … Segev, D. L. (2018). Association of race and ethnicity with live donor kidney transplantation in the United States from 1995 to 2014. *JAMA, 319*(1), 49.

Rust, G., Nembhard, W. N., Nichols, M., Omole, F., Minor, P., Barosso, G., & Mayberry, R. (2004). Racial and ethnic disparities in the provision of epidural analgesia to Georgia Medicaid beneficiaries during labor and delivery. *American Journal of Obstetrics and Gynecology, 191*, 456–462.

Sabin, J. A., Nosek, B. A., Greenwald, A. G., & Rivara, F. P. (2009). Physicians' implicit and explicit attitudes about race by MD race, ethnicity, and gender. *Journal of Health Care for the Poor and Underserved, 20*(3), 896–913.

Sabin, J. A., Rivara, F. P., & Greenwald, A. G. (2008). Physician implicit attitudes and stereotypes about race and quality of medical care. *Medical Care, 46*(7), 678–685.

Schulman, K. A., Berlin, J. A., Harless, W., Kerner, J. F., Sistrunk, S., Gersh, B. J., … Escarce, J. J. (1999). The effect of race and sex on physicians' recommendations for cardiac catheterization. *The New England Journal of Medicine, 340*, 618–626.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: The National Academic Press.

Staats, C., Capatosta, K., Tenney, L., & Mamo, S. (2017). Race and ethnicity: Views from inside the unconscious mind. *State of the science: Implicit bias review*. Kirwan Institute for the Study of Race and Ethnicity, The Ohio State University.

Steiner, H. A., & Miller, J. M. (2008). Disparity in utilization of implantable cardioverter-defibrillators in treatment of heart failure based on sex and race. *Women's Health, 4*(1), 23–25.

Stone, J., & Moskowitz, G. (2011). Non-conscious bias in medical decision making: What can be done to reduce it. *Medical Education, 45*, 768–776.

Sullivan, L. W. (2004). *Missing persons: Minorities in health professions, a report of the sullivan commission on diversity in the health care workforce*. Durham, NC: Sullivan Commission.

Telfer, P., Bahal, N., Lo, A., & Challands, A. (2014). Management of the acute painful crisis in sickle cell disease – a re-evaluation of the use of opioids in adult patients. *British Journal of Haematology, 166*(2), 157–164.

Todd, A. R., & Galinsky, A. D. (2014). Perspective-taking as a strategy for improving intergroup relations:

Evidence, mechanisms, and qualifications. *Social and Personality Psychology Compass, 8*(7), 374–387.

Todd, K. H., Samaroo, N. N., & Hoffman, J. R. (1993). Ethnicity as a risk factor for inadequate emergency department analgesia. *Journal of the American Medical Association, 269*(12), 1537–1539.

Van Dessel, P., Gawronski, B., Smith, C. T., & De Houwer, J. (2017). Mechanisms underlying approach-avoidance instruction effects on implicit evaluation: Results of a preregistered adversarial collaboration. *Journal of Experimental Social Psychology, 69*, 23–32.

Van Ryn, M., Burgess, D., Malat, J., & Griffin, J. (2006). Physicians' perceptions of patients' social and behavioral characteristics and race disparities in treatment recommendations for men with coronary artery disease. *American Journal of Public Health, 96*, 351–357.

Van Ryn, M., & Burke, J. (2000). The effect of patient race and socio-economic status on physicians' perceptions of patients. *Social Science and Medicine, 50*(6), 813–828.

Weiner, B., Perry, R. P., & Magnusson, J. (1988). An attributional analysis of reactions to stigmas. *Journal of Personality and Social Psychology, 55*(5), 738–748.

White, A. A. (2011). Diagnosis and treatment: The subconscious at work. In *Seeing patients: Unconscious bias in health care* (pp. 199–210). Cambridge, MA: Harvard University Press.

Xu, J., Murphy, B. S., Kochanek, K. D., & Arias, E. (2016). NCHS data brief: Mortality in the United States, 2015 (Report no. 267). Hyattsville, MD: National Center for Health Statistics. Retrieved from https://www.cdc.gov/nchs/data/databriefs/db267.pdf

Yadavaia, J. E., & Hayes, S. C. (2012). Acceptance and commitment therapy for self-stigma around sexual orientation: A multiple baseline evaluation. *Cognitive and Behavioral Practice, 19*, 545–559.

Zhang, S., Cardarelli, K., Shim, R., Ye, J., Booker, K., & Rust, G. (2013). Racial disparities in economic and clinical outcomes of pregnancy among Medicaid recipients. *Maternal and Child Health Journal, 17*(8), 1518–1525.

Microaggressions, Marginalization, and Stress: Issues of Identity, Place, and Home for Minority Faculty in Academia

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Abstract

Social relations between racial minority faculty and dominant group (white) faculty are chronicled by racial and ethnic minority faculty through their narrative accounts in the research literature of microaggressions they experience in academia. Treating these narrative accounts as archival data can serve as a research strategy for understanding the presence and voice of racial and ethnic minority faculty in colleges and universities. I examine the experiences of racial and ethnic minority faculty found in the research literature. My examination of their experiences frames the context for discussing the social relations between minority faculty and dominant group faculty. I argue that an examination of the social relations of racial and ethnic minority faculty with dominant group faculty serves as a window for observing institutional practices that situate the presence of racial and ethnic minority faculty in academia and which, as a result, produce social and psychological stress for minority faculty regarding questions of identity, place, and home in the academic culture.

Keywords

Microaggressions · Stress · Minority faculty · Narrative accounts · Identity

Institutions of higher education are contested terrain for minority faculty. The academic culture restricts the access of minority faculty to opportunity and the climate is uninviting for minority faculty (Aguirre Jr., 2000). The presence and prevalence of a dominant (White) group ideology in shaping academia's culture and climate transposes the presence and participation of minority faculty as *matter out of place* – transgressors in a culture and climate not intended for their presence. I have borrowed the term *matter out of place* from Mary Douglas (1966). For example, McKay (1995: 50) has noted that colleges and universities are "rooted in the premises that informed Western culture's white, male-dominated, closed intellectual system for hundreds of years … elite was this system that for centuries it excluded everyone outside of its designated knowers, including Anglo-American women." One might observe that given the exclusion of minority faculty from *presence-defining* activities, such as career advancement, by the academic culture, minority faculty are subject to microaggressions that situate them as *matter out of place* (Pittman, 2012).

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© Springer Nature Switzerland AG 2020
L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_19

Is it possible to observe the types of microaggressions that target the presence of minority faculty in the academic culture? Aguirre Jr. (2000) and Aguirre Jr. and Martinez (2007) argue that the microaggressions minority faculty experience in academia are nested within the following indicators: the expectation that minority faculty will assume responsibility for advising minority students and teaching minority-focused classes; the overloading of minority faculty with service (community) activities that constrain the time minority faculty can devote to research and publishing activities (Tack & Patitu, 1992). Taken together, these indicators operate to situate minority faculty in a subordinate status relative to dominant (White) faculty in the academic culture – a subordinate status that could be viewed as a type of structural violence minority faculty experience in academia (see Hamer & Lang, 2015). One could also view the microaggressions experienced by minority faculty in the academic culture as a mechanism for buffering the privileged position of dominant (White) group faculty (Padilla & Montiel, 1998; Turner, 2003).

My purpose in this essay is to construct a descriptive profile of the types of microaggressions minority faculty experience in the academic culture. Sue et al. (2007) have identified three types of microaggressions or micro-insults minority persons experience in their interactions with dominant group persons: (a) overt racial interactions involving a racial slur, (b) labeling the presence of minority persons in professional occupations as an outcome of preferential treatment, and (c) invalidation of the minority person's social reality. I argue that the microaggressions minority faculty experience in their social relations with dominant group faculty tend to be subtle and are often dismissed by dominant group faculty as "innocent comments," as "slips of the tongue," or as "a misunderstanding." The social relations between minority faculty and dominant group faculty provide a window for observing the practice of microaggressions that target minority faculty in academia. To that end, I will examine the narratives of minority faculty regarding their experiences in academia available in the research literature in order to illustrate how they contextualize the microaggressions they experience.

Much of the research literature regarding the life experiences of minority faculty in academia is narrative in its methodology, consisting mostly of autobiographical accounts by minority faculty regarding their presence in academia (Bell, 2003; Delgado, 1995; Lorimer & Parr, 2014). I treat the narrative accounts of minority faculty as stories regarding their struggles to find an identity, place, and home in academia. Taken together, the stories are a vehicle for minority faculty to narrate to others about their struggle to promote a collective sense of belonging in academia; in a sense, these narrative accounts are transformative for the presence of minority faculty.

The narrative accounts of minority faculty are found in collections that focus on situating the life experiences of minority faculty in academia (e.g., Altbach & Lomotey, 1991; Padilla & Chavez Chavez, 1995; Valverde & Castenell, 1998). In this essay, I have chosen to give voice to the lived experiences of minority faculty in order to show the reader that their stories are valid representations of academic life and that there are competing perceptions of social life that can instruct us regarding the rich texture of diverse life experiences in the academy. In what follows, I first present an overview of the narrative inquiry approach for examining the lived experiences of minority faculty. I then proceed to an examination of the narratives of minority faculty to illustrate how they are marginalized by the dominant group.

Telling Stories in Academia

The use of narrative inquiry is an accepted methodology in sociology for studying how persons interpret their social interactions with other persons and their participation in social institutions (Bruner, 1986). Narrative methodology has assumed various representations in sociology: case histories, personal interviews, urban ethnography, and content analysis (Daiute & Lightfoot, 2004; Ewick & Silbey, 1995; Maines, 1993; Richardson, 1990; Van Maanen, 1988). Regarding narrative inquiry, Alvermann (2000: 2) notes that it consists of a "variety of research practices, ranging from those that tell a story of how individuals understand their actions through oral and written accounts of historical episodes to those that explore certain methodological aspects of storytelling." The use of narrative inquiry allows researchers to show that social reality is a layered phenomenon that requires subjectivity based on personal experiences and intuitiveness as interpretive guides for its study (Bell, 1999; Delgado, 1989; Richardson, 1990, 1997; Van Maanen, 1988).

The *subjectivity* of the personal narrative has caused some critics to argue that treating the *personal narrative* as social data is suspect because it does not fit conventional methods that could be used to evaluate its validity and generalizability. According to the critics, the personal narrative is suspect because the narrator or storyteller is perceived as a potential source of bias and distortion (e.g., see Baron, 1998; Cizek, 1995; Delgado, 1993; Ewick & Silbey, 1995; Maines, 1993). However, I propose that the personal narrative is a valuable, and powerful, method for understanding everyday life because it gives substance to the narrative and establishes intersubjective identification between a narrator or storyteller and another person's narrative or story of their lived experience, thus indicating a degree of validity that a narrative makes sense.

The critics also perceive the personal narrative as *taking a side*. The personal narrative is perceived as the product of a storyteller who has decided to take a side in telling a story (Bochner, 2001). The critics are working with the assumption that social science researchers do not choose sides in their work. However, social scientists take sides just like most other persons in everyday life (Becker, 1967; Clandinin & Connelly, 1994). For example, the topic one chooses to study, the statistical procedures one utilizes for making inferences, and the language one uses for cloaking observations are products of choice. The choice a social scientist makes is, as a result, dependent on the side one takes to interpret the phenomenon under study. Ironically, despite arguing for the neutrality and objectivity of their research, it is not uncommon to observe that the social sciences are transformed into a contested terrain of competing interpretations as to what is neutrality and objectivity (Winter, 2000).

Living on the Margins in Academia

The journey into academia for minority faculty is an exceptional one. It is an exceptional journey because they have had to overcome obstacles in their social backgrounds, such as poverty, inadequate schools, and racism, in order to pursue a college or university education (Martinez, 1999; Turner & Myers, 2000; Washington & Harvey, 1989). Minority faculty are not simply survivors; they have overcome obstacles designed to be insurmountable. The journey minority faculty undertake in higher education is exceptional because it chronicles their ability to survive social forces and overcome institutional practices that seek to position them at the margin of an opportunity structure traditionally available only to dominant group faculty. For example, Kelly and McCann (2013: 29) note the following in their study of women faculty of color (WFOC) at predominantly White institutions of higher education:

> Although it is important to highlight barriers that impede WFOCs' success in the academy, it is also crucial to give voice to the challenges that WFOC experienced through successful tenure and promotion. In this way barriers and challenges are not falsely consigned only to WFOC who were not conventionally successful. Naming the barriers and challenges in stories of WFOC who surpassed the glass ceiling of tenure in predominately White, research extensive universities in the U.S. gives credence to the women's resiliency, to the core belief in their ability to earn tenure, and to how their socialization as newcomers could have derailed their success.

The ability of minority faculty to overcome barriers from the margin of higher education has been referred to by some scholars as examples of "resistance from the margins" (Thomas & Hollenshead, 2001) and as "instances of resistance and victory" (Allen, 1996). Despite undergoing an exceptional journey through academia, minority faculty face challenges from dominant group faculty and dominant group students regarding their presence in academia. Regarding dominant group students, research has argued that they are likely to evaluate minority faculty based on racial stereotypes instead of their teaching performance in the classroom (Lazos, 2012; Menges & Exum, 1983; Williams, 2007).

Unsurprisingly, with the university often seen as a meritocracy, discussions focused on the presence and participation of minority faculty are often the basis for attacking affirmative action programs and initiatives in higher education (Aguirre Jr. & Martinez, 2014). The lingering controversy over affirmative action policies has resulted in a mindset among dominant group faculty that portrays minority faculty as invaders storming the gates of academia. In particular, for dominant group students and faculty, minority faculty are regarded as undeserving of presence and voice in academia (Aguirre Jr., 2005). The centrality of a mindset in academia that nested in microaggressions against minority faculty is a structural issue that tests academia's commitment to eliminating racist practices.

Consider Aguirre Jr.'s (1995) reflections on those moments in the classroom when he reveals to students his accidental journey into higher education. He points out in his narrative that his migrant farm worker background was certainly not a pathway that dominant group persons pursue as a traditional path into academia. He can see the confusion on the faces of dominant group students as they transform his presence into matter out of place, especially when they hear him say that his journey into academia was accidental. In their eyes, his presence is illegitimate, as it occurred during the civil rights movement, when dominant group status was openly challenged across all institutions; he is only present in the views of some students because a dominant group person was overlooked in order for him to enter academia. He has come to the realization that dominant group students, as well as many minority students, prefer that he construct a fable of his journey into academia as the outcome of a well-designed plan, especially a rational and goal-driven tale.

Minority faculty often ask, "What are the images dominant group faculty construct of us?" If dominant group faculty tend to regard the presence of minority faculty in academia as illegitimate, then how might they express their perception of minority faculty as illegitimate participants in academia? In my conversations with minority faculty over the past three decades, I have learned that it's a question they often ask of themselves. I've come to believe that minority faculty ask themselves the question in order to resolve the ambiguity they experience as a result of being reconstituted as "matter out of place" in the eyes of dominant group faculty. Ironically, minority faculty in academia are often transformed into that odd family member that a family tries to hide from view as much as possible, but is never quite able to make them disappear.

Resistance in Academia

For minority faculty, presence and voice in the academy, and in its sponsored activities such as research conferences, is a struggle that wears at them with greater costs than those experienced by dominant group faculty (Aguirre Jr., 2000; Diggs, Garrison-Wade, Estrada, & Galindo, 2009; Nair, 2014; Padilla & Chavez Chavez, 1995; Turner & Myers, 2000). White (2007), for example, recounts her experience at an academic conference in which the conference presenter forgot her name: "The setting was simple enough. I gave a talk and the master of ceremonies forgot my name. He could have looked at the program when he referred to me in subsequent remarks, but he repeatedly called me something other than 'Dr. Gray White.' … I, a [B]lack female academic with 'Dr.' in front of my name, was someone who was not supposed to be there. For them, I would be 'matter out of place,' and as usual, on some unconscious level I understood that I would have to prove that I was in fact in the right place—where I was supposed to be" (p. 5). In forgetting Dr. White's name, the master of ceremonies, a dominant group member, made her invisible to conference attendees. Forgetting Dr. White's name in the introduction is a microaggression in that it serves to reinforce the Dr. White's positioning in academia *as matter out of place*. As such, minority faculty end up working harder than dominant group faculty because they need to overcome microaggressions that attack their presence and voice in academia (Bell, 1994).

In addition to dominant group faculty making minority faculty invisible, dominant group faculty resist their incorporation into the organizational culture of higher education by not recognizing the legitimate status of minority faculty. Incorporation into the organizational culture is necessary for acquiring and establishing meaningful roles in the knowledge production process in academia. In a study of minority faculty focusing on their perceptions of the institutional climate in academia, Delgado (1988: 12) writes, "A young Hispanic professor teaching at a major school approached a senior [W]hite male colleague to discuss some issues she was about to cover in class. The professor appeared not to recognize her and asked her to please see his secretary for an appointment – the treatment he routinely applies to students." The failure to recognize a minority faculty by dominant group faculty is a microaggression in that it makes minority group faculty invisible and positions them in a subordinate position by lowering their status to that of a student.

Furthermore, dominant group faculty marginalize minority faculty by the language they use to characterize them. Blackshire-Belay (1998: 32) provides the following example regarding Black faculty: "While a [W]hite professor is said to be vocal or assertive, a [B]lack one is seen to be out of line or aggressive. While a [W]hite professor is said to be confident, a [B]lack one is arrogant. While a [W]hite professor is said to be a strong leader, a [B]lack one is looked on as combative." Accordingly, a Chinese-American professor observes in the selection process of applicants for a faculty position that dominant group and minority group job applicants are perceived and treated differently by dominant group faculty. According to the Chinese-American professor, "I think it's obvious to other people too that when you are of an ethnic persuasion you get treated one way and when you are of a different ethnic persuasion you get treated another way. … This [minority] person didn't get a tour of the campus. This person did not get a chance to talk to junior faculty where we had another [W]hite male candidate come in and he got a tour of the campus; he got to talk to junior faculty" (quoted in Johnsrud & Sadao, 1998: 332).

Perhaps the most noticeable manner in which dominant group faculty marginalize the presence of minority faculty is by resisting the incorporation of their ideas and research into the organizational culture of higher education. Moreover, the most prevalent form of resisting the inclusion of the ideas of minority faculty is by devaluing their scholarship (Ross & Edwards, 1998). Devaluing the scholarship of minority faculty by dominant group faculty serves both to limit resource opportunities for them and to exclude their knowledge from the organizational cultures of colleges and universities. For example, Trueba (1998: 80) notes that dominant group faculty experience discomfort when dealing with minority faculty because they are unsure how the incorporation of minority faculty into academia will "affect [their] [W]hite life-style and their control of educational institutions." The *discomfort* dominant group faculty experience with minority faculty is regarded as a factor that promotes an *anti-minority mindset* among them. This *anti-minority mindset* is used by dominant group faculty to construct and promote images that marginalize minority faculty in the academic culture. The mindset also promotes insensitivity and racist motives in the social relations between dominant group faculty and minority faculty (Brown, 1990). A result from the *anti-minority mindset* held by dominant group faculty utilizes *differentness* as a rationale for locating the research and teaching activities of minority faculty on the periphery of the academic culture, such as minority studies programs or minority research centers (Aguirre Jr., 2000).

Resistance in the Classroom

The marginalization of minority faculty by dominant group faculty might be replicated in the social relations between dominant group students and minority faculty. For example, a Mexican American law professor notes that a "[W]hite student from a wealthy family attempted to curry favor by telling me out of the blue that she 'thought in Spanish'" (Johnson, 1999: 136). Instead of currying favor, the student's remark can be interpreted as a subtle reminder to the Mexican American professor that they are situated at the margins of academia. The example illustrates how dominant group students perceive minority faculty as *different* and that their *identifiability as different* creates the opportunity for initiating social relations that do not recognize their inclusion in academia. Hamilton (2002: 33) provides an example of an African American professor's experiences teaching an introductory African American literature class: "White students began coming to his office hours – not to ask for guidance on raising their grades, as the Black students had – but to ask to be allowed to take the class pass-fail." In the minority professor's eyes, White students making this request were marginalizing his presence by asserting an "arrogance, the sense of entitlement … [that] they just get to check out."

Another way by which dominant group students marginalize minority faculty is through course evaluations. Accordingly, Robinson (1997) provides an example based on his experience as an African American professor of law. He notes that some White students marginalize minority faculty by expressing their unwillingness to accept an African American in the role of intellectual or professor by providing negative and angry comments on their teaching evaluations. Robinson writes that some "[W]hite students who have never experienced us as institutional authorities or as intellectual role models … react on many unseen, but expressed levels, one of which is anger and jealousy" (p. 172).

Dominant group students also marginalize minority faculty by assuming that they do not possess the linguistic capabilities possessed by dominant group faculty. For example, an Asian woman faculty observes how dominant group students marginalize her presence in the classroom via the comments they make in their teaching evaluations (Han, 2012: 34). A dominant group student writes in their evaluation of her performance in the classroom: "There was a disconnect between the instructor and us. She [Dr. Han] is very smart, but I can't say I learn[ed] much or anything at all in her class. We were unable to understand some of her directions because of her broken English." Reference to the minority professor's English proficiency by dominant group students is a reflection of the privilege they exercise in reinforcing the minority professor's "otherness."

Perhaps the most egregious practice dominant group students exercise is to question the academic qualifications of minority faculty members. For example, an African American female law school professor offers an account of a conversation she had with an African American law school student who recounted a conversation with a White student (Harris, 1992: 346). According to the student providing the account, she was talking with a White student in the library about Professor Harris's class. The White student asked the African American student about her views regarding Professor Harris's teaching ability. After offering her views, the African American student asked the White student for her view of Professor Harris. The White student proceeded to say "Professor Harris is pretty good," but that this was unexpected since, as a Black woman, "she probably wasn't qualified." Ironically, Coston, Berry, Ross, Heard, and Jenks (1999) note in a discussion of how minority status affects the perception of dominant group students that Black faculty are not "real" professors but rather are "Black entertainers" in the classroom.

Dominant group students resist the presence of minority faculty in academia by exhibiting interpersonal behavior to communicate their perception that dominant group faculty are the only ones with privilege in the classroom. A Latina professor of education notes, for example, that White students in her classes "exhibit body language, verbal reactions, facial expressions, disengagement, judgmental attitudes, and a subtle resistance. I feel as if they had put up a glass wall, including low expectations, to impede my reaching them" (Torres, 2002: 89). Despite having satisfied the requirements for joining academia as faculty, minority faculty encounter obstacles from dominant group students and faculty to have presence in the classroom.

Similarly, a Chicana professor of psychology observes that when she subtitled a psychology course she was teaching as "a study in alienation, domination, and the psychology of oppression," the "[W]hite students, both male and female, quickly dubbed the course 'Oppression 151.' It was my impression that they subtitled it in reference to themselves – their own oppression at being forced to turn the magnifying glass on themselves, and I – a Chicana (rarely seen teaching at UCLA) – became their 'oppressor'" (Romero, 2000: 309). One can argue that the resistance exhibited by dominant group students toward minority faculty is an outcome of their privileged position in the classroom. From another perspective, the resistance exhibited by dominant group students toward minority faculty members reflects a nested context of racist attitudes and feelings in academia (e.g., see Bonilla-Silva & Forman, 2000; Harlow, 2003; Jackson & Crawley, 2003; Tierney & Bensimon, 1996), one that is embedded in and part of the increasingly overt racism found within the neoliberal culture in academia (Martinez, 2016).

Summary Remarks

I have utilized the research literature in order to compile narrative accounts that illustrate how minority faculty describe the resistance they encounter from dominant group students and faculty in academia. The narrative accounts portray minority faculty as involved in a constant struggle of introspection that seeks to answer basic questions of being and presence in a privileged social institution, academia, they were not expected to enter. It is a search for legitimacy, for voice and belonging, in a group struggle that has occurred across academic settings since the 1960s, when the civil rights movement opened the doors slightly to the academy for members of minority communities (Martinez, 1991). Minority faculty perceive the academic culture as marginalizing their presence and treating them as undeserving participants in academia.

The research literature conceptualizes microaggressions as statements, actions, and behaviors that target marginalized groups such as a racial or ethnic minority (Constantine, Smith, Rodington, & Owens, 2008; Sue, 2010; Whitfield-Harris & Lockhart, 2016). Microaggressions cause insult or injury to their targets. For example, forgetting a minority faculty's name by a moderator at a professional conference may be treated as an innocent mistake by dominant group faculty. However, it operates as a microaggression because it robs the minority faculty of their identity and makes them invisible. Microaggressions may also cause stress in a minority faculty's interpersonal interactions with dominant group faculty. It could become a personal struggle for minority faculty to figure out when they will be seen by dominant group faculty as belonging or not belonging in the academic culture.

While my review of the research literature has been rather modest, there is an abundance of literature that identifies the barriers for minority faculty and in academia (e.g., see Altbach & Lomotey, 1991; Dade, Tartakov, Hargrave, & Leigh, 2015; Kelly & McCann 2014; Nivet, 2010; Rodriguez, Campbell, Fogarty, & Williams, 2014; Turner & Gonzalez, 2008; Washington & Harvey, 1989; Valverde & Castenell, 1998). Despite the modest review of the literature, I argue that the narrative accounts identify microaggressions that typify the social relations between minority faculty and dominant group faculty. The prevalence of microaggressions that target minority faculty suggests that biased perceptions of minority faculty are foundational to the social structure in academia. The similarity in microaggression experienced by minority faculty across academic disciplines reinforces the notion that microaggressions which target minority faculty are not anomalies but rather they are expected outcomes in the social relations between minority faculty and dominant group faculty.

The microaggressions minority faculty in academia experience are indicative of academia's resistance to the incorporation of minority faculty. If one accepts the premise that most organizations in US society were designed to serve dominant group interests, especially maintaining their access to valued resources, then the presence of minority faculty results in behaviors or actions (e.g., microaggressions) that not only resist the presence of minority faculty but also their access to valued resources (see Alderfer & Thomas, 1988 ; Alvarez, 1979). The academic culture uses the identifiability of persons based on their status characteristics, race, and ethnicity for minority faculty. As such, the identifiability of minority faculty serves as a penalty that limits their access to valued resources and their representativeness in the academic culture. One valued resource for faculty in the academic culture is attaining tenure and promotion. For example, if the presence of minority faculty is marginalized in the academic culture by dominant group faculty, then their research and publications will also be marginalized in the tenure and promotion process. In the end, rather than examine the practices of a dominant group hegemonic structure in academia, the academic culture blames minority faculty in their efforts to attain tenure and promotion.

What is disturbing about the resistance minority faculty experience regarding their presence in academia as an outcome of biased perceptions promoted by a dominant group hegemonic structure is that *minority* status itself becomes a structural barrier to inclusion in academia. Academia portrays itself as a haven for faculty to debate ideas and promote enlightened views of society. In a sense, academia is often viewed as a paradise set away from the inequalities and inequities of everyday life. What then is the basis for the resistance minority faculty experience in academia? Is it because dominant group faculty are unwilling to share the fruits of academia with them? Is it because dominant group faculty perceive minority faculty members as undeserving of the opportunity to shed themselves of the inequalities associated with their minority status? Or is it that dominant group faculty are engaged in defending their privileged position in the university against the inclusion of racial and ethnic minorities? I argue that the resistance minority faculty experience in academia is an outcome of dominant group faculty using the privileges rooted in their dominant group membership to remind minority faculty that they are distant relatives but not members of the family.

Finally, after almost 40 years of studying minority faculty in academia, I have arrived at the observation that in order to understand how microaggressions affect the lives of minority faculty, one must focus on how minority faculty contextualize the microaggressions. The microaggressions experienced by minority faculty robs them of voice, erases their identity, and questions their social reality (e.g., academic qualifications). The microaggressions result in minority faculty experiencing social psychological stress in their identification with the academic culture, their access to valued resources, and legitimacy in the classroom. More importantly, minority faculty experience social and psychological stress in their efforts to answer questions of identity, place, and belonging. Perhaps the next step in understanding what it means to be a minority in academia is to examine those issues, processes, and practices that minority faculty contextualize as preventing them for having an identity, place, and home in academia.

References

Aguirre, A., Jr. (1995). A Chicano farmworker in academe. In R. Padilla & R. Chavez Chavez (Eds.), *The leaning ivory tower: Latino professors in American universities* (pp. 17–27). Albany, NY: SUNY Press.

Aguirre, A., Jr. (2000). *Women and minority faculty in the academic workplace: Recruitment, retention, and academic culture.* (ASHE-ERIC Higher Education Report, Volume 27, Number 6). San Francisco, CA: Jossey-Bass.

Aguirre, A., Jr. (2005). The personal narrative as academic storytelling: A Chicano's search for presence and voice in academe. *International Journal of Qualitative Studies in Education, 18*, 147–163.

Aguirre, A., Jr., & Martinez, R. (2014). Closing the gap: Affirmative action in higher education, the utilization of the diversity rationale, and select examples of legal challenges between 1995 and 2002. In *Controversies in affirmative action, volume 1: Historical dimensions* (pp. 159–178). Denver, CO: Praeger.

Aguirre, A., Jr., & Martinez, R. O. (2007). *Diversity leadership in higher education.* (ASHE Higher Education Report, Volume 32, Number 3). San Francisco, CA: Jossey-Bass.

Alderfer, C., & Thomas, D. (1988). The significance of race and ethnicity for understanding organizational behavior. *International Review of Industrial and Organizational Psychology, 1*, 1–41.

Allen, B. (1996). Feminist standpoint theory: A Black woman's (re)view of organizational socialization. *Communication Studies, 47*, 257–271.

Altbach, P., & Lomotey, K. (Eds.). (1991). *The racial crisis in American higher education*. Albany, NY: SUNY Press.

Alvarez, R. (1979). Institutional discrimination in organizations and their environments. In R. Alvarez, K. Leuuman, & Associates (Eds.), *Discrimination in organizations* (pp. 2–49). San Francisco, CA: Jossey-Bass Publishers.

Alvermann, D. (2000). Narrative approaches. *Reading Online, 4*(5). Available online at: http://www.readingonline.org

Baron, J. (1998). Storytelling and legal legitimacy. *College Literature, 25*, 63–77.

Becker, H. (1967). Whose side are we on? *Social Problems, 14*, 240–247.

Bell, D. (1994). *Confronting authority: Reflections of an ardent protester*. Boston, MA: Beacon Press.

Bell, D. (1999). The power of narrative. *Legal Studies Forum, 23*, 315–348.

Bell, L. (2003). Telling tales: What stories can teach us about racism. *Race Ethnicity and Education, 6*, 3–28.

Blackshire-Belay, C. A. (1998, July–August). The status of minority faculty members in the academy. *Academe, 84*, 31–36.

Bochner, A. (2001). Narrative's virtues. *Qualitative Inquiry, 7*, 131–157.

Bonilla-Silva, E., & Forman, T. (2000). I am not a racist but …: Mapping white college students' racial ideology in the USA. *Discourse & Society, 11*, 50–86.

Brown, D. (1990). Racism and race relations in the university. *Virginia Law Review, 76*, 295–335.

Bruner, J. (1986). *Actual minds, possible worlds*. Cambridge, MA: Harvard University Press.

Cizek, G. (1995). Crunchy granola and the hegemony of the narrative. *Educational Researcher, 24*, 26–28.

Clandinin, D., & Connelly, F. (1994). Personal experience methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 413–427). Thousand Oaks, CA: Sage Publications.

Constantine, M., Smith, L., Rodington, R., & Owens, D. (2008). Racial microaggressions against Black counseling and counseling psychology faculty: A central challenge in the multicultural counseling movement. *Journal of Counseling & Development, 86*, 348–355.

Coston, C., Berry, B., Ross, L., Heard, C., & Jenks, D. (1999). The pressures and joys of academic life: Minority statuses and other considerations. *The Justice Professional, 11*, 325–337.

Dade, K., Tartakov, C., Hargrave, C., & Leigh, P. (2015). Assessing the impact of racism on Black faculty in White academe: A collective case study of African American female faculty. *The Western Journal of Black Studies, 39*, 134–146.

Daiute, C., & Lightfoot, C. (Eds.). (2004). *Narrative analysis: Studying the development of individuals in society*. Thousand Oaks, CA: Sage Publications.

Delgado, R. (1988). *Minority law professors' lives: The Bell-Delgado Survey*. Madison, WI: University of Wisconsin – Madison Law School, Institute for Legal Studies Working Paper Series 3.

Delgado, R. (1989). Storytelling for oppositionists and others: A plea for narrative. *Michigan Law Review, 87*, 2411–2441.

Delgado, R. (1993). On telling stories in school: A reply to Farber and Sherry. *Vanderbilt Law Review, 46*, 665–676.

Delgado, R. (1995). Legal storytelling: Storytelling for oppositionists and others, a plea for narrative. In R. Delgado (Ed.), *Critical race theory: The cutting edge* (pp. 64–74). Philadelphia, PA: Temple University Press.

Diggs, G., Garrison-Wade, D., Estrada, D., & Galindo, R. (2009). Smiling faces and colored spaces: The experiences of faculty of color pursuing tenure in the academy. *Urban Review, 41*, 312–333.

Douglas, M. (1966). *Purity and danger: An analysis of the concepts of pollution and taboo*. London, UK: Ark Paperbooks.

Ewick, P., & Silbey, S. (1995). Subversive stories and hegemonic tales: Toward a sociology of narrative. *Law & Society Review, 29*, 197–226.

Hamer, J., & Lang, C. (2015). Race, structural violence, and the neoliberal university: The challenges of inhabitation. *Critical Sociology, 41*, 897–912.

Hamilton, K. (2002). Race in the college classroom. *Black Issues in Higher Education, 19*, 32–36.

Han, K. (2012). Experiences of faculty of color teaching in a predominantly white university: Fostering interracial relationships among faculty of color and white preservice teachers. *International Journal of Progressive Education, 8*, 25–48.

Harlow, R. (2003). "Race doesn't matter, but …": The effect of race on professors' experiences and emotion management in the undergraduate college classroom. *Social Psychology Quarterly, 66*, 348–363.

Harris, C. (1992). Law professors of color and the academy: Of poets and kings. *Chicago-Kent Law Review, 68*, 331–352.

Jackson, R., & Crawley, R. (2003). White student confessions about a black male professor: A cultural contracts theory approach to intimate conversations about race and worldview. *Journal of Men's Studies, 12*, 25–41.

Johnson, K. (1999). *How did you get to be Mexican?: A white/brown man's search for identity*. Philadelphia, PA: Temple University Press.

Johnsrud, L., & Sadao, K. (1998). The common experience of "otherness": Ethnic and racial minority faculty. *The Review of Higher Education, 21*, 315–342.

Kelly, B., & McCann, K. (2013). Women faculty of color: Success stories from the margins. *Journal of the International Association for the Study of Global Achievement, 1*, 29–44.

Kelly, B., and McCann, K. (2014). Women faculty of color: Stories behind the statistics. *Urban Review 46*, 681–702.

Lazos, S. (2012). Are student teaching evaluations holding back women and minorities? The perils of doing gender and race in the classroom. In G. Gutierrez y Muhs, Y. Niemann, C. Gonzalez, & A. Harris (Eds.), *Presumed incompetent: The intersections of race and class for women in academia* (pp. 164–185). Logan, UT: Utah State University Press.

Lorimer, H., & Parr, H. (2014). Excursions-telling stories and journeys. *Cultural Geographies, 21*, 543–547.

Maines, D. (1993). Narrative's movement and sociology's phenomena: Towards a narrative sociology. *Sociological Quarterly, 34*, 17–38.

Martinez, R. O. (1991). The politics of ethnicity in social science. In J. Brown & D. van Keuren (Eds.), *The Estate of Social Knowledge* (pp. 228–252). Baltimore, MD: Johns Hopkins University.

Martinez, R. O. (1999). *Hispanic leadership in American higher education*. Paper prepared for the Hispanic Association of Colleges and Universities. Available online: http://www.hacu.net/images/hacu/martinez.pdf

Martinez, R. O. (2016). The impact of neoliberalism on Latinos. *Latino Studies, 14*(1), 11–32.

McKay, N. (1995). Minority faculty in [mainstream white] academia. In A. DeNeef & C. Goodwin (Eds.), *The academic handbook* (2nd ed., pp. 49–61). Durham, N.C: Duke University Press.

Menges, R., & Exum, W. (1983). Barriers to the progress of women and minority faculty. *The Journal of Higher Education, 54*, 123–144.

Nair, S. (2014). Women of color faculty and the "burden" of diversity. *International Feminist Journal of Politics, 16*, 497–500.

Nivet, M. (2010). Minorities in academic medicine: Review of the literature. *Journal of Vascular Surgery, 51*, S53–S48.

Padilla, R., & Chavez Chavez, R. (Eds.). (1995). *The leaning ivory tower: Latino professors in American universities*. Albany, NY: SUNY Press.

Padilla, R., & Montiel, M. (1998). *Debatable diversity: Critical dialogues on change in American universities*. New York, NY: Rowman & Littlefield.

Pittman, C. (2012). Racial microaggressions: The narratives of African American faculty at a predominantly White University. *The Journal of Negro Education, 81*, 82–92.

Richardson, L. (1990). Narrative and sociology. *Journal of Contemporary Ethnography, 19*, 116–135.

Richardson, L. (1997). *Fields of play: Constructing an academic life*, (New Brunswick, NJ: Rutgers University Press.

Robinson, R. (1997). Teaching from the margins: Race as a pedagogical sub-text. *Western New England Law Review, 19*, 151–181.

Rodriguez, J., Campbell, K., Fogarty, J., & Williams, R. (2014). Underrepresented minority faculty in academic medicine. *Family Medicine, 46*, 100–104.

Romero, G. (2000). "No se raje, chicanita": Some thoughts on race, class, and gender in the classroom. In V. Ruiz (Ed.), *Las obreras: Chicana politics of work and family* (pp. 305–318). Los Angeles, CA: UCLA Chicano Studies Research Center.

Ross, L., & Edwards, W. (1998). Publishing among African American criminologists: A devaluing experience? *Journal of Criminal Justice, 1*, 29–40.

Sue, D. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation*. Hoboken, NJ: Wiley.

Sue, D., Capodilupo, C., Torino, G., Bucceri, J., Holder, A., Nadal, K., & Esquilin, M. (2007). Racial microaggressions in everyday life. *American Psychologist, 62*, 271–286.

Tack, M., & Patitu, C. (1992). *Faculty job satisfaction: Women and minorities in peril*. (ASHE-ERIC Higher Education Report No.4). Washington, DC: The George Washington University, Graduate School of Education and Human Development.

Thomas, G. D., & Hollenshead, C. (2001). Resisting from the margins: The coping strategies of black women and other women of color faculty members at a research university. *Journal of Negro Education, 70*, 166–175.

Tierney, W., & Bensimon, E. (1996). *Promotion and tenure: Community and socialization in academe*. Albany, NY: SUNY Press.

Torres, M. (2002). Reflecting on the games of academia: A view from "the porch". In L. Jacobs, J. Cintron, & C. Canton (Eds.), *The politics of survival in academia: Narratives of inequity, resilience, and success* (pp. 77–94). New York, NY: Rowman & Littlefield.

Trueba, H. (1998). Race and ethnicity in academia. In L. Valverde & L. Castenell Jr. (Eds.), *The multicultural campus: Strategies for transforming higher education* (pp. 70–93). Walnut Creek, CA: AltaMira Press.

Turner, C. (2003). Incorporation and marginalization in the academy: From border towards center for faculty of color. *Journal of Black Studies, 34*, 112–125.

Turner, C., & Gonzalez, J. (2008). Faculty of color in academe: What 20 years of literature tells us. *Journal of Diversity in Higher Education, 1*, 139–168.

Turner, C., & Myers, S. (2000). *Faculty of color in academe: Bittersweet success*. Boston, MA: Allyn & Bacon.

Valverde, L., & Castenell, L. (Eds.). (1998). *The multicultural campus: Strategies for transforming higher education*. Walnut Creek, CA: AltaMira Press.

Van Maanen, J. (1988). *Tales of the field: On writing ethnography*. Chicago, IL: University of Chicago Press.

Washington, V., & Harvey, W. (1989). *Affirmative rhetoric, negative action: African-American and Hispanic faculty at predominantly white institutions*. (ASHE-ERIC Higher Education Report Number 2). Washington, DC: The George Washington University, Graduate School of Education and Human Development.

White, D. (2007). 'Matter out of place': Arn't I a woman? Black female scholars in the academy. *The Journal of African American History, 92*, 5–12.

Whitfield-Harris, L., & Lockhart, J. (2016, Spring). The workplace environment for African-American faculty employed in predominantly white institutions. *The ABNF Journal, 27*, 28–38.

Williams, D. (2007). Examining the relation between race and student evaluations of faculty members: A literature review. *Profession, 2007*, 168–173.

Winter, G. (2000). A comparative discussion of the notion of 'validity' in qualitative and quantitative research, *The Qualitative Report 49(4/3)*. Available online at: http://www.nova.edu/ssss/QR/QR4-3/winter.html (accessed 19 December 2019).

Microaggressions in Human Service Organizations

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Abstract

Microaggressions are interpersonal communications that invalidate, tokenize, exoticize, and isolate those with nondominant group identities. The aim of this chapter is to discuss how human service organizations (HSOs), often designed to support people who live at the intersections of multiple forms of domination and marginalization, can maintain settings where microaggressions persist. This chapter provides examples of microaggressions from two distinct human service organizations and discusses how to respond to microaggressions at individual and interpersonal levels as both targets and perpetrators. This chapter also describes organizations getting *In View*, which means they are consistently self-correcting and seeking to disrupt the institutional power structures that support the perpetration of microaggressions. Future research, practice, and policy implications are discussed.

Keywords

Safe spaces · Microaggressions · Human service organizations

Microaggressions are interpersonal communications that invalidate, tokenize, exoticize, and isolate those with nondominant group identities. As a result, people who perpetrate microaggressions subtly (or overtly) devalue the lived experiences of the person to whom the microaggression was directed (Sue, 2010). Microaggressions are based on all dimensions of human diversity (e.g., race, sexual orientation, class, gender, religion) and are intimately connected to systems of privilege and oppression. Microaggressions can also be present in organizational policies, procedures, cultural norms, and practices. Both the content of the microaggression and the actors involved demonstrate how power is distributed within and across settings.

The aim of this chapter is to discuss how human service organizations (HSOs), often created to support people who live at the intersections of multiple forms of domination and marginalization, can maintain settings where microaggressions persist. We define microaggressions and discuss how they manifest in interpersonal communications and organizations. Using two organizational case examples studies, we demonstrate how HSOs can recreate the same oppressive power dynamics they seek to challenge by not developing procedures

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© Springer Nature Switzerland AG 2020
L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_20

to interrupt interpersonal microaggressions and maintaining environmental microaggressions. We summarize the empirical evidence on how people respond to and cope with microaggressions as well as discuss potential multilevel interventions for addressing microaggressions. We then introduce the concept of being *In View,* a type of organization that is consistently self-correcting and aims to disrupt institutional power structures that support the perpetration of microaggressions. The chapter concludes with a discussion on future research, practice, and policy implications for HSOs.

Overview of Microaggressions

Microaggressions have been defined as "everyday verbal, nonverbal and environmental slights, snubs or insults whether intentional or unintentional that communicate hostile, derogatory, or negative messages to a target person based solely upon their marginalized group membership" (Sue et al., 2007, p. 273). They are often perpetrated within interpersonal interactions and appear in organizational structures and cultures. The perpetration of microaggressions spans across multiple settings where individuals frequently interact. For example, researchers have studied microaggressions within academic libraries (Alabi, 2015), universities (Burrow & Hill, 2012), and rehabilitation programs (Cartwright, Washington, & McConnell, 2009). Within interpersonal communications, microaggressions can be categorized in three distinct types: microinvalidations, microinsults, and microassaults. When microaggressions manifest within organizations, they are called environmental microaggressions. Each of these types is discussed below.

Microinvalidations

Microinvalidations are the most common, and insidious, microaggression. They are "communications or environmental cues that exclude, negate or nullify the psychological thoughts, feelings or experiential reality of certain groups" (Sue et al., 2007, p. 274). Perpetrators can invalidate targets by ignoring them, insisting that the target is crazy, or denying the targets' experiences. Microinvalidations are often unconscious to the perpetrator and the interpretation of the incident depends on context (Sue et al., 2007). For example, when someone says, "I don't see race, gender, or sexual orientation. I see people as people," this is a microinvalidation because the statement assumes a universal human experience often typified by members of a dominant group. This statement both flattens and dismisses the complex lived realities and experiences of people who exist outside of dominant group.

Microinsults

Microinsults are "interpersonal or environmental communications that convey stereotypes, rudeness, and insensitivity which demean a person's racial, gender or sexual orientation, heritage or identity" (Sue et al., 2007, p. 274). Microinsults are more ambiguous forms of interpersonal communications. They are often unconscious and can convey hidden messages, which may seem positive, but are not. The target person often must expend cognitive energy to decipher whether these messages are related to stereotypes about their social identities (e.g., race, gender, sexual orientation) and their intersections.

For example, asking a young Black transwoman "Why are you so loud. You don't need to be loud to get my attention" is an example of a microinsult that pathologizes cultural values and communication style. In the context of race, the perpetrator insinuates a preferred communication style of quiet while also subtly pushing for assimilation toward this style. The stereotype that Black people are "loud" or "disruptive" sits in the cognitive awareness of the target. In addition, under the scope of gender, this message implies the expectation that women should not assert themselves. This microinsult reinforces discrimination at the intersection of Blackness and womanhood. Previous scholars found that Black women are often viewed as loud, threatening, and argumentative (Lewis & Neville, 2015; Nnawulezi & Sullivan, 2014). These characteristics can be traced back to a stereotypical image of Black women as Sapphires—women who are perceived to be pushy or hostile and for whom the use of assertive behavior is perceived as aggressive (West, 1995).

Microassaults

A microassault is the most visible and conscious form of microaggressions. They are the "explicit racial derogations characterized primarily by a violent verbal, nonverbal or environmental attack meant to hurt the intended victim through name-calling, avoidant behavior, or purposeful discriminatory actions" (Sue et al., 2007, p. 274). Unlike other forms of microaggressions that are subtler in content, microassaults are often conscious to the perpetrator (Sue et al., 2007). Therefore, critics suggest that the inclusion of microassaults as microaggressions is a categorical misclassification and trivializes overt racist acts (Lilienfeld, 2017). Some studies identified macroassaults as macroaggressions, while microinsults and microinvalidations are categorized as microaggressions (Donovan, Galban, Grace, Bennett, & Felicié, 2013).

While microassaults are conscious and deliberate, they still maintain subtlety through the situational context. Sue et al. (2007) purports that microassaults "are generally expressed in limited 'private' situations that allow the perpetrator some degree of anonymity" (p. 274) or publicly when situational anonymity creates a sense of safety for a perpetrator to engage in a microassault. Microassaults differ from other types of microaggressions because perpetrators excuse their behavior as humor, state that they are emotionally dysregulated, or ask the target to rely on their perceived intention rather impact of the communication (Sue, 2010). Situational obscurity allows for perpetrators to engage in microassaults in both private and public spheres.

