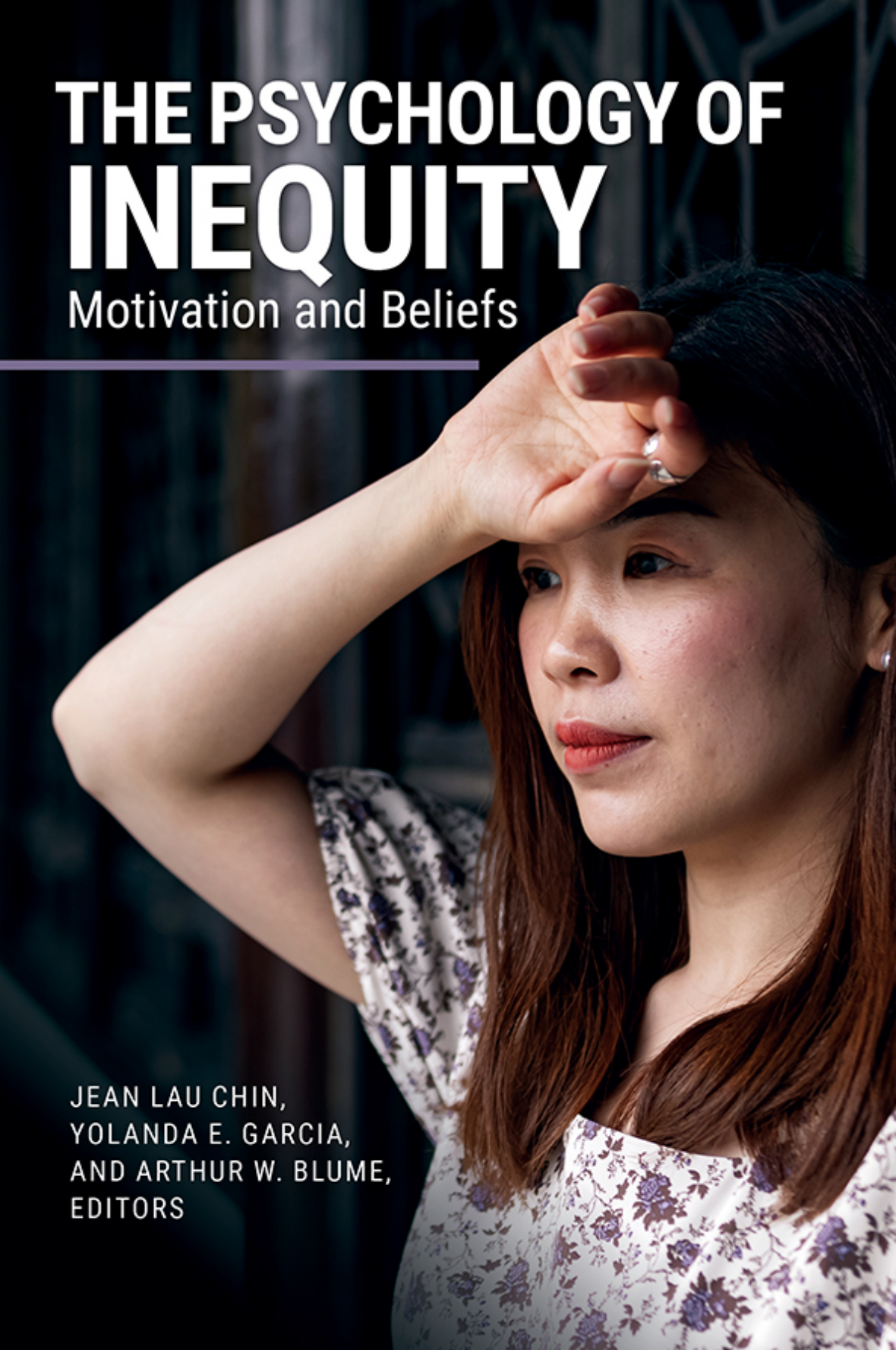
THE PSYCHOLOGY OF INEQUITY

Motivation and Beliefs



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JEAN LAU CHIN,
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ARTHUR W. BLUME, EDITORS

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Dedication

The Psychology of Inequity is dedicated to Dr. Jean Lau Chin (1944–2020). Jean was the primary editor of this work, which is a follow-up to *The Psychology of Prejudice and Discrimination* (Chin, 2004a, 2004b, 2004c, 2004d), a four-volume work, also published by Praeger. Volumes 1–4 of that set respectively covered *Racism in America, Ethnicity and Multiracial Identity, Bias Based on Gender and Sexual Orientation*, and *Disability, Religion, Physique, and Other Traits*. In contrast to the earlier volumes that explored discrimination experienced by distinct groups, Jean conceptualized the current text as a psychological overview of the intersectionality of inequities today. The trio of editors for this work examined motivations and beliefs that fuel inequities across the globe and the ways inequities are addressed and interpreted. As the editors finalized the completed chapters for submission to the publisher, the novel coronavirus swept from nation to nation, creating a global pandemic. Consistent with most disasters, the virus has disproportionately ravaged many of those described in these chapters who are already vulnerable due to long-standing inequities. Communities of color, those already disadvantaged by health-care and economic disparities, and those displaced due to war or other hardships have suffered the highest rates of illness and death from the virus, which took Jean and her husband, Gene Chin, in the months of April and May 2020. Jean's dauntless efforts in the pursuit of justice and equity and her dedication to completing this volume, even as she began to battle the virus, have resulted in this, in what may be her final work. Throughout this volume, her voice is heard, drawing attention to inequity and contributing to the solutions that make our world a better place.

