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

L. M. West (✉)
Department of Psychiatry and Health Behavior, The Medical College of Georgia, Augusta University, Augusta, GA, USA
e-mail: LIWEST@augusta.edu

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).

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 discrimi-

nation. 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 col-

leagues 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