Environmental Microaggressions

Environmental microaggressions are "demeaning and threatening social, educational, political or economic cues that are communicated individually, institutionally, or societally to marginalized groups" (Sue, 2010, p. 25). Organizations with formal policies or informal norms that assault, insult, or invalidate nondominant group members, either directly or indirectly, perpetuate environmental microaggressions. When environmental microaggressions are present, nondominant group members report not feeling welcomed or wanted or they report feeling like they do not deserve to be at the organization (Houshmand, Spanierman, & Tafarodi, 2014; Nnawulezi & Sullivan, 2014).

Microaggressions, Power, and Social Identity

Microaggressions are the daily consequences of living in a society with an unequal distribution of social, political, and economic power among groups. They are present in any setting where there are social groups that are dominant—has greater or total access to power—and nondominant —limited to now access to power. Dominant group identities such as being white, cisgender,[1] male, Christian, wealthy, able-bodied, neurotypical, heterosexual, and thin are rarely targets of microaggressions. Microaggressions are disproportionally directed toward, and negatively impact, those who have nondominant social identities (Burrow & Hill, 2012; Basford, Offermann, & Behrend, 2014). In fact, Donovan et al. (2013) surveyed 187 Black female university students and found that microaggressions such as being disrespected or ignored because of their race were more common in their daily lives than overt forms of discrimination. In this study, nearly 97% experienced microaggressions a least a few times a year.

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[1] When a person's gender identity aligns with the sex that was assigned at birth

The content of microaggressions also reflects the negative cultural stereotypes associated with nondominant group status. For example, in a university sample of racially diverse undergraduate students, students of color were much more likely to report microaggressions compared to white students. Black students reported more microaggressions associated with assuming they committed a crime and being treated like a second-class citizen while being less likely to report microaggressions related to exoticism compared to other students of color. Whereas Latinx and Asian students reported experiencing microaggressions where the perpetrator assumed that all members of their social group looked similar (Forrest-Bank & Jenson, 2015).

Impact of Microaggressions on Well-Being

Microaggressions are associated with numerous negative physical, psychological, and social health consequences. Those with multiple nondominant identities are disproportionately susceptible to health consequences which manifest in their bodies, psyche, and social interactions. We describe some below.

Physical health consequences People who experienced interpersonal microaggressions (microassaults, microinsults, and microinvalidations) reported poorer general physical health, feeling limited in their roles, being fatigued, and experiencing more pain. In the same study, environmental microaggressions were also significantly associated with having less energy, greater fatigue and being limited because of physical health concerns (Nadal, Griffin, Wong, Davidoff, & Davis, 2017).

Psychological and social health consequences Microaggressions were also associated with greater depressive symptoms (Choi, Lewis, Harwood, Mendenhall, & Huntt, 2017) and more social anxiety (Huynh, 2012). Targets had negative emotions and felt isolation and shame related to their microaggressive experiences (Gonzales, Davidoff, Nadal, & Yanos, 2015; Nadal et al., 2017). Targets were also more apt to internalize negative messages about themselves (Kohli & Solórzano, 2012). When people perpetrated microaggressions, targets felt less connected to society and reported cultural othering (Nadal et al., 2017). Microaggressions were also associated with decreased trust in counselors and lower likelihood to adhere to therapeutic treatment (Gonzales et al., 2015).

Microaggressions in Human Service Organizations

Human service organizations are the primary focus for practitioners who seek to provide supportive interventions to people who are the target of intersecting individual, community, and societal harms and come from social and geographic communities that have been historically disenfranchised. Yet, it is difficult to meet the goal of individual wellness when people experience microaggressions in human service contexts. Since microaggressions exacerbate negative physical and psychological health and reduce the efficacy of supportive psychosocial interventions (Hook et al., 2016; Nadal et al., 2017), it is imperative that practitioners identify the ways in which microaggressions can manifest in HSOs, undermine the organizational mission, and inadvertently harm communities.

There is limited evidence about how people view services after a microaggression is perpetrated. Owen, Tao, and Rodolfa (2010) found that when clients experience microaggressions in therapy, they reported lower therapeutic alliance and worse therapeutic outcomes. This was true no matter how bad they felt prior to the start of therapy. This study and others suggest that microaggressions can create distance between the practitioner and the people who are served (Constantine, 2007), which is problematic because therapeutic alliance and trust are often at the core of service provision. Below, we present two case examples that discuss the subtle ways microaggressions are perpetrated within two distinct HSOs.

Case Example 1: Microaggressions Experienced by a Transgender Client in a Healthcare Setting

The relationship that the transgender community maintains with human and health services can be both empowering and harmful. In comparison to gays and lesbians, transgender people face increased barriers to health due to a lack of available data, providers, and resources specifically about transgender communities. Transgender people are often not the focus of specialized clinical care. After navigating complicated systems, transgender patients often encounter healthcare environments where they struggle to be taken seriously or forced to interact with practitioners who are not equipped to provide appropriate sources of care (Kaufman, 2008).

This case example describes a multidisciplinary, not-for-profit health clinic that provides a wide range of services aimed primarily for, but not limited to, uninsured and low-income patients. In the past, the medical center was recognized by the LGBTQ community for their commitment to having inclusive and nondiscriminatory health providers. After a rapid expansion in services, the leadership team changed. Eighty percent of executive level leadership were heterosexual and white. Many patients also reported decreased satisfaction in their healthcare and sense of security. A patient of the health clinic, who identified as a transgender man, recalled experiencing microaggressions with a healthcare provider that later shaped his perception of the organization:

> *I've been on my hormones for about 10 years and it was great…however I had to stop taking my T* [testosterone] *due to a lack of insurance. A few years ago, I finally got really good insurance through my job. I made an appointment with [the health clinic] so I can start my hormones again. Of course, I had to wait months in order to see* [the practitioner] *because she was the only doctor serving trans men… We* [trans men] *have few options.*
>
> *During my first appointment, I told her that I would like to start taking my hormones. She looked at me and said, "Oh you look good now, but you will look better once you are back on your T* [testosterone]*". I was so insulted. When we started to talk about* [hormonal] *dosage, I shared with her the levels I was taking for 10 years, but she totally dismissed me. I told her that the dosage she was prescribing will not suppress my period. She said that she is prescribing a lower dose "because trans men have anger issues" on higher levels of T* [testosterone]. *I gave up at that point. What was I supposed to do? She is the only one in town that specializes in trans men health.*

There were a number of microaggressions that occurred within this example. An environmental microaggression occurred in the shifting of the organizational leadership to primarily white and heterosexual staff. A microaggression was also present in the limited number of practitioners in the organization that provided services to trans men. The practitioner engaged in a microinsult by assuming that the ultimate goal of the patient hormonal therapy was to assimilate to the dominant culture. In this case, the patient's gender identity as a man did not equate to the dominant culture conceptualization of masculinity or "passing." The client's gender identity was also challenged by the practitioner's notion that male secondary sex characteristics were requisites for masculine identities. Another microinsult was the assumption that all transgender men were susceptible to increased episodes of anger and should be regulated for it against their will—despite evidence that hormonal replacement therapy actually mitigates anxiety and depression symptoms, including decreased anger and hostility (Davis & Meier, 2014).

These microaggressions influenced the transgender patient's physical and psychological health. While secondary sex characteristics were likely side effects of testosterone therapy (Gooren & Giltay, 2008), hormonal therapy has also been attributed to the improvement in quality of life for transgender people, including a positive influx in mood and sexual function (Costantino et al., 2013; Gorin-Lazard et al., 2012). For the patient, the primary focus of his hormonal therapy was to increase quality of life. Not only were the practitioner's postulations unsubstantiated, it also confirmed to the patient that health services were unsafe.

Case Example 2: Microaggressions in a Positive Youth Development Program

Positive youth development (PYD) programs strive to be inclusive, empowering, and safe for young people from diverse backgrounds.

This is important because PYD programs serve an increasingly diverse group of young people. For example, by 2060 the US Census projects that non-white youth will comprise 64% of youth under 18 (Colby & Ortman, 2015). Despite the efforts to be inclusive, PYD organizations can unknowingly create a supportive context for some youth while leaving others behind. The following case describes examples of racial, ethnic, and cultural microaggressions in an organization that uses a PYD approach.

A local youth development center in a large urban city provides recreational opportunities for kids and informal mentorship and counseling, with a mission to prevent problem behaviors and delinquency. This program is housed in an under-resourced community with high rates of poverty and aims to serve low-income youth who are majority Black and Latinx. Two white women who are developmental psychologists created the program using evidence-based models. Consistent with the organizational mission to reduce problem behaviors, the center workers are instructed to interrupt any behaviors that they may view as problematic.

The one Black male staff member recalled a formative moment in his first year on the job:

> *My first year…I had a young lady… say 'Mr. Chad you're not like us.' And I didn't know how to respond, so I don't think I did respond. But I knew what she was saying…I was not the caricature of a young Black male that she had known. I think that's what she was saying, like you're not like us. That was weird to hear. And I thought…. [this is] part of this racial structure. What does it look like to be a twenty-one-year-old Black male in this world? Not teaching kids, right?*

Another staff member, an Asian American woman, witnessed another interaction at the center that bothered her. She said:

> *One day, a Black student accidently grazed the arm of a White staff member when he walked by. In response, the student said "Oh, my bad." And the teacher responded, "No, that's not how you talk. That's the wrong way to talk. What you should say is 'I'm sorry.'"*

Although the staff member was concerned about the interaction, she did not know how to address it.

As a PYD organization, there is an inherent assumption that the context aims to be inclusive of all youth. Yet, the current case portrays how environmental microaggressions and microinsults continue to operate despite the well-intentioned PYD practices implemented at the center. The first example of the young person who found it surprising that a Black man was working at the center points to an environmental microaggression. Although the center served majority low-income, Black and Latinx youth, white college-educated women primarily staffed the center. The inadvertent message this communicated to youth was that white women were the experts on teaching them to change behaviors.

The second example of the youth whose speech was corrected was indicative of a microinsult. The staff member viewed the student's speech as problem that needed to be addressed. The organization needs to also explore how they conceptualize youth problem behavior and the cultural and racial implications of that definition. Second, the onlooking Asian American staff member was bothered by the incident but did not know how to respond. When program staff do not know how to interrupt microaggressions, or they perpetuate microaggressions themselves, it may send a message to other staff or youth in the program that these behaviors, attitudes, or beliefs are normative and acceptable.

Multilevel Approaches to Interventions That Interrupt Microaggressions

The insidious nature of microaggressions requires overt intervention to prevent their reoccurrence and mitigate their negative impact. Given that microaggressions can occur at multiple levels, there is a need for multilevel interventions to address the individual harm that is caused by microaggressions (individual), change the interpersonal dynamics that impede the ability to create and engage in meaningful interactions with others (interpersonal), and create institutional cultures grounded in values of anti-oppression, inclusion, and respect (institutional). Researchers need to go beyond the individual because therapeutic or behavioral interventions alone will not rid organizations of the discriminatory and oppressive cultural dynamics that supported microaggressions. All intervention efforts must be grounded in an understanding of how power is distributed within an organization. Below, we describe some evidence on coping and intervening at individual and interpersonal levels when microaggressions occur and then introduce a concept to support setting-level interventions.

Individual

Targets Individuals engage in multiple strategies to cope with microaggressions. Intervention first requires appraisal or identifying whether someone perceives the microaggressions as discrimination. In one study, twelve Black female survivors of intimate partner violence experienced racial microaggressions while staying at a domestic violence shelter; yet, only one of them appraised the experience as racist (Nnawulezi & Sullivan, 2014). Data demonstrated that their lack of appraisal was associated with internalized sexism and racism, victim blaming beliefs, and perceptions of perpetrators as otherwise good and fair. The ability to forgive might also influence appraisal of microaggressions. Burrow and Hill (2012) found that dispositional forgiveness was related to being less likely to view microaggression as discriminatory. In other words, the more likely one was to forgive, the less likely they were to see the situation as discriminatory. This association is stronger for ethnic minorities than white people. After appraisal, targets have responded to microaggressions by either ignoring or directly confronting the perpetrator (Hall & Fields, 2015; Hernández, Carranza, & Almeida, 2010; Nnawulezi & Sullivan, 2014).

There are multiple strategies that people can use to lessen the negative psychological impact of microaggressions. Contemplative practices, such as meditation, can help to protect the target's mental health (Hernández et al., 2010; Holder, Jackson, & Ponterotto, 2015). Another protective practice is to develop a strong identity that validates and affirms the self (Choi et al., 2017; Holder et al., 2015). This extends into purposefully creating opportunities to engage meaningfully with members of similar social identity groups (Houshmand et al., 2014). In some studies, participants buffered the negative impact of microaggressions by utiliz ing in self-care practices such as exercise, vacations, and spending time with loved ones (Holder et al., 2015); while others engaged in activism and community organizing (Hernández et al., 2010).

Perpetrators Perpetrators, and potential perpetrators, of microaggressions can engage in numerous strategies to lessen the number of microaggressions they perpetrate against targets. Like those who are targeted, perpetrators should be able to appraise microaggressions as discrimination. Subsequently, a decrease in the likelihood to perpetrate a microaggression can also mean an increase in critical consciousness—awareness that people have unequal access to resources and experience multiple harms because of this unequal distribution of social power. Using perspective-taking strategies, a form of prejudice reduction, can help potential perpetrators to gain an more intimate understanding about how targets experience microaggressions (Nnawulezi, Ryan, & O'Connor, 2016). The adoption of a cultural humility provides a foundation of how to behave once consciousness is raised. Within a cultural humility framework, individuals make a commitment to constantly learn about themselves and others while also being open to critique. This framework centers the experiences of nondominant identities by asserting that people are the expert of their own lives and have valid experiences. Potential perpetrators must develop a commitment to social justice, which means engaging in efforts that ensure equitable treatment and distribution of resources among all groups while also seeking to eradicate exclusionary, oppressive policies that perpetuate the use of overt racial discrimination and microaggressions at the individual level.

Interpersonal

Microaggressions are most common in our direct and interpersonal communications with one another. They are, by definition, relational. Individual strategies can be useful to building awareness, appraising, and coping with microaggressions but understanding how to work in relationships is vital.

Targets When someone is a target of a microaggression, there are numerous practices that have been suggested or tested to mitigate the negative impact of microaggressions. First, having social support helps. When people feel like they have someone to ask for advice, it mitigates the negative impact of microaggressions (Holder et al., 2015). Relating to others decreases the anxiety that is associated with microaggressions (Liao, Weng, & West, 2016). Sue (2010) describes the process of sanity checks—processing the microaggression with an outside person to help appraise, often affirm, that the experience was microaggressive. Relying on trusted others, or providing affirming support, interrupts the internalization of the negative messages at the core of the microaggression.

Perpetrators There is limited evidence on what to do when someone perpetrates a microaggression. However, the adoption and practice of cultural humility within interpersonal interactions is an evidence-informed strategy that reduces the likelihood that a person will perpetrate a microaggression and lowers the negative impact of the microaggression on the target (Hook et al., 2016). Within a human services organization, this means that the provider maintains an interpersonal stance focused on the cultural identity or identities that are important to the possible target. They provide space for the potential target to talk about their life experiences and integrate and affirm these experiences in subsequent conversations.

Another realm for consideration of interpersonal interactions is in the alliance between the therapist and the client, because that alliance is vital for positive therapeutic outcomes. People who reported stronger alliances, compared to people with weaker alliances, perceived that therapists perpetrated less microaggressions (Owen, Tao, Imel, Wempold, & Rodolfa, 2014). Owen et al. (2014) found that when a microaggression was perpetrated within a therapeutic intervention, the impact of the microaggression was less hurtful when the therapist immediately identified the microaggression, admitted the mistake, apologized, and communicated to the client that they respected them. The therapist's communication about the experience was critical for maintaining the alliance. When a therapist discussed the microaggression with the client, they maintained a working alliance that was similar to the alliance scores of dyads who were in therapeutic relationship where a microaggression never occurred. However, if the therapist did not talk about the perpetrated microaggression, then the working alliance scores decreased significantly compared to those therapist-client dyads who discussed it and to therapist-client dyads who never experienced a microaggression in their relationship.

Integrating Settings into Microaggression Research: Bringing Organizations "In View"

Scholars often study microaggressions as an individual or relational phenomenon, yet the prevalence and acceptance of microaggressions are strengthened or weakened by the settings where they occur. How microaggressions appear in settings are as diverse and multidimensional as the range of social identities. Since microaggressions are varied and can manifest differently over time, it is likely that HSOs lack the capacity to completely eliminate microaggressions. However, it is essential *In View (an organization)* that HSOs work toward being *In View which describes* an organization that is consistently self-correcting and aims to disrupt institutional power structures that support the perpetration of microaggressions. An organization *In View* is supportive, aware, conscious, free of harm, safe, affirming, authentic, and missioned around justice and transformative change for those that they serve. Ultimately, HSOs need to get *In View* to promote individual and collective well-being, which aligns with the overall mission of human service work.

Organizational Culture An organization that is *In View* understands the role of social power within and outside of their organization. Members in the organization are attuned to how organizational power is being wielded, distributed, and allocated and how this distribution perpetuates oppression. *In View* organizations value learning, engage in iterative processes of self-examination, and provide opportunities for members to reflect on their personal experiences. This organization would continually examine how and why staff ended up in their various roles. For example, how does the requirement of an advanced degree for high-paying leadership positions influence employee demographics, especially with structural barriers related to accessing higher education vis-à-vis socioeconomic status?

Organization Structure Being *In View* means that organizational activities are developed, led, and staffed by people who live in the communities where the organization is located and/or included in meaningful decision-making and leadership roles. The organization would have policies, and engage in practices, that create a culture of responsiveness, honesty, and trust. Organizational members would advocate for public policies relevant to the reduction of microaggressions at multiple levels. They would institutionalize practices to affirm the humanity and worth of the individuals they serve. This organization would train its members to be aware of diverse social identities, acknowledge the microaggressions that manifest in the presence of these social identities, and provide members with the skills to interrupt microaggressions when they occur. The organization would develop and implement individual- and organizational-level accountability practices to equip relevant staff to effectively address microaggressions when they occur. Hiring criteria would require candidates to demonstrate their plan to honor, recognize, and respect the knowledge of people who have been historically marginalized. Finally, an organization *In View* would be able to locate itself within a larger social justice movement by recognizing that the microaggressions clients experience outside of the organization influence the ways they interact inside the organization.

Member Attitudes, Beliefs, and Behaviors Being *In View* means organizational members are self-reflective and take intra- and extra-organizational actions to align their personal practice with the organizational mission to ensure that all members, those who work in and receive services from the organization, can achieve well-being. Since microaggressions are rooted in implicit and explicit bias, members who operate within an organization *In View* would make microaggressive attitudes, beliefs, and behaviors visible so that they can be immediately addressed. When microaggressions do occur, organizational members would validate the experiences of the targets and provide sanity checks (Sue, 2010).

To move beyond the status quo, HSOs need to bring their members into consciousness about what microaggressions are and assure that their members and constituents are seen and heard. When existing HSOs are transformed into being *In View*, they are closer to meeting their collective mission to reduce suffering and increase well-being.

Complexities and Limitations of Microaggression Theory

Microaggression is a relatively novel and complex theory; yet, there are notable limitations to the current scholarship on microaggressions as well as opportunities to strengthen future research. First, microaggression theory would benefit from further refinement. For example, it is not always clear how overt acts of discrimination differ from microassaults. Lilienfeld (2017) argued the lack of clarity in the operationalization of microaggressions calls into question the reliability and validity of existing scales which measure the impact of microaggressions on mental and physical health. Also, numerous microaggression studies use self-report and qualitative methods, which is appropriate given the relational and context-dependent nature of microaggressions. Yet, future research would benefit from a wider range of methodological approaches. Another major criticism of microaggression research is appraisal. Who gets to decide whether a microaggression has occurred: the target or the perpetrator? According to Lilienfeld (2017), microaggressions are from the "eye of the beholder." He posits that subjective appraisals of microaggressions may be due to individual differences, such as personality. Therefore, for something to be deemed a microaggression, there needs to be some degree of consensus about its nature and intent.

Some of the empirical evidence supports the dichotomization of perpetrators and targets. Perpetrators occupy the dominant group while targets occupy the nondominant group. Or, the identity of the perpetrator is not identified or analyzed in the study at all. This contributes to the need to further nuance how scholars conceptualize the perpetration of microaggressions, especially when multiple intersecting identities often include both privileged and marginalized identities that are more or less prominent or powerful depending on the context. While there is currently limited evidence to support this claim, we suspect that internalized oppression could contribute to the perpetration of microaggressions against members of the same group. It is not clear in microaggression theory whether there is differential impact or experience of harm if a member of the same social identity group perpetrated a microaggression versus someone outside of the social identity group. Microaggressions contribute to the perpetuation of oppressive dynamics even if the perpetrator would not typically hold power within the larger social structure. Future research could examine these gaps in the literature by examining internalized subordination and internalized domination and its relationship to microaggression perpetration within the context of intersectionality. This would allow for more complex and nuanced understandings of how to respond to microaggressions at the individual and interpersonal levels.

While skepticism and constructive criticism enhance scholarship, critiques that challenge the lived realities of those who experience microaggressions may be a form of epistemic exclusion —“an unwarranted infringement on the epistemic agency of a knower, which reduces her/his ability to participate in the production of knowledge” (Dotson, 2014, p.115). In other words, critiques about appraisal that reduce the experience of the target to a misinterpretation of events or a result of specific personality traits seeks to reduce the credibility of the target. In addition, despite the popularity of Lilienfeld’s (2017) critiques of microaggression scholarship, they are grounded in several assumptions that dismiss the lived realities of those who experience discrimination and the methods used to understand those realities. For example, the suggestion that current microaggression scholarship is not robust enough to constitute sufficient evidence assumes that methods rooted in positivist approaches are the ideal way to gain empirical evidence on the human experience (Sue, 2017).

Critics and perpetrators also commonly respond to microaggressions by providing an alternate account of the event or defending the intentions or motivations of the well-meaning perpetrator. This suggests that the microaggression is a result of the target’s misinterpretation or individual characteristics (such as negative affect) (Berenstain, 2016). This response centers the voice and experience of those who are more privileged, without acknowledgment of the perpetrator’s biases or the consideration that the perpetrator will benefit from the dismissive notion that “microaggressions do not exist” or that “microaggressions are a perception based on individual characteristics of those that experience them.” For example, if the problem is defined in a way that suggests microaggressions are a product of individual characteristics of the victim of the microaggression, it places the onus on the target to change, rather than the perpetrator or the context (Ryan, 1976). In contrast, microaggressions deliberately center the experiences and realities of individuals with less power because their experiences and ideas are valuable contributions to knowledge of the human experience. By doing so, it encourages change in the context and/or among the people with more power.

Future Implications for Microaggression Research and Practice

Research There is a continued opportunity to refine microaggressions research in human service contexts. Specifically, there is a need for further theory development, to use different and new research methods, explore microaggressions research in diverse settings, and examine the relationships between microaggressions and other outcomes of interest.

Many studies on microaggressions use the framework and taxonomy introduced by Sue et al. (2007). Multiple scholars have generated evidence confirming and building on this taxonomy (Nadal, 2011), yet additional theoretical refinement is needed. This specifically pertains to differentiating between overt discrimination and microassault. Minikel-Lacocque (2013) argues that microassaults should not fit into the microaggression category, but rather be conceptualized as racialized aggressions, because they are not microaggression.

Many scholars employ quantitative and qualitative methods (focus group and interviews) to study microaggressions. The inclusion of more diverse study methods such as observational methods to identify microaggressions and responses in real time could augment self-report data methods. However, observational methods require significant time commitments and the presence of the researcher may influence the behavior of individuals in the setting. There could also be discrepancies between the observer's appraisal and the victim's appraisal of the incident. Another method that researchers might consider is the use of ecological momentary assessment (EMA) to assess responses to and outcomes of to microaggressions in real time. The appraisals of microaggressions differ based on context and individual awareness of oppression. This approach relies on self-report data and may also be time consuming for the participants.

Researchers mostly study microaggressions in higher education institutions and counseling and mental health supervisory relationships. To a lesser extent, microaggression research has taken place in K-12 school settings, workplaces, online, community, and other public spaces. Yet, there is limited research addressing microaggressions in human service settings. The evidence base would benefit from the exploration of microaggressions within diverse social settings. Research studies often focus on microaggressions within specific demographic dimensions, such as race/ethnicity (Sue et al., 2007), gender (Makin & Morczek, 2016), sexuality (Seelman, Woodford, & Nicolazzo, 2017), religion (Husain & Howard, 2017), and mental illness (Holley, Tavassoli, & Stromwall, 2016). Very few studies have examined microaggressions through an intersectional lens (Holley et al., 2016); yet people have multiple intersecting identities that create unique experiences of discrimination that are distinct from mono-focused explorations of microaggressions.

Parts of the taxonomy of microaggressions are similar across identity groups. For example, multiple microaggression studies demonstrate the theme of assumed universality—the act of assuming all individuals that share a social identity have the same experience. Assumed universality is present when exploring both racial and ethnic microaggressions (Henfield, 2011) and microaggressions among transgender individuals (Nadal, Skolnik, & Wong, 2012). A meta-analysis may be useful in identifying shared patterns and to develop generalizable interventions across settings and identities.

Few studies examine the cognitive processes that are related to the perpetration of microaggressions. Future research questions could examine how a person recognizes when they have committed a microaggression. There is also a need to further explore individual and community protective factors that support the targets of microaggressions. Many microaggression studies have not examined how people can actively respond or interrupt microaggressions as bystanders. How could intervening on microaggressions impact individuals, interpersonal interactions, and settings? How could it influence targets' appraisal and experience of that microaggression, and how safe they feel? There is also ample opportunity for researchers to explore the ways in which human service settings implement structures to reduce microaggressions and the short- and long-term impact of such efforts on staff or clients.

Practice HSOs have recognized the need to alter setting practices that decrease experiences of overt discrimination and microaggressions within the setting. However, in practice, acknowledging oppression tends to be reactive and problem centered emphasizing individual discriminatory practices while ignoring overall structural inequality and unequal resources (Evans, Hanlin, & Prilleltensky, 2007). An organization's ability to only acknowledge microaggressions as a detriment to human service is, at best, insufficient in addressing social injustice. An organization must join other community members who are actively fighting oppression within the community.

Organizational Settings In addition to staff training about microaggressions, organizations can also examine their hiring policies and determine who has access to positions of influence in the organization and the criteria mandated to gain access to these positions. After assessing if shared information will cause significant complications, the application of transparency in pay structure, hiring, advancement or termination may decrease microaggressions. Future research can also focus on whether a microaggressive climate relates to satisfaction and employee retention among diverse groups. This may be achieved by identifying external entities to evaluate an organization's blind spots for embedded systems that enable microaggressions.

Conclusion

Microaggression is a misnomer because while subtle in nature, it has significant impacts on peoples' lives. HSOs are not exempt from perpetrating microaggressions, but they also can be contexts where members can practice disrupting microaggressions and provide spaces for targets to bond and build solidarity. This aligns with the broader goal for HSOs to contribute to creating a more socially just society.

References

Alabi, J. (2015). Racial microaggressions in academic libraries: Results of a survey of minority and non-minority librarians. *The Journal of Academic Librarianship, 41*(1), 47–53. https://doi.org/10.1016/j.acalib.2014.10.008

Basford, T. E., Offermann, L. R., & Behrend, T. S. (2014). Do you see what I see? Perceptions of gender microaggressions in the workplace. *Psychology of Women Quarterly, 38*(3), 340–349. https://doi.org/10.1177/0361684313511420

Berenstain, N. (2016). Epistemic exploitation. *Ergo, 3*(22), 569–590. https://doi.org/10.3998/ergo.12405314.0003.022

Burrow, A. L., & Hill, P. L. (2012). Flying the unfriendly skies?: The role of forgiveness and race in the experience of racial microaggressions. *The Journal of Social Psychology, 152*(5), 639–653. https://doi.org/10.1080/00224545.2012.686461

Cartwright, B. Y., Washington, R. D., & McConnell, R. L. (2009). Examining racial microaggressions in rehabilitation counselor education. *Rehabilitation Education, 23*(3–4), 171–181. https://doi.org/10.1891/088970109805029996

Choi, S., Lewis, J. A., Harwood, S., Mendenhall, R., & Huntt, M. B. (2017). Is ethnic identity a buffer? Exploring the relations between racial microaggressions and depressive symptoms among Asian-American individuals. *Journal of Ethnic & Cultural Diversity in Social Work, 26*(1–2), 18–29. https://doi.org/10.1080/15313204.2016.1263815

Colby, S. L. & Ortman, J. M. (2015). Projections of the size and composition of the U.S. population: 2014 to 2060. Retrieved from: https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf

Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology, 54*(1), 1. https://doi.org/10.1037/0022-0167.54.1.1

Costantino, A., Cerpolini, S., Alvisi, S., Morselli, P. G., Venturoli, S., & Meriggiola, M. C. (2013). A prospective study on sexual function and mood in female-to-male transsexuals during testosterone administration and after sex reassignment surgery. *Journal of Sex & Marital Therapy, 39*(4), 321–335. https://doi.org/10.1080/0092623X.2012.736920

Davis, S. A., & Meier, S. (2014). Effects of testosterone treatment and chest reconstruction surgery on mental health and sexuality in female-to-male transgender people. *International Journal of Sexual Health, 26*(2), 113–128. https://doi.org/10.1080/19317611.2013.833152

Donovan, R. A., Galban, D. J., Grace, R. K., Bennett, J. K., & Felicié, S. Z. (2013). Impact of racial macro- and microaggressions in Black women's lives: A preliminary analysis. *Journal of Black Psychology, 39*(2), 185–196. https://doi.org/10.1177/0095798412443259

Dotson, K. (2014). Conceptualizing epistemic oppression. *Social Epistemology, 28*(2), 115–138.

Evans, S. D., Hanlin, C. E., & Prilleltensky, I. (2007). Blending ameliorative and transformative approaches in human service organizations: A case study. *Journal of Community Psychology, 35*(3), 329–346. https://doi.org/10.1002/jcop.20151

Forrest-bank, S., & Jenson, J. M. (2015). Differences in experiences of racial and ethnic microaggression among Asian, Latino/Hispanic, Black, and White young adults. *Journal of Sociology & Social Welfare, 42*, 141.

Gonzales, L., Davidoff, K. C., Nadal, K. L., & Yanos, P. T. (2015). Microaggressions experienced by persons with mental illnesses: An exploratory study. *Psychiatric Rehabilitation Journal, 38*(3), 234. https://doi.org/10.1037/prj0000096

Gooren, L. J., & Giltay, E. J. (2008). Review of studies of androgen treatment of female-to-male transsexuals: Effects and risks of administration of androgens to females. *The Journal of Sexual Medicine, 5*(4), 765–776. https://doi.org/10.1111/j.1743-6109.2007.00646

Gorin-Lazard, A., Baumstarck, K., Boyer, L., Maquigneau, A., Gebleux, S., Penochet, J. C., … Berbis, J. (2012). Is hormonal therapy associated with better quality of life in transsexuals? A cross-sectional study. *The Journal of Sexual Medicine, 9*(2), 531–541. https://doi.org/10.1111/j.1743-6109.2011.02564.

Hall, J. M., & Fields, B. (2015). "It's Killing Us!" Narratives of black adults about microaggression experiences and related health stress. *Global Qualitative Nursing Research, 2*. https://doi.org/10.1177/2333393615591569

Henfield, M. S. (2011). Black male adolescents navigating microaggressions in a traditionally white middle school: A qualitative study. *Journal of Multicultural Counseling and Development, 39*(3), 141–155. https://doi.org/10.1002/j.2161-1912.2011.tb00147.x

Hernández, P., Carranza, M., & Almeida, R. (2010). Mental health professionals' adaptive responses to racial microaggressions: An exploratory study. *Professional Psychology: Research and Practice, 41*(3), 202. https://doi.org/10.1037/a0018445

Holder, A., Jackson, M. A., & Ponterotto, J. G. (2015). Racial microaggression experiences and coping strategies of Black women in corporate leadership. *Qualitative Psychology, 2*(2), 164. https://doi.org/10.1037/qup0000024

Holley, L. C., Tavassoli, K. Y., & Stromwall, L. K. (2016). Mental illness discrimination in mental health treatment programs: Intersections of race, ethnicity, and sexual orientation. *Community Mental Health Journal, 52*(3), 311–322. https://doi.org/10.1007/s10597-016-9990-9

Hook, J. N., Farrell, J. E., Davis, D. E., DeBlaere, C., Van Tongeren, D. R., & Utsey, S. O. (2016). Cultural humility and racial microaggressions in counseling. *Journal of Counseling Psychology, 63*(3), 269. https://doi.org/10.1037/cou0000114

Houshmand, S., Spanierman, L. B., & Tafarodi, R. W. (2014). Excluded and avoided: Racial microaggressions targeting Asian international students in Canada. *Cultural Diversity and Ethnic Minority Psychology, 20*(3), 377. https://doi.org/10.1037/a0035404

Husain, A., & Howard, S. (2017). Religious microaggressions: A case study of muslim Americans. *Journal of Ethnic & Cultural Diversity in Social Work, 26*(1–2), 139–152. https://doi.org/10.1080/15313204.2016.1269710

Huynh, V. W. (2012). Ethnic microaggressions and the depressive and somatic symptoms of Latino and Asian American adolescents. *Journal of Youth and Adolescence, 41*(7), 831–846. https://doi.org/10.1007/s10964-012-9756-9

Kaufman, R. (2008). Introduction to transgender identity and health. In H. Makadon, K. Mayer, J. Potter, & H. Goldhammer (Eds.), *The Fenway guide to lesbian, gay, bisexual, and transgender health* (pp. 331–364). Philadelphia, PA: American College of Physicians.

Kohli, R., & Solórzano, D. G. (2012). Teachers, please learn our names!: Racial microagressions and the K-12 classroom. *Race Ethnicity and Education, 15*(4), 441–462. https://doi.org/10.1080/13613324.2012.674026

Lewis, J. A., & Neville, H. A. (2015). Construction and initial validation of the gendered racial microaggressions scale for black women. *Journal of Counseling Psychology, 62*(2), 289–302. https://doi.org/10.1037/cou0000062

Liao, K. Y. H., Weng, C. Y., & West, L. M. (2016). Social connectedness and intolerance of uncertainty as moderators between racial microaggressions and anxiety among Black individuals. *Journal of Counseling Psychology, 63*(2), 240. https://doi.org/10.1037/cou0000123

Lilienfeld, S. O. (2017). Microaggressions: Strong claims, inadequate evidence. *Perspectives on Psychological Science, 12*(1), 138–169. https://doi.org/10.1177/1745691616659391

Makin, D. A., & Morczek, A. L. (2016). X views and counting: Interest in rape-oriented pornography as gendered microaggression. *Journal of Interpersonal Violence, 31*(12), 2131–2155. https://doi.org/10.3102/0002831212468048

Minikel-Lacocque, J. (2013). Racism, college, and the power of words: Racial microaggressions reconsidered. *American Educational Research Journal, 50*(3), 432–465.

Nadal, K. L. (2011). The racial and ethnic microaggressions scale (REMS): Construction, reliability, and validity. *Journal of Counseling Psychology, 58*(4), 470–480. https://doi.org/10.1037/a0025193

Nadal, K. L., Griffin, K. E., Wong, Y., Davidoff, K. C., & Davis, L. S. (2017). The injurious relationship between racial microaggressions and physical health: Implications for social work. *Journal of Ethnic and Cultural Diversity in Social Work, 26*(1–2), 6–17. https://doi.org/10.1080/15313204.2016.1263813

Nadal, K. L., Skolnik, A., & Wong, Y. (2012). Interpersonal and systemic microaggressions toward transgender people: Implications for counseling. *Journal of LGBT Issues in Counseling, 6*(1), 55–82. https://doi.org/10.1080/15538605.2012.648583

Nnawulezi, N., Ryan, A. M., & O'Connor, R. (2016). Reducing prejudice within community-based organizations. *Journal of Community Practice, 24*(2), 182–204. https://doi.org/10.1080/10705422.2016.1157541

Nnawulezi, N., & Sullivan, C. M. (2014). Oppression within safe spaces: Exploring the presence of racial microaggressions within domestic violence shelters. *Journal of Black Psychology, 40*(6), 563–591. https://doi.org/10.1177/0095798413500072

Owen, J., Tao, K., & Rodolfa, E. (2010). Microaggressions and women in short-term psychotherapy: Initial evidence. *The Counseling Psychologist, 38*(7), 923–946. https://doi.org/10.1177/0011000010376093

Owen, J., Tao, K. W., Imel, Z. E., Wempold, B. E., & Rodolfa, E. (2014). Addressing racial and ethnic microaggressions in therapy. *Professional Psychology: Research and Practice, 45*(4), 283–290. https://doi.org/10.1037/a0037420

Ryan, W. (1976). *Blaming the victim*. New York, NY: Random House.

Seelman, K. L., Woodford, M. R., & Nicolazzo, Z. (2017). Victimization and microaggressions targeting LGBTQ college students: Gender identity as a moderator of psychological distress. *Journal of Ethnic and Cultural Diversity in Social Work, 26*(1–2), 112–125. https://doi.org/10.1080/15313204.2016.1263816

Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation*. Hoboken, NJ: Wiley.

Sue, D. W. (2017). Microaggressions and “evidence” empirical or experiential reality? *Perspectives on Psychological Science, 12*(1), 170–172. https://doi.org/10.1177/1745691616664437

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62*(4), 271. https://doi.org/10.1037/0003-066C.62.4.271

West, C. M. (1995). Mammy, Sapphire, and Jezebel: Historical images of Black women and their implications for psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 32*(3), 458–466. https://doi.org/10.1037/0033-3204.32.3.458

All You Have Gotten Is Tokenism

Albert R. Lee

Abstract

Tokenism is a sophisticated way of making institutions look progressive, while gender, race, and a host of other factors are the underlying hierarchy determining entrance and advancement in an institution. Psychologist Judith Long Laws provides an alternative foundation for our collective understanding of tokenism to the more often sited scholarship of Rosabeth Moss Kanter. Laws postulates that tokenism is built upon a mutually agreed to, although completely deceptive, relationship between two partners, the token and the sponsor. According to Laws, the relationship between token and sponsor is supported by a cultivated set of beliefs about the social system into which the token is being integrated. Their interaction is undergirded by agreements in several areas: exceptionalism, individualism, meritocratic mystique, boundary maintenance, definition of sponsor's role, the relationship between token and sponsor, and management of stigma. The author uses Laws' framework to illustrate his own tokenized experience in the workplace.

Keywords

Token · Exceptionalism · Individualism · Meritocracy · Diversity

Sociologist Rosabeth Moss Kanter is viewed by many as a seminal figure in tokenism research. After beginning her academic career at Brandeis University and continuing at Yale University, Kanter joined the faculty of Harvard's Business School in the late 1980s. Her early research in the 1970s on utopian communes in the United States garnered accolades leading to new opportunities beyond the traditional boundaries of sociology in the academy. Kanter received the Guggenheim fellowship in 1975 and subsequently wrote *Men and Women of the Corporation*, published in 1977. Kanter's work during this period centers around how corporate structure either promotes or stymies the success of its workers. Her work also chronicles the impact of being statistically underrepresented in an organization. Kanter found that performance pressure, increased visibility, and isolation together negatively affected the work performance of statistically underrepresented groups. In Kantar's view the crux of the problem was merely statistical and could be largely solved once the underrepresented group crossed the 15% threshold in representation within an organization.

In both the sociological and psychological research arena many have used the foundation

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L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_21

that Kanter's work provided to strengthen our collective understanding of tokenism from various perspectives. Frequently, psychologists believe Kanter's findings to be incomplete at best and fundamentally flawed at worst. Much of the research, as it stands, fails to view the issue of tokenism comprehensively with the myriad intersectional factors that can play a role in who is allowed to rise in an organization where the power is monopolized by white males.

Catherine Turco challenges Kanter's assertions in her article, "Cultural Foundations of Tokenism: Evidence from the Leverage Buyout Industry." Turco postulates that statistical representation and social standing within the society at large are inadequate factors in attempting to explain a token's experience. Underrepresented and historically marginalized populations have varied experiences when placed in different contexts. Turco's broader argument is that differences in a token's experience are grounded in the narrow context in which the tokenized existence is embedded. In short, the issues are local. While there are certainly regional factors that may give credence to the argument, it should be clearly understood that the system upon which tokenism is built has been in place in the USA for hundreds of years and it would be disingenuous to pretend that the foundation that undergirds all that we do can be repackaged to make us believe these issues are not embedded into the value system of America itself and the institutions built thereupon.

In "Composition of the Workplace and Psychological Well-Being: The Effects of Tokenism on America's Black Elite," Pamela Braboy Jackson, Peggy A. Thoits, and Howard F. Taylor pointed out significant limitations in Kanter's work. First, they felt that tokenism had not been studied systematically. Next, they felt the study focused its attention on women while disregarding other underrepresented groups. And, finally, the study focused on a single occupation failing to provide a general understanding across occupations. While the authors' findings are certainly valid, focusing attention on the elites of an underrepresented group privileges pedigree in a way that perpetuates tokenism at a different layer. If one can criticize tokenism on the basis of gender and race, it is equally important to challenge tokenism on the basis of class, lest we give in to the prescribed social hierarchy that governs the very system of American democracy. That social hierarchy has always had class as one of its pillars.

Janice Yoder's work on tokenism is in some respects a combination of the work of the aforementioned scholars. She uses Kanter's work as a framework and then builds upon it to go beyond Kanter's more limited scope. Yoder's body of work on gender specifically is extensive but it is the evolution of her work on gender and tokenism that makes her particularly important to this discourse. In 1985 she published a case study about academic women as tokens. The work uses her experiences as one of the first civilian faculty members at a United States military academy to discuss tokenism and its effect on the token. Yoder went on to study the ways in which men can succeed in female dominated professions while the inverse is not at all true. Some 10 years after Kanter's initial work on tokenism, Yoder begins to challenge Kanter's work. She found that gender issues were too complex to solve them simply by changing numbers. Also included in Yoder's body of work is a study of the varying experiences of black and white women in work environments using women firefighters as subject. In many respects Yoder's work can be its own case study of the manner in which academic fields often view studying race and racism as an afterthought, effectively exacerbating the difficulty of diversifying the workforce in too many fields. Additionally, it should be alarming to have more than 40 years of research on the topic of tokenism only to have institutions continue to hold on to the idea that merely increasing the numbers of underrepresented and historically marginalized people is the solution to issues of equity and inclusion.

Seven Years a Token

Psychologist Judith Long Laws provides an alternative foundation for understanding tokenism that has the potential to consider multiple factors at once. Defined as a conservative institution aimed at preserving the status quo, Laws postulates that tokenism is built upon a mutually agreed to, although completely deceptive, relationship between two partners: the token, a member of the "deviant class," and the sponsor, a member of the "dominant class." According to Laws, the relationship between token and sponsor is supported by a cultivated set of beliefs about the social system into which the token is being integrated. Their interaction is undergirded by agreements in several areas: exceptionalism, individualism, meritocratic mystique, boundary maintenance, definition of sponsor's role, the relationship between token and sponsor, and management of stigma. Although Laws' analysis was specific to women in the context of academia, her framework can be applicable to a myriad of tokenized existences in professions and institutions.

It should be pointed out that the sponsor can be seen as both institutional and individual. The institution as sponsor provides the structure necessary for this inequitable system to be perpetuated. The individual as sponsor acts as the agent of the institution to defend and protect it against attack from forces not dedicated to the perpetuation of the system. It is therefore difficult to know who to hold accountable and how to push back against these forces. Working against an individual may prove beneficial in the short term because it may initiate a personnel change. But as long as the structure remains the same, any personnel choice will still act as an agent of the institution. Working toward institutional change, especially in academia where everything is filtered through the veil of a committee, requires both a ground swell of support for change from the masses and an institutional leadership committed to real diversity, equity, and inclusion. A system that makes historically marginalized and underrepresented groups merely servants of the dominant group and not full members of the community with all the rights, privileges, and opportunities for advancement afforded to the dominant group might be diverse but it is not equitable or inclusive. For the purposes of this discourse, Laws' work will be used to understand how tokenism upholds the status quo in organizations through the lens of my own tokenized existence in the academy.

I arrived in Reno, NV, to begin my first full-time appointment after completing the Doctor of Music in Vocal Performance at Florida State University. Having completed a bachelor's and master's degree immediately after high school and spending 8 years as a professional singer in the classical genre, the terminal degree was the beginning of a newly balanced career where performing and teaching would be coequal pillars of my professional life. As a black man, from a single parent, working class home in an inner city, I was well aware of how privileged I was to have had the education and experiences I had. I was also keenly aware of the treacherous path that would lie ahead as I pursued my new professional aspirations.

While I felt very prepared to begin this new phase of my career, the uncertainty of what I would find when I began my new assignment was daunting. I was facing a new region of the country, a new institution, new colleagues, new students, and no easily identifiable community outside of my professional life where I would not be the only black person. After making an initial assessment of student performance in the department, I knew there was a great deal to accomplish in my teaching role. As a freelance classical singer with roots in the northeast, and having spent the previous 3 years in northern Florida, I would also be challenged in the area of my creative activity and research because I would be far removed from my field's center of gravity. While I was not on a tenure track when I arrived in Reno, if I aspired to achieve a tenure track position and earn tenure, it would be imperative for me to continue performing and to find new outlets for my research interests.

Thankfully, my concerns were greatly assuaged in my first few weeks in Reno. My department chair was very diligent in attempting to integrate me into the musical community on campus. I was introduced to new social and professional circles and was asked to perform the national anthem with the university orchestra for the new president of the university's inauguration. The most surprising overture came when I was informed that I would be featured on the front page of the university's website as a new faculty member. While I was excited for these opportunities, the latter seemed peculiar considering my status as a lecturer and not a tenure track faculty member. It would have been less peculiar if it was the music department's page but this feature was going to be on the main page of the university's website. I was honored but I also understood that my race was at play here and I was about to be catapulted into a level of visibility for which I had not planned.

My first semester was both productive and tumultuous. Within the first few weeks Kanter's assertion about performance pressure, increased visibility, and isolation began to have an effect. What saved me was the fact that I was too busy to succumb. In that first semester, I completed my first recording project alongside several other performances. During the same period, I found out that my position as lecturer had been converted to tenure track and I would have to apply and be considered as part of another national search if I wanted to remain at the institution.

Less than half way through the first semester, I was made aware that there had been complaints that I was intimidating. I was not informed of the source of these complaints. When I inquired about what I had said or done that rose to the level of intimidation, I was provided with no evidence of a no tangible accusation and was told that I should not worry because it was "not a bad thing." I was told that people were merely responding to my high standards and the way that I confidently went about my work. But the fact that I was called into the chair's office to discuss an accusation that did not seem to have merit was a sign that there was cause for concern. If it was not a warning of some sort, there would have been no reason to share this information with me. An institution committed to diversity, equity, and inclusion would have trained leaders with knowledge of pejorative terms, intimidating being one of several, that have been used against marginalized groups to further isolate them and put them on the defensive. In this early period of my affiliation with the institution, it was evident that its verbal commitment to diversity had no real structure, support, or tangible mandate from leadership or the community.