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Contents

Introduction ix

1 How and Why Are Inequities Maintained? 1
Christine Ma-Kellams

2 Social Privilege: Flipping the Coin of Inequity 21
Jude Bergkamp, Abi Martin, and Lindsay Olson

3 Psychology of Liberation: Strategies to Engage in Transformative Practice in Public Schools 49
Sally M. Hage, Charisse Del Vecchio, and Sesooter Ikpah

4 Racial Microaggressions and Self-Esteem 73
Gloria Wong-Padoongpatt and Aldo M. Barrita

5 Poverty and Mental Illness: Motivation, Beliefs, and the Cycle of Inequity 95
Maria Espinola, Julia McIntyre, Juliana Lavey, Rachael Crenshaw, and Meghan St. John

6 Perceived Discrimination in Health-Care Settings among Filipino Americans 125
Diana L. Arntz and Sukanya Ray

7 Political Extremism in the Wake of Charlottesville: The Motivations and Ideologies of the White Power Movement 159
Tina R. Lee

8 Asian Americans Rising Up, Speaking Out for Greater Equity
Matthew R. Mock 187

9 Psychiatry and the African American Community: A History of Diagnosis and Treatment for Social Control 213
H. Russell Searight and Lyndsey Ren Johnson

About the Editors and Contributors 237

Index 243

Introduction

Current events have demonstrated that prejudice and discrimination remain entrenched in today's world and that discussions concerning culture, ethnicity, privilege, and race still matter. Many have wondered recently if we have progressed or regressed since the height of the civil rights movement of the 1960s. Certainly, the good fight to bring about equity and social justice remains as important today as it did a generation ago and perhaps even more urgent. The consequences of inequity seem to be at the forefront of that good fight, as they have been for centuries. Psychological wellness of societies remains elusive until the consequences of inequity are resolved and the sources of psychological unwellness reversed.

The Psychology of Inequity: Motivation and Beliefs is dedicated to reviewing and substantially updating the extant body of knowledge on the impacts of inequity on the psychological health and well-being of people of color. The intent is to reexamine the psychology of what fuels and maintains inequity, the psychological effects on local and global communities, and the psychological resilience inherent in the ingenuity, persistence, and commitment of people of color and allies who work every day to bring attention to injustices and abuses. Concerns about the psychologically toxic effects of education, income, health, mental health, and wealth inequities have been discussed and debated for many years, yet the inequities have worsened rather than been alleviated, despite the individualized attention paid toward each of these categories of inequities (education, income, health, mental health, and wealth) historically.

Collective evidence concerning the nature of inequities has broadened and advanced their conceptualization over time. When examining how

inequities were conceptualized and discussed in the four-volume *Psychology of Prejudice and Discrimination* (Chin, 2004) through contemporary lenses, we find that the 2004 series focused mostly on discrete aspects of individual identity such as race, gender, ethnicity, religion, socioeconomic status, sexual orientation, physique, and disability within varying contexts such as work and academia. Moreover, these individualized identities were viewed through a unidimensional lens. Today, our emphasis is on intersectionality with greater recognition of the different statuses across identities that a single person may carry and how these identities often interact with one another, making for the complexity of addressing inequities. Intersectionality was first introduced by Kimberlé Crenshaw (1989), who indicated that an individual's identity consists of different aspects (i.e., "African American" and "woman") with overlapping effects creating multiple levels of social injustice, although the concept only became salient decades later. Compared to Caucasian males' median earnings, African American men were paid 72.5 percent of those earnings and Caucasian females were paid 81 percent, but African American women were paid only 68 percent. This example suggests that the intersection of gender and race for African American women is disadvantageous when considering the multiple layers of social injustice they have experienced (Economic Policy Institute, 2021).

The Psychology of Prejudice and Discrimination (Chin, 2004), also primarily focused on the discrete expressions of inequity rather than the underlying connectivity of those inequities to one another. The COVID-19 era has exposed how inequities have contributed to psychological vulnerabilities for people of color nationally and globally. The pandemic has clearly exposed the connectivity of the individual areas of inequity, suggesting the importance of a reconceptualization of inequity as a function of collective and holistic inequity rather than of individualized and discrete expressions of inequity. In the past, there was an emphasis on psychologically bandaging the harm from those discrete expressions of inequity, whereas today we also focus on transforming the inequitable systems that contribute to the need for psychological bandaging. In other words, this book is more systemically focused to reflect a better understanding of the etiology of inequity within social systems.