There is an adage that black parents in America often teach their children: you have to be twice as good to get half as much. One can debate the validity of such an assertion but, suffice it to say, the high standard I set for my students and the standard I set for my interactions with my colleagues was merely a reflection of the standard I set for myself. I worked diligently to "fit in" with my new colleagues while also making sure my work was above reproach in every way. I understood early on that if I were to be successful in this new context, I would have to manage how I was perceived in my department and build relationships outside of my department both to understand the institutional culture and as an antidote to the isolation I was beginning to feel, and I would need to be exceptional in every aspect of my work. There would be no room for error but I also had to temper my personal dedication to always be my best as to avoid negative attention from others.

Exceptionalism

It was only as I undertook the research for this project that I realized I had willingly but unknowingly entered into what is, according to Judith Long Laws, the first stage of a tokenized existence. Believing oneself to be exceptional is a part of what undergirds any lofty pursuit. That, in and of itself, was not the problem. Not only did I believe I was exceptional; the institution treated me as such while coupling it with veiled and not so veiled attempts to undermine my confidence and my ability to grow. The general assertion by the institution that I was "unusually able and competent" is consistent with Laws' work. In her analysis on the psychology of tokenism, Laws asks an extremely salient question about the idea of exceptionalism: exception to what? A token is exceptional "in exhibiting to a minimal degree the devalued attributes of the primary-deviant class, and to an exceptional degree the highly-valued attributes of the dominant class."

Exceptionalism lifts a token into rarefied air while simultaneously separating him or her from supportive connections to aspects of their identity be it gender, gender identity, race, sexual orientation, national origin, ability, and all of the categories often included in discussions of diversity, equity, and inclusion. This separation from potential avenues of support happens all while the token is not really received by the dominant group as an equal. It is important to point out that the idea of exceptionalism only tokenizes a person when it is an agreement between the token and institutional forces. In some respect the token's sense of self is validated while also being made to believe that the institution sees him or her as a valued member of the community. While it would be easy to simply blame the institutions for this, tokens must bear some responsibility in making this conscious or unconscious agreement with the institution. The institution is responsible for the deception around the idea of exceptionalism. The token is responsible for buying into the delusion in the face of all evidence that points to a lack of respect and a lack of appreciation for actual contributions they are making to an institution.

Laws goes on to state that the token's psychological distance from the primary-deviant class may make it easy for him or her to take on a role often assigned to tokens in any situation, that of gatekeeper. As a teacher, I had become guilty of demanding from black students a level of exceptionalism that I had required of myself and the system had required of me. Even before undertaking this research, I realized how unfair and ineffective I had become to students for whom my presence should have been a beacon of hope and understanding as they made their way through college. I recognized that I was becoming what frustrated me most during my doctoral studies, token professors operating as gatekeeper who might privately be supportive of my work but who would publically challenge me at every juncture without preparing me to meet the challenge. As a teacher, I decided that I would not change the standards but I would inform students in the beginning what I was grappling with as their teacher and ask them to meet me on the journey to discovering our highest and best as both teacher and student. This approach humanized me to my students and provided an atmosphere that both challenged and supported students of all backgrounds. I would go a step further than Laws and say that it is both psychological and physical distance that perpetuates this phenomenon. For me, at a university where the black student population has hovered around 3%, black academic faculty are significantly less, and the black population in the city at large also hovers around 3%, merely discussing psychological distance is an incomplete assertion.

With regard to the role of gatekeeping, one could reframe the narrative around student/faculty relationships and look at the roll of the token in hiring processes. In the token's role as gatekeeper, the bar for applicants coming through a search process who may represent different types of diversity becomes even higher. The level of exceptionality a token sees in themselves becomes the litmus test for others with similar identity to gain entry into the institution. Additionally, if one ascribes a sense of actual power to their role as token, the possibility of their being another is threatening to the token. This is why any effort to diversify an institution without addressing the systemic issues already at play, while placing tokens as ceremonial figureheads in those efforts is destined to fail. It should also be investigated how the gatekeeping phenomenon plays itself out among different groups. Anecdotally, my experience has shown a particularly high bar across all competencies for black people in relation to other underrepresented and historically marginalized groups. I have consistently witnessed other groups advocate for each other specifically in hiring processes. I have not witnessed the same among black people. And where multiple types of diversity exist, for example, race and gender or race and sexual orientation/gender identity, one has to wonder how much more daunting the road is. Further research in these areas would provide more information to aid in understanding the depths of the issue.

In the summation of her discussion on exceptionalism, Laws warns of the result when a token accepts the responsibility of gatekeeper. The fundamental structure of the institution or the profession is preserved. The token's existence in the structure and their work to perpetuate the structure is used to defend the system against charges of sexism, racism, homophobia, ableism, and the like. Laws astutely points out the value of tokens when the dominant group is the object of criticism, protest, and demands for change from primary-deviant groups. The token can become the target in these instances while members of the dominant group continue to operate unchecked. If institutions are truly interested in changing the campus climate for underrepresented and historically marginalized groups, this aspect of the tokenized existence must be addressed. Every effort must be made to encourage people to remain connected to every aspect of their identity. While there is no simple methodology to dismantling the practice of tokenization, creating safe spaces without direct influence from the dominant group could begin to facilitate an institutional culture where underrepresented groups have adequate opportunity to connect without what can often feel like the ever-watchful eye of the dominant group. Instead, organizations endeavor to manage and control narratives of underrepresented groups while keeping them siloed. The result of these efforts is ultimately the protection of privelege for the already powerful while simultaneously insuring that efforts to challenge that privilege can be put down before they gain traction.

Individualism

It should be said that I did not come to any part of my career as a novice with regard to operating in spaces that were not predominantly black. With the exception of family life and religious community, I was normally one of a very few black people in any given context. Because I was always deemed “exceptional” in those spaces, whether it be for my singing or intellectual engagement, it was difficult for me to fully embrace the notion that race could be a significant factor in one’s success or failure. My mother demanded that there be no excuses for preventable failures. And while she would point out situations that she deemed problematic during my educational journey, I was reluctant to buy into the idea that my race could play a role in opportunities that I did not receive. I was raised to believe that determined effort would ultimately dictate my destiny. While there is some truth to this notion, in essence, I was inadvertently preparing to be tokenized. It was easier to allow myself to be tokenized than to confront the reality that I would never be fully recognized for the fullness of what I can offer an institution.

Individualism is the second aspect of the token/sponsor reciprocal agreement. Individualism, as Laws describes it, “involves a belief that all outcomes are the result of individual effort. Success is one’s own achievement, and failure, one’s own fault. No category or class membership is acknowledged as relevant to achievement or failure.” Despite statistical and anecdotal evidence contradicting this ideology, individualism is a convenient belief system further separating tokens from aspects of their identity in service of preserving the underlying institutional structure. It also perpetuates a false notion that those in power in an institution achieved their status through individual effort alone. It is as if race, class, gender, and other factors have no bearing on institutional perception of historically marginalized and underrepresented groups and their collective ability to advance their careers against a backdrop of nepotism and cronyism. In contemporary culture it is no longer simply the “good old boys” doing this. It’s the good old boys and the women who protect and perpetuate unequal, unethical, and unjust institutional practices. For all of the statistical progress women have enjoyed since tokenism research began, it is disconcerting to see the ways in which that progress has not be extended to other groups in a robust manner.

Laws concludes her discussion on individualism with a keen observation about those occupying the token role. Individualism does not only preserve the status quo in a given institution; it also serves to exacerbate the delusion that there are not structural forces at play undermining their influence, their contribution, and their potential for growth within the institution. As long as the token holds on to the ideas of exceptionalism and individualism without acknowledging how these ideas are used, they never realize the true nature of their status within the organization and the institution celebrates themselves for diverse hires without doing the difficult work of wholesale cultural change that allows an institution to truly be transformed. Diverse hires become a revolving door because the environment is not conducive to growth or even survival in some instances when you are not a member of the dominant group.

Meritocratic Mystique

The third tenet in Laws' analysis of the psychology of tokenism is meritocratic mystique. Meritocratic mystique, as Laws describes, is based upon four tenets: membership into the elite is gained through achievement and not merely the domain of a certain group; institutionally high standards are justification for the organization's exclusivity; both of the aforementioned ideals must be upheld by members of the organization; and excellence will be rewarded. These four beliefs are often taken by members of the dominant group to deem any effort to diversify the workforce as compromising the lofty ideals of the field or the institution. Meritocratic mystique, in consort with exceptionalism and individualism, acts as an institutional buffer against outcries of discrimination. A token's willing participation in the structure provides a defense against accusations of discrimination to the constituency that matters most, the majority. As long as the dominant group believes their presence at the institution and the presence of those who look like them is based on meritorious standards, there is little cause for concern. The lack of diversity can be viewed as a lack of excellence outside of the dominant group, not a lack of access for the deviant group.

The idea of America as a meritocracy is the subject of extensive discussion in opinion editorials and research projects in various academic fields. One would be naïve to think that the same governing thought upon which the United States is founded would not translate to a belief that academia and other institutions are comprised of employees that are there purely on the basis of merit. In the absence of being a part of the dominant group, one has to be more than meritorious to enter these institutions and work twice as hard to be great at every aspect of the job in order to successfully advance in their career pursuits. The alternative for those not in the dominant group is to be more than meritorious but to check one's ambition at the door upon arrival. A token content in playing the role and not advancing up the career ladder will always have a place in an organization that does not truly understand what diversity, equity, and inclusion actually looks like in practice.

With regard to the four tenets Laws' lays out, my own experience tells a very different story. After a successful first year as a lecturer and after winning the tenure track position at the University of Nevada, Reno, albeit under circumstances that saw my immediate colleague and search committee chair removed from the process for making insensitive comments about the finalists for the position, my relationship with my colleague changed drastically. That change in relationship would not have been so challenging if strong standards of accountability for inappropriate behavior were a part of the institutional culture. Instead, I had to manage my relationship with my colleague without assistance from the department chair who was made aware of the challenges I was facing but offered nothing to remedy the situation.

Vague bylaws gave me no concrete information regarding what I should be working toward. There were no instructions or mentorship provided to navigate the tenure journey. And when racist and homophobic remarks were made by an immediate colleague, they were literally laughed off by the department chair. The idea of institutionally high standards was a farce. The standard for tenure and promotion were based on the meandering whims of the tenured faculty. The real truth is that when the idea of excellence in any institution is defined by the dominant group alone, those standards often lack the type of inclusivity that allows other groups to be viewed as excellent under the same metrics. Because my research interests and most important performances were not of the standard canon of classical music, that work was not viewed as important in the field. While I was able to achieve tenure one year earlier than the normal course, I did so by doing what my mother taught me to do; I worked twice as hard. The frustration is that although I was demonstrating excellence at every juncture, when it was time to reward me for that excellence, that reward was not freely given. I had to fight for it.

Boundary Maintenance

Boundary maintenance, as Laws describes it, serves to maintain relative distance between the classes or groups in an effort to uphold the credibility of the system. If those outside of the dominant group are ignorant of the inner workings of the system, there is no risk that the system will be credibly critiqued. The system's flaws function as privilege to the dominant group and as long as boundaries are maintained, those flaws remain unaddressed. The role of tokens here again protects the system from accusations of impropriety. In the token's role as gatekeeper, he or she is expected to act as a shield against infiltration from other members of the deviant class who are not willing to go along with the status quo. The assumption on the token's part is that while they are operating as gatekeeper, they are being fully integrated into the dominant group either. The evidence almost never supports a token's assumption of eventual integration into the primary group unless some aspect of the token's identity is being suppressed to make inclusion palatable. That, of course, is still tokenism.

To complicate the matter even more, boundary maintenance, when coupled with exceptionalism and individuality, keeps the deviant group separate and also deeply skeptical of one another. It is much easier to believe oneself to be exceptional when you are the only one or one of a very few working in the organization. Institutions that want to support underrepresented and historically marginalized populations will both encourage and facilitate the efforts of such persons to gather and support one another. Ultimately, this sense of community makes those segments of the university population feel supported and in a better position to be productive members of the institution. It also can expose practices within the organization that challenge members of the deviant group working in different areas but facing similar methods of marginalization. This type of effort requires a relatively small amount of resources to launch and maintain, yet at too many institutions, such work goes undone even when suggested repeatedly.

One must not be naïve. There is a valuable incentive for institutions not to engage in these efforts as an institutional priority. No matter the falsity and moral repugnance of the notion of white, male superiority, no one who's power is derived from that system is giving up their advantage willingly. In the absence of written policy and accountability around issues of micro- and macro-aggressive behavior, there can be no systemic change. Many attempt to point to the progress women have made in the workforce as a sign that efforts are proving successful. But the inclusion of white women into the realm of privilege is merely another act of tokenism where white women act as the gatekeepers against non-white peoples. The lack of racial and ethnic diversity among the ranks of women supports this assertion. Efforts to appear equitable and inclusive with no tangible policy and institutional structure to support the rhetoric are most of what we see. The time and effort it requires to debunk the institutional rhetoric as not being reflected in policy, action, or institutional culture leaves those working to dismantle such systems completely depleted and in danger of not being able to effectively do the work for which they were hired. And the system is left intact. The dominant group simply waits out those who would challenge the system in hopes that for one reason or another, they will move on.

Definition of Sponsor's Role and Relationship Between Token and Sponsor

The sponsor's role and the relationship between sponsor and token has already been defined to some degree. However, there is another layer that should be understood. The sponsor is viewed as liberal on the issues of diversity by all involved, according to Laws. That fact is borne out by the presence of the token. The sponsor is given credit for the presence of the token and is, therefore, shielded from criticism around issues that may arise. Laws also points out that the sponsor, while being liberal on issues of diversity, equity, and inclusion, is not viewed as a radical. In Laws' view, radicalism on the part of the sponsor is advocacy for all members of marginalized groups not simply the individual token. While that may not seem radical to some, any move that would upend the social order, push the sponsor out of favor with the dominant group, and therefore make the sponsor's hold on power precarious, is taken to be radical. Academia's perceived liberalism makes it the perfect incubator for tokenism to grow and flourish. The parallels one can draw between liberalism in the academic context and our more liberal political party as it relates to how deviant groups are included are startling. The same struggles for equity and inclusion are had by every institution where intentional efforts are not being made to truly make rhetoric actionable.

The relationship between the token and sponsor is a complex one. While the sponsor's liberalism may make them more sympathetic to the challenges a token may face, the sponsor also views the token through a lens that separates the token from the deviant group at large. The sponsor vouches for the token and helps to manage the way in which the token's presence is perceived, making the token dependent on the sponsor for their survival within the institution. The relationship is often rife with stereotypes, microaggressions, and an overall exacerbation of the problems. It is masked by a general liberalism and a relationship agreement that does not easily allow the token to challenge the sponsor in any meaningful way.

For me, accusations that I was intimidating were never substantiated with any type of evidence. The lack of accountability for these baseless accusations created an environment where the innuendo could be offered as fact because it was not summarily rejected by leaders within the dominant group as not only false but tinged with racial animus. The dog whistle was clear to me but somehow unrecognized by those supposedly committed to liberalism. My error was assuming that this liberalism included me.

Management Stigma

The final area that Laws puts forward in her research is called management stigma. Management stigma's primary goal is the integration of the token into the dominant class. Although it is known that the token cannot actually escape their origins in the deviant group and, therefore, can never be fully identified with the dominant group, the token's acceptance of the illusion signals to the sponsor that the token is ready to inhabit the role completely without the need for sponsorship. Getting to this place is a consequence of subtle maneuvering that happens over time and again with full agreement of both parties. As Laws describes it, compartmentalization is the mechanism through which the sponsor manages a token's stigma. The token is coached to present different aspects of themselves in different contexts to avoid upsetting the sensibilities of the dominant group. The expectation is that the token will act in the manner that the dominant group dictates. Any ambition beyond the role that the token has been assigned to is met with opposition. In some instances that opposition is severe.

Here are several examples using my experience as the point of reference. I received little attention when I was content to simply teach my classes, sing my performances, and remain a quiet presence in the department and on the campus. I became the head of the voice program purely by default. As I began to have success in that capacity, while also having success in my role as a teacher, and being a standout in my field, thus putting me on a path to early tenure, I bucked the agreement I unknowingly made early on to stay in my place. As long as I was serving on diversity committees that had no substantive charges or authority to enact policy and giving speeches at campus forums illuminating the concerns of the marginalized and underrepresented, I was operating in the capacity acceptable to the sponsor. When I was elected to the faculty senate, nominated for department chair, and nominated for Director of the School of the Arts, I had overstepped my bounds. Accusations that I was intimidating metastasized. I was accused of being intimidating, unapproachable, dictatorial, threatening, and noncommunicative. While there was never credible evidence to support the accusation, the mere suggestion of this historical trope was enough to stifle any forward motion to my own career aspirations. What is most peculiar is the ways in which the dominant group will sacrifice their own programs to prevent a member of the deviant group from moving outside of the role established for them. But then again, it is not peculiar at all. What it tells us is that within the academy, the program may not actually be as important as the member of the deviant group thinks it is. What is primary is that the social order be maintained by any means necessary. The notion of merit and much of the agreement between token and sponsor are exposed for what they are, a farce.

Understanding Tokenism Through the Lens of Martin Luther King, Jr., and Malcolm X

Predating the work of Kanter, Laws, and other psychologists and sociologists on the subject of tokenism, Martin Luther King, Jr.'s 1964 book, *Why We Can't Wait*, addresses the issue. Dr. King came to the following conclusion:

> In the last decade, still another technique had begun to replace the old methods for thwarting the Negroes' dreams and aspirations. This is the method known as "tokenism." The dictionary interprets the word "token" in the following manner: "A symbol. Indication, evidence, as a token of friendship, a keepsake. A piece of metal used in place of a coin, as for paying carfare on conveyances operated by those who sell the token. A sign, a mark, emblem, memorial, omen." When the Supreme Court modified its decision on school desegregation by approving the Pupil Placement Law, it permitted tokenism to corrupt its intent. It meant that Negroes could be handed the glitter of metal symbolizing the true coin, and authorizing a short-term trip toward democracy. But he who sells you the token instead of the coin always retains the power to revoke its worth, and to command you to get off the bus before you have reached your destination. Tokenism is a promise to pay. Democracy, in its finest sense is payment.

Predating Dr. King, in a 1963 interview with famed journalist and author Louis Lomax, civil rights icon Malcolm X vehemently pushed back against Lomax's assertion of black progress in the era:

> All you have gotten is tokenism–one or two Negroes in a job or at a lunch counter so the rest of you will be quiet. It took the United States Army to get one Negro into the University of Mississippi; it took troops to get a few Negroes in the white schools at Little Rock and another dozen places in the South. It has been nine years since the Supreme Court decision outlawing segregated schools, yet less than ten percent of the Negro students in the South are in integrated schools. That isn't integration, that's tokenism! In spite of all the dogs, and fire hoses, and club swinging policemen, I have yet to read of anybody eating an integrated hamburger in Birmingham.
>
> You Negroes are not willing to admit it yet, but integration will not work. Why, it is against the white man's nature to integrate you into his house. Even if he wanted to, he could no more do it than a Model T can sprout wings and fly. It just isn't in him.

In briefly summarizing their world view and strategies to attract converts to their thinking, Dr. King believed that the promise of democracy inherent in our governing documents demanded equity and inclusion in all vestiges of American life. His challenge to America as a whole was both a legal and moral one demanding that America live up to its commitments.

Malcolm X believed the only way forward for members of the African diaspora in America was to separate and create their own system. Malcolm X believed that the power structures in America would never acquiesce to include blacks except on a token basis.

While the legacy of Malcolm X is often dismissed as incendiary and divisive in mainstream culture, it is illuminating to look at the divergent legacies of these two pillars of the civil rights movement through our understanding of tokenism as presented by Laws. Dr. King was viewed by the sponsor (America) as ripe for token status in our system. Fundamentally, Dr. King was not calling for a dismantling of America's system; he was seeking broad applicability of the system's largess to all citizens. Conversely, Malcolm X was viewed as a radical. The way to neutralize the radical is to tokenize the most palatable of the deviant group. In almost every way, America has done this in the way it presents the civil rights movement to students and to its citizens at large. We have placed on a pedestal the work of Dr. King while ignoring many of the other voices and movements that collectively made up the civil rights movement. What is even more telling is that at the point that Dr. King begins moving in the direction of Malcolm X's world view by questioning whether advocacy for the integration of black people into a "burning house" was indeed the best way forward and deciding to broaden the scope of the movement to include economic justice for all people, he is assassinated. Poet and musician Carl Wendell Hines pens the following:

> Now that he is safely dead let us praise him, build
> monuments to his glory, sing hosannas to his name.
> Dead men make such convenient heroes.
> They cannot rise to challenge the images we would
> fashion from their lives.
> And besides, it is easier to build monuments than
> to make a better world.

One might believe that the poet is speaking specifically of Dr. King, but the date of composition in 1965, soon after the assassination of Malcolm X, gives greater understanding of what inspired the poet's word. The poem, however, appropriately encapsulates the way in which America has taken the King message, sanitized it, and tokenized him as a hero without actually doing the real work of institutional change.

The Way Forward

This discussion opened by introducing a foundational figure in the study of tokenism research. Currently, Rosabeth Moss Kantar holds the Ernest L. Arbuckle Professorship specializing in strategy, innovation, and leadership for change. Additionally, she is the chair and director of the Harvard University Advanced Leadership Initiative, an international model that helps successful leaders at the top of their fields apply their skills to national and global challenges in an effort to build a new leadership force for the world. What message are we to take from Kantar's fundamental misunderstanding of tokenism as the foundation for her ascendancy to one of the most revered business schools in the world? It would seem to suggest that we are accepting of and willing to reward "groundbreaking" work on the issues of diversity, equity, and inclusion as long as they in no way threaten the structure that keeps the powerful in power while only sharing power with those who demonstrate a complete commitment to the system as it is, no matter how inequitable we all know it to be.

More than 50 years after both Martin Luther King, Jr., and Malcolm X discussed tokenism in their speeches and writing, we are left to wonder why and how the research on the topic picks up tremendously in subsequent years without the groups for whom Dr. King and Malcolm X ultimately gave their lives attempting to improve being included in the research. One must inquire about the culpability of the field of psychology in its lack of research specifically focused on tokenism outside of a gender construct. The advancement in the statistical representation of women that has occurred alongside that body of research can be viewed as an achievement for the field, but the lack of representation and even representative research that goes beyond gender should raise extreme concern in the field. You cannot celebrate victory for what you have achieved without accepting culpability for what you have ignored. In this regard, tokenism as diversification will take more than a few trainings, updated hiring guidelines, and shifts in rhetoric.

In many respects, tokenism is the subtle method that has undergirded power structures as they are threatened by outside forces. With every movement, be it the struggle for the abolishment of slavery, women's rights, civil rights, LGBTQIA+ equality, immigrants' rights, and any movement like it, tokenism is used to squelch dissent and stymie progress. The perceived ordering of our social structure with regard to which movements make progress and who within those movements are the first tokens chosen is telling. Movements for women's equality have not actually benefitted all women. In similar fashion, the LGBTQIA+ movements and the organizations that support them have not benefitted all LGBTQIA+ people. Those for whom benefits have been realized have almost always been similar in terms of race. The movement for the abolishment of slavery and later for civil rights has been a little different. Many of the beneficiaries of those movements have been those who come from highly educated and often more affluent members of the group. What we begin to see is a social order that establishes race as primary and then a competition for gender and class as the secondary category that defines our social order. What does this mean? For all the talk about diversity, equity, and inclusion currently happening, if we wish to see progress on these issues, we must dismantle the tokenization of non-white, non-male members of our organizations who have a certain pedigree. If not, we are fooling ourselves into believing there is progress when people who are not white men are still bearing an undue burden in striving for professional advancement.

The system as we know has been built upon racial caste since the very founding of the country and it has not changed. Tokenism is a sophisticated way of making institutions look progressive, while racial caste, gender, and a host of other means of exclusion become the real guidelines for who is allowed to enter an institution and who is allowed to advance. This happens all while people suffer under the oppressive weight of daily macro- and micro-aggressions. In some instances, the token does not even realize it is happening and cannot pinpoint the cause of their challenges. Most often they take the burden upon themselves to fix and never challenge the context that is the driver of those challenges. Most want desperately to believe that the system is fair and people in leadership are operating with the stated value system of the institution as their guiding force. What may be even more deceitful are the ways in which the pleadings of those who recognize the injustice and demonstrate a commitment to improving the institution are seemingly taken seriously in meetings and public forums. Behind closed doors, those voices are marginalized around the tables of power within the institution so their influence cannot translate into real policy changes. Without systemic change, undergirded with measures of accountability, it will always be easiest to find members of historically marginalized and underrepresented groups to be the face of diversity efforts within an organization while not actually creating an environment where people are encouraged to bring themselves wholly to their work. The real conclusion is that the dominant group has no intention of giving up their advantage and the deviant groups have not sufficiently created the political climate for substantive change to actually occur. Until then, all you have got is tokenism.

References

Anisman-Razin, M., & Saguy, T. (2016). Reactions to tokenism: The role of individual characteristics in shaping responses to token decisions. *European Journal of Social Psychology, 46*, 716–731. https://doi.org/10.1002/ejsp.2215

Castilla, E. J., & Benard, S. (2010). The paradox of meritocracy in organizations. *Administrative Science Quarterly, 55*(4), 543–676. https://doi.org/10.2189/asqu.2010.55.4.543

Fenelon, J. (2003). Race, research, and tenure: Institutional credibility and the incorporation of African, Latino, and American Indian faculty. *Journal of Black Studies, 34*(1), 87–100. Retrieved from http://www.jstor.org.unr.idm.oclc.org/stable/3180859

Gündemir, S., Homan, A. C., Usova, A., & Galinsky, A. D. (2017). Multicultural meritocracy: The synergistic benefits of valuing diversity and merit. *Journal of Experimental Social Psychology, 73*, 34–41. https://doi.org/10.1016/j.jesp.2017.06.002

Hall, D. M., & Stevenson, H. C. (2007). Double Jeopardy: Being African American and "Doing Diversity" in Independent Schools. *Teachers College Record* Vol. 109 Number 1, pp. 1–23. http://www.tcrecord.org.unr.idm.oclc.org/library ID Number: 12715, Date Accessed: 11/23/2018 6:55:14 PM

Jackson, Y. (2006). *Encyclopedia of multicultural psychology*. Thousand Oaks, CA: SAGE Publications.

Jackson, P. B., & Stewart, Q. T. (2003). A research agenda for the black middle class: Work stress, survival strategies, and mental health. *Journal of Health and Social Behavior, 44*(3), 442–455. http://dx.doi.org.unr.idm.oclc.org/10.2307/1519789

Jackson, P. B., Thoits, P. A., & Taylor, H. F. (1995). Composition of the workplace and psychological well-being: The effects of tokenism on America's black elite. *Social Forces, 74*(2), 543. http://dx.doi.org.unr.idm.oclc/10.1093/sf/74.2.543

Karera, A. (2010). Profile of Janice Yoder. In A. Rutherford (Ed.), *Psychology's feminist voices multimedia internet archive*. Retrieved from http://www.feministvoices.com/janice-yoder/

King, M. L. (2018). *Why we cant wait*. Penguin Books. London

Laws, J. L. (1975). The psychology of Tokenism: An analysis. *Sex Roles, 1*, 51. https://doi.org/10.1007/BF00287213

Linkov, V. (2014). Tokenism in psychology: Standing on the shoulders of small boys. *Integrative Psychological and Behavioral Science, 48*, 143. https://doi.org/10.1007/s12124-014-9266-2

Lomax, L. E. (1963). A summing up: Louis Lomax Interviews Malcolm X. In *When the word is given: A report on Elijah Muhammad, Malcolm X, and the Black Muslim World*. https://teachingamericanhistory.org/library/document/asumming-up-louis-lomax-interviews-malcolm-x/

Roth, L. M. (2004). The social psychology of tokenism: Status and Homophily processes on wall street. *Sociological Perspectives, 47*(2), 189–189+. http://dx.doi.org.unr.idm.oclc/org/10.1525/sop.2004.47.2.189

Turco, C. (2010). Cultural foundations of tokenism: Evidence from the leveraged buyout industry. *American Sociological Review, 75*(6), 894–913. Retrieved from http://www.jstor.org.unr.idm.oclc.org/stable/25782171

Turner, C. S. V., González, J. C., & Wong, L. K. (2011). Faculty women of color: The critical nexus of race and gender. *Journal of Diversity in Higher Education, 4*(4), 199–211. https://doi-org.unr.idm.oclc.org/10.1037/a0024630

Walker, V. S. (2015). School "outer-gration" and "tokenism": Segrated black educators critique the promise of education reform in the civil rights act of 1964 1. *The Journal of Negro Education, 84*(2), 111–124. Retrieved from http://unr.idm.oclc.org/login?url=https://search-proquest-com.unr.idm.oclc.org/docview/1770939467?accountid=452

Yoder, J. D. (1985). An academic woman as a token: A case study. *Journal of Social Issues, 41*, 61–72.

Ageism in Behavioral Healthcare

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Abstract

Ageism is a pervasive problem at an individual, cultural, and systemic level, arguably one of the more socially acceptable forms of prejudice and bias at this point in today's culture. This chapter reviews the concept of ageism and highlights available literature on the topic as well as areas where more research is needed. The effect of ageism on behavioral and physical health outcomes, intersectionality between ageism and other forms of bias and prejudice, the problem of ageism within healthcare settings and training, and burgeoning areas of intervention to mitigate the problem are reviewed.

Keywords

Ageism · Older adults · Geriatrics · Behavioral Healthcare

Aging is a universal process, making ageism unique in that every individual is liable to experiencing it on some level if they live long enough. Psychiatrist Robert N. Butler coined the term "ageism" in 1969 and defined it as negative stereotyping and discrimination based on age including stereotypical attitudes, discriminatory practices, or institutional policies that have a negative effect at both the individual and the population levels. Within the history of psychotherapy there has been general negative attitudes on aging with Freud famously asserting that older adults have a lack of mental flexibility that impedes improvement through psychotherapy (Freud, 1905). This cynicism about older adults persisted and in 1975 Butler described the problem as "therapeutic nihilism," describing that this perspective leads to behavior and assumptions by the clinician that get in the way of a fair attempt at treatment with older adults.

Given the multiple factors that impact functioning as we age, it could be argued that there is the greatest variability in function, abilities, and quality of life for older adults compared to other points in the lifespan. There are 75-year-old individuals who continue to work in high demand roles such as CEOs of major corporations or hold important positions in the government, and there are 75-year-old individuals who need 24-hour supervised care, as well as every level of functioning in between these extremes. This variability means that behavioral healthcare providers

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© Springer Nature Switzerland AG 2020
L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_22

who see older adults must be prepared for a large spectrum of individuals, problems, and abilities.

Like many of the other -isms, ageism has permeated and ingrained itself into American culture. Stereotypical tropes of the elderly run anywhere between “your friendly neighborhood grandma” to the “conservative curmudgeon puttering aimlessly in a nursing home,” where older adults are gradually seen as less of a person and playing into a predefined caricature. And while that immediate stereotype may differ from person to person, some common themes underlying the stereotypes include: chronic and comorbid health problems; compromised mental and physical function; narrow, depressed, and lonely emotional experiences; diminished or nonexistent social life; and an inability to learn or “change with the times” (Thornton, 2002). Overall, these stereotypes suggest that older adults are imminently irrelevant or obsolete and posits them as a burden in American society.

The perception that all older adults are plagued by poor health and suffer from multiple comorbidities is perhaps the most salient stereotype. This stereotype, however, is nuanced and should be critically examined: how does the prevalence of chronic health conditions influence the self-perception of health within older populations? In population studies reviewing data from National Health Interview Survey (NHIS), approximately 60% of adults aged 65 or older reported having more than one chronic condition (e.g., arthritis, hypertension, diabetes, cancer, etc.) – as opposed to 18% in adults aged 64 years or younger (Ward & Schiller, 2013; Ward, Schiller, & Goodman, 2014). However, only 22% of respondents aged 65 or older assessed themselves as having fair-poor health status (Centers for Disease Control and Prevention [CDC], 2017). This incongruence between the objective measure of prevalence and subjective measure of perception implies that while many older adults do have chronic conditions, they are not subsequently defined by their illness. Many older adults are adept at managing chronic health conditions or balance “living with an illness.” Data from the NHIS on functional abilities also challenges the stereotype that older adults are often disabled as a result of their comorbidities. Approximately 22% of adults aged 65 or older reported having any disability, where disability is defined as having difficulty in vision, hearing, mobility, communication, cognition, and self-care (Federal Interagency Forum on Aging, 2016). This disconnect between older adults self-assessing fair-poor health and self-reporting disability suggests that only 1 in 5 older adults fall within the “ailing health” narrative and incidence of chronic conditions does not necessarily predict health status or functioning.

Another common stereotype of aging is the assumption that depression symptoms are a normal part of aging. The prevalence of major depression in older adults ranges from 1% to 5% in most epidemiological research in the USA and internationally, with most reports of prevalence closer to the lower end of the range (Fiske, Wetherell, & Gatz, 2009). The prevalence in younger and middle-aged adults is generally reported to be higher than older adults (SAMHSA, 2017). It is notable that within the older adult population, clinically significant symptoms that do not meet the diagnostic criteria for major depression are reported at higher rates (15%) (Blazer, 2003). While this data is notable, it still represents a small percentage of the older adult population. In contrast to this stereotype, psychologist Laura Carstensen has conducted several studies over the past decades that show that aging is associated with more positive emotional well-being and stability (Carstensen et al., 2011; Carstensen, Pasupathi, Mayr, & Nesselroade, 2000).

At a cultural level, ageism is an area of prejudice and bias that continues to be more socially acceptable compared to other types of -isms (Ayalon & Tesch-Römer, 2017). This is often reflected in the perspectives of older adults themselves and is referred to as negative self-perception of aging. As people age, they can carry forward the stereotypes they hold about older adults as they themselves enter that stage of the lifespan. Research on ageism has focused on this problem of self-perception of age stereotypes, along with more external forms of ageism. These external forms of ageism include bias, prejudice, discrimination, and micro-aggressions which can be insidious and difficult to quantify; health researchers have mainly relied on "perceived discrimination" as a proxy. Perceived discrimination refers to an individual's subjective interpretation of discrimination, where the individual perceives themselves as the target of discriminatory behavior (Paradies, 2006). Perceived discrimination has been conceptualized as a chronic stressor (Clark, Anderson, Clark, & Williams, 1999; Thoits, 2010), and reviews of contemporary scientific literature have confirmed robust correlations between discrimination and poor mental health (Paradies, 2006; Pascoe & Smart Richman, 2009; Williams & Mohammed, 2009). In a recent meta-analysis reviewing 285 cross-sectional and 43 longitudinal studies, Schmitt and colleagues found that discrimination along axes of race, gender, sexual orientation, physical illness/disability, HIV status, and weight was significantly negatively correlated with well-being. Individuals who reported higher levels of perceived discrimination also endorsed higher levels of psychological distress (Schmitt, Branscombe, Postmes, & Garcia, 2014). Similarly, the impact of ageism has been found to have significant negative effects across health domains.

Physical Health

A common assumption is that the passing of time guarantees physical decline so physical problems later in life are often attributed to age. The assumption of aging as the main reason for decline can be questioned as longitudinal research has found that how older adults are perceived and how they perceived themselves can either accelerate or reduce physical decline (Levy, 2009; Sargent-Cox, Anstey, & Luszcz, 2012). Several studies have shown that older adults who endorsed negative stereotypes about age had worse health outcomes than those with positive views. (Levy, Zonderman, Slade, & Ferrucci, 2009; Wurm, Tesch-Römer, & Tomasik, 2007). Older adults with negative perception of aging are also more likely to have functional impairments in their abilities to care for themselves (Moser, Spagnoli, & Santos-Eggimann, 2011). Sutin and colleagues, in a longitudinal study, found that age-based discrimination was associated with poorer subjective health appraisal, greater disease burden, lower life satisfaction, and greater loneliness. In this particular study, the effects of ageism were not only stronger than racism, sexism, or heterosexism/homophobia, but it also magnified over the 4-year study period – the effects of ageism became more pronounced as participants aged (Sutin, Stephan, Carretta, & Terracciano, 2015).

There even appears to be a link between self-perception of ageism and increased morbidity and mortality (Levy, Slade, Kundkel, & Kasl, 2002; Levy et al., 2009). Ng and colleagues found that individuals with positive attitudes about their mental and physical health as they aged live 2.5–4.5 years longer than those who held negative stereotypes (Ng, Levy, Allore, & Monin, 2016). Similarly, there is evidence of an association with perceived discrimination and mortality – in a population-based study on older adults (mean age 76). Barnes and colleagues found that perceived discrimination was significantly correlated with increased mortality risk even when controlling for negative affect and chronic illness (Barnes et al., 2008).

Wurm et al. (2007) propose two mechanism to explain these negative associations with ageism and health: beliefs related to locus of control and the impact of stress and anxiety. If an older adult believes that health problems are inevitable with aging, they may be less likely to seek care and adopt preventative behaviors that positively influence health. There also may be increased stress and anxiety related to this belief which contributes to overall decline as chronic stress negatively impacts the immune system and cardiovascular health (Cohen, Janicki-Deverts, & Miller, 2007; Rozanski, Blumenthal, Davidson, Saab, & Kubzansky, 2005). Taken together, these preliminary studies suggest that both self-perception of ageism and perceived discrimination have potent negative effects and warrant further investigation.

Behavioral Health

The impact of ageism on behavioral health is not as well researched as physical health, but what has been published has shown similar negative results. Lyons and colleagues found that older adults who recently experienced perceived discrimination were more likely to experience mental health problems (Lyons et al., 2018). Han and Richardson conducted a longitudinal study and found that perceived age discrimination was related to increases in depression scores over a 4-year period and interestingly found that negative self-perception of aging was a mediator of this relationship (Han & Richardson, 2015).

Studies focusing on negative self-perceptions of ageism alone have found similar negative associations. In a longitudinal study Wurm and Benyamini (2014) found that negative self-perceptions of aging were associated with higher levels of depression. Cross-sectional studies have shown an association between more positive attitudes toward aging and less depression (Bryant et al., 2012; Chachamovich, Fleck, Laidlaw, & Power, 2008). Levy, Pilver, and Pietrzak (2014) survey over 2000 older military veterans in the USA and found that those who had more negative stereotypical perceptions of their own aging reported a higher frequency of behavioral health symptoms (Levy et al., 2014). These associations were maintained even when controlling for social and demographic variables, with differences found in rates of suicidal ideation (30.1% vs. 5.0%), anxiety symptoms (34.9% vs. 3.6%), and post-traumatic stress disorder symptoms (18.5% vs. 2.0%).

These studies highlight an important area of clinical intervention in working with older adults – examining the relationship between social and cultural experiences of ageism and their own perceptions of aging. Change is warranted at a cultural level, but when clients seek treatment for behavioral health problems, they are seeking change at the individual level. Focusing on the impact of their own perceptions about the aging process and exploring the impact on their behavior and engagement life is an area that can be improved at the level of the individual.

Intersectionality Between Ageism and Other "Isms"

Intersectional feminist and civil rights activist Audre Lorde once said, "there is no such thing as a single-issue struggle because we do not live single-issue lives" (Lorde, 2007). The multiple identities that people hold ultimately inform them of their experiences in the world. Despite aging being a universal process, discrimination based on age persists; ageism intersects with other isms to produce compound toxicities that further disenfranchise the most vulnerable populations.

Despite the growing body of literature on social determinants of health (Braveman, Egerter, & Williams, 2011), research on ageism or age-based discrimination has been relatively overlooked. The majority of health psychology research has focused on the effects of racism and sexism and primarily in samples of adolescents to middle-aged adults (Sutin et al., 2015; Williams & Mohammed, 2009). In thinking critically about current practices in health research, the omission of ageism as a facet of perceived discrimination, and the systematic exclusion of older adults as research participants – whether intentional or unintentional – should very much be interpreted as manifestations of ageism (Cherubini, Signore, Ouslander, Semla, & Michel, 2010; Thake & Lowry, 2017). Inclusion of older adults in health research and clinical trials should be reprioritized to address needs unique to the older population, including (but not limited to) chronic conditions, frailty, and polypharmacy. Based on existing literature on perceived ageism and perceived discrimination in old age (the composite effects of intersectional discrimination in old age), results suggest that the effects of ageism parallel that of racism and sexism.

Racism x. Ageism

The interactions between racism and ageism in older adult populations are, comparatively, a burgeoning interest and an understudied need. Sorkin and colleagues highlight older Black/

African, Asian, and Latino Americans were more likely to have mental distress and mental illness but had worse access to mental health services compared to White Americans (Sorkin, Pham, & Ngo-Metzger, 2009). Of the handful of studies available, findings similar to those in younger populations are observed: perceived discrimination was associated with higher depressive symptoms in older African American adults (Barnes et al., 2004; Nadimpalli, James, Yu, Cothran, & Barnes, 2014) and older Latino/Latina American adults (Todorova, Falcón, Lincoln, & Price, 2010), higher levels of inflammation in older African Americans (Lewis, Aiello, Leurgans, Kelly, & Barnes, 2010), higher levels of diastolic blood pressure in older African Americans (Lewis et al., 2009), higher levels of bodily pain in older African Americans (Burgess et al., 2009), and higher risk of smoking and alcohol abuse in older Latino/Latina Americans and Black/African Americans (Borrell et al., 2010).

Perhaps noteworthy is that of the studies available, the majority of them have converged on studying the health outcomes for older African American adults, with older White American adults as comparison or "control." Given the context of United States history, addressing health inequities in Black/African Americans is, no doubt, pivotal. Thinking critically, however, this convergence might represent a myopic understanding of race through a black/white paradigm (Perea, 1997). Expanding the scope of work onto Latino/Latina, Asian, and Native American populations continues to be an important next step in health psychology research.

One of the major initiatives to tackle this gap in knowledge was the National Latino and Asian American Study (NLAAS) conducted in 2002–2003, with a sample of approximately 2500 Latino/Latina American and 2100 Asian American participants. From this inaugural study, researchers found that perceived discrimination was associated with chronic health conditions – cardiovascular, respiratory, and pain-related conditions – in middle-aged Asian American participants (Gee, Spencer, Chen, & Takeuchi, 2007). In a study exploring the interaction between ethnic identity and age, Yip and colleagues found that while ethnic identity served as a protective factor against the effects of discrimination in middle-aged Asian American participants, ethnic identity actually exacerbated the negative effects of discrimination on mental health in older Asian American participants (Yip, Gee, & Takeuchi, 2008). This differential effect of ethnic identity through the aging process for Asian Americans cannot be fully explained with either the buffering or centrality hypotheses based on available literature, but nonetheless highlights the importance of furthering research on interactions between race and age beyond a black/white paradigm.

Homophobia and Transphobia x. Ageism

Lesbian, gay, bisexual, and transgender (LGBT) awareness and advocacy is, comparatively, the latest social justice movement to reach critical mass and gain mainstream momentum, catalyzed by the Stonewall riots in 1969. From when gay raids and "outing" were commonplace to now where LGBT persons are more represented and accepted, LGBT older adults have witnessed a major change in societal values over their lifespans. Even with the societal changes, it's important to keep in mind that older LGBT individuals have lived through the HIV/AIDS epidemic in the 1980s and across their lifespan have endured a culture of unacceptance sometimes to the levels of abandonment by family and even violence. Based on this history, residual trauma and internalized homophobia are behavioral health challenges LGBT elders often have to reconcile with.

Unlike other demographic information, data on LGBT identities have not been consistently captured in official US population surveys and census. The lack of data not only contributes to a lack of understanding about the needs of older LGBT adults, but subsequently little to no funding to address LGBT-specific needs (O'Hara, 2017). According to a 2016 report published by the Williams Institute, a think tank at UCLA School of Law dedicated to research on LGBT identities and public policy, there are approximately 2.4 million LGBT adults aged 50 and older in the United States. The report highlights that older LGBT adults continue to face social disparities, such as discrimination in formal healthcare settings, lack of informal healthcare options due to nontraditional family dynamics, and financial instability due to lifetime employment discrimination. Other key findings of the report highlight that older LGBT adults also face staggering health disparities compared to cisgender heterosexual older adults, including higher risks of behavioral health issues, disability, chronic diseases, and risky health behaviors such as smoking, alcohol abuse, and risky sexual behavior (Choi & Myer, 2016).

Aging with Pride, a population study started in 2009, began expanding beyond characterizing health inequities and looking into salient risk and protective factors for older LGBT adults. In a cross-sectional study on LGB older adults within the cohort, Fredriksen-Goldsen and colleagues found that lifetime victimization and internalized stigma were independently associated with poor health outcomes, disability, and depressive symptoms, while social support and social network size were identified as protective factors (Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013). To explore the heterogeneity among older LGBT adults, a follow-up study also examined group differences between young-old (age 50–64), middle-old (age 65–79), and old-old (age 80+) LGBT older adults. The young-old and middle-old groups reported better identity management resources and higher levels of community connectedness, while the old-old group reported the lowest level of positive sense of sexual identity and community connectedness. In regression analyses, lifetime discrimination and victimization were negatively associated with physical and mental quality of life (QOL), while a positive sense of sexual identity was positively correlated with mental QOL (Fredriksen-Goldsen, Kim, Shiu, Goldsen, & Emlet, 2014). These preliminary findings not only highlight that there are generational differences even within an assumed monolithic group, but also demonstrate the importance of social and community support for older LGBT adults. Future studies building upon the success of the Aging with Pride study would help inform allocation of resources and public policy to address these underserved needs.

Ageism in the Behavioral Healthcare Setting

Behavioral healthcare providers are not immune to the problem of ageism. In fact, over the past four decades there have been several studies identifying negative views on aging as problematic in the field. A survey in the 1970s of over 1300 United States-based psychologists found generally negative views regarding the aging process and a preference against working with older patients (Dye, 1978). The respondents endorsed beliefs that older persons were rigid and that they had difficulty learning new material and lacked the required energy and resilience for therapeutic growth. Studies in the 1980s with psychiatrists and psychologists examined clinical responses to standardized case vignettes and found that older patients consistently received poorer prognoses than their younger counterparts and were perceived as less appropriate for therapy (Ford & Sbordone, 1980; Ray, McKinney, & Ford, 1987).

These studies were conducted on previous cohorts of behavioral health providers, but there is little evidence of improvement or change in more recent cohorts. Similar to the early case vignette research, an Australian sample of psychologists and counselors was presented with a vignette describing a fictional case and found that an older patient was rated as less able to engage in a proper therapeutic relationship, as having a poorer prognosis, and as being less appropriate for therapy compared with a younger patient with the same symptoms (Helmes & Gee, 2003). The problem is not just with providers who are established in professional practice. A survey of clinical psychology trainees revealed prevalent negative perceptions of older adults including: resistant to new ideas, limitations in opportunities, rigidness and inflexibility, and limited potential to change because they are close to the end of life (Lee, Volans, & Gregory, 2003).

Behavioral health providers are not the only healthcare providers with ageist views impacting practice; research on medical providers shows similar biases toward older adults. This is notable from a behavioral health perspective because often primary care providers (PCPs) are the main point of contact for an older adult needing behavioral health treatment (Alvidrez & Areán, 2002). In a survey that examined physician beliefs about the aging process, more than half endorsed that physical pain and forgetfulness was a normal part of aging. Additionally, more than 14% of that sample believed that depression was a natural part of aging (Davis, Bond, Howard, & Sarkisian, 2011). These attitudes appear to impact assessment and treatment of these problems. In a survey sent to older adult patients, more than 40% reported that their doctor communicated that “ailments were caused by [their] age” and 9% stated that they were refused medical treatment as a result of their age (Palmore, 2001). In a study focused on back pain, one of the most common complaints of older adults at a PCP visit, more than 70% of the sample reported a provider belief that back pain was a result of aging and that the physician had a negative attitude toward treating the ailment with medication or surgery (Makris et al., 2015).

These negative beliefs about the aging process can be detrimental to appropriate diagnosis and treatment, especially when it comes to appropriate mental health treatment. In a study by Zylstra and Steitz (2000) that analyzed both a physician’s knowledge of late-life depression and their attitude toward aging, it was found that misconceptions regarding late-life depression were associated with negative attitudes toward aging and limited contact with older adults (Zylstra & Steitz, 2000). Alvidrez and Areán (2002) surveyed 205 PCPs and found the majority endorsed that they would not refer older patients with depression for psychotherapy, with some citing a lack of optimism that psychotherapy is effective with older adults. A similar study conducted by Uncapher and Areán (2000) found that physicians were able to accurately identify suicidal ideation in older and younger adults, yet they were less willing to provide treatment intervention for their older patients, citing that suicidal ideation was “rational and normal” in the population and a lack of optimism that a behavioral health provider would be helpful to the patient. This is problematic as older adults have the highest suicide rate of any group in the USA and recent large longitudinal study found that 83% of suicide victims received health care services in the year before their death and 50% in the month before (Ahmedani et al., 2014). It appears that ageism may be contributing to missed opportunity for suicide prevention within the healthcare setting.

Professional Training

Considering the negative views of aging held by trainees and professional, perhaps an unsurprising problem is in the numbers of professionals who specialize in the field of geriatrics. Roughly 4% of psychologists specialize in geropsychology. With around eight million older adults experiencing a mental health or substance use issues in any given year, that leaves the ratio 3000 to one (Hoge, Karel, Zeiss, Alegria, & Moye, 2015). Geriatric psychiatry does not fare better. According to estimates in the President’s Commission on Mental Health Subcommittee on Older Adults (2003), “at the current rate of graduating approximately 80 new geriatric psychiatrists each year and an estimated 3% attrition, there will be approximately 2640 geriatric psychiatrists by the year 2030 or one per 5682 older adults with a psychiatric disorder” (Bartels, 2003).

The discrepancy of trained professionals working in geriatrics extends to the field of medicine as well. A 2017 report on the supply and demand of geriatrician by the US Department of Health and Human Services found that in 2013 there was a supply of roughly 3600 practicing geriatric physicians, with a need or demand of nearly 6 times as many specialized providers. Recent data has also pointed out that only 50% of fellowship-trained geriatricians will recertify, widening the gap of trained professionals able to work within the geriatric field (Bragg, Warshaw, Meganathan, & Brewer, 2012). According to the Association of Directors of Geriatrics Academic Programs (ADGAP), the number of geriatric fellowship opportunities has slowly increased over the last couple of years; however more than half of those open slots are unfilled.

Systemic Issues

Butler's definition of ageism includes institutional policies that negatively affect the individual and population. Insurance coverage falls into this category and is a barrier for older adults in accessing behavioral health treatment. Adults ages 65 and over represent roughly 13% of the US population. Around 26.7% of those individuals are currently only being covered by Medicare, as opposed to having a combination of Medicare and private insurance. This percentage of Medicare-only recipients has been steadily increasing for the past four decades (He, Sengupta, Velkoff, & DeBarros, 2005). Medicare requires healthcare providers to fill out additional paperwork and providers typically receive less compensation for the same work. On average, a private practice geriatrician, whose majority compensation comes from Medicare, makes 10% less than a general internist (Bragg et al., 2012). For mental health providers the discrepancy in compensation is even more discouraging providers from accepting Medicare into their practice and limiting the availability of providers to clients who are not able to private pay.

Systematic exclusionary practices are also demonstrated within the development of therapeutic treatments for the elderly. Not only is ageism an understudied phenomenon in social and health psychology but older adults are also often excluded from research trials for behavioral health and medical treatment. Even with older adults representing 60% of the national disease burden, they are only represented by 32% in phases II and III of clinical trials (Herrera et al., 2010). Although age is the most consistent risk factor for cancer, with 60% of all cancer patients being older than 65, they are only 36% of the patients included in all cancer trials (Talarico, Chen, & Pazdur, 2004). Furthermore, in a study done by Thake and Lowry (2017) that analyzed more than 4300 randomized clinical trial papers between the years 1997 and 2015, they found that 22.9% of those papers excluded older participants with no given explanation (Thake & Lowry, 2017). This marks an enormous misrepresentation of prescription consumers and allows for the inaccurate treatment to at-risk older adults.

Interventions to Combat Ageism with Providers

Just as ageist biases are apparent at systemic and individual levels of the healthcare field, ways to combat these ageist beliefs have also begun to be implemented. Aside from professional organizations explicitly condemning ageist practices, alternative measures have been applied to prevent discriminatory performances in the healthcare field. The most well-researched and common interventions have been increased positive exposure to healthy older adults and increased knowledge about the healthy aging process (Ory, Hoffman, Hawkins, Sanner, & Mockenhaupt, 2003).

Individuals entering into the healthcare field often have limited exposure to older adults outside of immediate family members and media portrayals. Some training programs have started programs focused both on education about aging and exposure to a broader range of older adults (Cummings & Galambos, 2003). Classes focused on reviewing healthy aging information and promoting volunteer experiences with older adults have been shown to reduce stigmatizing attitudes and behaviors toward the elderly (Allan & Johnson, 2008; Ferrario, Freeman, Nellett, & Scheel, 2007; Hantman, Oz, Gutman, & Criden, 2013). Other programs incorporate empathy-building interventions with aims to increase positive attitudes toward older adults (Samra, Griffiths, Cox, Conroy, & Knight, 2013). One of the more effective intervention methods to educate students about the aging experience and evoke empathy has been through simulation experiences ranging from role playing exercises, actor visualizations, and group discussions (Ross et al., 2013).

Like in other areas of bias, healthcare practitioners often reject an explicitly prejudiced bias of the "old and decrepit" aging adult. Tools to measure implicit bias toward age have also been implemented. As opposed to direct statements about negative attitudes toward aging, implicit association tests measure more inherent biases that may be affecting practitioner decision-making in a less blatant but equally harmful and exclusionary manner (FitzGerald & Hurst, 2017). Revolutionary methods have begun to surface to try and quantify these biases even outside individual reporting. Using artificial intelligence machine learning techniques that examine semantic prejudices virtually, "unintended discrimination" can be identified (Caliskan, Bryson, & Narayanan, 2017; Greenwald, 2017). Using this novel AI technology in the healthcare field could allow ageist practices to be identified in a more valid manner than relying on self-report forms and qualitative measurements.

Other methods used to generate more positive attitudes toward older adults have been the use of synthetic imitation tools to create more realistic role reversals for healthcare professionals. In a recent study focused on enhancing positive age attitudes within healthcare professionals at a US Veteran Affairs Center, artificial age simulation was incorporated into a training seminar. Participants were asked to wear impairing glasses to simulate glaucoma or other macular issues, listen to distorted conversations to simulate hearing impairment, and wear thick gloves to perpetuate loss of manual dexterity. More positive attitudes toward older adults and the aging process were reported after the seminar with the greatest increase being correlated with those with the highest years of education (Halpin, 2015). These pilot approaches are just the beginning in tackling systemic and individual ageist practices in the healthcare field, new innovative and collaborative methods need to be explored in order to ameliorate the attitudes of those providing service to older adults.

References

Ahmedani, B. K., Simon, G. E., Stewart, C., Beck, A., Waitzfelder, B. E., Rossom, R., … Solberg, L. I. (2014). Health care contacts in the year before suicide death. *Journal of General Internal Medicine, 29*(6), 870–877.

Allan, L. J., & Johnson, J. A. (2008). Undergraduate attitudes toward the elderly: The role of knowledge, contact and aging anxiety. *Educational Gerontology, 35*(1), 1–14.

Alvidrez, J., & Areán, P. A. (2002). Physician willingness to refer older depressed patients for psychotherapy. *The International Journal of Psychiatry in Medicine, 32*(1), 21–35.

Ayalon, L., & Tesch-Römer, C. (2017). Taking a closer look at ageism: Self- and other-directed ageist attitudes and discrimination. *European Journal of Ageing, 14*(1), 1–4. https://doi.org/10.1007/s10433-016-0409-9

Barnes, L. L., Leon, C. F., Wilson, R. S., Bienias, J. L., Bennett, D. A., & Evans, D. A. (2004). Racial differences in perceived discrimination in a community population of older blacks and whites. *Journal of Aging and Health, 16*(3), 315–337. https://doi.org/10.1177/0898264304264202

Barnes, L. L., Leon, C. F., Lewis, T. T., Bienias, J. L., Wilson, R. S., & Evans, D. A. (2008). Perceived discrimination and mortality in a population-based study of older adults. *American Journal of Public Health, 98*(7), 1241–1247. https://doi.org/10.2105/ajph.2007.114397

Bartels, S. J. (2003). Improving system of care for older adults with mental illness in the United States. Findings and recommendations for the President's New Freedom Commission on Mental Health. *The American Journal of Geriatric Psychiatry, 11*(5), 486–497.

Blazer, D. G. (2003). Depression in late life: Review and commentary. *The Journals of Gerontology: Biological Sciences and Medical Sciences, 58*(3), 249–265.

Borrell, L. N., Roux, A. V., Jacobs, D. R., Shea, S., Jackson, S. A., Shrager, S., & Blumenthal, R. S. (2010). Perceived racial/ethnic discrimination, smoking and alcohol consumption in the Multi-Ethnic Study of Atherosclerosis (MESA). *Preventive Medicine, 51*(3–4), 307–312. https://doi.org/10.1016/j.ypmed.2010.05.017

Bragg, E. J., Warshaw, G. A., Meganathan, K., & Brewer, D. E. (2012). The development of academic geriatric medicine in the United States 2005 to 2010: An essential resource for improving the medical care of older adults. *Journal of the American Geriatrics Society, 60*(8), 1540–1545. https://doi.org/10.1111/j.1532-5415.2012.04065.x

Braveman, R., Egerter, S., & Williams, D. R. (2011). The social determinants of health: Coming of age. *Annual Reviews Public Health, 32*(1), 381–398. https://doi.org/10.1146/annurev-publhealth-031210-101218

Bryant, C., Bei, B., Gilson, K., Komiti, A., Jackson, H., & Judd, F. (2012). The relationship between attitudes to ageing and physical and mental health in older adults. *International Psychogeriatrics, 24*(10), 1674–1683. https://doi.org/10.1017/s1041610212000774

Burgess, D. J., Grill, J., Noorbaloochi, S., Griffin, J. M., Ricards, J., Ryn, M. V., & Partin, M. R. (2009). The effect of perceived racial discrimination on bodily pain among older African American men. *Pain Medicine, 10*(8), 1341–1352. https://doi.org/10.1111/j.1526-4637.2009.00742.x

Butler, R. N. (1969). Age-ism: Another form of bigotry. *The Gerontologist, 9*(4), 243–246.

Butler, R. N. (1975). Psychiatry and the elderly: An overview. *American Journal of Psychiatry, 132*(9), 893–900.

Caliskan, A., Bryson, J. J., & Narayanan, A. (2017). Semantics derived automatically from language corpora contain human-like biases. *Science, 356*(6334), 183–186.

Carstensen, L. L., Pasupathi, M., Mayr, U., & Nesselroade, J. R. (2000). Emotional experience in everyday life across the adult life span. *Journal of Personality and Social Psychology, 79*(4), 644–655.

Carstensen, L. L., Turan, B., Scheibe, S., Ram, N., Ersner-Hershfield, H., Samanez-Larkin, G. R., … Nesselroade, J. R. (2011). Emotional experience improves with age: Evidence based on over 10 years of experience sampling. *Psychology and Ageing, 26*(1), 21–33. https://doi.org/10.1037/a0021285

Centers for Disease Control and Prevention. (2017). *National center for health statistics*. Retrieved from https://www.cdc.gov/nchs/fastats/older-american-health.htm

Chachamovich, E., Fleck, M., Laidlaw, K., & Power, M. (2008). Impact of major depression and subsyndromal symptoms on quality of life and attitudes toward ageing in an international sample of older adults. *The Gerontologist, 48*(5), 593–602. https://doi.org/10.1093/geront/48.5.593

Cherubini, A., Signore, S. D., Ouslander, J., Semla, T., & Michel, J. (2010). Fighting against age discrimination in clinical trials. *Journal of the American Geriatrics Society, 58*(9), 1791–1796. https://doi.org/10.1111/j.1532-5415.2010.03032.x

Choi, S., & Myer, I. H. (2016, August). *LGBT aging: A review of research findings, needs, and* … Retrieved from https://williamsinstitute.law.ucla.edu/research/lgbt-older-adults-highlighting-isolation-discrimination/

Cohen, S., Janicki-Deverts, D., & Miller, G. E. (2007). Psychological stress and disease. *Journal of the American Medical Association, 298*(14), 1685–1687. https://doi.org/10.1001/jama.298.14.1685

Clark, R., Anderson, N. B., Clark, V. R., & Williams, D. R. (1999). Racism as a stressor for African Americans: A biopsychosocial model. *American Psychologist, 54*(10), 805–816. https://doi.org/10.1037//0003-066x.54.10.805

Cummings, S. M., & Galambos, C. G. (2003). Predictors of graduate social work students' interest in aging-related work. *Journal of Gerontological Social Work, 39*(3), 77–94.

Davis, M. M., Bond, L. A., Howard, A., & Sarkisian, C. A. (2011). Primary care clinician expectations regarding aging. *Gerontologist, 51*(6), 856–866. https://doi.org/10.1093/geront/gnr017

Dye, C. J. (1978). Psychologists' role in the provision of mental health care for the elderly. *Professional Psychology, 9*(1), 38–49. https://doi.org/10.1177/2050312114566488

Ford, C. V, & Sbordone, R. J. (1980). Attitudes of psychiatrists toward elderly patients. *The American Journal of Psychiatry*. US: American Psychiatric Association. https://doi.org/10.1176/ajp.137.5.571

Federal Interagency Forum on Aging. (2016, August). *Aging stats*. Retrieved from https://agingstats.gov/

Ferrario, C. G., Freeman, F. J., Nellett, G., & Scheel, J. (2007). Changing nursing students' attitudes about aging: An argument for the successful aging paradigm. *Educational Gerontology, 34*(1), 51–66. https://doi.org/10.1080/03601270701763969

Fiske, A., Wetherell, J. L., & Gatz, M. (2009). Depression in older adults. *Annual Review of Clinical Psychology, 5*, 363–389.

FitzGerald, C., & Hurst, S. (2017). Implicit bias in healthcare professionals: A systematic review. *BMC Medical Ethics, 18*(1), 19.

Fredriksen-Goldsen, K. I., Kim, H., Barkan, S. E., Muraco, A., & Hoy-Ellis, C. P. (2013). Health disparities among lesbian, gay, and bisexual older adults: Results from a population-based study. *American Journal of Public Health, 103*(10), 1802–1809. https://doi.org/10.2105/ajph.2012.301110

Fredriksen-Goldsen, K. I., Kim, H., Shiu, C., Goldsen, J., & Emlet, C. A. (2014). Successful aging among LGBT older adults: Physical and mental health-related quality of life by age group. *The Gerontologist, 55*(1), 154–168. https://doi.org/10.1093/geront/gnu081

Freud, S. (1905). On psychotherapy. *The standard edition of the complete psychological works of Sigmund Freud, Volume VII (1901–1905): A case of hysteria, three essays on sexuality and other works*, 255–268.

Gee, G. C., Spencer, M. S., Chen, J., & Takeuchi, D. (2007). A Nationwide study of discrimination and chronic health conditions among Asian Americans. *American Journal of Public Health, 97*(7), 1275–1282. https://doi.org/10.2105/ajph.2006.091827

Greenwald, A. G. (2017). An AI stereotype catcher. *Science, 356*(6334), 133–134.

Halpin, S. N. (2015). Evaluating the efficacy of a short aging simulation workshop for an interdisciplinary group of health-care employees at a veterans affairs medical center. *Educational Gerontology, 41*(3), 207–215.

Han, J., & Richardson, V. E. (2015). The relationships among perceived discrimination, self-perceptions of aging, and depressive symptoms: A longitudinal examination of age discrimination. *Aging & Mental Health, 19*(8), 747–755. https://doi.org/10.1080/13607863.2014.962007

Hantman, S., Oz, M. B., Gutman, C., & Criden, W. (2013). Bringing older adults into the classroom: The sharing community model. *Gerontology & Geriatrics Education, 34*(2), 135–149.

He, W., Sengupta, M., Velkoff, V. A., & DeBarros, K. A. (2005). *65 + in the United States: 2005* (Current Population Report P23–209). Washington, DC: U.S. Census Bureau.

Helmes, E., & Gee, S. (2003). Attitudes of Australian therapists toward older clients: Educational and training imperatives. *Educational Gerontology, 29*(8), 657–670. https://doi.org/10.1080/03601270390225640

Hoge, M. A., Karel, M. J., Zeiss, A. M., Alegria, M., & Moye, J. (2015). Strengthening psychology's workforce for older adults: Implications of the Institute of Medicine's report to Congress. *American Psychologist, 70*(3), 265.

Herrera, A. P., Snipes, S. A., King, D. W., Torres-Vigil, I., Goldberg, D. S., & Wenberg, A. D. (2010). Disparate inclusion of older adults in clinical trials: Priorities and opportunities for policy and practice change. *American Journal of Public Health, 100*(SUPPL. 1), 105–112. https://doi.org/10.2105/AJPH.2009.162982

Lee, K. M., Volans, P. J., & Gregory, N. (2003). Attitudes towards psychotherapy with older people among trainee clinical psychologists. *Ageing & Mental Health, 7*(2), 133–141. https://doi.org/10.1080/1360786031000072303

Levy, B. (2009). Stereotype embodiment: A psychosocial approach to aging. *Current Directions in Psychological Science, 18*(6), 332–336.

Levy, B. R., Zonderman, A. B., Slade, M. D., & Ferrucci, L. (2009). Age stereotypes held earlier in life predict cardiovascular events in later life. *Psychological Science, 20*(3), 296–298.

Levy, B. R., Pilver, C. E., & Pietrzak, R. H. (2014). Lower prevalence of psychiatric conditions when negative age stereotypes are resisted. *Social Science & Medicine (1982), 119*, 170–174.

Lewis, T. T., Aiello, A. E., Leurgans, S., Kelly, J., & Barnes, L. L. (2010). Self-reported experiences of everyday discrimination are associated with elevated C-reactive protein levels in older African-American adults. *Brain, Behavior, and Immunity, 24*(3), 438–443. https://doi.org/10.1016/j.bbi.2009.11.011

Lewis, T. T., Barnes, L. L., Bienias, J. L., Lackland, D. T., Evans, D. A., & Leon, C. F. (2009). Perceived discrimination and blood pressure in older African American and white adults. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences, 64A*(9), 1002–1008. https://doi.org/10.1093/gerona/glp062

Lorde, A. (2007). *Sister outsider: Essays & speeches by Audre Lorde* (p. 2007). Berkeley, CA: Crossing Press.

Lyons, A., Alba, B., Heywood, W., Fileborn, B., Minichiello, V., Barrett, C., … Dow, B. (2018). Experiences of ageism and the mental health of older adults. *Aging & Mental Health, 22*(11), 1456–1464. https://doi.org/10.1080/13607863.2017.1364347

Makris, U. E., Higashi, R. T., Marks, E. G., Fraenkel, L., Sale, J. E. M., Gill, T. M., & Reid, M. C. (2015). Ageism, negative attitudes, and competing co-morbidities--why older adults may not seek care for restricting back pain: A qualitative study. *BMC Geriatrics, 15*, 39. https://doi.org/10.1186/s12877-015-0042-z

Moser, C., Spagnoli, J., & Santos-Eggimann, B. (2011). Self-perception of aging and vulnerability to adverse outcomes at the age of 65–70 years. *The Journals of Gerontology: Series B, 66*(6), 675–680. https://doi.org/10.1093/geronb/gbr052

Nadimpalli, S. B., James, B. D., Yu, L., Cothran, F., & Barnes, L. L. (2014). The association between discrimination and depressive symptoms among older African Americans: The role of psychological and social factors. *Experimental Aging Research, 41*(1), 1–24. https://doi.org/10.1080/0361073x.2015.978201

O'Hara, M. E. (2017, April 26). *How has Trump's first 100 days in office impacted LGBTQ rights?* Retrieved from https://www.nbcnews.com/feature/nbc-out/first-100-days-how-president-trump-has-impacted-lgbtq-rights-n750191

Ory, M., Hoffman, M. K., Hawkins, M., Sanner, B., & Mockenhaupt, R. (2003). Challenging aging stereotypes: Strategies for creating a more active society. *American Journal of Preventive Medicine, 25*(3), 164–171.

Palmore, E. (2001). The ageism survey: First findings. *The Gerontologist, 41*(5), 572–575.

Paradies, Y. (2006). A systematic review of empirical research on self-reported racism and health. *International Journal of Epidemiology, 35*(4), 888–901. https://doi.org/10.1093/ije/dyl056

Pascoe, E. A., & Smart Richman, L. (2009). Perceived discrimination and health: A meta-analytic review. *Psychological Bulletin, 135*(4), 531–554. https://doi.org/10.1037/a0016059

Perea, J. F. (1997). The black/white binary paradigm of race: The "Normal Science" of American racial thought. *California Law Review, 85*(5), 1213. https://doi.org/10.2307/3481059

Ray, D. C., McKinney, K. A., & Ford, C. V. (1987). Differences in psychologists' ratings of older and younger clients. *The Gerontologist, 27*(1), 82–86. https://doi.org/10.1093/geront/27.1.82

Ross, A. J., Anderson, J. E., Kodate, N., Thomas, L., Thompson, K., Thomas, B., … Jaye, P. (2013). Simulation training for improving the quality of care for older people: An independent evaluation of an innovative programme for inter-professional education. *BMJ Quality & Safety, 22*, 495–505.

Rozanski, A., Blumenthal, J. A., Davidson, K. W., Saab, P. G., & Kubzansky, L. (2005). The epidemiology, pathophysiology, and management of psychosocial risk factors in cardiac practice: The emerging field of behavioral cardiology. *Journal of the American College of Cardiology, 45*(5), 637–651.

Sargent-Cox, K. A., Anstey, K. J., & Luszcz, M. A. (2012). The relationship between change in self-perceptions of aging and physical functioning in older adults. *Psychology and Aging, 27*(3), 750–760. https://doi.org/10.1037/a0027578

Samra, R., Griffiths, A., Cox, T., Conroy, S., & Knight, A. (2013). Changes in medical student and doctor attitudes toward older adults after an intervention: A systematic review. *Journal of the American Geriatrics Society, 61*(7), 1188–1196.

Schmitt, M. T., Branscombe, N. R., Postmes, T., & Garcia, A. (2014). The consequences of perceived discrimination for psychological well-being: A meta-analytic review. *Psychological Bulletin, 140*(4), 921–948. https://doi.org/10.1037/a0035754

Sorkin, D. H., Pham, E., & Ngo-Metzger, Q. (2009). Racial and ethnic differences in the mental health needs and access to care of older adults in California. *Journal of the American Geriatrics Society, 57*(12), 2311–2317. https://doi.org/10.1111/j.1532-5415.2009.02573.x

Sutin, A. R., Stephan, Y., Carretta, H., & Terracciano, A. (2015). Perceived discrimination and physical, cognitive, and emotional health in older adulthood. *The American Journal of Geriatric Psychiatry, 23*(2), 171–179. https://doi.org/10.1016/j.jagp.2014.03.007

Talarico, L., Chen, G., & Pazdur, R. (2004). Enrollment of elderly patients in clinical trials for cancer drug registration: A 7-year experience by the US Food and Drug Administration. *Journal of Clinical Oncology, 22*(22), 4626–4631. https://doi.org/10.1200/JCO.2004.02.175

Thake, M., & Lowry, A. (2017). A systematic review of trends in the selective exclusion of older participant from randomised clinical trials. *Archives of Gerontology and Geriatrics, 72*, 99–102. https://doi.org/10.1016/j.archger.2017.05.017

Thoits, P. A. (2010). Stress and health: Major findings and policy implications. *Journal of Health and Social Behavior, 51*(S), 541–533. https://doi.org/10.1177/0022146510383499

Thornton, J. E. (2002). Myths of aging or ageist stereotypes. *Educational Gerontology, 28*(4), 301–312. https://doi.org/10.1080/036012702753590415

Todorova, I. L., Falcón, L. M., Lincoln, A. K., & Price, L. L. (2010). Perceived discrimination, psychological distress and health. *Sociology of Health & Illness, 32*(6), 843–861. https://doi.org/10.1111/j.1467-9566.2010.01257.x

Uncapher, H., & Areán, P. a. (2000). Physicians are less willing to treat suicidal ideation in older patients. *Journal of the American Geriatrics Society, 48*(2), 188–192. https://doi.org/10.1111/j.1532-5415.2000.tb03910.x

U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. (2017). *National and rgional projections of supply and demand for geriatricians: 2013–2025*. Rockville, MD. Retrieved from https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/GeriatricsReport51817.pdf

Ward, B. W., & Schiller, J. S. (2013). Prevalence of multiple chronic conditions among US adults: Estimates from the National Health Interview Survey, 2010. *Preventing Chronic Disease, 10*. https://doi.org/10.5888/pcd10.120203

Ward, B. W., Schiller, J. S., & Goodman, R. A. (2014). Multiple chronic conditions among US adults: A 2012 update. *Preventing Chronic Disease, 11*. https://doi.org/10.5888/pcd11.130389

Williams, D. R., & Mohammed, S. A. (2009). Discrimination and racial disparities in health: Evidence and needed research. *Journal of Behavioral Medicine, 32*(1), 20–47. https://doi.org/10.1007/s10865-008-9185-0

Wurm, S., Tesch-Römer, C., & Tomasik, M. J. (2007). Longitudinal findings on aging-related cognitions, control beliefs, and health in later life. *Journal of Gerontology: Psychological Sciences and Social Science, 62*(3), 156–164.

Wurm, S., & Benyamini, Y. (2014). Optimism buffers the detrimental effect of negative self-perceptions of ageing on physical and mental health. *Psychology & Health, 29*(7), 832–848. https://doi.org/10.1080/08870446.2014.891737

Yip, T., Gee, G. C., & Takeuchi, D. T. (2008). Racial discrimination and psychological distress: The impact of ethnic identity and age among immigrant and United States-born Asian adults. *Developmental Psychology, 44*(3), 787–800. https://doi.org/10.1037/0012-1649.44.3.787

Levy, B. R., Slade, M. D., Kunkel, S. R., & Kasl, S. V. (2002). Longevity increased by positive self-perceptions of aging. *Journal of personality and social psychology, 83*(2), 261.

Ng, R., Allore, H. G., Monin, J. K., & Levy, B. R. (2016). Retirement as meaningful: Positive retirement stereotypes associated with longevity. *Journal of Social issues, 72*(1), 69–85.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

Zylstra, R. G., & Steitz, J. A. (2000). Knowledge of late life depression and aging among primary care physicians. *Aging & Mental Health, 4*(1), 30–35.

Rural Prejudice-Urban Bias: The Stories and Structures That Oppress Rural Communities

Nathaniel Vincent Mohatt and Dennis Mohatt

Abstract

Rural communities account for somewhere between 72% and 97% of the land mass in the United States and approximately 15–20% of the country's population (United States Census Bureau. New census data show differences between urban and rural populations [Press release]. Retrieved from https://www.census.gov/newsroom/press-releases/2016/cb16-210.html, 2016; United States Department of Agriculture. Rural America at a glance 2016 Edition. Retrieved from https://www.ers.usda.gov/webdocs/publications/80894/eib-162.pdf?v=42684, 2017). Furthermore, rural communities are an important part of the American mythos, representing a population and lifestyle that features heavily in the identity of America (Stamm. Rural behavioral health care: An interdisciplinary guide. American Psychological Association, Washington, DC, 2003). As such, rural communities and people occupy both a large and socially important piece of the United States. Likewise, being only 20% of the population, rural residents are also an often overlooked and underserved minority. The dominant urban culture often portrays rural people in negative stereotypes that can both exacerbate behavioral health problems and impact the quality of care received by rural residents. Further, prejudice against rural people and communities is manifested in the lived realities of rural disadvantage and policy marginalization, which lead to challenges for the delivery of quality behavioral health care in rural communities. Taking a public narrative model for understanding community health outcomes (N. V. Mohatt et al. Soc Sci Med 106, 128–36, 2014; Rappaport. Am J Community Psychol 28(1), 1–24, 2000), we review how stigma and prejudices manifest in rural community life and relate to persistent rural health disparities. The objective of this chapter is to provide rural mental health practitioners with a deeper understanding of the ways in which stigma and prejudice toward rural communities shape the landscape of mental health in rural America. In conclusion, we provide a series of recommendations to reshape the structural and cultural biases and provide effective rural behavioral health treatment and community action.

Keywords

Rural · Urban bias · Stigma · Public narratives

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L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_23

Rural communities account for somewhere between 72% and 97% of the land mass in the United States and approximately 15–20% of the country's population (United States Census Bureau, 2016; United States Department of Agriculture, 2017), depending on the source and definition of rural. Furthermore, rural communities are an important part of the American mythos, representing a population and lifestyle that features heavily in the identity of America (Stamm, 2003). As such, rural communities and people occupy both a large and socially important piece of the United States. Likewise, being only 20% of the population, rural residents are also an often overlooked and underserved minority. The dominant urban culture, in terms of population size and social-political influence, often portrays rural people in negative stereotypes that can both exacerbate behavioral health problems and impact the quality of care received by rural residents. Further, prejudice against rural people and communities is manifested in the lived realities of rural disadvantage and policy marginalization, which lead to challenges for the delivery of quality behavioral health care in rural communities.

Throughout the world there exists a well-documented urban bias (Lipton, 1977). This urban bias manifests in both structural and cultural prejudices that interact with often harmful impacts on behavioral health delivery and outcomes. We first review the handful of structural prejudices that impact behavioral healthcare, including economic disadvantage and policy biases. We then turn to a discussion of cultural prejudices. In particular, we discuss the dominant cultural narratives that oppress rural people and communities through perpetuation of negative and/or romanticized stereotypes. Rural stigmas and prejudice provide a critical background to rural community health, reinforced and rarified by structural oppression. Taking a public narrative model for understanding community health outcomes (N. V. Mohatt, Thompson, Thai, & Tebes, 2014; Rappaport, 2000), we review how stigma and prejudices manifest in rural community life and relate to persistent rural health disparities. The objective of this chapter is to provide rural mental health practitioners with a deeper understanding of the ways in which stigma and prejudice toward rural communities shape the landscape of mental health in rural America.

Defining Rural

Before proceeding further with a discussion of rural prejudice, it is critical to underscore that rural American is far from homogeneous. Rural homogeneity is one myth that can be a barrier to effective behavioral health service delivery (Wagenfeld, Murray, Mohatt, & DeBruyn, 1997). Quite to the contrary, rural America is diverse. No stereotype can capture the level of diversity displayed across rural communities in the United States. Hence, the first notion we must understand is that there is no singular culture that we can clearly identify as rural. Any image we carry of what a rural place is, or who lives in rural America, is by necessity misleading at best.

One challenge is simply defining the boundaries or methods that we use to categorize somewhere as rural or not (Hart, Larson, & Lishner, 2005; Stamm, 2003). Most definitions of rural are based to some degree on population density or geographic isolation (United States Department of Agriculture Econmic Research Service, 2017b). A standard way of studying rural vs. urban is to draw the line based on definitions of metropolitan areas, as defined by the US Office of Management and Budget (Wilson, 2012). Metropolitan areas have at least one urban core with 50,000 or more people living in it. Every place or resident within a metropolitan area is urban; all else is rural. Within this system rural is often broken down further into open country side, small towns with fewer than 2500 people, and larger towns with between 2500 and 49,999 residents (United States Department of Agriculture Econmic Research Service, 2017a). Another term frequently used in distinguishing level of rurality is to distinguish frontier areas, which typically or defined as having a population density of less than 6 people per square mile (Hub, 2017). Recently, the Rural-Urban Commuting Areas (RUCA) are being used to define rurality by adding commuting patterns, based on the notion that rurality is dependent not only on population and geographic isolation, but on social patterns of connectedness to urban areas (WWAMI Rural Health Research Center, 2017).

Beyond the metric used, defining rural also relies on designating area boundaries. Political subdivisions, such as counties or census tracts, are an appealing means of defining area boundaries, but inevitably some defined areas will contain urban, rural, and highly rural populations within its boundaries. For example, the US Health Resources and Services Administration uses RUCA codes for identifying rural census tracts, but has identified 132 large area census tracts that they must break down even further to identify rural communities (U.S. Health Resources & Services Administration, 2017). In any and every system for defining and classifying rural, we could identify a flaw. However, at a very basic level we think of "rural" as places that are neither a city nor a city's suburbs; that is, places where fewer people live and where people must travel farther to reach a city and its services.

Understanding that a rural place, at its most fundamental level, simply refers to a place that is out of and away from a city, we can see that there is really no limit to how different and diverse rural places and the people who live in rural places can be. If rural, even as a contested concept, is only defined as "not city or suburb," then there can be and are many versions of rural places, many different landscapes where rural exists, and many different people that live in rural places.

Geographically, rural America extends from both coasts, through the plains, and across many different mountain ranges. The upper peninsula of Michigan is a land of dense forests and lakes, whereas the Great Plains is characterized by a sea of rolling grasslands. Southeast Alaska is made up of isolated coastal communities, rainforests, and unpassable mountains and ice fields—it is a land of lush greens and cold blues—whereas the Southwest United States provides an expanse of desert and mountains, dominated by shades of brown and red. Guam, Puerto Rico, the American Virgin Island, and Hawaii all offer tropical island life and a variety of rural landscapes including white, black, and green sand beaches, volcanic rock, mountains, and rainforests. And throughout our country are the small towns, farms, and ranches that we so often associate with "rural" and seem to begin immediately upon exiting the suburbs.

Rural America is economically diverse (Irwin, Isserman, Kilkenny, & Partridge, 2010). There are rural poor and rural wealthy, for sure. But more to the point, there are many different rural economies. Historically, a large share of the rural population engaged in agriculture and the notion that rural is equivalent to agricultural communities remains prevalent in popular American discourse (Irwin et al., 2010; D. T. Lichter & Brown, 2011). Although, spatially, much of rural American remains agricultural, over the last 100 years, the rural population engaged in agricultural work has declined from 42% to just over 1% (D. T. Lichter & Brown, 2011). Rural economic activity is broad, including industries often associated with rural (such as farming, fishing, forestry, or mining), but including also basic functions of towns (retail, government, health care, and so forth), manufacturing, construction, and transportation (Irwin et al., 2010). Urban economies and industry have had an increasing role in shaping rural life in recent years (D. T. Lichter & Brown, 2011). For example, the oil and gas industry, with demand largely driven by large urban populations, has had indelible impacts on rural Montana and North Dakota in recent years and in Texas and Alaska for much longer. Also important to understanding rural economies, tourism plays a central role in much of rural America—whether to visit a national park, take a snow mobile vacation, go hunting or fishing, go skiing, spend time at the lake, or take a cruise, rural America offers many of our country's favorite vacation destinations.

Likewise, rural America is culturally and ethnically diverse. Not only are there the stereotypical farming communities founded by white European immigrants but also pockets of rural American have long been home to Black Americans in the "Black Belt," Native Americans throughout the country, and Hispanic Americans in the Southwest (D. T. Lichter, 2012). Spanish colonists and Mexican immigrants have dominated the settling of the Southwest for over 400 years. There are 567 federally recognize Native tribes throughout our country (National Congress of American Indians, n.d.), most of whose lands remain in rural areas of the country. African Americans have long been a major cultural presence in the South and the Caribbean. Rural America is home to a variety of religious communities and cultures, such as the Amish and Mormons, in addition to being home to an immense religious diversity. Furthermore, over the last decade immigrants from throughout the world have increased the ethnic diversity of rural America; Pacific Island cultures are settling in large numbers in rural Hawaii; Southeast Asian cultures have transformed many rural Alaska Villages; and Hispanic Americans and new immigrants are moving in greater numbers to rural communities (D. T. Lichter, 2012).

Structural Prejudice

At the heart of rural stigma and prejudice is disadvantage. Economic disadvantage is rife throughout rural America and highly correlated to health disparities (Crosby, Wendel, Vanderpool, & Casey, 2012; Hale, Probst, & Robertson, 2016; Lupien, King, Meaney, & McEwen, 2001; Tough, 2011). The percent of the population living below the poverty rate has long been higher in rural vs. urban areas—in 2016 16.9% of rural Americans to 13.6% of urban Americans lived below the poverty line (United States Department of Agriculture Econmic Research Service, 2017c). Policy biases that favor urban issues and needs, such as urban health system models being disseminated to rural areas without adaptation (Hogan, 2003), only exacerbate the inequalities and further entrench rural disadvantage. In particular, we see the impact of rural disadvantage play out in the health care sector—rural behavioral health is characterized by diminished access to and quality of care (D. F. Mohatt, Bradley, & Adams, 2005).

Rural communities often struggle with substantial social and economic disadvantages that are linked to persistent health disparities. Rural communities have higher rates of poverty compared to metro counties (16.9% to 13.6% (United States Department of Agriculture Econmic Research Service, 2017c)), as well as lower annual median family income ($50,406 to $67,248), lower high school (81.71% to 85.05%) and college graduation rates (17.28% to 29.53%), and more than twice the income disparity (95.18 to 40.68[1]) when compared to all metro counties (Singh & Siahpush, 2014). Every one of these socioeconomic disparities is even more exacerbated as rurality increases (Singh & Siahpush, 2014). Of the 100 counties in the USA with the highest poverty rates, 95 are rural (Probst, Barker, Enders, & Gardiner, 2018). Furthermore, rural counties experience higher rates of deprivation—deprivation indexes assess the cumulative impact of a variety of social and economic indicators of disadvantage, with greater levels of deprivation being tied to a wide variety of negative physical and behavioral health outcomes (Singh, Williams, Siahpush, & Mulhollen, 2012). A greater percentage of rural counties (41.18%) are classified in the most deprived categories compared to urban counties (33.85%) (Hale et al., 2016).

Rural economic and social disadvantage are not just descriptive facts, but are also indicative of an economic system that oppresses rural communities. In particular, the wealth that is produced by rural economies largely leaves the rural communities to benefit urban economies (Lipton, 1977). Another way of saying this is that much of rural economies are extraction businesses—the goods, services, minerals, food, etc., produced in rural communities are taken out and sent to urban places, largely to the benefit of urban people and economies. Gaventa (1980) argues, for example, that the Appalachian region was systematically colonized and oppressed by industrialists. The coal industry used the natural resources in Appalachia to produce wealth for industrialists while exploiting the labor force of the rural region (Gaventa, 1980). Another way in which

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[1] Income disparity is defined as 100∗ratio of number of households with <$15,000 income to number of households with ≥$75,000 income (Singh & Siahpush, 2014).

the urban bias oppresses rural communities is through “brain drain,” where many young people entering the workforce leave their rural homes in search of better and more plentiful employment opportunities in the cities (Carr & Kefalas, 2009).

Similarly, governmental policies can be seen as prejudiced against rural. One story exemplifying this bias, which gained substantial national attention in 2005, was the discussion of proposed “bridges to nowhere” in Alaska (Murray, 2005; Utt, 2005). One bridge was to connect Ketchikan, Alaska, to an unpopulated island that also happened to be the airport for the town. Another bridge would have connected the city of Anchorage to the remote area of Big Lake, to open the Big Lake area up to housing and economic development. These proposals became “bridges to nowhere” and symbols of government waste because they would have cost hundreds of millions of dollars without clear benefit to *large* populations. Whether or not the proposals for bridges to unpopulated areas near Ketchikan and Anchorage are good policy is not necessary to see the urban bias in this discussion. Each bridge would have had substantial economic benefit for a rural area (Ketchikan would have had better transportation to and from its airport; and Big Lake would have been linked by a direct bridge to Alaska’s largest urban center). Nationally, however, the fact that a rural place could lack basic infrastructure, like a road to the airport in Ketchikan, was never or rarely discussed. Instead, there was a political uproar over spending large amounts of money to benefit a seemingly small number of people. In the end, opponents used the rural funding equation (fewer people but still costly) in a national political debate to symbolize government waste and by association fraud. This example is one high-profile discussion, but policy biases like this have a substantial impact on rural communities, especially in behavioral healthcare.

Urban bias in policy-making and government funding can lead to diminished rural health resources and quality of care. Approximately 10 years ago the President’s New Freedom Commission on Mental Health Rural Issues Subcommittee concluded that rural issues are often misunderstood and ignored in national behavioral health policy (Hogan, 2003). Furthermore, our scientific system, which emphasizes generalizable findings over local tailoring (Tebes, 2005), promotes the idea that health programs function equally across settings and cultures. Our health care system expands this assumption to the dissemination of health care policy and practices, implementing policies and programs developed and tested in urban settings to rural communities with no thought to adaptation to the rural context (Beeson, Britain, Howell, Kirwan, & Sawyer, 1999; Hart et al., 2005; Heflinger & Christens, 2006; Hogan, 2003). This policy bias manifests in health care workforce shortages, diminished quality of care, and a dearth of programs designed explicitly with rural needs in mind. 65% of all rural counties are health workforce shortage areas (MacDowell, Glasser, Fitts, Nielsen, & Hunsaker, 2010), and over 75% of rural counties have a severe shortage of behavioral health professionals (Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009). The effect of this provider shortage is exacerbated by data indicating that rural practitioners have less training (Brems, Johnson, Warner, & Roberts, 2006; Johnson, Brems, Warner, & Roberts, 2006). For example, rural primary care doctors report being substantially less prepared to manage suicidal patients compared to their urban counterparts (Diamond et al., 2012). Suicide prevention is a particularly strong illustration also of how programs and services are developed with an urban bias. Despite rural communities having persistently higher suicide rates than urban places (Centers for Disease Control and Prevention, 2015), only 1 out of 70 identified best practice resources for implementing a public health suicide prevention strategy was developed specifically for or tested in rural communities (N. V. Mohatt, Billera, Demers, Monteith, & Bahraini, 2018).

Overall, there is substantial evidence that the quality of care that rural patients receive for mental health problems may be poorer, particularly for residents in outlying rural areas (Peen, Schoevers, Beekman, & Dekker, 2010). Rural Americans with mental health and substance use disorders are significantly less likely to receive any type of treatment for their mental health and substance use problems than urban and suburban Americans (Wang et al., 2005). Individuals living in rural areas are significantly less likely than their urban counterparts to receive specialty mental health care, but more likely to receive general medical care only or human services only (Wang et al., 2005). Furthermore, this gap between need and accessibility and quality of behavioral healthcare for rural communities is not new. For at least half a century, 60% of rural America has been underserved for behavioral health needs, and more than 85% of the nation's behavioral health professional shortage areas are located in rural America (Hogan, 2003). State offices of rural health have consistently identified access to behavioral health care and concerns for suicide, stress, depression, anxiety disorders, and substance abuse as major rural health concerns (Bolin et al., 2015).

Rural communities are faced with three distinct burdens to adequate behavioral health care: accessibility, availability, and acceptability (D. F. Mohatt et al., 2005). In terms of accessibility, rural residents typically do not know when they need behavioral health care, where they can find that care, and what care options are available to meet their behavioral health needs (Hogan, 2003). When they do find behavioral health care, it is not uncommon for individuals in rural areas to travel hundreds of miles to access those services. The availability of behavioral health providers in rural areas is too limited to support urban models of service delivery, in which individuals needing behavioral health services have a variety of health care providers from which to choose. Structural prejudices against rural areas create a rural behavioral health system that is poorly funded and designed to meet the needs and challenges arising from rural contexts, rural stressors, and rural economic disadvantages.

Cultural Prejudice

The stories communities convey about their health and well-being also have direct and measurable impacts on a wide range of health indicators (N. V. Mohatt et al., 2014). In his seminal article on community narratives, Rappaport (2000) describes how narratives can oppress entire communities and cultures through perpetuation of negative stereotypes. According to this theory, majority cultures establish the dominant narratives that describe minority communities in ways that are disempowering. The objective, therefore, of community health work becomes to empower communities to recognize and overturn oppressive dominant cultural narratives and replace them with self-defined and empowered narratives. By doing, Rappaport (2000) argues, we can improve the overall well-being and health outcomes of communities. Similarly, Appadurai (2004) describes culture as the capacity to aspire—the capacity to aspire to a better future is subsequently linked to improved economic development outcomes. Like Rappaport, Appadurai (2004) describes how communities can develop this capacity to aspire through empowerment and participatory action, which in turn leads to a host of improved community wellness and economic indicators. Therefore, to understand how to improve the behavioral health of rural communities, we must also identify and condemn the negative stereotypes, prejudices, and dominant cultural narratives that oppress rural people and communities.

Just as we discussed earlier the role and manifestations of urban bias in perpetuating rural economic and social disadvantage, so too is there a rampant urban superiority narrative that sustains rural oppression. Our major cities are synonymous with being the cultural centers of the United States. Even the word "culture" is often used in casual conversation to refer to the arts and in the sense of locating *where* we can access culture and cultural activities—namely, cities. No matter how many artists live in rural places, we still speak of cities as having culture and rural places as having none. It is after all the cities that hold our major "cultural" institutions—museums and art galleries, concert halls, theaters, symphonies, operas, etc. To the extent that these exist in rural communities, they are considered minor local representations of culture, whereas the major cultural institutions are in the cities—the MET and

MOMA in New York City; the Smithsonian Institutes in Washington, DC; and so forth; every major museum, theater, and the like are in our big cities. But it is not where the cultural institutions are, but the discourse that emerges from this fact that betrays the prejudice inherent in urban superiority. Instead of identifying what types of culture exist in rural places, we often hear rural places described as having less culture, being uncultured and ignorant of culture, or being cultural wastelands.

But what is "culture"? The concept of culture is very difficult to define, with many competing definitions (Cohen, 2009). A traditional definition of culture comes from Geertz— culture is an "historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms by means of which men (sic) communicate, perpetuate, and develop their knowledge about and attitudes towards life" (Geertz, 1973, p. 89). A more recent definition from a review on culture and health is supplied by Napier et al.: "The shared, overt and covert understandings that constitute conventions and practices, and the ideas, symbols, and concrete artifacts that sustain conventions and practices, and make them meaningful" (2014, p. 4). Culture, then, as defined in social and health sciences is something inherent to human communities and activities—every community has its culture and every community and person is an expression of multitudes of cultures (Pedersen, 1991). We bring this up to underscore the point that the popular discourse linking culture to cities, and describing rural places as less cultured, is in and of itself a central aspect of the oppression of rural communities. By depicting rural as less cultured, the dominant cultural narrative describes rural places and people as inherently less human.