The chapters in this book specifically address the motivations and beliefs that sustain inequity. The book begins with an examination of how and why equities are maintained and how resistance and alliance in seeking equity are understood through a grounded theory of privilege awareness. Next, liberation psychology is used as a means to promote transformative change in the schools, followed by chapters addressing motivations and beliefs that sustain and foster inequities (i.e., microaggressions that affect self-esteem, poverty, mental illness, and discrimination in health care). Chapters following that examine the relationship of inequity to political extremism, social dominance, and the White power

movement. Media-based racism, stereotypes, and representation may impact racial inequities and community resilience. A common theme of the chapters is that motivations, beliefs, and behaviors associated with maintaining inequities may be responses to interpreted threats of change and loss of privilege by the advancement of equity and equitable inclusion of "others." The book ends with a chapter reflecting on how particular types of mental health services have been instruments of inequity historically for African and Black Americans in particular. The chapters collectively raise awareness of inequities and their psychological consequence while promoting transformative change toward a shared goal of eliminating inequities and promoting inclusiveness and social justice. From this compendium of chapters, it is hoped that the reader may comprehend the inherent connectivity of the themes of inequity and view the task of appropriately addressing inequities in the 21st century as involving both individualized care and transformative advocacy.

The Psychology of Inequity: Motivation and Beliefs provides an updated understanding for and addressing the psychological consequences of inequities in the context of globalism, intersectionality, and technological advances that have significantly impacted racism. This book sets the stage for understanding the global extent of inequities and their consequences, and the movements for social change that have emerged from the urgency to address worsening inequities. The intent of this book is to present cutting-edge perspectives on how psychology may be wielded to decolonize inequitable beliefs and motivate movement toward equitable societies.

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CHAPTER 1

How and Why Are Inequities Maintained?

Christine Ma-Kellams

Inequity takes many forms, including most commonly those related to race/ethnicity, class/socioeconomic status (SES), gender, and ability. Likewise, the motivational underpinnings for inequity are just as varied. Although inequity is a social problem with consequences at the societal level, its origins and proximal effects can be observed at the level of the individual psyche. From a social-psychological perspective, the questions of how and why inequities are maintained often take the form of classic and well-documented processes such as self-fulfilling prophecy, stereotype threat (and lift), and self-stereotyping, as well as newer phenomena such as in-group derogation. Importantly, these explanations can themselves be traced to more basic underlying processes, each with its own rich history of evidence and frameworks. These include sociocognitive processes such as system justification, cognitive dissonance, cognitive miser theory, and self-serving biases, which all center on the motivated social cognition that promotes the perpetuation of beliefs contributing to the maintenance of nonexistent inequalities, most often tied to assumptions about differences between groups.

Social cognitions, in turn, may also be related to more fundamental biological factors, including evolved dominance and counterdominance instincts. Given that arguably one of the best ways to understand a species is to figure out what it was programmed to do, evolutionary psychological

approaches have focused on how ancestors and the societies they lived in may have developed and selected for instincts that continue to inform modern-day behaviors. To this end, a growing body of studies has focused on the existence of both instincts toward dominance and those that promote egalitarianism as dual evolutionary forces, each with its advantages and downsides, that may have differentially promoted survival.

Finally, the individual also matters, and a substantive body of literature from personality psychology has highlighted crucial individual differences related to social dominance and right-wing authoritarianism as crucial predictors of how a person responds to inequality. Of all the ways one person may differ inherently from another, these two constructs are the most readily tied to a variety of inequities, including racism, sexism, and support for systemic inequalities across a variety of national contexts (e.g., the caste system in India: Cotterill, Sidanius, Bhardwaj, & Kumar, 2014; the disenfranchisement of Blacks in South Africa: Duckitt & Farre, 1994).

First, a broad overview of the classic social-psychological theories can inform our modern-day understanding of inequality, examining early theories surrounding self-fulfilling prophecy, stereotype threat, and self-stereotyping. Some of these have applications that extend beyond inequality (e.g., self-fulfilling prophecy), while others (e.g., those related to stereotyping) have always been more centrally focused on group inequalities. I then move on to explore the major motivational approaches that have been used to explain these processes, including those related to cognition (e.g., system justification, cognitive dissonance, cognitive miser theory), as well as those related to biological factors (dominance vs. counterdominance instincts) and personality (e.g., social dominance orientation, right-wing authoritarianism). The chapter ends with a discussion of the future of inequality and some of the gaps that remain yet to be explored.

THE ROLE OF SELF-FULFILLING PROPHECIES

As a phenomenon, self-fulfilling prophecies have been widely studied from the social sciences and have been used to explain a host of phenomena, from economic crises (e.g., Azariadis, 1981) to educational disparities (Jussim, Robustelli, & Cain, 2009). In its original iteration, self-fulfilling prophecies were primarily studied in dyadic contexts where perceivers' expectations about targets could lead those targets to fulfill those expectations (for review, see Jones, 1977). In this form, self-fulfilling prophecies could be used to explain both general patterns of interaction among dyads (e.g., rejection sensitivity and subsequent rejection in close relationships: Downey, Freitas, Michaelis, & Khouri, 1998) and specific patterns of stereotype threat and fulfillment (e.g., for review, see Jussim, Palumbo, Chatman, Madon, & Smith, 2000).