By extension, the people who live in rural places are less "cultured," less *human*. We see this unfortunate stereotype frequently in popular culture depictions of rural people (Avery et al., 2016)—in particular, the iconic hillbilly. Movies and television shows commonly portray rural people as uneducated, not just as having less education, but in the sense of having less intellect and being easy to manipulate. The comic strip *Li'l Abner*, often credited with inventing the hillbilly stereotype (Wessels Living History Farm, 2017), featured a lead character who is simpleminded and gullible (Wikipedia, 2017). Shows such as *The Beverly Hillbillies* and characters like Cletus from *The Simpsons* sustain and extend the stereotype of the uneducated and backward hillbilly (Wessels Living History Farm, 2017). Recently, reality TV has taken to promoting the stereotype of backward rural folk through finding and sensationalizing real people who epitomize stereotypes (Massey, 2017)—conservative, gun-toting, and politically backward characters in *Duck Dynasty*; strange and socially awkward *Alaskan Bush People*; and young out-of-control rednecks drinking moonshine in *Buckwild*. The less-than-human aspect of this rural stereotype is drawn into sharp focus with movie and TV depictions of violent, inbred, and developmentally disabled characters in movies like *Deliverance*, *The Hills Have Eyes*, and more recently *American Horror Story: A Roanoke Nightmare* (Avery et al., 2016; Mabie, 2017; Wessels Living History Farm, 2017).

These negative cultural stereotypes are not just forms of entertainment, but are for many urban people a primary way in which they get to know about rural life. Other than pop culture, the news media is not much better in portraying real pictures of rural life. In a 2002 study, the Kellogg Foundation found that news media portrayals of rural life present a very limited story (S. R. Lichter, Amundson, & Lichter, 2003). Where there are rural stories in the national media, they primarily present a story of places that are hanging onto the past in the face of change and uncertainty; that is, they are out of synch with the times (S. R. Lichter et al., 2003). Alternately, rural communities are fighting urbanization; that is, fighting a losing battle (S. R. Lichter et al., 2003). And, finally, many news stories about rural places focus on crime, portraying an image of a rural ghetto (S. R. Lichter et al., 2003). So, rural places are either idyllic and out of synch, fighting a losing battle, or poor and dangerous "rural ghettos" (Davidson, 1996). This representation in the news media only furthers prejudices that rural places are culturally backward and stuck in old worldviews that are wrong.

On the other hand, representations of rural places will also often rely on quaint, idyllic, and romantic portrayals. Such positively skewed stereotypes are no less harmful—in fact, positive stereotypes may be *more* likely to produce negative opinions toward the stereotyped group (Kay, Day, Zanna, & Nussbaum, 2013). Just as any other stereotype, positive stereotypes create social distance and reduce understanding (Kay et al., 2013). Stereotypes intended to romanticize rural life, such as the hardworking and fiercely self-reliant folk who take care of each other and themselves, may also exacerbate problems in the behavioral health system. If all rural people and communities are self-reliant, then they don't really need, or want, government to solve health care shortages. Moreover, "they" may not even want "our" help. This line of reasoning is dangerous. It may negatively influence policy debates, exacerbating policy and government funding biases.

Another potentially harmful stereotype is the notion that rural people are more connected to community. This myth is so pervasive that rural residents largely endorse the notion (DelReal & Clement, 2017). But the reality is that rural people are more likely to experience isolation (Beeson et al., 1999). Geographic distances and transportation barriers create very real limits on how easy it is for people in remote and rural place to interact and participate in social events. In particular, vulnerable populations, including the mentally ill, may experience greater social isolation in rural places (Leight, 2003; Letvak, 2002). For example, as people age in rural places they become increasingly isolated in their homes, reliant on others having the time and transportation to visit them (Averill, 2003). This also creates a major challenge for rural behavioral health systems—how do you find and support the isolated? Not only may you not know where they are, but then you also need resources to conduct home visits that may take substantial time due to travel distances.

The romanticized stereotypes are also just plain incorrect and, as such, harm rural people and communities by hiding the realities and challenges that rural people face. Rural life is not an idyllic land-based existence, but instead rural life is empirically more stressful (Hansen, 1987). As described earlier, rural areas are more likely to score poorly on deprivation indexes and the most economically disadvantaged counties in the United States are by an large rural (Hale et al., 2016; Probst et al., 2018). Additionally, rural communities experience higher rates and severity of malnutrition; the majority of substandard occupied housing is in rural communities; rural communities have the highest maternal and infant mortality rates; unemployment and underemployment rates are higher in rural communities; increases in divorce rates are growing faster in rural compared to urban places; and rural drinking water is more likely to not meet EPA standards (Hansen, 1987). Given the strong link between stress and behavioral health (Lupien et al., 2001; Sinha, 2009; Tough, 2011), it is critical for behavioral health practitioners and systems to be highly attuned to the realities of rural stress and not blinded by idealized stereotypes.

Conclusions

Stigmas, prejudice, and oppression against rural communities and people in the United States take on many forms. Structural prejudices in the political and healthcare systems economically exploit rural communities and maintain a system wherein rural communities experience diminished access to behavioral healthcare and diminished quality of care. Cultural stereotypes range from harmful and negative portrayals of hillbillies and hicks to romanticized notions of the rural idyllic. These stereotypes serve to exaggerate differences and diminish appropriate health system responses. But there is another side to the interplay between structural and cultural prejudices—the ways in which negative cultural narratives become internalized and reflected in population level health outcomes.

There is a robust literature on rural health disparities. However, even these disparities must not be rarified with a broad brush stroke. Different disparities are evident in different settings and communities. For many behavioral health outcomes, rural residents actually experience similar prevalence rates to urban residents (Peen et al., 2010). For others, such as suicide, rural rates are higher (Hirsch, 2006). What is central to any understanding of rural health disparities is that many of the same issues drive health disparities in either urban or rural settings—in particular, poverty, stress, and access to quality care. Unfortunately, rural residents may be more likely to experience these central risk factors when compared broadly to urban and suburban populations. Therefore, a first step toward addressing rural disparities is to identify and recognize structural and cultural disadvantages that are tied to health disparities.

Beyond recognition to promote discussion and problem-solving, urban biases that negatively impact rural behavioral health can be addressed systematically. The President's New Freedom Commission Rural Issues Subcommittee (Hogan, 2003) presented an analysis of the biases and needs in rural behavioral health care, concluding with a set of recommendations. The 16 recommendations of this subcommittee are as follows:

1. Increase access to mental health emergency response, early identification, diagnosis, treatment, and recovery services to equal levels as provided in urban areas.
2. Develop a national Rural Mental Health Plan.
3. Establish a full-time position within the Department of Health and Human Services Administrator's Office focused on rural issues and require a "rural impact statement" be prepared for all new national behavioral health policies.
4. Implement a single rural definition across all HHS programs.
5. Provide increased research funding on the prevalence, incidence, and etiology of behavioral disorders across a wide array of rural environments.
6. Develop federal policies to enable rural individuals and small business to enter insurance purchasing pools to enhance access to affordable health insurance.
7. Ensure that nonfederal matching fund requirements are not placed at levels unrealistic for rural entities competing for federal funding opportunities.
8. Enhance dissemination of telehealth.
9. Establish a public information initiative to increase rural residents' understanding of mental illnesses and best practices in treatment.
10. Implement a study and tracking mechanism to monitor the relinquishment of child custody to obtain mental health treatment for children.
11. Convene a cross-agency work group to examine workforce enhancement programs.
12. Articulate a federal rural mental health workforce strategy.
13. Support the training, deployment, and continuing education of rural mental health professionals to strengthen the capacity and competency of the workforce to support an evidence-based practice care delivery system.
14. Include master's-level psychologists and counselors in federal loan repayment and scholarship programs.
15. Provide a basic safety net continuum of rural mental health care for underserved areas.
16. Initiate and support research to identify, verify, and disseminate evidence-based practices suitable for application in rural practice environments.

While an exhaustive review on the implementation of these recommendations has not been conducted, the majority of them have never been implemented even to a limited degree. Yet, all these 16 recommendations are still applicable and would greatly improve the delivery of behavioral health care in rural communities to overcome systemic urban bias.

Of particular importance for this book and this chapter are the prejudices that oppress rural communities. Dominant cultural stereotypes are one such prejudice. In the case of rural communities, stereotypes that portray rural people as uncultured, backward, naïve, less intelligent, uneducated, easy to manipulate, etc., and by contrast those that represent rural places as bastions of goodness, community, and old-fashioned American values are two central dominant cultural narratives that discredit and discount rural needs and diversity. Such public narratives may be harmful to human health.

Negative, or traumatic, public narratives have been empirically linked to a variety of health disparities including social, behavioral, and physical health indicators (N. V. Mohatt et al., 2014). In a review of the literature on historical trauma, Mohatt et al. (2014) identified a model for how historical trauma can influence population-level health outcomes via a narrative model. Of particular relevance to this discussion is the relationship between a public narrative, such as the negative stereotypes of rural people, and symbolic reminders of the narrative in everyday life. In this public narrative model, oppressive narratives become exaggerated and internalized by structural reminders of oppression. In this way, the structural and cultural forms of prejudice build off of each other in a snowball-like effect—each in turn raising the salience and stressfulness of the other. The model, therefore, describes how public narratives are stressors made more salient by daily reminders in the form of disadvantage, microaggressions, oppression, and discrimination. As stressors, the negative cultural stereotypes are directly tied to behavioral health disparities.

Rappaport (2000) described how communities oppressed by dominant cultural narratives can take back their stories through emancipatory and participatory action research. In doing so, he argues that communities can reshape their narratives and improve community health and wellness (Rappaport, 2000). In this seminal article, he describes three examples: changing the narrative in a Christian church related to gay and lesbian individuals to promote continued inclusion in the spiritual community, the growth of mutual help organizations allowing people with substance abuse and mental illness challenges to chart their own pathway of recovery and social inclusion, and a large initiative to change the setting and story of an inner city school struggling with a stigma of being dangerous. At the end of the third example he concludes that more programs are not needed; instead what this school needs is “a new setting narrative that speaks of the talents, skills, and abilities of the students, their families and neighbors” (Rappaport, 2000).

Another example of how participatory research can overturn dominant cultural narratives and promote improved behavioral health is the People Awakening study on sobriety among Alaska Natives (G. V. Mohatt, Hazel, et al., 2004; G. V. Mohatt, Rasmus, et al., 2004). Alaska Native leaders approached the university researchers and asked them to study all the Alaska Natives who are not addicted to alcohol in direct contrast to the prevailing literature and national dialog on a crisis of alcoholism in Alaska Native villages. Through this work, the dialog around Alaska Native health shifted dramatically, with identifying and leveraging wellness and strengths becoming a central guiding principal of behavioral health care for Alaska Natives. We cannot claim for certain the People Awakening study ushered in a new era, but it certainly has inspired a number of research and programs grounded in a wellness and asset orientation as oppose to only focusing on deficit. Some examples include the Qungasvik youth suicide and substance abuse prevention program for Alaska Natives which is the direct descendant of the People Awakening study, operationalizing the theory of sobriety into a program to promote culture-based strengths as a means of prevention (Allen et al., 2018), as well as the formation and research of the Center for Alaska Native Health Research and an interrelated series of studies to promote health among diverse Alaska Natives (Allen & Mohatt, 2014). Such efforts are limited in scope to any particular narrative or community. Overturning a national stereotype is not the scope of these efforts—instead the emphasis is on working with defined communities to support them in taking back their own stories. In this way, participatory research may never dispel the national stereotypes, but it can support individual communities in striking out on their own, self-defined path of wellness.

Rural stigmas and stereotypes serve as harmful and oppressive dominant cultural narratives. These stories are made all the more real by the lived experience of economic exploitation, structural disadvantage, and political bias. The conjoined stressors of cultural and structural prejudices are further exacerbated by a disadvantaged and urban-biased behavioral health system. The rural behavioral health system is disadvantaged in particular through diminished access and quality of care stemming from the urban model of care, training, and funding. Furthermore, cultural stereotype of rural self-reliance and hardiness may exacerbate the situation by promoting a rural stigma toward seeking help and promoting a policy bias against providing extra services to rural communities. Taken together, rural prejudice is expressed in multiple forms of oppression and disadvantage that interact with each other in complex ways that must be carefully attended to in providing behavioral health in rural contexts. However, through careful attention to and promotion of local rural strengths and resources, these dominant narratives can become less meaningful and harmful to individual people and communities. Furthermore, should we as a nation succeed in implementing a series of policy changes to level the playing field and support local rural solutions and needs, positive narratives of wellness and resilience will become more meaningful. Together structural reform and local participatory health promotion can turn the "tales of terror" to "tale of joy" and build a less prejudiced and more robust future for rural behavioral health care.

References

Allen, J., & Mohatt, G. V. (2014). Introduction to ecological description of a community intervention: Building prevention through collaborative field based research. *American Journal of Community Psychology, 54*(1–2), 83–90.

Allen, J., Rasmus, S. M., Fok, C. C. T., Charles, B., Henry, D., & Team, Q. (2018). Multi-level cultural intervention for the prevention of suicide and alcohol use risk with Alaska Native youth: A nonrandomized comparison of treatment intensity. *Prevention Science, 19*(2), 174–485.

Appadurai, A. (2004). Culture and the terms of recognition: The capacity to aspire. In V. Rao & M. Walton (Eds.), *Culture and public action* (pp. 59–84). Stanford, CA: Stanford University Press.

Averill, J. (2003). Keys to the puzzle: Recognizing strengths in a rural community. *Public Health Nursing, 20*(6), 449–455.

Avery, L. M., Ching, B., Hayden, K. E., Jicha, K. A., Lowe, B. M., McKay, P. E., & Sipple, J. W. (2016). *Reimagining rural: Urbanormative portrayals of Rural life*. Lexington Books. New York and London: Lanham, Boulder.

Beeson, P. G., Britain, C., Howell, M. L., Kirwan, D., & Sawyer, D. A. (1999). Rural mental health at the Millenium. In R. W. Manderscheid & M. J. Henderson (Eds.),Beeson, P. G., Britain, C., Howell, M. L., Kirwan, D., & Sawyer, D. A. (1999). Rural mental health at the Millenium. In Center for Mental Health Services. Mental Health, 1998. Manderscheid, R. W. & Henderson, M. J., eds. DHHS Pub. No. (SMA)99-3285. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1998

Bolin, J. N., Bellamy, G. R., Ferdinand, A. O., Vuong, A. M., Kash, B. A., Schulze, A., & Helduser, J. W. (2015). Rural healthy people 2020: New decade, same challenges. *The Journal of Rural Health, 31*(3), 326–333.

Brems, C., Johnson, M. E., Warner, T. D., & Roberts, L. W. (2006). Barriers to healthcare as reported by rural and urban interprofessional providers. *Journal of Interprofessional Care, 20*(2), 105–118.

Carr, P. J., & Kefalas, M. J. (2009). *Hollowing out the middle: The rural brain drain and what it means for America*. Boston, MA: Beacon Press.

Centers for Disease Control and Prevention. (2015). *Age-adjusted rates for suicide, by urbanization of county of residence — United States, 2004 and 2013* (Vol. 64, p. 401). Morbidity and Mortality Weekly Report.

Cohen, A. B. (2009). Many forms of culture. *American Psychologist, 64*(3), 194.

Crosby, R. A., Wendel, M. L., Vanderpool, R. C., & Casey, B. R. (2012). *Rural populations and health: Determinants, disparities, and solutions*. New York, NY: Wiley.

Davidson, O. G. (1996). Broken heartland: The rise of America's rural ghetto.

DelReal, J. A., & Clement, S. (2017). New poll of rural Americans shows deep cultural divide with urban centers. *Washington Post*. Retrieved from https://www.washingtonpost.com/graphics/2017/national/rural-america/?utm_term=.8539d5a2874b

Diamond, G. S., O'Malley, A., Wintersteen, M. B., Peters, S., Yunghans, S., Biddle, V., … Schrand, S. (2012). Attitudes, practices, and barriers to adolescent suicide and mental health screening: A survey of Pennsylvania primary care providers. *Journal of Primary Care & Community Health, 3*(1), 29–35.

Gaventa, J. (1980). *Power and powerlessness: Rebellion and quiescence in an Appalachian valley* (Vol. 198, pp. 197–230). Urbana, Kolkata: University of Illinois Press.

Geertz, C. (1973). *The interpretation of cultures* (Vol. 5019). New York, NY: Basic Books.

Hale, N., Probst, J., & Robertson, A. (2016). Rural area deprivation and hospitalizations among children for ambulatory care sensitive conditions. *Journal of Community Health, 41*(3), 451–460.

Hansen, T. D. (1987). *On myth and reality: The stress of life in rural America.* Paper presented at the Journal of Research in Rural Education.

Hart, L. G., Larson, E. H., & Lishner, D. M. (2005). Rural definitions for health policy and research. *American Journal of Public Health, 95*(7), 1149–1155.

Heflinger, C. A., & Christens, B. (2006). Rural behavioral health services for children and adolescents: An ecological and community psychology analysis. *Journal of Community Psychology, 34*(4), 379–400.

Hirsch, J. K. (2006). A review of the literature on rural suicide. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 27*(4), 189–199.

Hogan, M. F. (2003). New Freedom Commission report: The President's New Freedom Commission: Recommendations to transform mental health care in America. *Psychiatric Services, 54*(11), 1467–1474.

Hub, R. H. I. (2017). *Health and healthcare in frontier areas*. Retrieved from https://www.ruralhealthinfo.org/topics/frontier

Irwin, E. G., Isserman, A. M., Kilkenny, M., & Partridge, M. D. (2010). A century of research on rural development and regional issues. *American Journal of Agricultural Economics, 92*(2), 522–553.

Johnson, M. E., Brems, C., Warner, T. D., & Roberts, L. W. (2006). Rural–urban health care provider disparities in Alaska and New Mexico. *Administration and Policy in Mental Health and Mental Health Services Research, 33*(4), 504–507.

Kay, A. C., Day, M. V., Zanna, M. P., & Nussbaum, A. D. (2013). The insidious (and ironic) effects of positive stereotypes. *Journal of Experimental Social Psychology, 49*(2), 287–291.

Leight, S. B. (2003). The application of a vulnerable populations conceptual model to rural health. *Public Health Nursing, 20*(6), 440–448.

Letvak, S. (2002). The importance of social support for rural mental health. *Issues in Mental Health Nursing, 23*(3), 249–261.

Lichter, D. T. (2012). Immigration and the new racial diversity in rural America. *Rural Sociology, 77*(1), 3–35.

Lichter, D. T., & Brown, D. L. (2011). Rural America in an urban society: Changing spatial and social boundaries. *Annual Review of Sociology, 37*, 565–592.

Lichter, S. R., Amundson, D., & Lichter, L. S. (2003). *Perceptions of rural America: Media coverage*. Washington, DC: WW Kellogg Foundation.

Lipton, M. (1977). *Why poor people stay poor: A study of urban bias in world development*. London, UK: Temple Smith.

Lupien, S. J., King, S., Meaney, M. J., & McEwen, B. S. (2001). Can poverty get under your skin? Basal cortisol levels and cognitive function in children from low and high socioeconomic status. *Development and Psychopathology, 13*(3), 653–676.

Mabie, N. (2017). *Rural Americans and the language too many people use to talk about them*. Retrieved from http://inthesetimes.com/rural-america/entry/20605/rural-urban-divide-donald-trump-stereotypes-hillbilly-redneck-white-trash

MacDowell, M., Glasser, M., Fitts, M., Nielsen, K., & Hunsaker, M. (2010). A national view of rural health workforce issues in the USA. *Rural and Remote Health, 10*(3), 1531.

Massey, C. (2017). The rhetoric of the real: Stereotypes of rural youth in American reality television and stock photography. *Discourse: Studies in the Cultural Politics of Education, 38*(3), 365–376.

Mohatt, D. F., Bradley, M. M., & Adams, S. J. (2005). Rural Mental Health: Challenges and Opportunities Caring for the Country. In N. A. Cummings, W. T. O'Donohue, & M. A. Cucciare (Eds.), Universal healthcare: Readings for mental health professionals (p. 127–150). Context Press: Reno, NV.

Mohatt, G. V., Hazel, K. L., Allen, J., Stachelrodt, M., Hensel, C., & Fath, R. (2004). Unheard Alaska: Culturally anchored participatory action research on sobriety with Alaska Natives. *American Journal of Community Psychology, 33*(3), 263–273.

Mohatt, G. V., Rasmus, S. M., Thomas, L., Allen, J., Hazel, K., & Hensel, C. (2004). "Tied together like a woven hat:" Protective pathways to Alaska native sobriety. *Harm Reduction Journal, 1*(10), 1–12.

Mohatt, N. V., Billera, M., Demers, N., Monteith, L. L., & Bahraini, N. H. (2018). A Menu of options: Resources for preventing veteran suicide in rural communities. *Psychological Services, 15*(3), 262–269.

Mohatt, N. V., Thompson, A. B., Thai, N. D., & Tebes, J. K. (2014). Historical trauma as public narrative: A conceptual review of how history impacts present-day health. *Social Science & Medicine, 106*, 128–136.

Murray, S. (2005). For a Senate foe of pork barrel spending, two bridges too far. *The Washington Post, 21*.

Napier, A. D., Ancarno, C., Butler, B., Calabrese, J., Chater, A., Chatterjee, H., … Jadhav, S. (2014). Culture and health. *The Lancet, 384*(9954), 1607–1639.

National Congress of American Indians. (n.d.). *Tribal nations and the United States: An introduction*. Retrieved from http://www.ncai.org/tribalnations/introduction/Tribal_Nations_and_the_United_States_An_Introduction-web-.pdf

Pedersen, P. B. (1991). Multiculturalism as a generic approach to counseling. *Journal of Counseling & Development, 70*(1), 6–12.

Peen, J., Schoevers, R. A., Beekman, A. T., & Dekker, J. (2010). The current status of urban-rural differences in psychiatric disorders. *Acta Psychiatrica Scandinavica, 121*(2), 84–93.

Probst, J. C., Barker, J. C., Enders, A., & Gardiner, P. (2018). Current state of child health in rural America: How context shapes children's health. *The Journal of Rural Health, 34 Suppl 1*, s3–s12.

Rappaport, J. (2000). Community narratives: Tales of terror and joy. *American Journal of Community Psychology, 28*(1), 1–24.

Singh, G. K., & Siahpush, M. (2014). Widening rural–urban disparities in life expectancy, US, 1969–2009. *American Journal of Preventive Medicine, 46*(2), e19–e29.

Singh, G. K., Williams, S. D., Siahpush, M., & Mulhollen, A. (2012). Socioeconomic, rural-urban, and racial inequalities in US cancer mortality: Part I—All cancers and lung cancer and Part II—Colorectal, prostate, breast, and cervical cancers. *Journal of Cancer Epidemiology, 2011*, 107497.

Sinha, R. (2009). Stress and addiction: A dynamic interplay of genes, environment and drug intake. *Biological Psychiatry, 66*(2), 100.

Stamm, B. (2003). *Rural behavioral health care: An interdisciplinary guide*. Washington, DC: American Psychological Association.

Tebes, J. K. (2005). Community science, philosophy of science, and the practice of research. *American Journal of Community Psychology, 35*(3), 213–230.

Thomas, K. C., Ellis, A. R., Konrad, T. R., Holzer, C. E., & Morrissey, J. P. (2009). County-level estimates of mental health professional shortage in the United States. *Psychiatric Services, 60*(10), 1323–1328.

Tough, P. (2011). The poverty clinic: Can a stressful childhood make you a sick adult? *New Yorker (New York, NY: 1925)*, 25.

U.S. Health Resources & Services Administration. (2017). *Defining rural population*. Retrieved from https://www.hrsa.gov/rural-health/about-us/definition/index.html

United States Census Bureau. (2016). *New census data show differences between urban and rural populations [Press release]*. Retrieved from https://www.census.gov/newsroom/press-releases/2016/cb16-210.html

United States Department of Agriculture. (2017). *Rural America at a glance 2016 Edition*. Retrieved from https://www.ers.usda.gov/webdocs/publications/80894/eib-162.pdf?v=42684

United States Department of Agriculture Econmic Research Service. (2017a, November 30). *Rural classifications overview*. Retrieved from https://www.ers.usda.gov/topics/rural-economy-population/rural-classifications/

United States Department of Agriculture Econmic Research Service. (2017b). *Rural classifictions what is rural?* Retrieved from https://www.ers.usda.gov/topics/rural-economy-population/rural-classifications/what-is-rural/

United States Department of Agriculture Econmic Research Service. (2017c). *Rural poverty and well-being poverty overview*. Retrieved from https://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being/poverty-overview/

Utt, R. D. (2005). The bridge to nowhere: A National Embarrassment. *Web Memo* (889). Retrieved from https://www.heritage.org/budget-and-spending/report/the-bridge-nowhere-national-embarrassment

Wagenfeld, M. O., Murray, J. D., Mohatt, D. F., & DeBruyn, J. C. (1997). Mental health service delivery in rural areas: Organizational and clinical issues. *NIDA Research Monograph, 168*, 418–437.

Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 629–640.

Wessels Living History Farm. (2017). *Rural America in pop culture*. Retrieved from http://www.livinghistoryfarm.org/farminginthe70s/life_08.html

Wikipedia. (2017). *Li'l Abner*. Retrieved from https://en.wikipedia.org/wiki/Li%27l_Abner

Wilson, S. G. (2012). *Patterns of metropolitan and micropolitan population change: 2000 to 2010*. US Department of Commerce, Economics and Statistics Administration, US Census Bureau.

WWAMI Rural Health Research Center. (2017). *Rural Urban Commuting Areas Codes (RUCAs)*. Retrieved from http://depts.washington.edu/uwruca/

Sociopolitical Values: The Neglected Factor in Culturally-Competent Psychotherapy

Richard E. Redding

Abstract

The role of sociopolitical values remains a neglected factor in clinical practice. Many clinicians regularly commit "cultural malpractice" by failing to take into account their own sociopolitical values and those of their clients. However, sociopolitical values may be the most important factor to consider in any culturally-competent psychotherapy that is truly client-centered. Sociopolitical values are often central to a client's personality and identity. As such, understanding a client's sociopolitical values can be useful therapeutically, and a congruence between therapist and client sociopolitical values may enhance the therapeutic relationship. Although a lack of value congruence can be detrimental to the therapeutic relationship, this need not be the case if the therapist is culturally sensitive. Because mental health professionals overwhelmingly tilt to the left politically, they should be cognizant of the fact that their politically conservative, libertarian, and centrist clients will not share many of their values. Clinicians must be sensitive to the impact this may have on the therapeutic alliance and the ways in which this influences their diagnostic and therapeutic choices. Ensuring that clinicians are culturally sensitive with respect to sociopolitical values will require systemic changes in how mental health professions conceptualize culturally- and ethically-competent practice, develop and evaluate standards and guidelines for multicultural practice, and recruit and educate clinicians. While such advances are developing, however, clinicians can adopt practices to help ensure that they will be culturally competent when working with clients who have sociopolitical values different from their own.

Keywords

Political beliefs · Cultural competence · Bias · Psychotherapy · Therapeutic relationship

> Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups.
>
> Where scientific or professional knowledge… establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, or socioeconomic status is essential… psychologists

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© Springer Nature Switzerland AG 2020
L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_24

have to obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services.

[P]sychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, or socioeconomic status … (**American Psychological Association**, 2018, Principle E, Standards 2.01 & 3.01).

A psychiatrist should not be a party to any type of policy that excludes, segregates, or demeans the dignity of any patient because of ethnic origin, race, sex, creed, age, socioeconomic status, or sexual orientation (**American Psychiatric Association**, 2013).

Counselors are aware of—and avoid imposing—their own *values, attitudes, beliefs*, and behaviors. Counselors respect the diversity of clients, trainees, and research participants and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature.

Counselors do not condone or engage in discrimination against prospective or current clients, students, employees, supervisees, or research participants based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital/partnership status, language preference, socioeconomic status, immigration status, or any basis proscribed by law (**American Counseling Association**, 2014, Principles A.4.b and C.5) (emphasis added).

Marriage and family therapists provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, sexual orientation, gender identity, or relationship status (**American Association of Marriage and Family Therapists Code of Ethics**, 2015, Standard 1.1).

Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, *political belief*, religion, immigration status, and mental or physical ability.

Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, *political belief*, religion, immigration status, or mental or physical ability (**National Association of Social Workers**, 2017, Standards 1.05 & 4.02) (emphasis added).

As seen above, the ethical standards of the mental health professions prohibit discrimination or bias against clients on the basis of demographic characteristics such as race, ethnicity, gender, or sexual orientation as well as disability, language, socioeconomic status, or religion (For a discussion of the numerous scientific, clinical, and ethical problems with such an enumerated list in the ethics codes, see Cummings & O'Donohue, 2018; O'Donohue, 2016). Likewise, the multicultural practice guidelines of these professions require clinicians to be culturally competent, meaning that they are sensitive to client differences and needs as a function of the enumerated cultural factors (APA, 2003, 2017). Indeed, some suggest that multiculturalism is near the apex of the ethical imperatives: "[p]sychologists who privilege ethics over multiculturalism have a flawed understanding of the APA ethics code" (Fisher, 2014, p. 36). Cultural competence is thought to be a touchstone for efficacious treatment (see Whaley & Davis, 2007), and the accreditation standards of the American Psychological Association (APA) and the American Counseling Association (ACA) require that graduate programs incorporate multicultural training throughout the curriculum (APA, 2003, 2009; Council for Accreditation of Counseling and Related Educational Programs, 2016).

Except for those of the National Association of Social Workers (NASW) and to a lesser extent those of the American Counseling Association, the ethical and practice standards do not include *sociopolitical values* (SPVs) among the list of client characteristics that culturally-competent clinicians should consider, nor do they mandate that clinicians not discriminate on this basis. The APA's *Guidelines on Multicultural Education, Training, Research, and Organizational Change for Psychologists* (2003), which has become the standard for culturally-sensitive practice, say that "psychologists are urged to gain a better understanding and appreciation of the worldview and perspectives of those racially and ethnically different from themselves" (p. 385). The *Guidelines* repeatedly mention the "worldview" of clients and psychologists, but always within the context of racial and ethnic differences. The Association for Multicultural Counseling and Development's *Multicultural Counseling Competencies* (1996) are also framed in the context of demographic or religious differences. Likewise, leading treatises on multicultural practice (e.g., Comas-Diaz, 2012; Cornish, Schreier, Nadkarni, Metzger, & Rodolfa, 2010; Fouad & Arredondo, 2010; Leong, Comas-Diaz, Hall, McLoyd, & Trimble, 2014; Ponterotto, Cass, Suzuki, & Alexander, 2010; Sue, Sue, Neville, & Smith, 2019) generally fail to credit SPVs (independent of race, ethnicity, etc.) as an important cultural factor for clinicians to consider.

Yet, despite calls almost 20 years ago (Redding, 2001) to include sociopolitical values (SPVs) among the culturally relevant considerations, they remain a neglected factor in clinical practice. Many clinicians regularly commit "cultural malpractice" (see Hall, 1997) by failing to take SPVs into account. But SPVs may be the most important factor to consider in any culturally-competent psychotherapy that is truly client centered.

This chapter discusses why SPVs are often central to a client's personality and identity. As such, understanding a client's SPVs can be useful therapeutically, and a congruence between therapist and client SPVs may enhance the therapeutic relationship. Although a lack of value congruence can be detrimental to the therapeutic relationship, this need not be the case if the therapist is culturally sensitive. Because mental health professionals overwhelmingly tilt to the left politically, they should be cognizant of the fact that their politically conservative, libertarian, and centrist clients will not share many of their values. Clinicians must be sensitive to the impact this may have on the therapeutic alliance and the ways in which this may influence their diagnostic and therapeutic choices. Ensuring that clinicians are culturally sensitive with respect to SPVs will require systemic changes in how mental health professions conceptualize culturally and ethically competent practice, develop and evaluate standards and guidelines for multicultural practice, and recruit and educate clinicians. While such advances are developing, however, there are practices that clinicians can adopt to help ensure that they will be culturally competent when working with clients who have sociopolitical values different from their own.

Empirical Study of the Role of Sociopolitical Values (SPVs) in Therapy

As Lambert & Baldwin (2009) pointed out, researchers have focused on the efficacy of various treatment approaches and have neglected to study the effects of therapist variables. However, our discussion of the role of clinician and client SPVs in therapy will be supplemented by the results of an exploratory study of the impact of clinician and client values on the therapeutic alliance and processes. The study (Redding, 2019) included 131 practicing clinicians (65% male, 35% female; 47% Caucasian, 24% African-American, 27% Asian-American, 1% Hispanic) who volunteered to complete a survey. Ninety were doctoral-level clinical or counseling psychologists, 13 were clinical social workers, and 8 were master's level psychologists or marriage and family therapists. Approximately half had been in clinical practice for four or more years, and most subscribed to a cognitive-behavioral, psychodynamic, or family systems therapeutic orientation. Regarding the socioeconomic status of most of their clients, 32% were middle class, 45% upper-middle or upper class, and 23% lower-middle or lower class. Most were diagnosed with an adjustment disorder, somatoform disorder, mood disorder, and/or anxiety disorder. Fifty-eight surveys were completed by clinicians attending a continuing education seminar in Virginia;[1] 73 were completed by licensed mental health professionals in Massachusetts and Texas who completed the surveys, which were mailed to a random sampling of clinicians in their states.

The study also surveyed 152 Americans (51% male, 45% female, 4% did not specify their gender; 70% Caucasian, 9% Asian-American, 7% African-American, 5% Hispanic, 9% other race or did not specify; 51% had college degrees), who were paid $10 to complete an online Mechanical Turk (MTurk) survey. Research using participants drawn from MTurk, a 500,000-member online labor market run by Amazon.com, is now common in social science. Recent studies show that the "data quality on MTurk is good" (Paolacci, Chandler, & Ipeirotis, 2010), including when used with clinical populations (Shapiro, Chandler, & Mueller, 2013). A total of 44% were treated by a psychologist, 23% by a psychiatrist, 10% by a marriage and family counselor, and 6% by licensed counselor. They had completed at least 5 sessions of psychotherapy during the last 5 years for an average of 10 sessions, most reported having been diagnosed with a mood or anxiety disorder, and at least 40% were receiving some form of cognitive-behavioral therapy.

The clinician and client surveys asked a series of Likert-scale and free-response questions about their SPVs (e.g., political views generally and on social and economic issues); whether SPVs (defined as "political, sociopolitical, or moral beliefs") were discussed in therapy and, if so, how they arose (e.g., did the client volunteer, did the therapist ask, and what was the context); the therapist's reaction to the client's disclosure of their SPVs; whether discussing SPVs was beneficial or harmful to the therapeutic relationship (e.g., did it increase or decrease the bond between therapist and client, the client's confidence/trust in the therapist, how well the client and therapist liked each other, and the therapist's understanding of, and empathy for, the client); and whether it was beneficial or harmful to treatment (e.g., was it helpful in case conceptualization or in addressing the presenting problems). The clinicians were asked how these factors typically play out in their cases. They were also asked to recall a recent salient case in which SPVs arose and answered a series of questions about that particular case.

The quotes at the beginning of the sections below were selected from the qualitative responses provided by the clinicians and clients who participated in the study.

SPVs: The Most Important Factor in Culturally Competent Practice?

Clients: It was very helpful to discuss my values. My values are the core of me. It affects everything.

It was helpful to me [to discuss our political beliefs] because it kept me from wasting any more time and money with someone who was clearly too different from me to be able to see life through my lens.

Clinicians: Clients' [SPVs] are exceptionally important for them as it defines them.

Some clients liked the idea that I was interested in them as people and not just their problems, but their identity as well.

Discussing the dimensions of client identity that a culturally competent practitioner should consider, the APA's recent multicultural guidelines identify "racial identity, multiracial identity, biracial identity, ethnic identity, gender identities, religious identity, and sexual orientation" (APA, 2017, p. 16), *yet make no mention of SPVs, which are a central aspect of cultural identity*. Such an omission might be understandable in 2003 when the guidelines were first promulgated. But not in 2017, by which time there was a con-

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[1] I would like to thank Mary Alice Fisher, Ph.D., Director of the Center for Ethical Practice in Charlottesville, VA, for distributing the surveys in her continuing education seminars. Dr. Fisher is the author of *Confidentiality Limits in Psychotherapy: Ethics Checklists for Mental Health Professionals* (2016), American Psychological Association.

siderable body of research (in neuroscience, social and personality psychology, and behavior genetics) suggesting that SPVs are not only often central to identity but that bias and discrimination on the basis of political beliefs are as pervasive and powerful as racial bias.

People's SPVs are often foundational to their self-identity, reflecting neurologically-wired personality traits and cognitive styles (see Mendez, 2017) arising from early gene (see Caprara & Zimbardo, 2004; Tesser, 1993) and environment interactions (Verhulst, Hatemi, & Eaves, 2012). Moreover, people are frequently discriminated against because of their political beliefs, especially when they are in the sociopolitical outgroup. One of the most robust findings in social psychology is that we tend to have affinity for those who share our values. "Belief in a common vision of reality, or rather a shared, social construction of reality, may be a far more potent social glue than the color of one's skin, cultural heritage, or gender" (Shafranske & Maloney, 1996, p. 564). Conversely, we tend to dislike those whose values differ substantially from our own (Rosenbaum, 1986). Because opposing sociopolitical values challenge our foundational worldview and the sense of understanding, purpose, security, and belongingness it provides (see Pyszcynski, Solomon, & Greenberg, 2003), we often are repelled by those who do not share our SPVs. Sociopolitical bias in interpersonal relationships may be stronger than racial or ethnic bias (see Haidt, Rosenberg, & Hom, 2003; Insko, Nacoste, & Moe, 1983; Mezei, 1971), as suggested even by studies conducted in the 1960s when racism was more potent than it is today in American society (see Hyland, 1974; Rokeach & Mezei, 1966; Rokeach, Smith, & Evans, 1960).

Frequently, SPVs are important to people because foundational moral values underlie them (Haidt, 2007, 2012) along with views about human nature (see Frisby, 2018a, 2018b). Liberals and conservatives tend to differ in the moral values supporting their political views, with liberals prioritizing concerns about harm vs. care, fairness vs. cheating, and liberty vs. oppression and with conservatives prioritizing concerns about loyalty vs. betrayal, authority vs. subversion, and sanctity/purity vs. defilement (Haidt, 2007, 2012). Consider the client who said of her therapist, "because we share basic opinions about topics such a fracking, I feel we connect on another level now" (Redding, 2019). To be sure, the environmental issue of oil fracking was not relevant to her presenting problems. But the fact that the therapist shared her view on this particular issue likely signaled to the client that they shared a broader, fundamental moral worldview.

SPVs Often Arise in Therapy

Clients: Talking about my political and social beliefs made it easier for me to discuss my problems. I didn't have to worry as much about what she would think of me.

I liked the chance to express how I stand on [political] subjects so that my therapist could better understand me.

We were talking about times when I felt really angry and I described a lady that was very against abortion. We then discussed the subject.

I was in a bad mood and felt like voicing my opinion on Obama and how he was going to destroy America. His socialist healthcare will ruin my access to mental health care.

Clinicians: Allowing them to talk about their [SPVs] is exceptionally effective. They WANT you to know.

The utility [of discussing SPVs] is evident in understanding their worldview.

"It is tricky to avoid political discussions in the course of therapy, because they may have psychological meanings under the surface, just as psychological discussions may be latently political" (Strupp, 1980). Forty-three percent of clients reported that SPVs were explicitly discussed during therapy, with 26% reporting that the therapist initiated the discussion about the client's SPVs (Redding, 2019). Indeed, many issues of concern to clients implicate SPVs, including child-rearing practices, unwanted pregnancy, abortion, substance use, lifestyle choices, death, sexual orientation issues, and marital relations, to name but a few. Moreover, as the partisan divide has become more pronounced in recent years, many clients are now anxious, angry, or depressed about political issues. Roughly half of those surveyed in the APA's 2018 Stress in American Survey reported feeling stress over news and political issues such as mass shootings, climate change, and immigration (Bethune, 2019). Clinicians reported that their clients discussed, among other things, the current president, their views on government and personal responsibility, healthcare policy, tax policy, gun control, family differences in political views, and their dislike of those with opposing political views (Redding, 2019).

Differences over politics are affecting clients' relationships with family members, friends, and work colleagues. As one clinician explains, "We're seeing families and friendships fractured along political lines…. [some clinicians] now inquire, at the outset of a session, whether clients are following what's going on in the political world right now, and if so, how it's affecting them. The result is that many clients open up about anxieties and relationship strains they hadn't previously shared… probably because they thought the therapy room was supposed to be a politics-free zone… I see both liberal and conservative members of our community feeling as if their values are no longer acceptable in the public arena… and to their friends and family" (Doherty, 2017, p. 34).

Thus, issues relating to SPVs frequently arise in therapy, and enabling a discussion of such values can enhance the therapeutic relationship. Just as "[a] therapist's willingness to discuss racial matters is of central importance in creating a therapeutic alliance with clients of color," it is important for therapists to discuss SPVs when clients directly or indirectly broach such issues. A clinician's failure to do so may hinder therapy because the clinician will be out of sync (see Leong, 2007) on a matter of foundational importance to the client: his or her sociopolitical self-identity. "[S]ince who we are depends on the circumstances we are placed in and the discourses available in the setting we find ourselves in" (Monk, Winslade, & Sinclair, 2008, p. 122), the therapy room certainly should provide clients a comfortable space to give voice to that identity. "[T]he discourse that dominates always gives some people more entitlement to speak, to do things, and to be recognized in their social world" (Monk et al., 2008, p. 123). Perhaps because a person's SPVs are reflective of their foundational moral values and their personality, temperament, and cognitive style, clients inevitably intuit the therapist's values (Strupp, 1980). The client's intuitions about the therapist's SPVs may affect whether the client feels comfortable discussing such issues in therapy (just as the therapist's intuitions about the client's SPVs may have positive or negative biasing effects in how he or she handles the therapeutic relationship). If, for example, the clinician adopts an implicitly liberal discourse in therapy with a conservative client (see next section), that client will likely feel less empowered to speak their truth in therapy. Indeed, clients may "unconsciously submit their therapists to 'transference tests'" to see whether the therapist will behave toward them in a manner that "confirm[a] a pathogenic belief" (Muran, 2007, p. 265) – that the therapist will reject the client's SPVs, for instance. "If the therapist passes the test by not confirming the belief, therapeutic progress takes place" (Muran, 2007, p. 265). Likewise, the therapist may become aware of his or her biases "only in dialogue with [the client], where there is a possibility for a 'fusion of horizons' – a moment when a prejudice can be differentiated from its alternative" (Muran, 2007, p. 262).

It is beneficial to the "special kind of friendship" that is the therapeutic relationship (Hallam, 2018) when the clinician likes and empathizes with the client (see Hall, Horgan, Stein, & Roter, 2002; Pederson, Crethar, & Carlson, 2008; Spiro, Peschel, McCrea Curnen, & St. James, 1996). When recalling a recent case in which SPVs were salient, 59% of the clinicians said that the client disclosure had the potential to improve the therapeutic relationship (Redding, 2019). Fifty-seven percent reported that their empathy for the client increased after the client disclosed his or her SPVs; only 7% said it decreased their empathy. Twenty-eight percent said that the client disclosure made them like the client more; only 14%

said it made them like the client less. Not surprisingly, these factors are correlated. Increased empathy was correlated with increased liking ($r = 0.33$, $p < 0.01$) and a potentially improved therapeutic relationship ($r = 0.27$, $p < 0.05$). Moreover, increased empathy was correlated with increased clinician confidence ($r = 0.50$, $p < 0.001$), improved problem conceptualization ($r = 0.47$, $p < 0.001$), and an improved treatment approach ($r = 0.26$, $p < 0.05$).

Clinician and Client SPVs Will Sometimes Differ

Clients: My therapist likes to talk about his disgust with the government and the president. It came up when talking about honesty.

During the elections my therapist asked me if I was going to vote and if I paid attention to politics. She shared with me a story about her right-wing conservative relatives and how she has to deal with them during the holidays.

Clinicians: I am very liberal; most of my clients are politically or religiously conservative.

The client's hesitation [about sharing her SPVs] revealed other issues that she feared might not be "approved" given her (correct) assumption of my liberal bias.

A female client was excited about purchasing her first gun and was hesitant to share it with me because she assumed I would not "approve."

Not infrequently, there is a mismatch between the clinician's and client's SPVs, with the most common mismatch involving a liberal therapist and conservative client. Surveys find that the overwhelming majority of psychologists are politically liberal, many quite so, particularly on social issues (Duarte et al., 2015; Redding, 2012). A 2002 random survey of members of the clinically oriented APA divisions found that 67% were Democrats and only 6% Republicans; 77% were liberal and only 9% were conservative (Bilgrave & Deluty, 2002). A recent survey of mental health professionals in Florida found that 54% were identified as liberal, progressive, or socialist, whereas only 24% identified as conservative or libertarian (Norton & Tan, 2018). In the Redding (2019) study, only 27% of clinicians described themselves as politically conservative, whereas 67% were liberal. With respect to social issues, which are the kinds of SPVs most likely to arise in therapy and those most likely to drive bias and discrimination, the liberal tilt was more pronounced. Only 15% of clinicians described themselves as social conservatives, whereas 69% were socially liberal. In contrast, the clinicians reported that many of their clients were politically conservative or centrist, and there was only a modest correlation ($r = 0.32$, $p < 0.01$) between the political views of clinicians and those of their clients.

Indeed, the strong liberal tilt of the mental health professions may be one reason why conservatives are reluctant to seek mental health treatment (see Brody, 1994), just as the underrepresentation of minority clinicians may partly explain the relatively low utilization of mental health services by minorities (see Holden et al., 2014; Meyer & Takeuchi, 2014). The liberal-humanistic values inherent in much of psychotherapeutic practice are likely to be seen by liberals as more consistent with their SPVs than they will be for conservatives. Indeed, 61% of clients in the Redding (2019) study self-identified as politically liberal.

SPV Similarity Is Often Beneficial to the Therapeutic Relationship

Clients: Discussing political, sociopolitical and moral beliefs helped me to connect better with the therapist, who had similar beliefs, and allowed me to become more open with him.

The therapist felt as comfortable with me as I felt as comfortable with him, knowing that we each had similar political, sociopolitical, and moral beliefs.

When we had this conversation [about politics] it just reinforced that we were a good match for our therapist.

Instead of a patient, I became a person [when we talked about politics], and I think that the dynamic of the therapy changed for the better.

Clinicians: A client specifically asked me on the initial consultation what my general political leanings are because he is so liberal that he would not be able to work with a conservative therapist.

If we are similar, I have more to work with.

Attitudinal similarity between clinician and client is, in most cases, likely to be beneficial for establishing a strong therapeutic relationship and for mutual understanding between client and clinician. The personal rapport between client and clinician is thought to be the touchstone for therapeutic outcomes (Lacewing, 2014; Luborsky et al., 2002; Vasquez, 2007; Zilcha-Mano, 2017), with research consistently showing it to be a key determinant of treatment success irrespective of presenting problem, diagnosis, setting, or treatment approach (Horvath, Fluckiger, Re, & Symonds, 2011; Martin, Garske, & Davis, 2000). A strong therapeutic relationship is conducive to clients' self-disclosure, confidence in the therapist, positive expectations of improvement, active participation in therapy, development of insight, and internalization of behavioral and relationship modeling from the therapist. Clients are also more likely to terminate therapy early when the therapeutic relationship is poor (Tryon & Kane, 1993). When clinicians feel that they have strong relationships with clients, they tend to be more invested in the therapeutic relationship, have greater confidence in their ability to help the client, and show greater warmth, empathy, and positive regard for the client (see Lacewing, 2014). The therapeutic relationship is especially important in psychodynamic therapies, where the client transfers feelings onto the therapist and develops new, more adaptive mental models of functioning and relationships out of the object relationship formed with the therapist (see Shedler, 2010).

Because "the therapeutic relationship is 'an intermingling of two value systems'" (Gass, 1984, p. 230, quoting Glad, 1959), a positive relationship is more likely when both parties share a common worldview. As Kottler (2010, p. 148–149) notes, "[o]f course, we are supposed to treat all clients with an equal degree of respect, seriousness, and caring… It even says so in our ethical codes! But we know that is not nearly the case. We genuinely like some clients better than others – we are drawn to them (or even overly drawn to them) because they share our most cherished values." Clients likewise prefer clinicians who share their values, whom they perceive as being more trustworthy than clinicians who do not (Lewis & Walsh, 1980).

Thus, a significant mismatch between clinician and client SPVs may adversely impact the therapeutic relationship (Bergin, Payne, & Richards, 1996; Sue, 1998). Atkinson and Schein (1986) examined 16 studies comparing the effects of attitudinal similarity between clinician and client to other studies comparing the effects of similarity in race, sexual orientation, socioeconomic status, or personality and cognitive variables. They concluded that there was little effect of demographic or personality variables on the therapeutic relationship (e.g., rapport, trust, empathy), but often significant effects of attitudinal similarity, primarily during the initial rapport-building phase of therapy. A case vignette study of 363 clinical psychologists found that the ideological match between the therapist and client significantly affected the therapist's empathy for the client, with politically liberal therapists having less empathy for conservative clients (Gartner et al., 1990). These research findings on clinician-client congruence in psychotherapy mirror those on racial or ethnic concordance between physician and patient, which leads to better physician-patient communication, patient participation in the treatment process, treatment adherence, patient satisfaction, quality of care, and outcomes (Powe & Cooper, 2004; Cooper et al., 2003).

SPV Dissimilarity May Bias Clinical Judgment

Clients: I think that the therapist's different beliefs temporarily made her not care much about helping me because she seemed to cut that session short and acted distant.

There was a "look" [from the therapist]….

By some of what she said, her body posture, and the way she said what she did, it became very clear to me that my beliefs (and thus me) were the epitome of everything she was raised to think of as "wrong." Her demeanor took on a coldness after this exchange.

I liked the therapist less – due to the judgment I felt.

Clinicians: [Our different SPVs] made me feel tense or irritated, which I considered to be my own counter transference.

Finding out that my client was raised hard core Christian and understanding the impact of her strict religious culture has had on her made it difficult for me to find a way to work with her because her beliefs were so rigid – this contributed to me liking her less.

In my opinion, it was a good thing that I might impose my values on the client, because this kid's views foster prejudice, hate, and materialism which I do not believe will serve him well in the wrong run… The client's assumption that those less fortunate than he do nothing but collect money from the government… I came to see him as an entitled, privileged, materialistic brat.

Psychotherapy is inherently value laden, and the therapeutic process is heavily infused with politics (Halleck, 1971). Therapists' SPVs can influence their diagnoses, therapeutic interventions, and relationships with clients (Cushman, 1995; Woolfolk, 1998), and a relative match between clinicians' and clients' treatment goals and means for achieving them is positively related to treatment outcomes and client satisfaction with therapy (Sue, 1998). In fact, studies suggest that SPV differences between client and therapist may bias clinical judgment and practice far more than differences in race, gender, or socioeconomic status (Abramowitz & Dokecki, 1977; Mazer, 1979). Since often in therapy the client's values gravitate toward those of the therapist (Bergin et al., 1996), there also is the concern that therapists may unwittingly impose their values on clients. Thirty-four percent of clinicians in the Redding (2019) study said that knowing the client's SPVs had the potential to bias their diagnosis, 31% said it had the potential to negatively affect the treatment approach, 40% said it posed the risk of the clinician imposing his or her values on the client, and 50% said it had the potential to negatively impact the therapeutic relationship.

Forty-nine percent of clinicians say that their political beliefs moderately or strongly influence how they practice psychotherapy (Bilgrave & Deluty, 2002). When asked to choose among a list of 11 demographic and cultural factors (age, race, gender, religion, political preference, language, sexual orientation, country of origin, socioeconomic level, immigration status, other cultural factors), 23% of clinicians identified *a client's political preference as being among the top three factors that affect them most* when working with clients who are different from them (Redding, 2019).

Consider the following case composite, provided by a practicing clinician. The client likes to talk about his support for Trump and cancelled a therapy session to attend a Trump rally. Schwartz (2016) illustrates the dilemmas that such a case, which may not be uncommon today, poses for the client's politically-liberal therapist and liberal clinical supervisor:

> [We] saw Trump as an authoritarian populist, a demagogue neo-Fascist… We asked ourselves, is [the client's] support of Trump is essentially a grievance compensation for impotence, inadequacy, and envy? Are his politics essentially vicarious identification, an unconscious wish to merge with a strong-man leader?… Still, regardless of his compensations, identity politics, or wishes to merge, we need to ask, is his unconscious justification unreasonable for someone in his situation? Doesn't a person's politics often attempt to address grievance?… When is inquiry into the roots and significance of Bob's politics appropriate and to what end? And when is the absence of inquiry collusion?… I worried how silent is assent to an aggrieved and violent movement.

We see how the politically-liberal clinician interprets certain conservative SPVs as being pathological or maladaptive and the clinician's temptation to frame therapeutic goals so as to shift the client's SPVs, perhaps implicitly imposing his values on the client. Moreover, therapy sessions here may be shortchanged by "missed empathic opportunities … moments when a client reports emotional issues and the clinician changes the topic without addressing or reflecting the client's feelings" (Vasquez, 2007, p. 882). "Dr. James has to choose between being a therapist for Bob or sticking to his own political/religious guns … the latter is unprofessional and unethical. Dr. James has no play here unless he genuinely gets Bob's world and recognizes the core therapeutic issue: Bob lives in a world that has not authentic place for him … He needs a world that does" (see Schwartz, 2016).

It is useful to consider the concept of "racial microaggressions," which "are brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group" (Sue et al., 2007, p. 273). Microaggressions take one of three forms: microassaults (intentionally discriminatory or insulting behaviors), microinsults (subtle slights, insults, or gestures communicating lack of regard or insensitivity), and microinvalidations (behaviors that exclude or dismiss the other's psychological or experiential reality). Microaggressions can also be environmental or contextual, such as an exhibit that features notable white Americans but none of color (Sue et al., 2007).

Sue et al. (2007, p. 280) argue that "therapists must make a concerted effort to identify and monitor microaggressions within the therapeutic context … reminiscent of the importance of becoming aware of potential transference and countertransference issues between therapist and client and how they may unintentionally interfere with effective therapy." The validity and usefulness of microaggression theory is debatable (see critiques by Campbell & Manning, 2014 and Lilienfeld, 2017, and rejoinder by Sue et al., 2019). However, consider how clinicians can unwittingly communicate to clients that their SPVs are not well received in the therapy room. Consider a therapist reacting to a client's sharing about his or her SPVs by making a derisive comment about those political views (microassault) and body language that evinces derision for the client's expressed SPVs (microinsult), or reacting to a client's disclosure of SPVs by changing the subject or discounting their relevance (microinvalidations). Environmental microaggressions might include a therapist having in their office political stickers or literature that evince hostility toward certain political groups or photos of prominent liberals but none of conservatives.

Clinicians may be prone to commit microaggressions against sociopolitically diverse clients because it is human nature to harbor implicit or explicit biases against those having different sociopolitical views. However, in the particular case of a liberal therapist working with a conservative client, there is an added reason. Research had apparently established the cognitive rigidity and authoritarianism of conservatives as well as the self-serving or immoral motives underlying their political views (see Adorno, Frenkel-Brunswick, Levinson, Sanford, & Gordon, 2019; Altemeyer, 1988; Jost, Glaser, Kruglanski, & Sulloway, 2003; Lakoff, 2016; Sears & Henry, 2003). This research, which received widespread attention in the psychological community and popular press, has no doubt seeped into the consciousness of many practitioners. Recent research strongly challenges this pathologizing of conservatives and conservatism while also showing that partisan bias and motivated reasoning exist as much on the left as on the right (see Ditto et al., 2018; Greenberg & Jonas, 2003; Haidt, 2012; Haidt & Graham, 2007; Haidt, Graham, & Joseph, 2009; Redding, 2001). But the earlier research likely had a lasting ambient effect on the ethos of many psychologists, however, particularly since it only validated their preconceptions and biases about the sociopolitical (conservative) other. There is the danger that, when working with conservative clients, politically liberal psychologists may invalidate their values and see them as inferior.

In addition, since "clients often pursue psychological care due to deeply held religious and moral beliefs and may experience significant emotional distress in addressing these issues" (Rosik, 2016), we must consider how differences in religious values, which are often closely related to SPVs, can bias the therapeutic process. Historically, psychology has viewed religion with suspicion or hostility (Cummings, O'Donohue, & Cummings, 2009; see Willis and Lancaster, this volume) and certainly as an unscientific competitor to psychotherapy. "When we look at the content of what both psychology and religion offer the individual, the similarity is rather striking: Both move away from the social and material world, to deal with the invisible world of feelings and fantasies. Both offer salvation at the individual and internal level … Both psychology and religion tell us that the road to happiness is through individual change" (Beit-Hallahmi, 1974, p. 126). Psychology has become more receptive to religion in recent years, now recognizing (at least in principle if not always in practice) the relevance and potential value of religious belief in therapy (see Aten & Leach, 2008; Fisher, 2014; Miller & Delaney, 2005; Milstein, Manierre, & Yali, 2010). Yet Christian therapists report having experienced relatively high levels of prejudice by colleagues and fear that it will be increasingly difficult to be a Christian in professional psychology and apply religious values in their work (Rosik, Teraoka, & Moretto, 2016). The mental health professions have far fewer people of faith than the general population or most other professions (Bilgrave & Deluty, 2002; Delaney, Miller, & Bisono, 2013; Miller & Delaney, 2005; Whitley, 2010). Thus, there is the danger that clinicians may not appreciate the relevance of a client's religious values in therapy. Mental health professionals may even equate religious beliefs with authoritarianism, anti-egalitarianism, or pathology (see Cremmins, 2002; Ellis, 1983).

Client SPVs Can Inform Treatment

Clients: We discussed how my sexuality plays a significant role in my anxiety and how this has been affected by the larger sociopolitical landscape and the greater acceptance of homosexuality and gay marriage across society.

My therapist challenges the way I think about the world and for me that is a good thing.

Clinicians: Knowledge [of the client's SPVs] impacted the choice of therapeutic intervention. An approach was adopted that meshed with the client's value system.

Knowing the client's views can shape an intervention to be understood in terms familiar to the client.

Usually the issue is not the client's beliefs, but how those beliefs impact their thoughts and interactions with others.

Because of the client's cognitive/emotional rigidity [which I discovered by exploring his SVPs], my treatment approach was adjusted to take that into account.

"[T]herapeutic approaches are no longer applied in universal ways but are adapted according to the values and needs [of the client]" (Kottler, 2010, p. 7–8), and effective client pacing will be tailored to the client's personality and values (see Hirsh, Kang, & Bodenhausen, 2012). A therapist in sync with the conservative SVPs of their client may opt for an approach that emphasizes personal responsibility or religious models of coping, which provide a particularly good example of how the client's SPVs can be important for fashioning the most effective therapy (see Miller, 1999; Shafranske, 1996). Noting the possible clash in values between traditional CBT, which values self-efficacy, and religious clients who value dependence on God, Propst, Ostrom, Watkins, Dean, et al. (1992) found that religious clients who received religiously based cognitive-behavioral therapy (CBT) for depression improved more than matched clients who received traditional CBT. "Religious therapists may also better understand certain problems of religious clients, such as struggles around sexual orientation, sexuality, abortion, marital problems, or depression arising out of religious conflicts" (Neumann, Harvill, & Callahan, 1995), and a better therapeutic alliance may be established when religious clients are matched with a religious therapist (Shumway & Waldo, 2012). Clients of faith may benefit when religious values and practices are incorporated into therapy (Fisher, 2014). For instance, "Biblical passages can be employed by a therapist within a framework of other methods and strategies to foster emotional support, challenge maladaptive beliefs, or confront maladaptive behavior" (Gass, 1984, p. 235). There are available evidence-based spiritual and religious-based therapies (Hook, Worthington, Davis, Jennings, & Gartner, 2010).

With respect to their salient cases involving SPVs, 67% of clinicians said that they tried to ascertain the client's SPVs (Redding, 2019). Clinicians were asked whether knowing about the client's SVPs was (1) relevant in therapist selection and/or treatment choice (yes = 52%), (2) had the potential to improve their conceptualization of the client's problems (yes = 52%), (3) had the potential to improve the treatment approach (yes = 59%), (4) had the potential to point the way to alternative treatment approaches for the client (yes = 56%), and (5) affected their overall confidence in their ability to help the client (increased = 28%, decreased = 25%, no effect = 47%). Not surprisingly, these factors are correlated. Ascertaining the client's SPVs was correlated with improved problem conceptualization ($r = 0.26$, $p < 0.05$) and treatment approach ($r = 0.30$, $p < 0.01$). Clinicians' increased confidence was correlated with improved problem conceptualization ($r = 0.44$, $p < 0.001$) and treatment approach ($r = 0.48$, $p < 0.001$).

Knowing the client's SPVs may also be relevant for tailoring treatments to address the types of behavioral and attitudinal changes that would be therapeutically beneficial (with appropriate caution that the therapist not impose values). Sixty-nine percent of clinicians said that the client's SPVs had the potential to be detrimental to the client's adaptive functioning (Redding, 2019). Some examples they provided included:

The strength and inflexibility of the client's beliefs rather than the beliefs themselves

The client's extreme anger toward those who held different views

The client's values that included cultural components that devalued women

The client's racial beliefs that generalized that everyone discriminated against him

The client's assumption that those less fortunate than he, particularly other races, do nothing but collect money from the government for sitting around… this negative view contributes to his bitterness and discontent, and his cognitive rigidity about things like this impair his adaptive coping

Forty-eight percent of clinicians thought it is appropriate to challenge the client's SPVs in therapy, though they apparently recognized the ethical risks in doing so.[2]

Although there were modest positive correlations between thinking it appropriate to challenge the client's SPVs and the view that knowing the client's SPVs improved problem conceptualization ($r = 0.25$, $p < 0.05$) and treatment approach ($r = 0.22$, $p < 0.05$), it was also correlated with the potential to negatively affect the therapeutic relationship ($r = 0.22$, $p < 0.05$) and to bias diagnosis ($r = 0.29$, $p < 0.01$).

Toward Sociopolitically-Competent Clinical Practice

Clinicians should engage in ongoing introspection into their own SPVs and how those may play out in their practice, and "may want to actively increase their tolerance and trust" (APA, 2003, p. 384) of *sociopolitical* "Others." Will they understand and appreciate their values, so that they are effective mutual collaborators with them in the therapeutic process, appropriately modify-

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[2] An interesting example of the relevance of knowing a client's SPVs and religious beliefs and how such values may affect treatment goals, is research showing that authoritarian parenting, which has been well established in the literature as being potential harmful to children's development, may not necessarily be harmful to children in conservative religious families because "children immersed in a supportive community in which a systematic rationale for strict governing is explicitly promoted experience this governing differently from children lacking such support and rationale" (Gunnoe, Hetherington, & Reiss, 2006, p. 590).

ing treatment modalities to be consistent with their values and goals? Clinicians ought to adopt a "multicultural virtue ethic" for working with clients of diverse SPVs, "including respectfulness, reverence, openness to the other, and willingness to engage in a collective effort to identify and achieve the good" (Fisher, 2014, p. 37). Clinicians should also consider how their chosen therapeutic approach may be influenced by their SPVs and be cognizant of SPVs implicit in different approaches. For example, clinicians who adhere to certain therapeutic orientations (humanistic, psychodynamic) are more likely to be atheistic or agnostic than those who adopt a cognitive-behavioral orientation (Bilgrave & Deluty, 2002), which conservative clinicians tend to prefer, whereas liberal clinicians tend to prefer psychodynamic or humanistic orientations (Norton & Tan, 2018).

While practice guidelines for sociopolitical competence await future development, clinicians can assess their sociopolitical competence with the client. How do the client's SPVs, clinicians' SPVs, and the interaction between client and clinician SPVs implicitly influence case conceptualization, diagnoses, and therapeutic goals and choices? Clinicians should consider how their SVPs affect clients' "treatment expectations, perception of clinician credibility, trust, engagement, and the development of a therapeutic alliance" (Comas-Diaz, 2014, p. 423). Does the clinician understand the client's value system and how it shapes his or her behavior, relationships, and life choices, in both adaptive and maladaptive ways? Does he or she empathize with the client's values or hold implicit or explicit sociopolitical biases against the client? If so, what steps can they take to overcome such biases and minimize their impact on the therapeutic relationship? Does the clinician experience countertransference with the sociopolitically different client?

Clinicians should determine the salience and centrality (see Phinney, 1996) of SPVs to the client generally and with respect to his or her presenting problems, assessing how discrepancies between the client's SPVs and those inherent across the client's environments and relationships affect his or her social, occupational, and psychological functioning. They should also assess the similarities and differences between client and clinician SPVs (asking the client how he or she feels about their differences and similarities; see Comas-Diaz, 2014) and their relevance to the therapeutic relationship and process. But for purposes of first establishing the therapeutic rapport, the clinician should discuss similarities in their SPVs first before discussing differences. Client SPVs should be seen as assets beneficial to therapy (LaRoche & Maxie, 2003), and clinicians should be alert to how "the meanings and saliency of cultural differences are influenced by ongoing issues within the therapeutic relationship" (p. 183). It may be useful for clinicians to tell clients something along the lines of: "Please let me know if there are things that I say in our work together that do not fit with your values, beliefs, or life experiences. I would like for you to challenge me on these differences, because I think it will be useful in our working together" (LaRoche & Maxie, 2003, p. 184). In addition, providing clients with relevant information early on in therapy about the therapists' values may serve as a prophylaxis against subtle values imposition by the therapist (Neumann et al., 1995).

With respect to religious values, Aten and Leach (2008) provide a comprehensive resource for how therapists can become aware of the role of their religious values in the therapeutic process; how a client's religious values ought to be considered in clinical intake, assessment, case conceptualization, and treatment design; and how a client's religious values can impact client commitment and the therapeutic alliance.

Toward Sociopolitically Competent Mental Health Professions

To improve the quality and appropriateness of psychotherapy with sociopolitically diverse clients as well as to encourage such clients to utilize needed mental health services, the mental health professions must: (1) incorporate in the professional codes a provision prohibiting discrimination based on sociopolitical values, (2) include SPVs in the enumerated lists found in multicultural guides of relevant factors to consider in culturally sensitive practice, (3) develop evidence-based best practices for working with sociopolitically diverse clients and critically evaluate the values and assumptions underlying current practice guidelines, (4) incorporate issues involving SPVs along with cultural awareness about diverse sociopolitical groups into multicultural education in graduate and clinical training programs and provide continuing clinical education programs involving culturally sensitive practice, and (5) take steps to encourage those having diverse sociopolitical backgrounds and values to enter the profession, particularly political and religious conservatives, who are vastly underrepresented in the mental health professions. Each is briefly discussed below.

Given that people are often discriminated against because of their SPVs, the potentially strong biasing effects that client SPVs can have on clinical judgment, the importance of SPVs to clients' identity, and the frequent relevance of SPVs to clients' presenting problems and their psychological as well as interpersonal functioning, sociopolitical values must be included in the lists of enumerated cultural factors found in our ethics codes and multicultural practice guidelines (see Duarte et al., 2015; Redding, 2001). Multicultural training, which has "been found to promote students' self-awareness and to increase their therapeutic competence" (APA, 2003, p. 386; for a review of the effectiveness of training programs, see Rogers & O'Bryon, 2014), is now an important component of every APA and ACA accredited training program. Graduate programs should include training on SPVs, perhaps including "safe zone" training geared toward developing understanding and sensitivity toward sociopolitically diverse clients, much like the training programs developed to sensitize students to LGBTQ issues (see Finkel, Storaasli, Bandele, & Schaefer, 2003).

Importantly, we must develop evidence-based best practices for working with sociopolitically diverse clients, just as we have for other kinds of culturally diverse populations, and multicultural practice guidelines, treatises, and training programs must incorporate such content. In addition, multicultural competency assessment tools (for reviews, see Cartwright, Daniels, & Zhang, 2008; Frisby, 2018a, 2018b) should be expanded to assess SPV awareness. "Cultural competence" and related constructs (e.g., microaggressions, multicultural assessment, cultural oppression) still lack sufficient definition and empirical validation (Frisby, O'Donohue, Benuto, & Casas, 2018; O'Donohue & Benuto, 2010; Satel & Redding, 2004) and, importantly, research on their application in the context of sociopolitical values. We must develop training curricula (see Rogers & O'Bryon, 2014) for SPVs as well as best practices for clinical supervision (see Inman & Ladany, 2014) so that supervisors have the awareness, knowledge, and skills necessary for training and mentoring supervisees.

In developing evidence-based practices for serving sociopolitically diverse clients, we must also consider how the liberal SPVs of the mental health professions can impact clinical practice broadly. For example, some therapy approaches adopt a leftist-oriented victimology approach designed to help clients gain insight into how their problems may be due to societal oppression (e.g., racism, sexism) and privilege (e.g., white privilege) (see Comas-Diaz, 2012; Munoz & Mendelson, 2005; Smith, Reynolds, & Rovnak, 2009). Indeed, some suggest that the multicultural practice movement is driven by a politically liberal identity politics that views certain demographic groups as victims and others as oppressors (see Frisby & O'Donohue, 2018; Lukianoff & Haidt, 2018; O'Donohue & Benuto, 2010; Satel & Redding, 2004). For example, "multicultural ethics" is seen as including a commitment to social justice and a focus on the role of oppression (Fisher, 2014).

On the other hand, some therapies perhaps associated with conservative SPVs are deemed unethical. Consider therapies aimed at changing a client's unwanted same-sex attraction (see Santero, Whitehead, & Ballesteros, 2018). The APA condemned these therapies as being ineffective, potentially harmful, and homophobic (see APA, 2009). Commenting on the APA's *Task Force on Appropriate Therapeutic Responses to Sexual Orientation* (APA, 2009), an APA official said, "We cannot take into account what are fundamentally negative religious perceptions of homosexuality-they don't fit into our worldview" (Yarhouse, 2009). The APA's position is framed by the view that homosexuality is normative and that a client's desire to change his sexual orientation reflects societal stigma and discrimination (APA, 2009). Perhaps, however, clients should have the freedom to choose their own therapeutic goals. There are many reasons (e.g., to avoid discrimination or rejection by family or friends, to have a biological child in a traditional family structure, to conform to their religious beliefs, to explore a heterosexual lifestyle) that a client may wish to try to change their normative sexual behavior, if not their normative sexual orientation. Should our professional guilds reject clients' values and life choices by blocking access to such therapies, particularly when the evidence for their ineffectiveness or harm is at least arguable? (For counterarguments to the extant scientific and clinical evidence against these therapies, see Rosik et al., 2016).

Finally, we need more sociopolitical diversity in the mental health professions. In particular, we need more politically and religiously conservative clinicians if we are to competently and fully serve these populations. Increasing the number of conservatives in the profession will likely require affirmative reaching out and recruiting efforts not only in graduate admissions but also in faculty hiring (Redding, 2001, 2012). In addition, we certainly should not be doing what Eastern Michigan University's counseling program did when it dismissed a conservative graduate student because she introspected on her values and religious beliefs, concluded that she could not work with a gay client who was sociopolitically different from herself, and took the ethically appropriate action of referring the client to another counselor (Ward v. Polite, 2012).

These five professional reforms are necessary to move toward being sociopolitically competent mental health professions. If we fail to do so, sociopolitically diverse clients may be reluctant to seek needed mental health services, our training programs will not adequately prepare clinicians to work with sociopolitically diverse clients, and our therapeutic success with these clients will be compromised.

References

Abramowitz, C. V., & Dokecki, P. R. (1977). The politics of clinical judgment: Early empirical returns. *Psychological Bulletin, 84*(3), 460–476.

Adorno, T. W., Frenkel-Brunswik, E., Levinson, D. J., Sanford, N., & Gordon, P. E. (2019). *The authoritarian personality.* New York: Verso.

Altemeyer, B. (1988). *Enemies of freedom: Understanding right-wing authoritarianism.* New York: Jossey-Bass.

American Association of Marriage and Family Therapists Code of Ethics. (2015). Retrieved 2019, from: https://www.aamft.org/Legal_Ethics/Code_of_Ethics.aspx

American Counseling Association. (2014). *2014 ACA code of ethics*. Alexandria, VA: Author.

American Psychiatric Association. (2013). The principles of medical ethics with annotations especially applicable to psychiatry. Arlington, VA: Author.

American Psychological Association. (2018). *Ethical principles of psychologists and code of conduct*. Washington, DC: Author.

American Psychological Association. (2009). *Guidelines and principles for accreditation of professional programs in psychology*. Washington, DC: Author.

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58*, 377–402.

American Psychological Association. (2017). *Multicultural guidelines: An ecological approach to context, identity, and intersectionality*. Washington, DC: Author.

Arredondo, P., Toporek, R., Brown, S., Sanchez, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 24*, 42–78.

Aten, J. D., & Leach, M. M. (Eds.). (2008). *Spirituality and therapeutic process: A comprehensive resource from intake to termination*. Washington, DC: American Psychological Association.

Atkinson, D. R., & Schein, S. (1986). Similarity in counseling. *The Counseling Psychologist, 14*(2), 319–354.

Beit-Hallahmi, B. (1974, Feb). Salvation and its vicissitudes: Clinical psychology and political values. *American Psychologist, 29*, 124–129.

Bergin, A. E., Payne, I. E., & Richards, P. S. (1996). Values in psychotherapy. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 297–321). Washington, DC: American Psychological Association.

Bethune, S. (2019, Jan). Gen Z more likely to report mental health concerns. *APA Monitor*, 20–21.

Bilgrave, D. P., & Deluty, R. H. (2002). Religious beliefs and political ideologies as predictors of psychotherapeutic orientations of clinical and counseling psychologists. *Psychotherapy: Theory, Research, Practice, Training, 39*(3), 245–260.

Brody, S. (1994). Traditional ideology, stress, and psychotherapy use. *Journal of Psychology, 128*, 5–13.

Campbell, B., & Manning, J. (2014). Microaggressions and moral cultures. *Comparative Sociology, 13*, 692–726.

Caprara, G. V., & Zimbardo, P. G. (2004). Personalizing politics: A congruency model of political preference. *American Psychologist, 59(7)*, 581–594.

Cartwright, B. Y., Daniels, J., & Zhang, S. (2008). Assessing multicultural competence: Perceived versus demonstrated performance. *Journal of Counseling & Development, 86*(3), 318–322.

Comas-Diaz, L. (2012). *Multicultural care: A clinician's guide to cultural competence*. Washington, DC: American Psychological Association.

Comas-Díaz, L. (2014). Multicultural psychotherapy. In F. T. L. Leong, L. Comas-Díaz, G. C. Nagayama Hall, V. C. McLoyd, & J. E. Trimble (Eds.), *APA handbook of multicultural psychology, Vol. 2: Applications and training* (p. 419–441). Washington, DC: American Psychological Association.

Cooper, L. A., Roter, D. L., Johnson, R. L., Ford, D. E., Steinwachs, D. M., & Powe, N. R. (2003). Patient-centered communication, ratings of care, and concordance of patient and physician race. *Annals of Internal Medicine, 139*(11), 907–915.

Cornish, J. A. E., Schreier, B. A., Nadkarni, L. I., Metzger, L. H., & Rodolfa, E. R. (Eds.). (2010). *Handbook of multicultural counseling competencies*. Hoboken, NJ: Wiley.

Council for Accreditation of Counseling and Related Educational Programs. (2016). *2016 CACREP standards*. Accessed at www.cacrep.org/wp-content/uploads/2018/05/2016-standards-with-glossary-5.3.2018

Cremmins, J. (2002). The rift between religion and psychotherapy: Can it be healed? *Journal of Pastoral Counseling, 37*, 10–26.

Cummings, N., & O'Donohue, W. (2018). Problems in professional and ethical standards and guidelines regarding culturally competent practice with racial, ethnic, linguistic, and culturally diverse groups. In C. L. Frisby & W. T. O'Donohue (Eds.), *Cultural competence in applied psychology: An evaluation of current status and future directions* (pp. 155–168). New York, NY: Springer.

Cummings, N., O'Donohue, W., & Cummings, J. (2009). *Psychology's war on religion*. Scottsdale, AZ: Tucker & Zeig.

Cushman, P. (1995). *Constructing the self, constructing America: A cultural history of psychotherapy*. Reading, MA: Addison-Wesley.

Delaney, H. D., Miller, W. R., & Bisono, A. M. (2013). Religiosity and spirituality among psychologists: A survey of clinician members of the American Psychological Association. *Spirituality in Clinical Practice, 1*(S), 95–106.

Doherty, W. (2017, May/June). On therapy in the age of Trump. *Psychotherapy Networker*, 34–35.

Duarte, J. L., Crawford, J. T., Stern, S., Haidt, J., Jussim, L., & Tetlock, P. E. (2015). Ideological diversity with improve psychological science. *Behavioral and Brain Sciences, 38*, 1–13.

Ditto, P. H., Brittany, S., Liu, B. S., Clark, C. J., Wojcik, S. P., Chen, E. E., … Zinger, J. F. (2018). At least bis is bipartisan: A meta-analytic comparison of partisan bias in liberals and conservatives. *Perspectives on Psychological Science, 14*(2), 1–19.

Ellis, A. (1983). *The case against religiosity*. New York, NY: Institute for Rational Emotive Therapy.

Finkel, M. J., Storaasli, R. D., Bandele, A., & Schaefer, V. (2003). Diversity training in graduate school: An exploratory evaluation of the safe zone project. *Professional Psychology: Research and Practice, 34*(5), 555–561.

Fisher, C. B. (2014). Multicultural ethics in professional psychology practice, consulting, and training. In F. T. L. Leong, L. Comas-Diaz, G. C. N. Hall, V. C. McLoyd, & J. E. Trimble (Eds.), *APA Handbook of multicultural psychology, Volume 2: Applications and training* (pp. 35–58). Washington, DC: American Psychological Association.

Fouad, N. A., & Arredondo, P. (2010). *Becoming culturally oriented: Practical advice for psychologists and educators.* Washington, DC: American Psychological association.

Frisby, C. L. (2018a). History and development of cultural competence evaluation in applied psychology. In C. L. Frisby & W. T. O'Donohue (Eds.), *Cultural competence in applied psychology: An evaluation of current status and future directions* (pp. 57–94). New York, NY: Springer.

Frisby, C. L. (2018b). Viewpoint bias and cultural competency advocacy within applied psychology. In C. L. Frisby & W. T. O'Donohue (Eds.), *Cultural competence in applied psychology: An evaluation of current status and future directions* (pp. 169–207). New York, NY: Springer.

Frisby, C., & O'Donohue, W. (Eds.). (2018). *Cultural competence in applied psychology: An evaluation of current status and future directions*. New York, NY: Springer.

Frisby, C. L., O'Donohue, W., Benuto, L. T., & Casas, J. B. (2018). Conceptual and empirical issues in training culturally competent psychologists. In C. L. Frisby & W. T. O'Donohue (Eds.), *Cultural competence in applied psychology: An evaluation of current status and future directions* (pp. 95–102). New York, NY: Springer.

Gartner, J., Harmatz, M., Hohmann, A., Larson, D., & Gartner, A. F. (1990). The effect of patient and clinician ideology on clinical judgment: A study of ideological countertransference. *Psychotherapy: Theory, Research, Practice, Training, 27*(1), 98–106.

Gass, C. S. (1984). Orthodox Christian values related to psychotherapy and mental health. *Journal of Psychology and Theology, 12*(3), 230–237.

Glad, D. D. (1959). *Operational values in psychotherapy*. New York, NY: Oxford University Press.

Greenberg, J., & Jonas, E. (2003). Psychological motives and political orientation – The left, the right, and the rigid: Comment on Jost et al. (2003). *Psychological Bulletin, 129*(3), 376–382.

Gunnoe, M. L., Hetherington, E. M., & Reiss, D. (2006). Differential impact of fathers' authoritarian parenting on early adolescent adjustment in conservative protestant versus other families. *Journal of Family Psychology, 20*(4), 589–596.

Haidt, J. (2001). The emotional dog and its rational tail: A social intuitionist approach to moral judgment. *Psychological Review, 108*, 814–834.

Haidt, J. (2007). The new synthesis in moral psychology. *Science, 316*(5827), 998–1002.

Haidt, J. (2012). *The righteous mind: Why good people are divided by politics*. New York, NY: Pantheon Books.

Haidt, J., & Graham, J. (2007). When morality opposes justice: Conservatives have moral intuitions that liberals may not recognize. *Social Justice Research, 20*, 98–116.

Haidt, J., Graham, J., & Joseph, C. (2009). Above and below left-right: Ideological narratives and moral foundations. *Psychological Inquiry, 20*, 110–119.

Haidt, J., Rosenberg, E., & Hom, H. (2003). Differentiating diversities: Moral diversity is not like other kinds. *Journal of Applied Social Psychology, 23*, 1–36.

Hall, C. I. (1997). Cultural malpractice: The growing obsolescence of psychology with the changing U.S. population. *American Psychologist, 52*, 642–651.

Hall, J. A., Horgan, T. G., Stein, T. S., & Roter, T. L. (2002). Liking in the physician-patient relationship. *Patient Education and Counseling, 48*, 69–77.

Hallam, R. (2018). *The therapy relationship: A special kind of friendship*. New York, NY: Taylor & Francis.

Halleck, S. L. (1971). *The politics of therapy*. New York, NY: Science House.

Hays, P. A., & Iwamasa, G. Y. (2006). *Culturally responsive cognitive-behavioral therapy: Assessment, practice, and supervision*. Washington, DC: American Psychological Association.

Hirsh, J. B., Kang, S. K., & Bodenhausen, G. V. (2012). Personalized persuasion: Tailoring persuasive appeals to recipients' personality traits. *Psychological Science, 23*(6), 578–581.

Holden, K., McGregor, B., Thandi, P., Fresh, E., Sheats, K., Belton, A., … Satcher, D. (2014). Toward culturally centered integrative care for addressing mental health disparities among ethnic minorities. *Psychological Services, 11*(4), 357–368.

Hook, J. N., Worthington, E. L., Davis, D. E., Jennings, D. J., & Gartner, A. L. (2010). Empirically supported religious and spiritual therapies. *Journal of Clinical Psychology, 66*, 46–72.

Horvath, A. O., Re, A. C. D., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (p. 25–69). New York: Oxford University Press.

Hwang, W. (2006). The psychotherapy adaptation and modification framework. *American Psychologist, 61*(7), 702–715.

Hyland, M. (1974). The anticipated belief theory of prejudice: Analyses and evaluation. *European Journal of Social Psychology, 4*, 179–200.

Inman, A. G., & Ladany, N. (2014). Multicultural competencies in psychotherapy supervision. In F. T. L. Leong, L. Comas-Diaz, G. C. N. Hall, V. C. McLoyd, & J. E. Trimble (Eds.), *APA Handbook of multicultural psychology, Volume 2: Applications and training* (pp. 643–658). Washington, DC: American Psychological Association.

Insko, C. A., Nacoste, R. W., & Moe, J. L. (1983). Belief congruence and racial discrimination: Review of the evidence and critical evaluation. *European Journal of Social Psychology, 13*(2), 153–174.

Jost, J. T., Glaser, J., Kruglanski, A. W., & Sulloway, F. J. (2003). Political conservatism as motivated social cognition. *Psychological Bulletin, 129*(3), 339–375.

Jost, J. T., & Amodio, D. M. (2012). Political ideology as motivated social cognition: Behavioral and neuroscientific evidence. *Motivation and Emotion, 36*(1), 55–64.

Kottler, J. A. (2010). *On being a therapist* (4th ed.). New York, NK: Jossey-Bass.

Lacewing, M. (2014). Psychodynamic therapy, insight, and therapeutic change. *Clinical Psychology: Science and Practice, 21*(2), 154–171.

Lambert, M. J., & Baldwin, S. A. (2009). Some observations on studying therapists instead of treatment packages. *Clinical Psychology: Science and Practice, 16*(1), 82–85.

LaRoche, M. J., & Maxie, A. (2003). Ten considerations in addressing cultural differences in psychotherapy. *Professional Psychology: Research and Practice, 34*(2), 180–186.

Lakoff, G. (2016). *Moral politics: How liberals and conservatives think.* Chicago: University of Chicago Press.

Leong, F. T. L. (2007). Cultural accommodation as method and metaphor. *American Psychologist, 62*(8), 916–927.

Leong, F. T. L., Comas-Diaz, L., Hall, G. C. N., McLoyd, V. C., & Trimble, J. E. (Eds.). (2014). *APA Handbook of multicultural psychology*. Washington, DC: American Psychological Association.

Lewis, K. N., & Walsh, W. B. (1980). Effects of value-communication style and similarity of values on counselor evaluation. *Journal of Counseling Psychology, 27*, 305–314.

Lilienfeld, S. (2017). Microaggressions: Strong claims, inadequate evidence. *Psychological Science, 12*, 138–169.

Luborsky, L., Rosenthal, R., Diguer, L., Andrusyna, T. P., Berman, J. S., Levitt, J. T., et al. (2002). The dodo bird verdict is alive and well – Mostly. *Clinical Psychology: Science and Practice, 9*, 2–12.

Lukianoff, G., & Haidt, J. (2018). *The coddling of the American mind: How good intentions and bad ideas are setting a generation up for failure*. New York, NY: Penguin Press.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting & Clinical Psychology, 68*, 438–450.

Mazer, D. B. (1979). Toward a social psychology of diagnosis: Similarity, attraction, and clinical evaluation. *Journal of Counseling & Clinical Psychology, 47*, 586–588.

Mendez, M. F. (2017). A neurology of the conservative-liberal dimension of political ideology. *Journal of Neuropsychiatry and Clinical Neurosciences, 29*(2), 86–94.

Meyer, O. L., & Takeuchi, D. T. (2014). Help seeking and service utilization. In F. T. L. Leong, L. Comas-Diaz, G. C. N. Hall, V. C. McLoyd, & J. E. Trimble (Eds.), *APA Handbook of multicultural psychology, Volume 2: Applications and training* (pp. 529–542). Washington, DC: American Psychological Association.

Mezei, L. (1971). Perceived social pressure as an explanation of shifts in the relative influence of race and belief on prejudice across social situations. *Journal of Personality and Social Psychology, 19*, 69–81.

Miller, G. (1999). The development of the spiritual focus in counseling and counselor education. *Journal of Counseling and Development, 77*(4), 498–501.

Miller, W. R., & Delaney, H. D. (2005). *Judeo-Christian perspectives on psychology: Human nature, motivation, and change*. Washington, DC: American Psychological Association.

Milstein, G., Manierre, A., & Yali, A. M. (2010). Psychological care for persons of diverse religions: A collaborative continuum. *Professional Psychology: Research and Practice, 41*, 371–381.

Monk, G., Winslade, J., & Sinclair, S. (2008). *New horizons in multicultural counseling*. Los Angeles, CA: Sage.

Munoz, R. F., & Mendelson, T. (2005). Toward evidence-based interventions for diverse populations: The San Francisco general hospital prevention and treatment manuals. *Journal of Consulting and Clinical Psychology, 73*, 790–799.

Muran, J. C. (2007). A relational turn on thick description. In J. C. Muran (Ed.), *Dialogues on difference: Studies of diversity in the therapeutic relationship* (pp. 257–274). Washington, DC: American Psychological Association.

National Association of Social Workers. (2017). *Code of ethics*. Washington, DC: Author.

Neumann, J. K., Harvill, L. M., & Callahan, M. (1995). Impact of humanistic, liberal Christian, and Evangelical Christian values on the self-reported opinions of radiologists and psychiatrists. *Journal of Psychology and Theology, 23*(3), 198–207.

Norton, A. L., & Tan, T. X. (2018). The relationship between licensed mental health counselors' political ideology and counseling theory preference. *American Journal of Orthopsychiatry, 89*(1), 86–94.

O'Donohue, W. (2016). Oppression, privilege, bias, prejudice, and stereotyping: Problems in the APA code of ethics. *Ethics & Behavior, 26*(7), 527–544.

O'Donohue, W., & Benuto, L. (2010). The many problems of cultural sensitivity. *The Scientific Review of Mental Health Practice, 7*(2), 34–37.

Orlinsky, D. E., Ronnestad, M. H., & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavioral change* (5th ed., pp. 307–390). New York, NY: Wiley.

Paolacci, G., Chandler, J., & Ipeirotis, P. G. (2010). Running experiments on Amazon Mechanical Turk. *Judgment and Decision Making, 5*(5), 411–419.

Paolacci, G., & Chandler, J. (2014). Inside the Turk: Understanding Mechanical Turk as a participant tool. *Psychological Science, 23*(3), 184–188.

Pederson, P. B., Crethar, H. C., & Carlson, J. (2008). *Inclusive cultural empathy: Making relationships central in counseling and psychotherapy*. Washington, DC: American Psychological Association.

Ponterotto, J. G., Casas, J. M., Suzuki, L. A., Alexander, C. M. (Eds.). (2010). *Handbook of multicultural counseling* (3rd ed.). Thousand Oaks, CA: Sage.

Powe, N. R., & Cooper, L. A. (2004). *Disparities in patient experiences, health care processes, and outcomes: The role of patient-provider racial, ethnic, and language concordance.* Commonwealth Fund.

Phinney, J. S. (1996). When we talk about American ethinic groups, what do we mean? *American Psychologist, 51*, 918–927.

Propst, L. R., Ostrom, R., Watkins, P., Dean, T., et al. (1992). Comparative efficacy of religious and nonreligious cognitive-behavioral therapy for the treatment of clinical depression in religious individuals. *Journal of Consulting and Clinical Psychology, 60*(1), 94–103.

Pyszczynski, T. A., Greenberg, J., & Solomon, S. (2012). *In the wake of 9/11: The psychology of terror.* W. Ross MacDonald School Resource Services.

Pyszczynski, T., Solomon, S., & Greenberg, J. (2003). In the wake of 9/11: The psychology of terror. American Psychological Association. https://doi.org/10.1037/10478-000.

Redding, R. E. (2019). *Client and clinician values in psychotherapy*. Unpublished manuscript.

Redding, R. E. (2012). Likes attract: The sociopolitical groupthink of (social) psychologists. *Perspectives on Psychological Science, 7*(5), 512–515.

Redding, R. E. (2013). Politicized science. *Society, 50*, 439–446.

Redding, R. E. (2001). Sociopolitical diversity in psychology: The case for pluralism. *American Psychologist, 56*(3), 205–215.

Rokeach, M., & Mezei, L. (1966, Jan. 14). Race and shared belief as factors in social choice. *Science, 151*, 167–172.

Rokeach, M., Smith, P. W., & Evans, R. I. (1960). Two kinds of prejudice or one? In M. Rokeach (Ed.), *The open and closed mind* (pp. 132–168). New York, NY: Basic Books.

Rogers, M. R., & O'Bryon, E. C. (2014). Multicultural training models and curriculum. In F. T. L. Leong, L. Comas-Diaz, G. C. N. Hall, V. C. McLoyd, & J. E. Trimble (Eds.), *APA Handbook of multicultural psychology, Volume 2: Applications and train-*

ing (pp. 659–680). Washington, DC: American Psychological Association.

Rosenbaum, M. E. (1986). The repulsion hypothesis: On the nondevelopment of relationships. *Journal of Personality and Social Psychology, 51*(6), 1156–1166.

Rosik, C. H. (2016). My conversation with a typical opponent of professional therapies that include change. *Journal of Human Sexuality, 7*, 74–98.

Rosik, C. H. (2014). Same-sex marriage and the boundaries of diversity: Will marriage and family therapy remain inclusive of religious and social conservatives? *Marriage & Family Review, 50*, 714–737.

Rosik, C. H., Teraoka, N. K., & Moretto, J. D. (2016). Religiously-based prejudice and self-censorship: Perceptions and experiences among Christian therapists and educators. *Journal of Psychology and Christianity, 35*(1), 52–67.

Santero, P. L., Whitehead, N. E., & Ballesteros, D. (2018). Effects of therapy on religious men who have unwanted same-sex attraction. *Linacre Quarterly*, 1–17.

Satel, S., & Redding, R. E. (2004). Sociopolitical trends in mental health care: The consumer/survivor movement and multiculturalism. In B. J. Sadock & V. A. Sadock (Eds.), *Kaplan and Sadock's comprehensive textbook of psychiatry* (8th ed.) (Vol 1, pp. 644–655). Philadelphia, PA: Lippincott Williams and Watkins.

Schwartz, W. (2016). *Politics and religion: Psychotherapy's third rail*. Accessed at: http://www.socialjusticesolutions.org/2016/03/25/politics-religion-psychotherapys-third-rail/

Sears, D. O., & Henry, P. J. (2003). The origins of symbolic racism. *Journal of Personality and Social Psychology, 85*(2), 259–275.

Shafranske, E. P. (Ed.). (1996). *Religion and the clinical practice of psychology*. Washington, DC: American Psychological Association.

Shafranske, E. P., & Malony, H. N. (1996). Religion and the clinical practice of psychology: A case for inclusion. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (p. 561–586). Washington, DC: American Psychological Association.

Shapiro, D. N., Chandler, J., & Mueller, P. A. (2013). Using mechanical Turk to study clinical populations. *Clinical Psychological Science, 1*(2), 213–220.

Shedler, J. (2010). The efficacy of psychodynamic therapy. *American Psychologist, 65*, 98–109.

Shumway, B., & Waldo, M. (2012). Client's religiosity and expected working alliance with theistic psychotherapists. *Psychology of Religion and Spirituality, 4*(2), 85–92.

Smith, S. D., Reynolds, C. A., & Rovnak, A. (2009). A critical analysis of the social advocacy movement in counseling. *Journal of Counseling and Development, 87*, 483–491.

Spiro, H., Peschel, E., McCrea Curnen, M., & St. James, D. (Eds.). (1996). *Empathy and the practice of medicine: Beyond pills and the scalpel*. New Haven, CT: Yale University Press.

Strupp, H. H. (1980). Humanism and psychotherapy: A personal statement of the therapist's essential values. *Psychotherapy: Theory, Research, and Practice, 26*, 1–10.

Sue, D. W. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist, 53*, 440–448.

Sue, D. W., Alsaidi, S., Awad, M. N., Glaeser, E., Calle, C. Z., & Mendez, N. (2019). Disarming racial microaggressions: Microintervention strategies for targets, white allies, and bystanders. *American Psychologist, 74*(1), 128–142.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62*(4), 271–286.

Sue, D. W., Sue, D., Neville, H. A., & Smith, L. (2019). *Counseling the culturally diverse: Theory and practice* (8th ed.). Hoboken, NJ: Wiley.