Of particular interest to this chapter is the role self-fulfilling prophecies play in the maintenance of inequity. In this particular context, the idea is

that prejudice against a group can lead to a series of events that involves negative outcomes, such as worse performance and perception, which in turn can contribute to further inequality (Jussim et al., 2000). In Word, Zanna, and Cooper's classic (1974) study, interviewers were found to act colder in their nonverbal behaviors toward Black targets when compared to White targets; moreover, when a new set of White targets was treated coldly in the same way the Black targets were treated, they performed worse on the actual interview. Subsequent studies have shown similar phenomena when it came to gender inequality. For example, women who thought they were being interviewed by a sexist male behaved in ways more consistent with gender stereotypes (e.g., more makeup; less eye contact; more traditional discussion of marriage and children: von Baeyer, Sherk, & Zanna, 1981).

Other studies have gone on to demonstrate that not only can self-fulfilling prophecy lead to behaviors that exacerbate and confirm existing stereotypes and prejudices, but it can actually have direct and measurable outcomes on inequity at the societal level. For example, it is well established that teacher expectations are a powerful factor in shaping student performance (e.g., McKown & Weinstein, 2008; Smith, Jussim, & Eccles, 1999). Consistent with this finding, a number of researchers have shown that both official forms of institutional tracking (Guyll, Madon, Prieto, & Scherr, 2010) and unofficial beliefs teachers have about students based on their ethnicity (e.g., McKown & Weinstein, 2008) can lead to greater, not smaller, achievement gaps between racial or ethnic groups. For example, McKown and Weinstein (2008) found that differences in teacher expectations accounted for an average of 0.29 of the standard deviation of achievement gaps between White, Asian, Black, and Latino/a students in high-bias classrooms. Other studies have shown that the same pattern of teacher expectations reifying existing inequity also occurs with class: at schools with more working-class students, teacher expectations were lower, and this impacted achievement via influencing students' perception about the utility of school (Agirdag, Van Avermaet, & Van Houtte, 2013).

Self-fulfilling prophecies, however problematic, are not the only or primary force that contributes to the maintenance of inequity. If anything, the literature as a whole suggests that the effect is real but its magnitude of influence is small to moderate, with effect sizes that range from 0.03 to 0.40, with stronger effects in lower grades (Jussim et al., 2009). Below, I review related but distinct additional forces that can also contribute to the persistence of inequality.

STEREOTYPE THREAT AND LIFT

Similar to self-fulfilling prophecies, stereotype threat and lift effects occur when the mere specter of an activated stereotype causes changes in

performance for worse (in the case of negative stereotypes and threat: e.g., Steele & Aronson, 1995; for a recent review, see Spencer, Logel, & Davies, 2016) or, in certain cases, for better (in the case of positive stereotypes and lift: e.g., Walton & Cohen, 2003). In the original studies, stereotype threat effects focused on women and math (Spencer & Steele, 1992) as well as African Americans and academic performance (Steele & Aronson, 1995). In both cases, participants who were reminded of their gender or their race prior to completing a diagnostic task relevant to the stereotypes applied to their group performed worse. Importantly, these effects only occurred when participants believed that the tasks they were engaging in were diagnostic of their abilities (Steele & Aronson, 1995).

Subsequent studies have found that stereotype threat effects can occur with class, with low SES students performing worse on tasks that were framed as intelligence rather than problem-solving tests (Croizet & Claire, 1998). Since then, stereotype threat has also been shown to occur with other races/ethnicities (e.g., Latinos: Nadler & Clark, 2011), age (i.e., in a variety of cognitive as well as physical tasks: see Lamont, Swift, & Abrams, 2015, for review), and sexual orientation (i.e., in interactions with preschool children: Bosson, Haymovitz, & Pinel, 2004).

On a broader societal level, the literature on stereotype threat has shown that stereotype threat can account for very real inequities in the workplace, including in explaining the relative paucity of women in leadership (Hoyt & Murphy, 2016), engineering (Cadaret, Hartung, Subich, & Weigold, 2017), and finance (von Hippel, Sekaquaptewa, & McFarlane, 2015), as well as lower levels of adjustment for older individuals in the workplace (Manzi, Paderi, Benet-Martínez, & Coen, 2019). In other words, the stereotype that women are less likely to be good at leadership, engineering, or finance compared to men can lead women in these fields to perform worse because of the anxiety caused by this awareness; likewise, the ageist stereotypes against older workers can also make them perform worse in the workplace. Researchers have gone on to argue that despite the limited research on stereotype threat in the workplace, the body of literature as a whole suggests that factors such as underrepresentation, harassment, and even diversity statements can contribute to threats that exacerbate inequality by reifying concerns about stereotypes and stereotype threat (Walton, Murphy, & Ryan, 2015).