Tesser, A. (1993). The importance of heritability in psychological research: The case of attitudes. *Psychological Review, 100*(1), 129–142. https://doi.org/10.1037/0033-295X.100.1.129.

Tryon, G. S., & Kane, A. S. (1993). Relationship of working alliance to mutual and unilateral termination. *Journal of Counseling Psychology, 40*(1), 33–36.

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity-a supplement to mental health: A report of the surgeon general*. Washington, DC: Author.

Vachon, D. O., & Agresti, A. A. (1992). A training proposal to help mental health professionals clarify and manage implicit values in the counseling process. *Professional Psychology: Research and Practice, 23*(6), 509–514.

Vasquez, M. J. T. (2007). Cultural difference and the therapeutic alliance: An evidence-based analysis. *American Psychologist, 62*(8), 878–885.

Verhulst, B., Hatemi, P. K., & Eaves, L. J. (2012). Disentangling the importance of psychological predispositions and social constructions in the organization of American political ideology. *Political Psychology, 3*(3), 375–393.

Ward v. Polite. (2012). 667 F.3d 727.

Whaley, A. L., & Davis, K. E. (2007). Cultural competence and evidence-based practice in mental health services: A complementary perspective. *American Psychologist, 62*(6), 563–574.

Whitley, R. (2010). Atheism and mental health. *Harvard Review of Psychiatry, 18*, 190–194.

Woolfolk, R. L. (1998). *The cure of souls: Science, values, and psychotherapy*. San Francisco, CA: Jossey-Bass.

Yarhouse, M. A. (2009). The battle regarding sexuality. In N. Cummings, W. O'Donahue, & J. Cummings (Eds.), *Psychology? War on religion* (pp. 63–94). Phoenix, AZ: Zeig, Tucker & Thiesen.

Zilcha-Mano, S. (2017). Is the alliance really therapeutic? Revisiting this question in light of recent research. *American Psychologist, 72*(4), 311–325.

Calling a Cease Fire: Ending Psychology's Long Conflict with Religion

Brendan Willis and Cynthia L. Lancaster

Abstract

Psychology and religion have endured a complicated and often strained relationship, which has continued to escalate in recent years. This conflict exists both at the organizational level of psychology (e.g., policies implemented by the American Psychological Association (APA)) and at the level of individual psychologists, including both researchers and practitioners. Unfortunately, the antagonism is often directed at religious students, faculty members, and, perhaps most concerning, religious patients. The continuation of this conflict presents a serious barrier to the ongoing efforts to improve inclusivity and sensitivity within the field of psychology and also to promote the quality and efficacy of behavioral health services. The goal of this chapter, therefore, is threefold: first, to briefly document examples of the continuing rift between psychology (and the larger field of mental health) and religion; second, to examine barriers that may be impeding the field from overcoming this rift; and third, to present possible solutions to these barriers and potential pathways for improving relations between religion and the field of psychological science.

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Keywords

Psychology and religion · Epistemology · Religious discrimination · Bias · Empirical decision-making

> We explore our lives day by day…trying to expand the boundaries of our knowledge. And that is why I am here. Not to conqueror you…with ideas, but to coexist and learn. – Captain Benjamin L. Sisko

This quote represents the spirit of inclusivity, curiosity, and openness that should be central to the profession of psychology (Piller & Carson, 1993). Unfortunately, these tenants are not always applied at the intersection of psychological science and religion. Psychology and religion have endured a complicated and often strained relationship. From the inception of modern psychology, early pioneers such as Sigmund Freud, Albert Ellis, and B.F. Skinner took a decidedly negative view of religion (O'Donohue, 2009). Consequently, there have been efforts to conceptualize psychology as being in opposition to spirituality and religious experiences, often times suggesting that religious beliefs and behaviors are in some way negative or psychologically problematic (Hage, Hopson, Siegel, Payton, & DeFanti, 2006). Of late, it appears the conflict between psychology and religion has continued to escalate. In their book *Psychology's War on Religion,* Cummings, O'Donohue, and Cummings (2009) argued there exists open antagonism, both at the organizational

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L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3_25

level of psychology (e.g., policies implemented by the American Psychological Association (APA)) and at the level of individual psychologists, including both researchers and practitioners. Unfortunately, the antagonism tends to be directed at religious students, faculty members, and, perhaps most concerning, religious patients (Jenkins, 2006; Knox, Catlin, Casper, & Schlosser, 2005; Rosik, Teraoka, & Moretto, 2016). This situation is especially problematic, as the field's code of ethics endorses inclusivity and sensitivity and condemns prejudice and discrimination (APA, 2017). Furthermore, the antagonism has spread to allied disciplines in mental healthcare, such as social work (Thyer & Myers, 2009). The continuation of this conflict presents a serious barrier to the ongoing efforts to improve the quality and efficacy of behavioral health services.

For an in-depth account of the conflict between psychology and religion, we refer readers to Cummings et al. (2009). While some progress has been made in the intervening decade (such as research into how religion impacts the psychotherapy process; Zagożdżon & Wrotkowska, 2017), individuals of religious orientation still face prejudice, bias, and antagonism within the field of psychology (e.g., Rosik et al., 2016). The goal of this chapter, therefore, is threefold: first, to briefly document examples of the continuing rift between psychology (and the larger field of mental health) and religion; second, to examine barriers that may be impeding the field from overcoming this rift; and third, to present possible solutions to these barriers and potential pathways for improving relations between religion and the field of psychological science.

Antagonism Toward Religion

Recent empirical research suggests the conflicts between religion and psychology have shown little sign of abating (Parent, Brewster, Cook, & Harmon, 2018). This antagonism is not limited to academia but also extends into professional and clinical settings. The bulk of current research on religious discrimination in the fields of psychology and mental health has tended to focus predominantly on Christian groups. This focus on Christianity is somewhat appropriate, particularly in the USA, given that the majority of Americans self-identify as a member of one of the various Christian denominations (46.5% of the American population identifies as Protestant, 20.8% as Roman Catholic, 1.6% as Mormon, and 0.9% as other Christian denominations; Central Intelligence Agency, 2018). Additionally, discrimination against Christian groups has become an especially salient issue, considering the number of immigrants entering the USA from predominately Catholic countries such as Mexico (on average, more than half of migrants entering the USA are identified as Catholic, and 76% of those migrants come from Latin America or the Caribbean; Barranco, 2016).

However, this focus on Christianity also represents a significant limitation in the research literature. Currently, there are more than 700 non-Christian groups throughout the USA, and other religious groups, such as Islam, Buddhism, and Hinduism, have been growing (Hage et al., 2006). While general principles regarding how psychology currently treats non-Christian religions can be extracted from Christian-focused studies, researchers still need to expand investigation to include other religious communities. Although many studies we discuss in this chapter relay the wealth of research on Christian groups, particularly in the USA, findings should be interpreted with caution when applied to non-Christian groups.

The field of psychology desperately needs additional research into fast-growing, non-Christian religious groups. This is vital in light of the findings that certain religious groups, such as Judaism, are often ignored and neglected in the research and training literature (e.g., Hodge, Baughman, & Cummings, 2006; Weinrach, 2002). Weinrach (2002) observed the American Counseling Association's concerning trend of insensitivity and neglect of Jewish clinicians and Jewish populations. For example, the American Counseling Association has repeatedly scheduled their yearly conference at times that conflict with important Jewish festivals, such as Passover. Additionally, in a sample of 43 counseling psychology training textbooks, the majority failed to include to significant discussion of Judaism or anti-Semitism (Weinrach, 2002). This represents a critical area of neglect, considering that of all the hate crimes reported in 2005, nearly 70% were anti-Semitic (Schlosser, Ali, Ackerman, & Dewey, 2009). Although the likelihood of working with a member of the Jewish community who has experienced discrimination is especially high, there is little research on this particular religious group.

It is important, however, to note that certain religious groups appear to escape the brunt of faith-based discrimination in the field of psychology. For example, Buddhism has enjoyed a rise in popularity within the field, and a number of therapies have been developed incorporating Buddhist principles (Masuda & O'Donohue, 2009). Despite the surface acceptance that some religious traditions have achieved, there still remains a great deal of misinformation and misunderstanding about religions such as Buddhism within the field of psychology (Hodge et al., 2006; Masuda & O'Donohue, 2009).

In examining the existing scientific literature on the experience of religious discrimination within the field of psychology and mental health, most findings fall into one of the three categories: discrimination experienced by religious faculty members and professionals, by students and supervisees, and, lastly, by patients. Below is a summary of recent findings within each of these groups, as well as a short selection of examples of discrimination that exists on a more systemic and organizational level within the field of psychology.

Discrimination Against Faculty and Professionals

There exists a growing body of empirical literature examining instances of discrimination leveled at religious faculty members and professionals (Rosik et al., 2016). This research suggests that there may be an unwritten rule that permits or allows more leniencies for discriminatory actions against religious individuals. This unwritten rule may stem from the predominately secular nature of academia. As Ecklund and Scheitle (2007) observed, the majority of academic scientists describe themselves as lacking any type of religious orientation (of the scientists surveyed, 51.8% had no religious affiliation, 30.1% identified as type of Christian, 15.3% identified as Jewish, 1.8% identified as Buddhist, 1.0% identified as Hindu, and 0.5% identified as Muslim; Ecklund & Scheitle, 2007). This secular majority may incidentally lead to a sense of secular privilege that can make it difficult for religious individuals to voice dissenting opinions.

A study by Inbar and Lammers (2012) offers support to the idea of secular privilege leading to the discrimination of religious individuals in academia. The researchers conducted a survey of personality and social psychologists regarding their willingness to act in a discriminatory fashion toward their conservative colleagues. (While political views and religion are not wholly dependent on one another, research by Hout and Fischer (2014) has demonstrated that less than 15% of conservatives have no religious preference. This indicates a high rate of religious belief among conservative groups.) Inbar and Lammers (2012) found in their sample of 800 social psychologists that 25% or more were willing to actively discriminate against conservative colleagues in hiring decisions, tenure decisions, grant funding, and invitations to speak at symposium. Without further research, it is impossible to say how much of this discrimination is based on political as opposed to religious views. However, discrimination against the conservative political perspective could subsequently produce a lack of representation in religious perspectives within academia. This, in turn, can lead to a lack of diversity of religious perspectives and insensitivity to the needs of religious patients and students. This concern has been raised by other authors (Hodge, 2009; Redding, 2012); however, little has been done to develop practical solutions.

Rosik et al. (2016) found further evidence of discrimination against religious clinicians. These researchers investigated the daily experiences of 343 Christian mental health professionals and sought to determine how many of the sampled professionals had experienced some form of religious discrimination during their training or professional career. The researchers also elicited participants' opinions regarding how psychology treats the subject of religion. More than one in three of the participants (37.4%) reported unfair or prejudicial treatment from secular colleagues, occurring at least occasionally. This number increased to 79.9% when those who reported such treatment as occurring rarely were also included. Additionally, 70.5% of the sample endorsed hearing disparaging remarks about Christian therapists or educators from their colleagues at least occasionally. These findings highlight that many Christian mental health professionals are concerned about discrimination toward themselves or colleagues and that a significant number actually experience religious discrimination at some time point (even if it is relatively infrequent for some). The authors also included examples of discrimination reported by participants, a few of which we have provided as follows:

> The director of a community health agency I had worked with for about six months (at that time) told my immediate supervisor and myself one evening that he liked having Christians working under him, "Because you can do anything you want to them, and they can't do anything back to you." (p. 57)

> Particularly at conferences, there is an assumption (APA in particular, but also APS) that almost no one in the room is evangelical. When the usual demeaning comments are made, when I speak up and note the condescension toward people of faith in general, but toward evangelicals in particular, the chill in the room is palpable. There is a smug ignorance of theology and church history, coupled with dismissive condescension, in APA especially. (p. 57)

These examples provide illustrations of derogatory and dismissive comments about religion that mental health professionals have encountered from their peers and supervisors. It also highlights an issue of differential treatment. If such statements and institutional condescension were leveled at other minority groups (such as ethnic minorities or members of the LBGTQ+ community), the psychology community would likely quickly and strongly condemn this behavior. However, religious individuals have unfortunately been targeted for discriminatory treatment within the field of psychology, with little consequence for the wrongdoers (Jenkins, 2006; Rosik & Smith, 2009).

Another serious source of concern relates to academic psychologists deciding not to peruse research on religious topics out of fear of reprisal from their colleagues. This represents a shift away from the more tolerant view of religion advocated by William James, one of the founders of modern psychology (James, 1928). His seminal work, *The Varieties of Religious Experience: A Study in Human Nature*, examined a number of religious concepts, such as conversion and the construct of saintliness, demonstrating his view that religious constructs merited psychological study (James, 1928). However, recent findings suggest that researchers in psychology are more hesitant to investigate religious issues (Rosik et al., 2016). This presents a serious problem for the field; as in theory, psychology is predicated on the unbiased empirical investigation of human behavior. As a result, aspects of culture that influence human behavior, including religion, should be open to empirical study. Despite this, Rosik and colleagues (2016) found that nearly half (46.6%) of the participants in their study reported to have (at least sometimes) chosen to not speak, write, or conduct research a topic due to concerns about potential negative professional consequences from secular colleagues. More specifically, these concerns motivated more than one quarter of the sample (26.8%) to avoid researching topics regarding Christian spirituality or faith (Rosik et al., 2016). Unless a research topic is inappropriate for ethical reasons (e.g., risks outweighing potential benefits), no topic should be off limits for empirical investigation. Although the field of psychology generally regards itself as an empirical discipline, evidence suggests that important areas of research involving the intersection of religion and psychology may be avoided because researchers of a religious background fear discrimination from their colleagues. For example, little empirical data exist evaluating the best strategies for navigating value-based conflicts between therapists and patients, which, in some instances, arise from religious differences in viewpoint. The resulting empirical blind spots are especially problematic in the USA, given the vast number of Americans that self-identify as religious (Central Intelligence Agency, 2018). These empirical gaps can hamper efforts in resolving the conflicts between psychology and religion. Furthermore, the lack of empirical understanding may impede efforts to understand how to best utilize a patient's religious beliefs in the therapeutic setting as well as how to give competent supervision to students with strong religious beliefs.

Discrimination Against Students and Supervisees

Unfortunately, the discrimination experienced by faculty members also affects students and supervisees. There is an overall lack of research focusing exclusively on religious discrimination experienced by psychology students. However, general principles can still be gleaned from existing investigations of perceptions of religious discrimination among the general student population in higher education. While additional research will be necessary to confirm if these trends hold true in psychology departments, the extent of discrimination is still troubling. Research has demonstrated that such religious discrimination is detrimental to the mental health of those who experience it (Jordanova, Crawford, McManus, Bebbington, & Brugha, 2015). Given existing ethical codes and professional principles, psychology and other mental health fields have a special responsibility to not be complacent in environments that are hazardous to the mental health of students.

This responsibility makes the level of discrimination observed by Rosik and Smith (2009) impacting Christian students at a secular university all the more troubling for psychology departments. These researchers found that more than one third of the sampled students felt it was necessary to conceal their Christian beliefs to avoid harassment or unequal treatment by faculty, administrators, secretaries, and other staff members of the university. Additionally, 13.3% felt that they had to hide their beliefs from their fellow undergraduate students. In terms of actual events of discrimination, 20.6% reported being treated unfairly by university staff and faculty members due to religious reasons, and 4.5% reported unfair treatment by their department chair due to their religious beliefs. While this is thankfully a small proportion, it nevertheless points to instances of department heads using their considerable influence and power to disrupt the education of Christian students. Furthermore, nearly all of participants in the sample reported at least occasionally hearing anti-Christian statements in the university setting. The reported acts of discrimination fortunately did not escalate into physical violence. However, 21.3% of the sample knew at least one person in their community who had been harassed, threatened, or attacked due to their religious beliefs. These data represent a worrying trend in academia to discriminate against students who hold Christian beliefs. Additional research will be necessary to confirm if these trends also apply to other religious groups; however, they still indicate areas requiring intervention.

In an effort to capture more of the content of religiously based discrimination, Hyers and Hyers (2008) studied a sample of 42 conservative Christian participants at a mid-sized nonreligious university. They asked their participants to keep a diary detailing any incidents involving anti-Christian prejudice or discrimination during a 7-day period. Their results were sobering. During the 1-week reporting period, each participant recorded on average two separate incidents of anti-Christian prejudice or discrimination, for a total of 87 separate events across the entire sample. The majority of the sample (62%) experienced deliberate derogation of their beliefs or of Christian people, churches, and practices in general. Perhaps most concerning, more than one fourth of participants reported experiencing, at least once during the week, overtly hostile, spiteful, hateful, or rejecting comments of behaviors against Christians, such as one participant overhearing a fellow student saying "They should kill all Christians" (p. 122). Other participants reported that professors made fun of them in front of the class for being Christian and told them that God cannot exist because of evolution. Essentially, as the academic world and the culture of the USA becomes more secular, hostility toward those of religious faith has increased, and students who are also members of religious groups are experiencing significant prejudice and discrimination within academia.

Regrettably, the allied field of social work is not immune to antireligious biases that have been growing throughout academia. Thyer and Myers (2009) undertook a qualitative examination of allegations of religiously based discrimination in both bachelor's level and master's level social work programs. They provided vivid examples of discrimination targeted at religious students. Of the accounts provided, one stands out as particularly dramatic involving a masters of social work (MSW) intern, John Watts. Mr. Watts included a Catholic support group in his treatment recommendations for a bereaved Catholic client. In response, Mr. Watts was terminated from his field placement and eventually from the MSW program itself on the grounds of inappropriate behavior regarding religion. In this case, there is a concerning lack of justification as to why the religious based referral was considered inappropriate, particularly given its clear consistency with the client's own values. There was no attempt at discussing the referral or attempting to find common ground. It is curious that the response to his suggestion was so severe. Typically, if a misstep has been made in treatment, unless it results in serious harm to the patient, trainees are offered guidance and correction, rather than dismissal. Yet there was something so utterly inappropriate about suggesting a religious support group to a religious patient that the only recourse was termination of Watt's social work career. These cases are important for the mental health field in general, but are of particular importance to psychologists, who often are called upon to act as supervisors for master's level clinicians such as social workers. It is vital for such supervisors to understand how their own biases may lead to extreme escalations such as the case presented here.

Another particularly troubling example is the case of counseling psychology student Ms. Julea Ward. Ms. Ward was expelled by her master's degree counseling program after she inquired of her supervisor whether she should refer a gay patient to another therapist; she expressed concern that due to her religious beliefs, she would be unable to affirm and support his sexual orientation (*Ward v. Polite*, 2012; *Ward v. Wilbanks*, 2010). Although there may be much contention about the appropriate course of action in this case, the decision to end a supervisee's career when she sought consultation regarding a values conflict is surprising. It could be viewed as antithetical to the hopes of supervisors that when faced with ethical dilemmas and values conflicts, supervisees will seek their guidance in resolving these issues. Examples such as the court cases of Ward and Watts, alongside reported religious discrimination among undergraduate and graduate students (e.g., Hyers & Hyers, 2008; Rosik & Smith, 2009; Thyer & Myers, 2009), highlight the importance of continuing to pursue ways to reduce the experience of religious discrimination for students and supervisees within the field of mental health and psychological science.

Discrimination Against Patients

Discrimination against religious individuals also appears to extend to patients undergoing psychotherapy. Discrimination is a grave concern to therapists, as it can have a deleterious impact on the therapeutic process and the patient's well-being and overall trust in the field of psychotherapy (i.e., willingness to seek out therapy in the future). Jenkins (2006) interviewed 12 patients at various stages of psychotherapy and recorded a number of poignant examples of this kind of religious discrimination. Examples ranged from therapists refusing to talk about religion in session to more extreme experiences, such as pathologizing religious beliefs. For example, one participant reported that it was common knowledge at the hospital that doctors would prevent patients from leaving and/or increase the medication of patients who discussed religious issues during therapy sessions. Another participant reported that her therapist had said that her religious beliefs were largely responsible for her psychopathology. The participant reported feeling marginalized and ridiculed by her therapist. This, in turn, led to significant damage to their therapeutic relationship, and the patient eventually terminated treatment. Sadly, such pathologizing of religious belief has a long tradition inside of the field of psychology, stretching back to the works of Albert Ellis and others (O'Donohue, 2009). For example, Ellis stated in *The Case Against Religion*, "Religiosity, to a large degree, essentially is masochism; and both are forms of mental sickness" (Ellis & Murray, 1985, p. 6), clearly demonstrating his perspective that religious belief is a psychological disorder necessitating correction. Further emphasizing the point, he later states, "the conclusion seems inescapable that religion is, on almost every conceivable count, directly opposed to the goals of mental health" (p. 12). An unqualified statement that religious belief is psychologically harmful is not only inconsistent with the literature, which demonstrates a more complex relationship between these two constructs (e.g., Rosmarin, Alper, & Pargament, 2016), but also further damages the relationship between the field of psychology and religion.

Qualitative research by Knox et al. (2005) further contributes to the evidence that psychotherapy patients have experienced religious discrimination. They interviewed 12 religious patients regarding their experience in psychotherapy and found that one quarter of the participants felt that their therapists had imposed their own religious beliefs on their patients. For example, one therapist stated that their patient was "too Catholic" (p. 296). Such value imposition by therapists can lead to significant damage to the therapeutic relationship. Patients reported feeling confused, angry, and judged. As a result, one patient terminated therapy completely due to the discrimination experienced at the hands of their therapist. Simply ignoring the patient's religion does not appear to lead to significantly better results either. Another fourth of the participants reported that there was no discussion about religion during their treatment. Of those participants, only one reported being satisfied with the treatment and with the therapist personally. Other qualitative research suggests a slightly more optimistic picture. Research by Mayers, Leavey, Vallianatou, and Barker (2007) found that religious patients often feared having their religious values and experiences devalued and disrespected by a therapist, but that the actual occurrence of such biased treatment was relatively rare. However, like the previously mentioned study, this research involved an extremely small sample ($n = 10$).

The qualitative nature and small sample sizes of these studies make it difficult to draw firm, generalizable conclusions. For example, the Knox et al. (2005) study recruited participants who had been in psychotherapy and had considered raising religious issues during the course of therapy. Such criteria leave open the possibility of sampling bias. It is not clear if the patients in the Knox et al. (2005) study were more disgruntled or had experienced more discrimination than the average patient. Therefore, the results call for further investigation. One important avenue will be in examining which types of religious patients are most at risk for experiencing discrimination. This might help to explain the apparent discrepancies in findings between the religious discrimination identified by Knox et al. (2005) and the low frequencies of discrimination found by Mayers et al. (2007). Furthermore, the qualitative research needs to be expanded with larger, more generalizable samples. These samples should include both patients who have successfully completed treatment as well as those who may have dropped out before treatment was completed in order to reduce potential bias. These qualitative findings can be supplemented with larger, quantitative investigations on the overall prevalence of religious discrimination in psychotherapy. One potential study could involve following larger groups of religious patients from the beginning of treatment through to termination. Such a study could record how many patients experience religious discrimination, at what points in therapy this discrimination occurs, and how the discrimination impacts treatment efficacy. These data will be critical in further generalizing the qualitative findings across larger populations and better understanding how and when to address religious discrimination in therapy. If patients, even a minority of patients, are experiencing religiously based discrimination from their therapists, this finding would point to a serious failure in training and supervision.

Organizational and Systemic Discrimination

In addition to these more current examples of bias and prejudice directed toward religious individuals within the field of psychology, some past examples of the antagonism between psychology and religion bare mentioning. In some cases, the antagonism toward religion even extends to actions of the main professional organization of psychology, the American Psychological Association. A particularly dramatic example occurred in 2004 when the APA Ad Hoc Committee on Film and Other Media at the APA National Convention screened a film that described the Church of Jesus Christ of Latter-Day Saints as a "corporation with no heart" and the film as "a must see film for any psychologist interested in mind control, brainwashing, and self-esteem issues" (Byrd, 2009, p. 175). It took 10 months, numerous letters from the APA, and a visit from the Utah Psychological Association delegation to finally convince the APA to issue a statement on the film. In the statement, the APA apologized for the offensive description (p. 178) of the LDS Church in the film and noted they were taking steps to prevent the use of offensive language in the future (APA, 2005). The apology itself was an important first step in acknowledging that the film's description was in fact offensive and stating that such language would be avoided in the future. However, the APA missed an important opportunity to take a stronger stand against religious discrimination with this lukewarm apology. The APA did not actually acknowledge any wrong doing in allowing such a biased and blatantly prejudicial film to be screened at an official convention. This is especially concerning, as allowing the film to be screened implies the APA's stamp of approval, thus potentially communicating to the APA membership that antireligious biases are acceptable. The APA's actions surrounding this film suggest insensitivity to the LDS Church's long history of being the target of violence and prejudice. Such history stretches back to the more than 180 years, including the infamous 1838 Extermination Order signed by Governor Lilburn Boggs calling for the genocide and expulsion of LDS Church members from the state of Missouri (Boggs, 1838).

Moving from larger issues of APA policy to examples of religious discrimination in training and education, Lehr and Spilka (1989) examined how introductory textbooks used in psychology classes dealt with the issue of religion. They sampled 98 introductory psychology textbooks from 1980 to 1988 and compared them to similar samples of textbooks from previous decades. They noted that the bulk of textbooks in the sample contained little current research on the psychology of religion, indicating a serious gap in introductory psychological literature. Additionally, they noticed more recent textbooks were more likely to include negative interpretations of religion than earlier textbooks.

A more recent study from the allied field of social work uncovered a similar trend in how religion is presented in student textbooks. Hodge et al. (2006) conducted a content analysis of 71 influential social work textbooks to examine how they approached the subject of religion. Overall, they found that religious topics often received minimal attention in their sampling of textbooks. For example, Islam was usually only afforded a few sentences of attention. This lack of detail is especially troubling considering the speed at which Islamic groups in the USA are growing (Smith, 2002). Evangelical Christian references appeared with more frequency; however, these depictions were typically more negative in nature. The researchers found that evangelical Christians were repeatedly framed as extremists who were less intellectually sophisticated than others and who were oppressive, anti-Semitic, deviant, rigid, and perpetrators of violence against women and children. One textbook went so far as to say that Christian values were a cornerstone of racism. In summary, the researchers found 101 paragraphs containing negative or derogatory information regarding evangelical Christianity and only four paragraphs containing positive information.

One significant issue with these findings is that "evangelical" is a somewhat nebulous and ill-defined term. It can be difficult to exactly determine what groups qualify as evangelical and which do not. Furthermore, some denominations that evangelize (i.e., send out missionaries to spread their beliefs) may not be recognized as evangelical. To use a previous example, the Church of Jesus Christ of Latter-Day Saints is renowned for its missionary efforts, but is often not regarded as an evangelical (or even a Christian) denomination (Jackson, 2000). Despite the lack of clarity regarding this construct, there is significant concern regarding how religious students might react when studying this decidedly negative interpretation of a large portion of religious individuals in the USA. This biased perspective may serve to reinforce existing religious prejudices in some students and curtail religious students from pursuing careers in social work and other mental health fields.

Taken together, these studies point to two significant problems in the field that have yet to be sufficiently addressed. The first is an overall lack of dissemination of quality research on the intersection of psychology and religion. Research on how psychology and religion interact (such as how religion impacts the psychotherapy process) exists, but the above findings suggest that it is not being included in textbooks that introduce students to the field of psychology. Secondly, these studies demonstrate a continuing trend to view religion in a negative light, even among mainstream textbooks used in psychology and related classes (Hodge et al., 2006). Such textbooks are potentially biasing undergraduates at the beginning of their training to view religion as negative and, therefore, unhealthy. Not only could this potentially exclude students with religious backgrounds from studying psychology, it has serious implications for clinical practice as well. If undergraduates who plan on pursuing clinical careers are indoctrinated with this perspective from their first experiences in psychology and related fields, how will they later be able to interact successfully with individuals who find that religion is a positive factor in their lives? Furthermore, will this biased introduction to religion prevent students interested in the intersection of religion and psychology from pursing such research?

A Question of Epistemologies

Part of the difficulty in resolving the long-standing conflict between psychological science and religion may stem from epistemological differences (Houts, 2009). Science and religion operate under different, and in some cases incompatible, epistemologies. For example, empiricism (i.e., use of the scientific method to discern truth) is often directly contradictory to the methods used to discern truth among religious traditions. We rely heavily on empiricism in this paper, but in doing so, we do not wish to imply that religious individuals should adopt an empirical epistemology. Instead, while both acknowledging and respecting alternative epistemologies, this chapter aims to contribute to the development of psychological science, and thus is written from the perspective of empiricism. This is an epistemological perspective that provides common ground for those operating within the field of psychological science and is, therefore, likely to be the most productive framework for studying and resolving the barriers between the field of psychological science and religion.

Barriers to Progress

The experiences of religious discrimination identified in the preceding sections are not new. Prior publications over the last several decades have repeatedly discussed the need for improved relations between religion and the field of psychology and mental health (Cummings et al., 2009; Hodge, 2009; Lehr & Spilka, 1989; Marsden, 2015; Oxhandler, Parrish, Torres, & Achenbaum, 2015; Parent et al., 2018; Redding, 2012). These issues are of particular concern due to the negative impact of religious discrimination on those who experience it. Jordanova and colleagues (2015) found that individuals who endure religious discrimination also show in increased prevalence of all common mental disorders (depression, anxiety, etc.). The discrimination experienced by students and faculty members, whether in or out of the field of psychology, has likely led to a variety of negative outcomes among those who have experienced it. Therefore, these issues should be of concern to psychology as potential targets of intervention in efforts to improve the mental health of students and faculty in academic settings. The APA's own code of ethics lists, as the first of the General Principles, the core values of beneficence and nonmaleficence, clearly stating that psychology has the special responsibility to not only avoid acts of discrimination but also to help those who are suffering from its ill effects (APA, 2017).

Furthermore, most psychologists and other mental health professionals would likely agree that respecting diversity includes respecting religious groups. While many in the field would undoubtedly concur that improvements to the relations between psychology and religion are long overdue, the previously reviewed research suggests that that there has been little to no change in close to 30 years. In examining the existing scientific literature, it becomes apparent that a number of barriers may be preventing advancement in resolving the conflict between religion and psychology. The barriers we have identified include (1) the potential of freedom of religion to infringe on the rights and freedoms of other groups, such as women and LGBTQ+ communities, (2) the minority status of religious groups in academic psychology departments, (3) a focus on broader social movements to the exclusion of individual interactions, (4) a focus on making people bias free instead of the bias-free processes, (5) the lack of empirically based practice guidelines, and (6) the lack of training in religious sensitivity among psychologists and a lack of research on the efficacy of religious sensitivity training.

Each of these barriers has posed a significant challenge in advancing our understanding of how to heal the divide between psychology and religion. They also demonstrate that the solution to the ongoing conflict may not be simple. Solutions must be found to each of these barriers and implemented in an integrated fashion. For example, improved religious sensitivity training (barrier 5) is vitally important, but its effectiveness may be limited without a viable method for resolving disputes between patient and therapist values (barrier 1). The remainder of the chapter will focus on defining each of these barriers, as well as proposing a few potential solutions to overcoming said barriers.

Barrier 1: Potential to Infringe on Rights of Other Groups

The Problem

One of the primary barriers to overcoming the history of conflict between psychological science and religious individuals is the potential for religious freedom to infringe on other personal freedoms. This barrier arises when religious beliefs stand in direct opposition to other personal beliefs and freedoms. The perfect case study for this is the conflict between gay rights and the opposition of many religious belief systems to the morality of non-heterosexual orientations. One of the challenges of supporting religious freedom is the concern that this could be equated with being in favor of discrimination against the lesbian, gay, bisexual, and queer (LGBQ[1]) community.

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[1] This section focuses exclusively on sexual orientation; therefore, only gay, lesbian, bisexual, and queer popula-

These concerns about discrimination against the LGBQ community are firmly rooted in recent history. For example, LGBQ orientations were pathologized and labeled as mental illness in early versions of the Diagnostic and Statistical Manual of Mental Disorders (APA, 1952, 1968, 1973, 1980).[2] Not long ago, some psychotherapists even promoted the use of conversion therapy in an attempt to switch LGBQ orientations to heterosexual (Ford, 2002; Nicolosi, 1991; Nicolosi, Byrd, & Potts, 2000; Shidlo & Schroeder, 2002; Spitzer, 2003). More recently, the APA has produced clear statements, grounded in research, that variance in sexual orientation is not indicative of psychopathology (APA, 2009). The APA has furthermore stated that "sexual orientation change efforts" (SOCEs; i.e., conversion therapy) should not be used because SOCEs have the potential to cause harm, including effects such as "loss of sexual feeling, depression, suicidality, and anxiety" (APA, 2009, p. 3). Although recent statements situate the APA as firmly supporting the rights of LGBQ clients, psychologists and psychological organizations have only recently begun to rectify transgressions against the LGBQ community.

Given this historical context, attempting to sensitively navigate conflicts between LGBQ rights and religious freedoms is understandably complex. In accordance with the APA principles, psychologists must "be aware of and respect cultural, individual, and role differences, including those based on … religion [and] sexual orientation," among other groups (APA, 2017). Based on the ethical principles of the field, it is therefore tempting to simply state that the psychology should strive to support the right to both gay rights and religious freedoms equally. However, when the personal beliefs of two groups are in direct conflict, supporting all personal beliefs completely equally becomes untenable. Policies simply cannot provide completely equivalent support for gay rights and religious objections to non-heterosexual orientations.

Proposed Solutions

In order to resolve disputes between contradicting personal freedoms, one option is to appeal to a value held in higher regard by the healing practices than freedom of personal belief: the value of beneficence and non-maleficence, which is the first ethical principle in the APA ethics code (APA, 2017). In essence, the field could support freedom of personal beliefs, to the extent that it does not cause harm to others, particularly those in vulnerable positions such as clients, students, and supervisees. Here, harm is defined as a non-optimal therapeutic outcome, such as the client's symptoms worsening or the development of new symptoms or maladaptive behaviors. The rules of beneficence and non-maleficence have already been applied in some instances. For example, it is fully consistent with the APA's statement (2009) that they would not support the use of SOCEs because of empirical evidence that these treatments may cause harm to clients. However, as an additional exercise to demonstrate the use of this rule of thumb, we will discuss it in application to a specific scenario, the decision of a therapist, who holds religious beliefs in opposition to the morality of LGBQ orientations, to refer an LGBQ client to another provider.

This specific scenario has arisen in at least two court cases (see Hancock, 2014 for additional review). The first was the aforementioned Ward case (*Ward v. Polite*, 2012; *Ward v. Wilbanks*, 2010). Ms. Ward's (*Ward v. Polite*, 2012; *Ward v. Wilbanks*, 2010) school counseling program dismissed her based on charges of discrimination because she requested to refer a gay client. In

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tions were included in the abbreviation. In other sections, in which sexual orientation is not the exclusive focus, the more common LGBTQ+ abbreviation is used, with the T indicating Transsexual.

[2] Note that we do not intend to imply that religious groups were arguing for pathologizing sexual orientation; religious groups more often make judgments in terms of morality rather than pathology. Instead, we are describing the history of psychological science characterizing some sexual orientations as pathological. We believe this historical context is relevant to the current (and justified) sentiment in the field of psychological science to protect this group of individuals. This historical context may come into play when one is negotiating the ethics of supporting both the right to religious freedom and LGBQ rights.

reviewing her client's file prior to his first session, she discovered that he was gay. Ms. Ward had been taught that ethical therapy involves therapists refraining from imposing their own values. Due to her religious beliefs, she expressed the concern that if therapy shifted to focus on romantic relationships, she would be unable to affirm the client's relationship choices and sexual orientation. The program stated that she had violated the ethical code of the American Counseling Association because her actions were discriminatory and because she imposed personal values that were not consistent with the goals of therapy. Her enrollment in the program was terminated, and she later filed lawsuits against her program (*Ward v. Polite*, 2012; *Ward v. Wilbanks*, 2010) for infringing on her rights to free speech and religious freedom. The case was eventually settled by the university; Ms. Ward received financial compensation, and the dismissal was removed from her record (*Ward v. Polite*, 2012), but the university's educational policies and procedures were not changed. A second and somewhat different scenario occurred in the Bruff case (*Bruff v. North Mississippi Health Services, Inc.*, 2001). In this case, a client disclosed, several sessions into therapy, that she was a lesbian and wished to work on relationship concerns. Her therapist at the university counseling center stated that she could not provide her client with counseling on her relationship because this would be contrary to her religious views, but suggested that she could continue assisting with other issues. The client did not return to therapy and submitted a complaint against the counselor, and the counselor was terminated from her position. The court upheld the termination (*Bruff v. North Mississippi Health Services, Inc.*, 2001).

These two cases provide clear evidence that the conflict between religious beliefs and LGBQ rights is alive and well in the profession and has emerged in the context of both counseling and counseling education. We will now use this specific scenario, the request of a therapist with religious objections to LGBQ orientations to refer an LGBQ client, to explore the application of utilizing beneficence and maleficence as arbiters in the conflict between values.

Discriminatory Referrals When evaluating the potential for harm in referring LGBQ clients, it is important to consider the reason for the referral. If a therapist proposes to refer a client simply because they have an LGBQ sexual orientation, this could be considered discriminatory. This would be no different than a therapist referring a devout Jewish patient because the therapist is a staunch and uncompromising atheist and simply does not want to work with religious clients.

LGBQ clients already experience harmful discrimination in society more broadly (e.g., Hong, Woodford, Long, & Renn, 2016). It is clearly harmful to the client to provide them with yet another discriminatory experience when they are seeking out mental healthcare. This type of referral may cause further harm by reducing an LGBQ client's ability to trust future therapists and to seek out therapeutic services. LGBQ clients are already at heightened risk for anxiety, depression, and other mental health issues (e.g., Grant et al., 2014), and discriminatory experiences contribute to psychological distress (e.g., Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Kelleher, 2009). Thus, a therapist with religious beliefs referring an LGBQ client for discriminatory reasons (i.e., simply because of their LGBQ status) could be harmful to the client. However, it is important to note the nuance of this issue, in particular, the intent behind the referral. For example, one could argue that referring an individual simply because the therapist does not like their religious beliefs or practices could be discriminatory. On the other hand, under some circumstances, it could be beneficial for the patient to receive a referral if the therapist is concerned about their own competency for treating the patient (rather than personal dislike). Referrals with these intents could potentially result in improved patient care.

Competency-Based Referrals A therapist might be motivated to refer an LGBQ client due to limitations in their own competence. For example, the therapist may not have appropriate training and/or access to training, supervision, and consultation, appropriate for working with this population. A referral in this case would be consistent with APA code 2.01, which states that "psychologists [should] provide services… with populations and in areas only within the boundaries of their competence" (APA, 2017, p. 5). Additionally, there are many cases in which a therapist may have personal values that would make it challenging for them to work effectively with a certain population. Personal values can influence the direction a student takes in their training and, therefore, can have a significant impact on the limits of their competence. This is true of not just religious values but other personal beliefs as well. For example, therapists who have trained for, and worked with, survivors of sexual trauma may feel ill-equipped to provide therapeutic rehabilitation to perpetrators of sexual violence. Therapists who have strong pro-life personal beliefs may be concerned about incidentally imposing personal values on a client who is struggling to decide whether to have an abortion. A therapist with strong pro-choice personal beliefs may find it difficult to be empathetic to a client with equally strong pro-life sentiments and may be concerned that the mismatch in values may compromise their ability to establish an effective therapeutic alliance. Similarly, therapists who have religious beliefs that oppose LGBQ orientations could have concerns that they might impose their own values (even if only through unintentional acts) on LGBQ clients. Relatedly, researchers have documented the negative impact of microaggressions, which are often unintentional acts of discrimination, on LGBQ clients in therapy (Shelton & Delgado-Romero, 2011; Willging, Salvador, & Kano, 2006) and in society more broadly (Platt & Lenzen, 2013; Sue, 2010). (The construct of microaggressions could benefit from further clarification and refinement (see Lilienfeld, 2017 for a detailed discussion), and thus additional research on this construct could be quite useful for moving the field forward in its understanding of the impact of microaggressions on psychological outcomes.) In these cases, clients' well-being may be best protected by providing a referral to a therapist who has greater competence for working with a specific population. This view aligns with APA ethics code 2.06, which states that "psychologists [should] refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner" (APA, 2017, p. 5). Here, the "personal problem" takes the form of the conflict in values. It is not the values themselves that are necessarily problematic. Conflicts in values present a problem for clinicians due to the risk that such disagreements will damage the therapeutic relationship and thus undermine efforts to deliver competent and effective care. Such value conflicts can occur in many domains, not just religion. For example, a value conflict can arise between a highly conservative therapist and a highly liberal patient, if this issue were to become relevant to the content of therapy sessions.

Referring a patient to a therapist with greater competence in working with a specific population also aligns with the recommendations of other psychologists, such as Aten and Hernandez (2004), who wrote that "psychologists who are unable to provide therapy to religious clients because those beliefs are too difficult to support or understand will provide ethical service by referral to other therapists who are able to work with such clients" (p. 158). However, as stated before the critical factor here is not the referral itself, but the intention behind the referral: specifically, whether the therapist refers the patient due to personal dislike (discriminatory) or in the spirit of improved patient care (possibly nondiscriminatory). Understandably, this introduces a great deal of subjectivity to the decision-making process regarding when it is appropriate to refer a patient. However, allowing therapists to assess their own personal beliefs and continue treatment only if they judge themselves to be competent to work with a particular population moves the focus of decision from therapist preferences (which one could argue are less important due to the power differential in the patient-therapist relationship) to protecting beneficence and nonmaleficence for the patient.

A question might remain regarding why intentionality is so important in this proposed solution. The reason surrounding this can be found in examining the Hippocratic Oath taken by medical professionals, namely, the standard that medical doctors should endeavor to do no harm. In medicine, personal dislike and value conflicts will not dull the surgeon's scalpel. However, one of psychology's primary therapeutic tools, a scalpel so to speak, is arguably the empathy a clinician feels and expresses for their patient (Rogers, 1995). A clinician's empathy could potentially be dulled or damaged by value conflicts. Thus, in the spirit of preventing harm to patients, each clinician must personally evaluate whether their closely held beliefs will dull their empathy and thus damage their therapeutic relationship. If so, then a referral may be appropriate. However, if the therapist can suspend or otherwise deal with the value conflict, then the therapeutic relationship may not be in danger, and thus a referral may be inappropriate and unnecessary.

Abandonment However, when making such competency-based referrals, therapists should do so cautiously to avoid causing harm by engendering feelings of abandonment. Therapists must weigh the risk of unintentional discriminatory actions and value imposition against the risk that they may cause harm by producing feelings of abandonment. This issue is one of the striking differences between the *Ward* and *Bruff* cases; in the *Ward* case, there was a low risk of producing feelings of abandonment because the referral occurred before therapy began. In contrast, in the *Bruff* case, there was a high risk of producing feelings of abandonment because the referral occurred after several sessions of therapy. The context of the referral, such as the number of sessions already completed, should be considered when weighing the potential risks of harm for the patient. To be clear, this is not to say that termination or referral should never be considered when deciding how to deal with unresolvable value conflicts. Instead, the risks of termination (i.e., feeling that one has been abandoned, terminating therapy before a treatment protocol has been completed, the possibility of discouraging the patient from seeking future mental health help, etc.) should be taken into account when deciding how to best proceed and how best to handle the termination process if needed.

Access to Care Finally, when considering referring an LGBQ client due to the therapists' competence for working with this population (e.g., due to lack of training or problems caused by personal beliefs), one must consider the possibility that a referral could negatively impact access to care. In this case, there would be a balancing act of two issues related to beneficence/nonmaleficence for the client: (a) lack of access to care and (b) the potential for harm from a therapist who is not certain they can refrain from (even slight) value imposition. However, based on current demographic data, this exception (i.e., referrals leading to reduced access to care) is relatively unlikely to occur.

The prevalence of any religious identification across mental health practitioners is comparable to the overall US population; the overall majority of those in the helping professions indicate attending religious activities several time or more a month (Oxhandler, Polson, Moffatt, & Achenbaum, 2017; however, note that this survey was restricted to one state, Texas). Despite this parallel, cases of conservative religious therapists finding difficulty in treating a member of the LGBQ community are likely to be few in number. First, according to demographics collected by the Public Religion Research Institute, support for gay rights is on the rise even among religious groups in the general population (Cox, Navarro-Rivera, & Jones, 2014). This represents a marked historical shift: as of 2003, all major religious groups in the USA opposed legalizing gay marriage (Cox et al., 2014). However, as of 2014 (Cox et al.), 83% of Jewish Americans, 56–58% of Catholic Americans, and 27–62% of Protestant Americans supported legalizing same-sex marriage. Second, the proliferation of access to a variety of mental health providers via telehealth (Gros et al., 2013) serves to further reduce the risk of harm when making referrals. Telehealth services allow access to specialists with the proper training and competency to effectively treat members of the LGBQ community, even in rural areas. Evidence suggests that telehealth-delivered treatments can be as effective as in person modalities (Yuen et al., 2015). Taken together, these findings suggest it is more reasonable to expect that in most cases, even in rural areas, referral is an option that allows for both supporting the religious freedom of the therapist and, perhaps more importantly, for preserving beneficence/nonmaleficence for an LGBQ client seeking psychotherapy.

In summary, one way to settle the contention between religious freedoms and gay rights in the field of psychology is to appeal to the principle of beneficence/nonmaleficence as the arbiter. Specifically, holding the principle that freedom of personal (and religious) beliefs should be respected, to the extent that it does not cause harm to others. Viewed another way, this rule involves banning potentially harmful practices (i.e., practices with evidence of causing harm to the patient, such as conversion therapy) rather than banning certain people (e.g., therapists who hold certain religious beliefs) from practicing therapy. This discussion provides one example of how the field might preserve religious freedom without infringing on other personal rights and freedoms, thus providing one possible pathway toward healing the divide between psychology and religion.

Barrier 2: The Minority Status of Religious Groups in Academic Psychology Departments

The Problem

Although religion (in particular, Christianity) may have a historically privileged history in American culture, this privilege does not appear to extend to their professional environment among fellow psychologists (see section "Antagonism Toward Religion" for a review of the evidence). Thus, caution is needed to ensure that religious individuals are not being discriminated against in an academic environment, in which they are the minority voice. Discouraging their inclusion may silence a cultural perspective that is broadly relevant to contemporary society and thus to the development psychological theories, research, and practice.

The secular majority in academia is well documented. Research by Ecklund and Scheitle (2007) found that 52% of scientists in academia describe themselves as lacking any sort of religious affiliation, and 75% do not attend religious services regularly (i.e., attended a service 5 times or less during the last year). In examining the interface between science in general and religion, Ecklund, Johnson, Scheitle, Matthews, and Lewis (2016) found that in the USA only about 30% of scientists describe themselves as being even slightly religious, indicating that a majority of researchers do not identify with a particular religion. They also found that only 12% of scientists felt religion and science could collaborate in a meaningful way. The majority (51%, in the USA) felt that science and religion occupy completely separate and independent spheres and should not influence each other. While this can be true for many scientific fields (such as physics, astronomy, or biology), it may be less true for psychology and other helping professions. For example, religion can impact how participants respond in experimental studies or alter their answers to surveys.

The minority status of religious individuals in academia represents a significant barrier to resolving religious conflicts within the field of psychology. The preponderance of a single, secular world view may make it easier to ignore instances of religious discrimination. It may also serve to make the field less sensitive to the needs of religious students, clients, and faculty members, and more discouraging research focused on the intersection of religion with psychology. Of additional concern, the small number of religious individuals in academia decreases the chances of positive interactions between nonreligious and religious faculty members. Research has repeatedly demonstrated that positive intergroup contact can significantly reduce bias and improve intergroup relations (Hewstone & Swart, 2011).

However, the lack of positive intergroup contact may increase the risk that negative religious stereotypes and preconceptions will go unchallenged and thus remain entrenched.

Interestingly, the minority status of religious individuals in academic psychology does not seem to apply to clinical psychology practiced outside of academia. As mentioned in Barrier 1, overall it appears that the percentage of mental health professionals with religious views mirrors the overall US population. Oxhandler and colleagues (2017) found in a sample of five helping professions in Texas (psychologists, licensed professional counselors, advanced practice nurses, licensed marriage and family therapists, and licensed clinical social workers) that the overall majority attended religious activities several times or more a month. However, about half of the licensed clinical social workers (55.9%) and psychologists (46.8%) reported rarely or never attending religious services. In terms of nonorganized religious activities, 83.9% of licensed marriage and family therapists and 81.6% of licensed professional counselors participated in private religious activities once a week or more. A lower, but still significant, number of psychologists (56.4%) participate in some variety of private religious activities at least once per week. Provided that these findings are generalizable, this suggests there are a significant number of religious individuals among practitioners despite their relative minority status within academia. This calls into question whether the research being generated inside of predominantly secular academia is sensitive to the beliefs and perspectives of the religious clinicians that will need to implement such research in the field.

Proposed Solutions

It is important to note that one does not necessarily need to be religious to study religion. Furthermore, not all religious individuals in psychology should study religious topics. However, having an insider perspective on religious institutions and beliefs can provide a unique and useful perspective, particularly in cases such as developing treatments that will be implemented for religious clients or by religious therapists.

Unfortunately, the reality that religious individuals are a minority in academia is a problem without a simple solution. One necessary step is to identify at the organizational level factors that make academia less welcoming to individuals of religious belief. The reported hostilities reported toward religion may be a prime factor in discouraging religious individuals from pursuing careers in academia. After determining what these factors are, empirically based action will be needed to reduce them. Simply raising awareness about these issues is unlikely to solve the problem. A number of articles have been published detailing the resistance that religious individuals face in academia (Inbar & Lammers, 2012; Rosik et al., 2016; Rosik & Smith, 2009), thus raising some awareness of these issues. However, little progress has been made in resolving these difficulties. Instead of focusing exclusively on awareness of potential religious discrimination, faculty members should also cultivate their own skills for identifying and helping religious individuals who are experiencing discrimination. When intolerance and discrimination are detected, faculty members in a position of power can approach the student or junior faculty member involved in order to offer support, provide a safe place to discuss the experiences, and help devise effective solutions to the individual's difficulties. A willingness to provide this sort of aid to students and fellow colleagues who are experiencing religious discrimination may help to increase the number of religious individuals willing to pursue a career in academia.

Student groups offer another alternative solution to the problem of underrepresentation of religion in academia. Psychology programs could encourage religious students and faculty to form groups focused on supporting diversity in religion with academia. These groups can serve as forums where differing views on religion can be expressed openly in the spirit of finding common ground. Additionally, they can act as gathering points where students of diverse religious backgrounds as well as nonreligious students can interact positively, thus providing an opportunity for positive intergroup contact. Providing such an environment where these issues can be discussed without fear of reprisal from nonreligious students and faculty may also serve to strengthen the commitment of religious students to continue a career in academia.

Regardless of the particular form of the solution, action is needed to ensure that academia's overwhelming secular orientation does not become desensitized to the religious needs the majority of Americans still have. Due to the privileged influence that religion (and especially Christianity) still wields in other areas of American society, it may be difficult for many to recognize the need to prevent academia from excluding religious individuals. However, this focus on broad societal level movements (such as the changing power of religion in our culture more broadly) may present another barrier to resolving the conflicts between religion and psychology.

Barrier 3: Conflicting Priorities: Social Movements Versus Individual Interactions

There are a number of considerations that may potentially influence how decisions are made regarding issues of religion in clinical and training environments, especially when religious factors are involved. Two particularly important forces are the ideographic needs of individual interactions and pressures from large societal movements. Individual interactions involve exchanges between patient and therapist or trainee and supervisor. Such interactions can include, for example, a clinician prescribing a treatment that is optimal for a particular patient's presenting problem, given the context of that patient's culture and religious belief system. Societal level issues, on the other hand, are concerned with changes in demographics and shifts in popular opinion and beliefs, such as opinions regarding religion or the LGBTQ community. While such societal level movements are of great importance, in the field of psychology there is a danger that large-scale concerns could overshadow the significance of the person-to-person interactions. This is particularly troubling in clinical applications, where the individual interactions are the key to therapeutic success and good patient care. The danger lies in allowing decontextualized rules based on abstract social movements to dictate decisions in training and clinical contexts that may not take into consideration what action is best for the patient or student.

An article by Russell and Bohan (2014) provides a clear example of the problems of allowing societal level issues to supersede individual level factors in therapy and training. They proposed a possible solution to the specific issue of religiously based value disagreements between a therapist and patient or a supervisor and trainee. Their article argues that conservative Christian therapists do not, in actuality, experience religious value conflicts. Russell and Bohan argued that a disagreement between a conservative Christian therapist and a patient over a matter involving religious belief (e.g., sexual orientation or contraception) does not reflect a disagreement between two differing sets of personal values and morals. Instead, the distress felt by the conservative Christian therapist is merely their reaction to losing his or her previously favored status in society and the accompanying loss of power and privilege. Russell and Bohan suggest that by informing trainees that their conflict is in reality a reaction to societal level issues (power, privilege, and the changing demographics of the USA) instead of the interpersonal factors (the value conflict between patient and therapist and determining what course of action is in the best interests of the patient), the conflict should become easier for the therapist to resolve.

This perspective of replacing the focus on the therapist-patient interaction with a focus on more abstract, societal-level conflicts is problematic for several reasons. The message that a supervisee's perceived moral dilemma is simply a symptom of larger social changes may have the unintended effect of invalidating the supervisee's concerns. This may, in turn, result the supervisee becoming more hesitant to seek advice from the supervisor in the future. For supervisees who hold strong moral values that might contradict their patients' values, it is critical that they are encouraged rather than (even unintentionally) discouraged from seeking supervision on these issues, which may be particularly challenging for them to navigate with patients. Moreover, is not clear that such a reconceptualization will lead to improved patient/therapist interactions (however, this could be empirically examined). This last point is of particular importance to the field. Cases such as *Ward vs. Polite* seem to demonstrate a concerning trend to judge clinical or training decision by whether they agree with particular social movements instead of whether the action was in the best interest of the ideographic situation. For example, it is possible that the decision Ms. Ward made to refer her client may have resulted in the client receiving better and more sensitive clinical care. Furthermore, many of these decisions are being made in the absence of clear empirical data, which could potentially serve as a better arbiter in deciding how to best handle individual level interactions such as religiously based value disagreements.

Barrier 4: Conflicting Priorities: Bias-Free People Versus Bias-Free Processes

Another source of influence in clinical and training decision-making processes regarding religion has been the suggestion that researchers and clinicians completely eliminate their personal biases. For example, phrase such as "check your biases at the door" is used in trainings to convey the idea it is possible for a clinician to completely remove biases while delivering therapy. (Note, however, that bias is a broad concept, and despite the proposed ideal of objectivity, it is unlikely that psychologists would truly want to eliminate all biases, for example, it may be beneficial to preserve biases in favor of tolerance and acceptance.) Overall, being bias free is a deeply entrenched idea inside the field of mental health. The APA has codified the idea of the Code of Ethics, stating in General Principle E (Respect for People's Rights and Dignity), that psychologists should try to eliminate from their work biases derived from factors including differences in religion, age, gender, etc. (APA, 2017).

While certainly idealistic, suggesting that therapists become completely bias free may be impractical. Limited empirical data exists on how to effectively reduce bias, especially in the context of psychotherapy and psychological training. Thus far, research has suggested that biases can be reduced, but that it likely requires a prolonged and intensive effort (Gonzalez, Kim, & Marantz, 2014). For example, Gonzalez et al. (2014) implemented a bias reduction intervention where medical students attended a 2-hour class focusing on bias and disparities in healthcare. In this study, Gonzalez, Kim, and Martin reported that after the educational intervention, 65% of the participants reported that they were aware that they had a favorable bias toward people who were similar to themselves. Additionally, these students were more likely to believe that there are disparities in the US healthcare system. Gonzalez and colleagues concluded that additional sessions would be needed to convince the "deniers" that there are indeed disparities in the American healthcare system and that their personal biases may influence their decision-making. Unfortunately, this was a one-time study with no pretest data and no follow-up. Therefore, it is impossible to determine if the intervention had any impact on student beliefs, despite the stated goal of building an educational intervention targeting student bias. This study also focused only on raising awareness, rather than promoting specific skills or competencies for reducing bias while interacting with patients. These limitations highlight the overall lack of empirical data supporting effective and enduring programs of bias reduction.

Furthermore, the emphasis on becoming bias-free clinicians and researchers may inadvertently discourage discussion and research about the problems this perspective is supposed to be resolving. Simply restating the ideal of "be bias free" appears to have become the overly simple solution to the complex interpersonal problem of bias. This simple solution then, in turn, potentially inhibits further empirical research into how to best handle bias in training and clinical contexts.

Solution to Barriers 3 and 4: Empirical Decision-Making

Interestingly enough, both barriers 3 and 4 may share a common solution. A better alternative to the problems discussed above could be to refocus attention on evaluating psychologists' decision-making processes. Specifically, the field can emphasize the importance of using solid scientific data when making treatment and training decisions with regard to religion (among other areas). Reliance on empirical decision-making also takes advantage of what cosmologist Carl Sagan called the error-correcting machinery of science (Sagan, 1996). Individual scientists are by no means perfect; however, the scientific process has built in mechanisms for identifying and correcting individual's biases and error. Mental health professionals are free to, and should, evaluate and critique empirical findings and methods, thus facilitating the detection of errors and biases. Different methods of resolving the religious conflict can be tested against each other and objective data can be used to determine the best approaches. This shifts the responsibility for detecting and reducing bias from individual professionals to the entire field of psychology. Should biased or prejudicial research be published, the scientific community itself can help correct the errors through the peer review process and via additional research.

Furthermore, empirical decision-making resolves many of the issues raised in previous two sections and helps to refocus the attention of the field onto the ideographic needs of each patient or student. Despite the limitations of empirical research, decision-making based on data is nonetheless grounded in what has been shown to actually work, rather than on relatively ambiguous value statements (e.g., based on social movements or the general idea of being "bias free"). Furthermore, training clinicians and students on what is empirically the best treatment options for their patients may be less time consuming than programs designed to reduce bias or appeals to larger social issues (Gonzalez et al., 2014). Utilizing empirical decision-making also allows for clear decision rules when evaluating students and trainees. The treatment decisions of supervisees can be examined against empirical evidence to determine if their choices were in line with what research suggests may be in the best interest of the patient, instead of comparing their decisions to unclear and imprecise mandates. If a student is in error, such data can also provide clear suggestions on what they should have done and what to do in the future. In essence, this perspective assumes that religious sensitivity is a skill to select appropriate treatment options instead of an innate ability to suspend the impact of bias. Skills, for the most part, can be taught (although much work still remains to empirically define best practices in religious sensitivity; see section "Barrier 6: Deficits in Religious Sensitivity Training").

Koenig and colleagues (2015) provide an excellent example of the type of data needed for unbiased, empirically based, ideographic clinical decision-making. They compared religiously tailored cognitive behavioral therapy (CBT) to conventional CBT in order to gauge which was more effective at reducing depressive symptoms in patients with chronic illnesses. The researchers found that both therapies were equally effective at reducing patient symptoms over the course of treatment. However, they also found that religiosity seemed to interact with the treatment group (traditional CBT vs. religiously tailored CBT). Their findings suggest that for patients who were more religious, religiously tailored CBT may be more efficacious and could potentially lead to better treatment adherence. While the study had a number of limitations (such as not controlling for the religious beliefs of the therapist), the findings are nevertheless useful should further research continue to support them. The results illustrate that in many cases religiously tailored interventions may not necessarily increase the efficacy of therapy. However, for cases in which patients are particularly high in religiosity, tailoring therapy around their beliefs may increase treatment adherence and improve outcomes. Overall, both empirically driven results can serve to inform efforts to develop best practices that are sensitive to the needs of individual patients and their unique life circumstances.

Finally, empirical decision-making in the context of training and clinical work avoids the pitfalls associated with following the trends of large, societal level movements. Public opinion is an unreliable measure of what behaviors can be considered ethical. For example, previously cited evidence suggests that discrimination against religious individuals in the field of mental health occurs with relative regularity and may even be condoned by some individuals (see section "Antagonism Toward Religion"). However, it is becoming increasingly inappropriate to show similar discrimination against minority groups. Fifty years ago, this situation would have been reversed (i.e., discrimination against religion was relatively less common in previous decades, and discrimination against minorities occurred more frequently). Clearly, discriminations on the basis of ethnicity, race, and religion are all highly unethical practices. Therefore, relying on public opinion to determine what constitutes unacceptable bias is an unreliable method for making clinical decisions. Instead, clinicians can rely on the empirical process, and its self-correcting processes, to decide what is likely to be best for their patients. This eliminates the guess work of what treatment and training decisions would be politically acceptable as well as the risk that those politically acceptable decisions might actually be iatrogenic for students or trainees.

However, it is vital to note that the approach of relying on empirical decision-making practices depends upon having accurate information available in the literature to call upon. Currently, the research literature regarding how to approach a student's or client's religious beliefs in a sensitive way is extremely limited. There is a similar lack of research in how to effectively train and supervise students in religiously sensitive practices and behaviors. This gap must be addressed in order to improve clinicians' abilities to make bias-free decisions and improve their understanding of how religion impacts the ideographic needs of their patients.

Barrier 5: Lack of Empirically Based Practice Guidelines

The Problem

The overall lack of empirically supported practices in navigating religious issues in teaching, supervision, and therapy is another serious barrier. Some general principles, such as the principles of beneficence and nonmaleficence, can to some extent provide helpful general guidance for making decisions (i.e., which of the available options will be in the best interest of the patient and least likely to cause harm). In general, however, there seems to be a disconnect in translating general policies into more specific, evidenced-based practices. The APA's statement, "Addressing Conflicts between Professional Competence and Trainee Beliefs" (APA, 2013a, 2013b), provides an example of this disconnect in its proposal of general values and ideas as opposed to more specific practices. The document is intended to provide guidance for situations in which student beliefs may interfere with delivering competent therapeutic care (APA, 2013a, 2013b). The guidelines state that disagreements between a trainee's worldview and the policies of the program should be worked though "in a developmentally sound manner to navigate value- or belief-related tensions that negatively impact professional competence" (APA, 2013a, 2013b, p. 1). However, without additional research into what a "developmentally sound manner" actually is, or what such pedagogical methods entail, the guidelines unfortunately provide little help to supervisors and program developers. Other areas of the guidelines are similarly vague, such as asking programs to determine a "consistent" approach to respond to trainee value disagreements; such statements offer no direction on what these "consistent" policies should be (APA, 2013a, 2013b). Overall, the principles discussed are nonspecific value statements, and while general principles are helpful, there are no clear guidelines for resolving situations, such as the one raised by *Ward v. Polite* or any of the other preceding court cases. The *Ward v. Polite* case is especially instructive, as the court and the school came to two different conclusions regarding the appropriateness of Ms. Ward's actions, and either action could be supported by the APA's ethical principles. The school's decision to terminate Ms. Ward could be supported under the APA's justice principle, which details the importance of protecting minority populations from discrimination (APA, 2017). However, the court's finding that Ms. Ward had not behaved in an unethical fashion can be defended using the APA's principle of beneficence and nonmaleficence. The court decided that the point of her referral was to avoid imposing her values on gay and lesbian clients, thus complying with the ethical principles of not engaging in behavior that will potentially harm patients or the therapeutic process. Drawing such differing conclusions is an indicator that, in addition to setting good intentions with the statement of overall principles, the field could greatly benefit from more specific guidelines on how these principles should be implemented.

Proposed Solutions

The overall idea of providing general principles is not necessarily faulty, as it is impossible to write policy for every possible situation. However, general and nonspecific principles mandating religious sensitivity cannot be used to replace empirical research regarding best practices for improving religious competency in the field of psychology. Therefore, we propose a fourfold solution to this particular problem. First, the field needs to clarify what foundational principles should take priority in making decisions. As we have argued in this chapter, the principle of beneficence and nonmaleficence could be used as arbiter in disagreements between other values. Second, the field should put forth testable (i.e., specific and falsifiable) hypotheses regarding the most helpful techniques for resolving value conflicts (due to religion or other value judgments), both between trainees and supervisors and also between clinicians and patients. Third, these hypotheses should be subjected to empirical study. Fourth, once these hypotheses are empirically validated, they should be implemented as guidelines. The guidelines should not be set in stone, but should be revised constantly in the light of new empirical data, in line with general scientific methodology. This way, practices can be written that do not outpace our empirical knowledge in these areas, which is admittedly sparse at the moment (Knox et al., 2005).

Part of the search for empirically based practice guidelines should include the explosive growth of pastoral-based counseling (Sperry & Shafranske, 2005). Clinicians should know how and when to incorporate pastoral counseling (or when to provide a referral for it) and in what circumstances pastoral counseling may be more effective as a primary treatment modality. Additionally, researchers should investigate which situations, populations, and diagnoses are best helped by a pastoral counseling approach. Armed with such research, pastoral counseling can become an even more effective tool in clinical psychology's repertoire of treatment methods.

Barrier 6: Deficits in Religious Sensitivity Training

The Problem

Unfortunately, few empirical data exist on best practices in religious sensitivity training in general. Religious topics themselves tend to be ignored or undervalued in current course of psychological training. This deficit in religious sensitivity training has persisted for a number of decades. For example, in their review of the clinical literature, Shafranske and Malony (1996) found that 85% of psychologists reported that religious topics were rarely, if ever, discussed during the course of their training. A more recent review by Vieten and colleagues' (2013) demonstrated a continuation of this trend. In their study, 90% of psychologists practicing in the early 2000s reported that spiritual beliefs and religion were not discussed at all during their training. This suggests a serious skill gap in which the majority of clinicians are not sufficiently prepared to handle religious issues. Because of the high rate of religious belief in the population of the USA, these issues are quite likely to arise in clinical training and practice.

In examining training programs, research by Schafer and colleagues (2011) found that only around one quarter of APA accredited training programs provide even one course in religion and spirituality. Building on this finding, research by Vogel, McMinn, Peterson, and Gathercoal (2013) found that the majority of surveyed APA accredited clinical and counseling psychology training programs neglect religion as an area of training entirely. Furthermore, respondents reported that when religion is addressed, it is often done so informally or unsystematically (Vogel et al., 2013). The research indicated trainees most often learn about religion and spirituality through direct clinical experiences (supervision and patient contact) as opposed to more structured course work. Although direct clinical experience with religious patients can provide an important component of training, it may be useful to supplement this with didactic training from professors and supervisors. This is important particularly in light of the Vogel and colleagues' (2013) finding that students depend primarily on peers (and to a lesser extent, supervisors) as sources of information on religion. This type of informal attention to religion does little to equip students with the skills necessary to interact successfully with clients of diverse religious backgrounds. Gathering religious information from a client first assumes that the therapist knows how to talk about religious matters with their client in a sensitive way. These findings suggest that it is unlikely that students receive enough, if any, didactic training on how best to approach these issues in therapy. This lack of effective instruction can translate to therapists feeling unable to talk about religion with their patients. Research has found that many LCSWs perceive that integration of religion into therapy is feasible, but report low levels of actually using a patient's spiritual beliefs in practice (Oxhandler et al., 2015). However, Oxhandler and colleagues also found that a major predictor of successfully using a patient's religion during treatment was previous didactic training. Therefore, effective didactic training may be a crucial component in better preparing mental health professionals to serve religious patients.

The preceding research points to a severely impoverished training regimen with regard to religion and spirituality in the field of psychology. This lack of training puts the field at a significant disadvantage, as it hampers both attempts at research and at resolving potential conflicts such as the *Ward v. Polite* case. On the side of supervision, if a supervisor also lacks the necessary competency and training on religious issues, it becomes difficult to provide competent supervision to students and interns. Therefore, a supervisor with little to no experience or training in religious issues will potentially struggle when confronted with a training issue involving a conflict of values. In such cases, supervisors with limited training in religious issues may avoid discussing religion as part of the supervisory process, resulting in training deficits in their students. This, in turn, then feeds the observed cycle of poor training in religious sensitivity. In terms of research, psychology is constantly attempting to evaluate programs to verify their effectiveness. However, in the case of religious sensitivity, we have been unable to assess which programs work and which do not because so there are so few currently in operation. Obtaining these data is absolutely vital, as it will be impossible to assess whether training programs in religious sensitivity are having the desired effects. Limited empirical data does exist regarding the effectiveness of religious sensitivity training, although up to date research is needed to confirm if these findings still hold true. Shafranske and Malony (1996) found in reviewing clinical literature that only a third of clinical psychologists reported having personal competence in interacting with their client's religious beliefs. Oxhandler and colleagues (2015) found that social workers report much higher levels of self-efficacy with respect to integrating religious topics into treatment. However, this feeling of competency is overshadowed by low rates of actual instances of using religion in the context of therapy. For example, 58.5% of LCSWs surveyed report routinely involving their clients in deciding whether or not religion should be integrated into therapy. Additionally, 58.7% stated that they rarely or never use empirically supported interventions that outline how to best integrate a client's religious belief into treatment. These findings demonstrate a need to improve education in religious sensitivity in the context of therapy.

Unfortunately, it appears that religious sensitivity training or skill development does not improve once students leave the class room for the clinical field. Oxhandler et al. (2015) surveyed 442 LCSWs from across the USA to assess their views about and behaviors toward patient religion. They found that a sizable number (43.6%) of clinicians surveyed rarely or never consult empirical research when making clinical decisions involving the patient's religion. The previously discussed lack of empirical data on best practices when dealing with religion can partially explain this finding. The results were even more startling for rates of consultation, with 47.5% of clinicians rarely or never seeking consultation regarding religious issues with their clients. This last finding can somewhat be explained by the time it takes to obtain competent consolation on religious issues, or perhaps the overall lack of availability of such expertise. However, in the age of the internet, it becomes increasingly unlikely that no expert could be found for the purposes of consulting on a religious case. Being unaware of empirical findings and failing to obtain competent consultation make empirically based clinical decision increasingly more difficult.

Proposed Solutions

Examining Client Needs Research has revealed several potential pathways to improve religious sensitivity training. An important first step is investigating what kinds of experiences religious people expect to have in therapy, as well as their expectations regarding how their therapist will treat them. Mayers et al. (2007) found that religious patients valued acceptance, respect, and understanding. Furthermore, the researchers stated that a willingness to work with the patient's perspective on presenting problem and potential solutions enhanced the development of a sound therapeutic relationship. More research is needed to confirm that when the therapist conforms to these preferences, they result in better outcomes.

Interestingly, the aforementioned factors of acceptance, respect, understanding, and so forth are many of the same treatment nonspecific factors advocated by Carl Rogers (1995). Regardless of the theoretical orientation, these foundational skills for building a strong therapeutic relationship are taught and practiced widely in the vast majority of therapy training programs. This raises an important question for empirical investigation. Many training programs teach the use of these foundational skills; but are they alone sufficient to create a religiously sensitive therapeutic environment? If these basic skills are sufficient and they are being taught effectively to trainees, then it would be expected that current religious patients would feel sufficiently accepted and supported. However, it is unclear if providers are able to effectively use these basic skills in the context of religious discussions with their patients. Additionally, patients still report concerns that their therapist will be invalidating with regard to religion or attempt to impose their own values onto the patient (Harris, Randolph, & Gordon, 2016). It will be vital to determine if there is a difference between the kinds of skills that religious patients are asking therapists to have and the basic Rogerian skills that are often taught in clinical training programs. The field needs to determine if there is something about the topic of religion in psychotherapy that makes it difficult or insufficient for therapists to simply apply the basic Rogerian therapeutic skills of being genuine and empathetic and displaying unconditional positive regard toward their patients.

Examining Training and Supervision As stated before, it is not clear how effective our current method of informally addressing religious matters during training is at equipping therapists to navigate value conflicts and other dilemmas during practice. However, it is clear that despite general trainings in diversity and ethics, the prejudice against religious individuals is still relatively the common field itself (e.g., Rosik et al., 2016; Thyer & Myers, 2009). Therefore, change is needed in how we train clinicians and academics alike. Aten and Hernandez (2004) provide a supervisory framework for integrating religious topics into clinical training. This framework will require additional empirical work to verify its effectiveness. However, it provides an excellent foundation to guide the development of new training programs. Their model is divided into eight separate skill domains. For example, one domain is knowing what evidenced-based religious interventions exist (such as religiously tailored CBT techniques) and knowing when it would be appropriate to use them. Additional domains include being trained in methods of assessing the influence and impact of religion on a patient's life and their presenting problem, as well as helping supervisees see how their personal actions and/or convictions are helping or hindering the therapeutic process. This last domain is especially important and appears to be largely avoided in current training models. By not discussing religious topics in training, students who are not religious may be deprived of the skills they need to interact with religious patients. However, religious students are also placed at a disadvantage, as they lose the opportunity to learn how to identify when their own religious beliefs may be influencing the therapeutic process. Programs can use this model as a guide to identify the skills students should develop during religious sensitivity training and to assess whether the skills were acquired.

Another, more specific, practice is the so-called "know-nothing" approach. First coined by Anderson and Goolishian (1992), it was adapted for religious use (specifically for treating Muslim couples) by Springer, Abbott, and Reisbig (2009). The know-nothing stance requires therapists to approach religion by assuming they know close to nothing about it. Even if they have expertise about religion in general, they may not understand how a patient's specific religious beliefs and practices influence them on a personal, day-to-day basis. By taking the position of not knowing about the patient's religion ahead of time, the clinician is encouraged to ask the patient to teach the clinician about how the patient's religion impacts their daily life. Additionally, therapists are encouraged to approach a patient's religion with curiosity and a desire to understand it, instead of either ignoring it or being afraid of it. The know-nothing stance does not necessarily replace efforts to educate oneself on the basic tenants of religious groups. Instead, it provides therapists with an improved toolset in determining how religion influences the daily life of an individual patient. In theory, this should lead to improvements in therapists' understanding of patient religions, as well as enhanced rapport and trust. However, like most techniques described in this section, empirical verification of the "know-nothing" approach is needed. While this strategy has a number of theoretical advantages, the pragmatics of training clinicians in using the perspective are also not known. Questions regarding how to best instruct students in this technique need to be thoroughly investigated.

Another potential method of religious sensitivity training relies on the well-documented effects of intergroup contact (Hewstone & Swart, 2011). Intergroup contact theory states that personal, positive contact with members of an outgroup leads to reduced intergroup tensions and reduced intergroup bias. However, such intergroup contact may be missing from many diversity trainings. If diversity trainings focus on large, societal level categories (as suggested by Sue, 2001), then there is the possibility that such training can effectively serve to reinforce, rather than diminish, stereotypes. If students, instead, had the opportunity to personally meet and interact with various members of religious groups in positive settings, tension and biases could be significantly reduced. It is, however, not feasible for a student to meet a member of every religion they are likely to encounter during their training. Thus, such a regimen of intergroup contact could be complimented with a general skills training from the know-nothing approach, focusing on how to sensitively elicit information from a patient about the role and impact of religion in their life. Intergroup contact theory also states that positive interactions with members of outgroups tend to generalize beyond an initial encounter (Hewstone & Swart, 2011). That is, after having a positive interaction with an outgroup member, individuals tend to evaluate that specific person as well as other members of that outgroup more positively, leading to an overall decrease in negative bias. Therefore, facilitating positive interactions between students, faculty, and members of religious groups has the potential to significantly improve how psychologists view religion.

Role-play and modeling should additionally help students become more comfortable with conversations about religious issues. Beidas and Kendall (2010) found that trainings with role-plays lead to behavior change in therapists that is more robust than trainings without. The practice component inherent in role-plays is especially important, as one potential reason for the reluctance of many therapists to discuss religious matters could be fear of offending a client or fear of committing a microaggression. In behavioral therapy, one of the most effective ways of overcome fears is through the use of exposure, and in a parallel fashion, simply practicing the talking about religion through the use of role-play may accomplish that function. Such skills can also be applied to supervisors, who also need to be able to discuss religion with their supervisees, including learning about how religion impacts supervisees' work as therapists and researchers. Role-plays and other more skill-based interventions for supervisors may be another, more practical solution to the problems discussed previously. Role-plays can allow supervisors to learn and practice improved techniques for validating a student's religious experience. This in turn will help supervisors avoid inadvertently minimizing religious conflicts by labeling them as "mere" power conflicts (see section "Barrier 3: Conflicting Priorities: Social Movements Versus Individual Interactions"). The stage will then be set for a more collaborative way of solving religious differences encountered during training or clinical practice.

Conclusions

The strained relationship between psychology and the religious has continued for far too long. Modern psychology, which is founded on principles of acceptance, tolerance, and a respect for diversity, must divest itself of the prejudices and biases which have led to discrimination against religious groups and individuals. At the same time, a concerted effort must be made to better understand how to resolve religious conflicts that occur both in training and in the clinical sphere. Finding solutions to these conflicts and respecting religious diversity are goals that many individuals in the mental health field support. Despite this consensus, there has been little to improvement in the conflicts between psychology and the religious in close to 30 years (Lehr & Spilka, 1989; Parent et al., 2018). This chapter has enumerated several barriers that may be contributing to this lack of progress. The proposed solutions will hopefully provide a framework for rigorous empirical investigations leading to practical methods for resolving each barrier and improving how the mental health field interfaces with religion. The prime directives of beneficence and nonmaleficence are key to this endeavor. They remind clinicians and researchers alike that client welfare and empirical decision-making must be the arbiters of value conflicts, not popular ideas or what is currently in vogue politically. To continue to ignore and incorrectly conceptualize religious conflicts with the mental health field issues does a disservice to both religious individuals and the field of psychology as a whole. Millions of American still claim some type of religious belief (CIA, 2018), and such beliefs likely have an important impact on mental health treatment, on supervisor/supervisee relationships, and in the development of psychological theories. We should strive to make psychology a science and a profession where all are welcome and can coexist and learn from one another.

References

Almeida, J., Johnson, R. M., Corliss, H. L., Molnar, B. E., & Azrael, D. (2009). Emotional distress among LGBT youth: The influence of perceived discrimination based on sexual orientation. *Journal of Youth and Adolescence, 38*(7), 1001–1014.

American Psychiatric Association. (1952). *Diagnostic and statistical manual of mental disorders* (1st ed.). Washington, DC: American Psychiatric Association.

American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). Washington, DC: American Psychiatric Association.

American Psychiatric Association. (1973). *Homosexuality and sexuality orientation disturbance: Proposed change in DSM-II, 6th printing, page 44*. Washington, DC: The American Psychiatric Association. APA Document Reference No. 730008.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Arlington, VA: American Psychiatric Association.

American Psychological Association. (2005, August). 113th Annual Convention Program. [Brochure] Washington, DC.

American Psychological Association. (2009). *Report of the American Psychological Association task force on appropriate therapeutic responses to sexual orientation*. Washington, DC: American Psychological Association.

American Psychological Association. (2013a). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Association.

American Psychological Association. (2013b). *APA policy statements on LGBT concerns.* Retrieved November 29, 2018, from American Psychological Association: https://www.apa.org/pi/lgbt/resources/policy/diversity-preparation.pdf

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct*. Retrieved July 2018, from American Psychological Association: https://www.apa.org/ethics/code/

Anderson, H., & Goolishian, H. (1992). The client is the expert: A not-knowing approach to therapy. *Therapy as Social Construction*, 25–39. In N.Cummings, W. O'Donohue, & J. Cummings (Eds.), *Therapy as social construction* (pp. 7-24). London, UK: Sage Publications, LTD.

Aten, J. D., & Hernandez, B. C. (2004). Addressing religion in clinical supervision: A model. *Psychotherapy: Theory, Research, Practice, Training, 41*(2), 152–160.

Barranco, R. E. (2016). Suicide, religion, and Latinos: A macrolevel study of US Latino suicide rates. *The Sociological Quarterly, 57*(2), 256–281.

Beidas, R. S., & Kendall, P. C. (2010). Training therapists in evidence-based practice: A critical review of studies from a systems-contextual perspective. *Clinical Psychology: Science and Practice, 17*(1), 1–30.

Boggs, L. W. (1838). *The Missouri Mormon War Executive Orders.* Retrieved 2018 October, from Missouri Secretary of State Recors and Archives: https://www.sos.mo.gov/archives/resources/findingaids/miscMormonRecords/eo

Bruff v. North Mississippi Health Services, Inc. (2001). Retrieved November 29, 2018, from http://www.ca5.uscourts.gov/opinions/pub/99/99-60175.cv0.wpd.pdf

Byrd, A. D. (2009). Psychology's assault on religion: A case for Mormonism. In N. Cummings, W. O'Donohue, & J. Cummings (Eds.), *Psychology's war on religion* (pp. 173–209). Phoenix, AZ: Zeig, Tucker, & Theisen, Inc..

Centeral Intelligence Agency. (2018, August 07). *United States*. Retrieved August 13, 2018, from CIA World Fact Book: https://www.cia.gov/library/publications/the-world-factbook/geos/us.html

Cox, D., Navarro-Rivera, J., & Jones, R. P. (2014). *A Shifting landscape: a decade of change in american attitudes about same-sex marriage and LGBT Issues*. Washinton, DC: Public Religion Research Institute.

Cummings, N., O'Donohue, W., & Cummings, J. (Eds.). (2009). *Psychology's war on religion*. Phoenix, AZ: Zeig, Tucker, & Theisen, Inc.

Ecklund, E. H., Johnson, D. R., Scheitle, C. P., Matthews, K. R. W., & Lewis, S. W. (2016). Religion among scientists in international context: A new study of scientists in eight regions. *Socius, 2*, 2378023116664353.

Ecklund, E. H., & Scheitle, C. P. (2007). Religion among academic scientists: Distinctions, disciplines, and demographics. *Social Problems, 54*(2), 289–307.

Ellis, A., & Murray, J. G. (1985). *The case against religion: A psychotherapist's view and the case against religiosity*. Austin, TX: American Atheist Press.

Ford, J. G. (2002). Healing homosexuals: A psychologist's journey through the ex-gay movement and the pseudo-science of reparative therapy. *Journal of Gay & Lesbian Psychotherapy, 5*(3–4), 69–86.

Gonzalez, C. M., Kim, M. Y., & Marantz, P. R. (2014). Implicit bias and its relation to health disparities: A teaching program and survey of medical students. *Teaching and Learning in Medicine, 26*(1), 64–71.

Grant, J. E., Odlaug, B. L., Derbyshire, K., Schreiber, L. R., Lust, K., & Christenson, G. (2014). Mental health and clinical correlates in lesbian, gay, bisexual, and queer young adults. *Journal of American College Health, 62*(1), 75–78.

Gros, D. F., Morland, L. A., Greene, C. J., Acierno, R., Strachan, M., Egede, L. E., et al. (2013). Delivery of evidence-based psychotherapy via video telehealth. *Journal of Psychopathology and Behavioral Assessment, 35*, 506–521. https://doi.org/10.1007/s10862-013-9363-4

Hage, S. M., Hopson, A., Siegel, M., Payton, G., & DeFanti, E. (2006). Multicultural training in spirituality: An interdisciplinary review. *Counseling and Values, 50*(3), 217–234.

Hancock, K. A. (2014). Student beliefs, multiculturalism, and client welfare. *Psychology of Sexual Orientation and Gender Diversity, 1*, 4–9. https://doi.org/10.1037/sgd0000021

Harris, K. A., Randolph, B. E., & Gordon, T. D. (2016). What do clients want? Assessing spiritual needs in counseling: A literature review. *Spirituality in Clinical Practice, 3*(4), 250.

Hewstone, M., & Swart, H. (2011). Fifty-odd years of inter-group contact: From hypothesis to integrated theory. *British Journal of Social Psychology, 50*(3), 374–386.

Hodge, D. R. (2009). Secular privilege: Deconstructing the invisible rose-tinted sunglasses. *Journal of Religion & Spirituality in Social Work: Social Thought, 28*(1–2), 8–34.

Hodge, D. R., Baughman, L. M., & Cummings, J. A. (2006). Moving toward spiritual competency: Deconstructing religious stereotypes and spiritual prejudices in social work literature. *Journal of Social Service Research, 32*(4), 211–231.

Hong, J. S., Woodford, M. R., Long, L. D., & Renn, K. A. (2016). Ecological covariates of subtle and blatant heterosexist discrimination among LGBQ college students. *Journal of Youth and Adolescence, 45*(1), 117–131.

Hout, M., & Fischer, C. S. (2014). Explaining why more Americans have no religious preference: Political backlash and generational succession, 1987–2012. *Sociological Science, 1*, 423–447.

Houts, A. (2009). Reformed theology is a resource in conflicts between psychology and religious faith. In N. Cummings, W. O'Donohue, & J. Cummings (Eds.), *Psychology's war on religion* (pp. 257–313). Phoenix, Arizona: Zeig, Tucker, & Theisen, Inc.

Hyers, L. L., & Hyers, C. (2008). Everyday discrimination experienced by conservative Christians at the secular university. *Analyses of Social Issues and Public Policy, 8*(1), 113–137.

Inbar, Y., & Lammers, J. (2012). Political diversity in social and personality psychology. *Perspectives on Psychological Science, 7*(5), 496–503.

Jackson, K. P. (2000). Are Mormons Christians? Presbyterians, Mormons, and the question of religious definitions. *Nova Religio, 4*(1), 52–65.

James, W. (1928). *The varieties of religious experience: A study in human nature*. New York: Longmans, Green & Co.

Jenkins, C. (2006). *A voice denied: Clients' experience of the exclusion of spirituality in counselling and psychotherapy* (Doctoral dissertation). University of Manchester.

Jones, R. P., Cox, D., & Navarro-Rivera, J. (2014). A shifting landscape: *A decade of change in American attitudes about same-sex marriage and LGBT issues*. Washington, DC: Public Religion Research Institute.

Jordanova, V., Crawford, M. J., McManus, S., Bebbington, P., & Brugha, T. (2015). Religious discrimination and common mental disorders in England: A nationally representative population-based study. *Social Psychiatry and Psychiatric Epidemiology, 50*(11), 1723–1729.

Kelleher, C. (2009). Minority stress and health: Implications for lesbian, gay, bisexual, transgender, and questioning (LGBTQ) young people. *Counselling Psychology Quarterly, 22*(4), 373–379.

Knox, S., Catlin, L., Casper, M., & Schlosser, L. Z. (2005). Addressing religion and spirituality in psychotherapy: Clients' perspectives. *Psychotherapy Research, 15*(3), 287–303.

Koenig, H. G., Pearce, M. J., Nelson, B., Shaw, S. F., Robins, C. J., Daher, N. S., et al. (2015). Religious vs. conventional cognitive behavioral therapy for major depression in persons with chronic medical illness: A pilot randomized trial. *Journal of Nervous and Mental Disease, 203*, 243–251. https://doi.org/10.1097/NMD.0000000000000273

Lehr, E., & Spilka, B. (1989). Religion in the introductory psychology textbook: A comparison of three decades. *Journal for the Scientific Study of Religion, 28*(3), 366–371.

Lilienfeld, S. O. (2017). Microaggressions: Strong claims, inadequate evidence. *Perspectives on Psychological Science, 12*(1), 138–169.

Marsden, G. M. (2015). Religious discrimination in academia. *Society, 52*(1), 19–22.

Masuda, A. & O'Donohue, W. (2009). Buddhims: It's chic, but they could have it wrong. In N. Cummings, W. O'Donohue, & J. Cummings (Eds.), *Psychology's war on religion* (pp. 209–228). Phoenix, Arizona: Zeig, Tucker, & Theisen, INC.

Mayers, C., Leavey, G., Vallianatou, C., & Barker, C. (2007). How clients with religious or spiritual beliefs experience psychological help-seeking and therapy: A qualitative study. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice, 14*(4), 317–327.

Nicolosi, J. (1991). *Reparative therapy of male homosexuality*. Northvale, NJ: Jason Aronson.

Nicolosi, J., Byrd, A. D., & Potts, R. W. (2000). Retrospective self-reports of changes in homosexual orientation: A consumer survey of conversion therapy clients. *Psychological Reports, 86*, 1071–1088.

O'Donohue, W. (2009). The culture wars and psychology's alliance. In N. Cummings, W. O'Donohue, & J. Cummings (Eds.), *Psychology's war on religion* (pp. 3–21). Phoenix, AZ: Zeig, Tucker, & Theisen, Inc..

Oxhandler, H. K., Parrish, D. E., Torres, L. R., & Achenbaum, W. A. (2015). The integration of clients' religion and spirituality in social work practice: A national survey. *Social Work, 60*(3), 228–237.

Oxhandler, H. K., Polson, E. C., Moffatt, K. M., & Achenbaum, W. A. (2017). The religious and spiritual beliefs and practices among practitioners across five helping professions. *Religions, 8*(11), 237.

Parent, M. C., Brewster, M. E., Cook, S. W., & Harmon, K. A. (2018). Is minority stress in the eye of the beholder? A test of minority stress theory with Christians. *Journal of Religion and Health, 57*(5), 1–12.

Piller, M. (Writer), & Carson, D. (Director). (1993). Emissary [Television series episode]. In R. Berman. (Executive Producer), *Star Trek: Deep Space Nine*. Los Angeles, CA: Columbia Broadcasting System.

Platt, L. F., & Lenzen, A. L. (2013). Sexual orientation microaggressions and the experience of sexual minorities. *Journal of Homosexuality, 60*(7), 1011–1034.

Redding, R. E. (2012). Likes attract: The sociopolitical groupthink of (social) psychologists. *Perspectives on Psychological Science, 7*(5), 512–515.

Rogers, C. R. (1995). *On becoming a person: A therapist's view of psychotherapy*. Boston, MA: Houghton Mifflin Harcourt.

Rosik, C. H., & Smith, L. L. (2009). Perceptions of religiously based discrimination among Christian students in secular and Christian university settings. *Psychology of Religion and Spirituality, 1*(4), 207.

Rosik, C. H., Teraoka, N. K., & Moretto, J. D. (2016). Religiously-based prejudice and self-censorship: Perceptions and experiences among Christian therapists and educators. *Journal of Psychology & Christianity, 35*(1), 52–67.

Rosmarin, D. H., Alper, D. A., & Pargament, K. I. (2016). Religion, spirituality, and mental health. *Encyclopedia of Mental Health, 4*. https://doi.org/10.1016/B978-0-12-397045-9.00190-7

Russell, G. M., & Bohan, J. S. (2014). Toward a contextual understanding of psychology trainees' religious conflicts. *Psychology of Sexual Orientation and Gender Diversity, 1*(4), 293.

Sagan, C. (1996). *The demon haunted world: Science as a candle in the dark*. New York, NY: The Random House Publishing Group.

Schafer, R. M., Handal, P. J., Brawer, P. A., & Ubinger, M. (2011). Training and education in religion/spirituality within APA-accredited clinical psychology programs: 8 years later. *Journal of Religion and Health, 50*(2), 232–239.

Schlosser, L. Z., Ali, S. R., Ackerman, S. R., & Dewey, J. J. H. (2009). Religion, ethnicity, culture, way of life: Jews, Muslims, and multicultural counseling. *Counseling and Values, 54*(1), 48–64.

Shafranske, E. P., & Malony, H. N. (1996). Religion and the clinical practice of psychology: A case for inclusion. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 516–586). Washington, DC: American Psychological Association.

Shelton, K., & Delgado-Romero, E. A. (2011). Sexual orientation microaggressions: The experience of lesbian, gay, bisexual, and queer clients in psychotherapy. *Journal of Counseling Psychology, 58*, 210–221. https://doi.org/10.1037/a0022251

Shidlo, A., & Schroeder, M. (2002). Changing sexual orientation: A consumer's report. *Professional Psychology: Research and Practice, 33*, 249–259.

Smith, T. W. (2002). Religious diversity in America: The emergence of Muslims, Buddhists, Hindus, and others. *Journal for the Scientific Study of Religion, 41*(3), 577–585.

Sperry, L. E., & Shafranske, E. P. (2005). *Spiritually oriented psychotherapy*. Washington, DC: American Psychological Association.

Spitzer, R. L. (2003). Can some gay men and lesbians change their sexual orientation? Two hundred participants reporting a change from homosexual to heterosexual orientation. *Archives of Sexual Behavior, 32*, 403–417.

Springer, P. R., Abbott, D. A., & Reisbig, A. M. (2009). Therapy with Muslim couples and families: Basic guidelines for effective practice. *The Family Journal, 17*(3), 229–235.

Sue, D. W. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist, 29*(6), 790–821.

Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation*. Hoboken, NJ: Wiley.

Thyer, B. A., & Myers, L. L. (2009). Religious discrimination in social work academic programs: Whither social justice? *Journal of Religion & Spirituality in Social Work: Social Thought, 28*(1–2), 144–160.

Vieten, C., Scammell, S., Pilato, R., Ammondson, I., Pargament, K. I., & Lukoff, D. (2013). Spiritual and religious competencies for psychologists. *Psychology of Religion and Spirituality, 5*(3), 129.

Vogel, M. J., McMinn, M. R., Peterson, M. A., & Gathercoal, K. A. (2013). Examining religion and spirituality as diversity training: A multidimensional look at training in the American Psychological Association. *Professional Psychology: Research and Practice, 44*(3), 158.

Ward v. Polite. (2012). 667 F. 3d. 727 (U.S. Ct. App., 6th Cir. 2012).

Ward v. Wilbanks. (2010). 700 F. Supp. 2d. 803 (Dist. Ct., S. D. Mich., 2010).

Weinrach, S. G. (2002). The counseling profession's relationship to Jews and the issues that concern them: More than a case of selective awareness. *Journal of Counseling & Development, 80*(3), 300–314.

Willging, C. E., Salvador, M., & Kano, M. (2006). Unequal treatment: Mental health care for sexual and gender minority groups in a rural state. *Psychiatric Services, 57*(6), 867–870.

Yuen, E. K., Gros, D. F., Price, M., Zeigler, S., Tuerk, P. W., Foa, E. B., & Acierno, R. (2015). Randomized controlled trial of home-based telehealth versus in-person prolonged exposure for combat-related PTSD in veterans: Preliminary results. *Journal of Clinical Psychology, 71*(6), 500–512.

Zagożdżon, P., & Wrotkowska, M. (2017). Religious beliefs and their relevance for treatment adherence in mental illness: A review. *Religions, 8*(8), 150.

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L. T. Benuto et al. (eds.), *Prejudice, Stigma, Privilege, and Oppression*,
https://doi.org/10.1007/978-3-030-35517-3