Interestingly, studies on the role of stereotype threat on standardized tests have been more controversial. Some researchers have concluded that these effects do not emerge as key factors in predicting group differences in scores (e.g., Cullen, Hardison, & Sackett, 2004). Other work has shown that stereotype threat effects can account for real outcomes: Black and Latino students who self-reported more stereotype threat had lower GPAs even when controlling for demographics and previous performance, especially in contexts when there was little diversity (e.g., Massey & Fischer, 2005, as cited in Walton, Spencer, & Erman, 2013). More direct evidence came

from Walton and Spencer (2009), whose meta-analyses demonstrated that stereotyped students' performance improved under conditions that challenged stereotype threat (e.g., in contexts where the test was deemed as nondiagnostic or unrelated to group differences). This is also in line with intervention studies geared toward reducing stereotype threat, which have also been shown to be effective (Walton & Spencer, 2009).

SELF-STEREOTYPING AND IN-GROUP DEROGATION

If self-fulfilling prophecies and stereotype threat can be construed as situations whereby stereotypes held by one group influence and shape the outcomes experienced by another, then self-stereotyping and in-group derogation involve the complementary and often concurrent tendency for groups to endorse the very same stereotypes used against themselves. Like self-fulfilling prophecy, self-stereotyping, in its earlier iterations, was used to explain both phenomena related to intergroup conflict and inequality as well as phenomena outside this domain—for example, self-stereotyping in advantaged, self-selected, temporary social groups (e.g., fraternities and sororities: Biernat, Vescio, & Green, 1996; psychology students vs. students from other majors, such as physics and business: Spears, Doojse, & Ellemers, 1997). However, insofar as its relation to the maintenance of inequity, the focus here will be on the cases where self-stereotyping and in-group derogation led to promoting preexisting gaps between groups.

Like stereotype threat, most of the work on self-stereotyping and in-group derogation has focused on women and ethnic minorities. Here, self-stereotyping refers to the tendency to see oneself in line with the existing stereotypes that are relevant to one's in-group (Hogg & Turner, 1987), whereas in-group derogation refers to the more specific phenomenon of holding negative attitudes against one's in-group (Ma-Kellams, Spencer-Rodgers, & Peng, 2011). In other words, while self-stereotyping is not necessarily valenced, because it depends on the nature and content of the stereotype, in-group derogation, by definition, is.

In the context of self-stereotyping in particular, Asian American women viewed themselves as better verbally when reminded of their gender but better mathematically when reminded of their ethnicity; European American men and women also viewed themselves in line with the relevant stereotype in terms of verbal versus math abilities as a function of whether their gender or ethnicity was activated (Sinclair, Hardin, & Lowery, 2006—parallel to what has been shown in stereotype threat contexts: Shih, Pittinsky, & Ambady, 1999). Interestingly, African Americans did not show evidence of self-stereotyping (Sinclair et al., 2006), which suggests that at least in this case, self-stereotyping may not be a relevant force in explaining inequity. Additional studies have confirmed that self-stereotyping is common for gender (e.g., Guimond, Chatard, Martinet, Crisp, & Redersdorff,

2006), sexual orientation (e.g., Simon, Glässner-Bayerl, & Stratenwerth, 1991), ethnicity (e.g., Verkuyten & Nekuee, 1999), and age (Levy, 1996), to name several.

Although self-stereotyping has been shown to offer protective benefits (in helping stigmatized groups achieve well-being: Latrofa, Vaes, Pastore, & Cadinu, 2009), it nevertheless also serves to contribute to inequity and the status quo by promoting system justification. For example, Laurin, Kay, and Shepherd (2011) reasoned that women's tendency to self-stereotype as relational and warm (vs. competent and competitive, traits typically reserved for men) stood as a route to justifying existing gaps between men's and women's achievement in male-dominated fields such as Fortune 500 companies and the U.S. Senate. Consistent with this argument, they showed that inducing system justification led to more self-stereotyping and, conversely, self-stereotyping also led to more system justification (Laurin et al., 2011).

In-group derogation goes one step further and involves endorsement of outright negative characterizations of one's own group (e.g., Hewstone & Ward, 1985; Ma-Kellams et al., 2011). Although not all forms of in-group derogation relate to system justification (Ma-Kellams et al., 2011), many forms of in-group derogation in the context of status-relevant traits have been shown to be system justifying. For example, Jost and Burgess (2000) showed that when they manipulated perceived SES, low-status groups favored the out-group rather than the in-group on traits related to status such as intelligence, industriousness, and verbal skills.

UNDERLYING COGNITIVE PROCESSES

In these cases of self-fulfilling prophecy, stereotype threat, and self-stereotyping, the existence of a difference between social groups—usually based on stereotypes—is enough to initiate a self-perpetuating cycle that involves either expectations shaping actual behaviors, anxiety contributing to stereotype fulfillment, and/or internalization of biases. However, broader cognitive processes can explain why such stereotypes exist in the first place. These include system justification, cognitive dissonance, cognitive miser theory, and self-serving biases.

System Justification

System justification is arguably one of the most oft-cited explanations for inequity and addresses the paradox of how a species that cares intuitively and innately about equity can also be so prone to striking inequalities (Jost, Gaucher, & Stern, 2015). At its core, system justification theory argues that the disadvantaged do not attempt to change or leave the existing system that is unfairly pitted against them because they are motivated to believe in a just world, which is in itself psychologically rewarding

or palliative (Jost, Banaji, & Nosek, 2004). Although the strength of this system-justifying motive varies as a function of a host of other factors related to both the individual and the context, inequality typically gets maintained through mechanisms such as endorsement of ideologies, obedience to authorities or institutions, denial of societal problems, and resistance to societal change (Jost et al., 2015).

Practically speaking, system justification has been used to explain why women, the socioeconomically disadvantaged, and ethnic minorities endorse gender, status, and other stereotypes and victim blame (e.g., Kay et al., 2007). For example, it can explain why Black and low-income Americans are more likely to endorse limitations on citizens' rights, believe in the inevitability of economic inequality, and believe in meritocracy; moreover, less wealthy Latinos were more likely to trust the government than their wealthier counterparts (Jost, Pelham, Sheldon, & Sullivan, 2003). Across these contexts, the argument (from a system justification perspective) is that people get what they deserve, so the "have-nots" in society must have done something to justify or explain their lesser lot in life; therefore, efforts to undercut such differences in outcome or promote equality are deemed unnecessary at best and nefarious at worst.

Cognitive Dissonance

A related but distinct explanation is cognitive dissonance, which argues that people are motivated to perceive and enact consistency and stability (Jost et al., 2015). More specifically, cognitive dissonance contends that people will try to bring their attitudes in line with the realities of their world, although conversely, they could also try to change reality to become consistent with their attitudes (Owuamalam, Rubin, & Spears, 2016). However, these efforts to reduce tension should primarily come into play on strong, salient attitudes than weaker ones (Festinger, 1962, as cited in Owuamalam et al., 2016). Still, cognitive dissonance has also been used to explain inequity, particularly in terms of wages (e.g., Adams, 1963; Adams & Rosenbaum, 1962). Here, however, inequity is conceptualized primarily in terms of underpayment of wages (e.g., overpaying workers can lead to changes in their productivity: Adams, 1963; Adams & Rosenbaum, 1962) as opposed to broader, societal level inequalities.

Cognitive Miser Theory and Social Cognition

Social cognition in general and cognitive miser theory in particular suggests that much of inequality is based on how we perceive groups in the first place and on the social schemas that drive this perception (Hollander & Howard, 2000). Whether it's race, gender, or class, the drive for cognitive efficiency has made it so that people tend to take an essentialist, stereotypical view of groups (Hollander & Howard, 2000). Said differently,

people are lazy or stingy in their willingness to engage their cognitive resources, and so instead of exerting the effort to get to know someone as an individual, they will opt to rely on stereotypical assumptions about the person because it is less work (e.g., instead of getting to know a woman or a man, assuming that they are good at humanities in the case of the former and good at science/math in the case of the latter). Other researchers have argued that these same processes can be extended to explain inequities based on additional social divisions, including those related to disability, sexual orientation, and weight (North & Fiske, 2014). Here, North and Fiske's (2014) argument is that the act of creating social categories inherently promotes inequalities, and much of this process is automatic and implicit.

Self-Serving Biases

More specific studies on self-serving biases have shown that those in advantaged positions in society can be motivated to deny the existence of their own privilege and, conversely, endorse a meritocratic view of society (e.g., Knowles & Lowery, 2012). In this particular case, these studies were on White denial of White privilege and on anti-Black discrimination (Knowles & Lowery, 2012). Other studies have shown that perceptions of privilege are tied to self-regard, and racial inequity itself was threatening to White participants' own self-image (Lowery, Knowles, & Unzueta, 2007). These can be self-serving because they suggest that White individuals' relative dominance in American society can be attributed to their own efforts and talents rather than advantages afforded to them based on their skin color.

BIOLOGICALLY BASED AND EVOLUTIONARY EXPLANATIONS FOR INEQUITY

Evolutionary approaches to understanding human social cognition have argued that survival pressures on our hunter-gatherer forebears promoted the development of cooperation, egalitarianism, and mind reading, or theory of mind, among other features (e.g., language, culture: for review, see Whiten & Erdal, 2012). At the same time, however, biologically based dominance instincts also evolved along with these counterdominance instincts. If much of our modern psychological processes arose during the Environment of Evolutionary Adaptedness (EEA), and this environment was a nomadic one primarily characterized by tribes, then the argument is that humans during this era—like other primates—developed dominance hierarchies because of adaptations such as nepotism, social exchange, and the seeking of social rank (for review, see Charlton, 1997). In other words, humans' capacities and tendencies to favor their own, form coalitions, and seek status all converged on contributing to status differences

in ancient societies, and this lay the groundwork for modern societal inequities between groups (Charlton, 1997). Although Charlton (1997) was primarily using this evolutionary argument to explain modern-day health disparities by class, the premise is broadly applicable to a wide array of inequalities. For example, this approach suggests that the tendencies to view certain racial, gender, or socioeconomic groups as superior to others can be traced back to the ancient ways in which humans were organized in tribes, wherein people associated and formed alliances within their own group based on shared characteristics.

At the same time, other evolutionary theorists have focused on the development of counterdominance instincts. From these perspectives, the dominance behavior more clearly aligns with our primate ancestors, and one of the defining features of hunter-gatherer societies was their relatively high degree of egalitarianism (Erdal, Whiten, Bohm, & Knauft, 1994). To explain the move away from such egalitarian societies over time, the argument is that humans' original dominance instincts were countered but never completely eliminated by counterdominance instincts; as a result, changes in environmental circumstances could—and did—incapacitate the counterdominance instincts that were developed later (Erdal et al., 1994). In other words, the development and growth of the human brain led to strategies that made counterdominance or egalitarianism viable, but then changing circumstances and new incentives activated old dominance instincts (Erdal et al., 1994). To illustrate, even though our ancestors formed tribes with divisions of labor that dictated what different groups could do, the labor itself was relatively equitable in that everyone's job was important to the overall functionality of the group (e.g., gatherers were just as essential as hunters). As a result, humans also evolved a tendency to want to view and treat different groups equitably and equally.

INDIVIDUAL DIFFERENCES: PERSONALITY-BASED AND IDEOLOGICAL EXPLANATIONS FOR INEQUITY

Personality trait or individual difference approaches such as that of social dominance theory make a similar argument as the aforementioned evolutionary approaches, in that they also argue for the existence of dual forces that promote or attenuate inequity; in this context, they are referred to as hierarchy-enhancing (HE) or hierarchy-attenuating (HA) forces (Sidanius, Cotterill, Sheehy-Skeffington, Kteily, & Carvacho, 2016). Of these—which include institutions, myths, context, behaviors, and individual differences—one of the most well studied is social dominance orientation (SDO), an individual difference reflecting the desire for group-based hierarchies (Sidanius et al., 2016). People who are high in SDO believe that some groups are naturally superior to others and consider this a positive state of the world. To this end, SDO has been shown to impact inequity both directly, through processes such as collective action (e.g.,

Henry, Sidanius, Levin, & Pratto, 2005; Levin, Henry, Pratto, & Sidanius, 2009) and criminal justice (e.g., Gerber & Jackson, 2013; Kteily, Cotterill, Sidanius, Sheehy-Skeffington, & Bergh, 2014), and indirectly, through processes such as legitimizing myths (e.g., Cotterill et al., 2014; Kteily, Sidanius, & Levin, 2011).

Moreover, additional research has shown that although SDO itself is construed primarily as an individual difference variable, it nevertheless is subject to "cross-level processes" (Sidanius et al., 2016, p. 170)—that is, it mutually constitutes institutional forces in that people who are high in SDO tend to seek out occupations or industries whose work matches their own preferences for dominance. The quintessential example of this is Sidanius, Liu, Shaw, and Pratto's (1994) work on how police officers and public defenders had divergent SDO scores, with the former scoring higher than the latter. In other words, police officers tended to be high in SDO, and public defenders tended to be low, and these differences corresponded with their jobs, which involved displays of dominance or displays of equality/service for the underserved. Although this finding could be due to a number of factors that the authors outlined—including self-selection, institutional selection, institutional socialization, institutional reward, and attrition (Sidanius et al., 2016)—the overall consensus is that person-level differences in ideology can feed into system-wide practices that promote—or challenge—inequity.

A related construct is right-wing authoritarianism (RWA), which often goes hand in hand with SDO to promote attitudes and behaviors that further inequity. As an individual difference, RWA reflects the tendency to defer to authority (authoritarian submission) and act hostile to those who violate social norms (authoritarian aggression and conventionalism; Altemeyer, 1988). To illustrate, Cotterill et al. (2014) found that both SDO and RWA predicted endorsement of the notion of karma and anti-egalitarian policies in India—most notably, the caste system, including opposition to intercaste romantic relationship and government aid to low-status groups.

In a related vein, RWA is often linked to higher prejudice. For example, it predicted anti-Black prejudice among South Africans (Duckitt & Farre, 1994) and sexist attitudes across cultures (e.g., Lee, 2013; Sibley, Wilson, & Duckitt, 2007). In other words, people who are more right-wing authoritarians also tend to be more likely to discriminate on the basis of race or gender. Interestingly, some studies have shown that individuals high on this dimension prefer more inclusiveness in certain contexts such as education—in this case, supporting the idea that gifted education should not be separated from nongifted education (Cross, Cross, & Finch, 2010).

These individual differences in SDO and RWA are part of a broader group of ideologies or beliefs that can contribute to HE versus HA environments (e.g., see De Oliveira, Guimond, & Dambrun, 2012). For example, De Oliveira et al. (2012) found that being in an HE environment (such as a consulting firm for big companies) compared to being in an HA

environment (such as a consulting firm for helping the disadvantaged) changed participants' attitudes toward not only SDO and system justification but also multiculturalism (e.g., whether people should welcome different cultures or force assimilation). Other studies in additional applied contexts have found that hierarchy beliefs are pervasive and can be found in a variety of settings, such as health care, wherein beliefs about the normative roles, duties, and powers of higher- versus lower-status personnel can have important consequences for how people behave in group settings (Weiss, Kolbe, Grote, Spahn, & Grande, 2017).

Consistent with this latter finding, other studies have suggested that hierarchy beliefs are both ubiquitous and variable. Although hierarchies themselves have been around across time and species, modern societies vary widely in terms of how much they believe in the validity, desirability, or legitimacy of them (Fischer, 2013). Interestingly, in Fischer's (2013) analyses of data from 29 different countries, he found that both the presence of certain genetic alleles and environmental factors such as disease and food availability interacted to predict how much people in general supported the idea of hierarchies.

IMPLICATIONS AND FUTURE DIRECTIONS

The Psychological Consequences of Inequity

Although the substantive and varied body of work reviewed in this chapter has explained the social, psychological, cognitive biological, and personality-based explanations for why inequity exists and is maintained, newer research suggests that the existence of inequity is not without its own consequences; as a result, those interested in increasing well-being should also be motivated to decrease—rather than maintain—inequity. To illustrate, both objective and subjective inequalities in income are linked to less happiness, and this link is mediated by factors such as competition over status, lack of trust, and pessimism (Buttrick, Heintzelman, & Oishi, 2017). Furthermore, the consequences do not appear to be limited to just affective outcomes, such as happiness, but rather extend to a whole host of additional effects, including morality, mortality, health, and government (Buttrick & Oishi, 2017). In other words, in equitable societies, everyone benefits because they are less competitive, more trusting, and less pessimistic, and this makes them happier, healthier, better run, and more upright.

Despite the well-established effects of habituation—which should work against the perception of, and consequences following, inequality—recent or sudden shifts in inequality can change its salience (Buttrick et al., 2017). The resulting consequences at both the individual and interpersonal level across countries (e.g., see Buttrick et al., 2017; Guzzo, 2019) suggest that we, as a society, should be concerned with efforts at undermining it regardless of our own personal lot in life. Beyond the ethical considerations, this

empirical literature suggests that equity benefits everyone, and inequity hurts even those who are not the direct targets of inequality.

INTERVENTIONS AIMED AT REDUCING INEQUITY

Given the importance and urgency of the need to reduce inequality, this raises the other implication and possible future direction of the extant literature: How can we reduce inequity? The answer, of course, depends on the context and nature of the inequity. To illustrate, take the domain of discipline inequalities insofar as who is punished in school, and for what. In this context, it is well established that inequities exist based on factors that include sexual orientation, race/ethnicity, and gender (for review, see Skiba, Mediratta, & Rausch, 2016). Efforts aimed at reducing such inequalities have involved student-teacher ethnic matching, structured decision-making, and movements away from punitive discipline to more restorative approaches (e.g., Skiba et al., 2016).

Similar efforts to reduce inequity in schools have been documented in other domains beyond discipline. Another well-documented inequity is socioeconomic inequality, which is related both to educational and financial outcomes. Interventions that can ameliorate the effects of low SES on educational attainment include early childhood education—for example, enrolling low-income children in preschool (Magnuson & Duncan, 2016). Early enrollment in center-based early childhood education appears to have far-reaching advantages that can subsequently lower socioeconomic inequalities (Magnuson & Duncan, 2016). Additional interventions for reducing socioeconomic inequity have also been tested in higher education settings. These include self-affirmation (e.g., writing about one's most important values), difference education (e.g., acknowledging how college can be a different experience for first-generation and non-first-generation students), and goal reframing (e.g., thinking of an exam as a learning opportunity instead of a way of selecting students; for a review, see Jury et al., 2017).

Outside of education, health disparities stand as an additional domain in which numerous interventions have been tested. Here, an interesting divergence emerges: while some interventions aimed at promoting public health have decreased inequalities between groups, others have ironically increased them. For example, mass media campaigns and bans on smoking in places such as work have been shown to exacerbate disparities in health outcomes between groups (Williams & Purdie-Vaughns, 2016). In contrast, other interventions that involving giving people resources, increasing the prices of maladaptive products (e.g., cigarettes), and improving conditions at work appear to effectively reduce inequities (for review, see Williams & Purdie-Vaughns, 2016). However, there is evidence that both universal (e.g., laws about safety behaviors, health standards in food and water, taxes on unhealthy products) and targeted

interventions (e.g., programs that provide services and material goods, such as contraceptives, to specific communities) can help reduce disparities both among racial and socioeconomic groups (Williams & Purdie-Vaughns, 2016).

Additional efforts to undercut inequality may involve intersections between different fields of existing research—for example, the aforementioned work on SDO and studies on racial bias in police shootings. As discussed previously, existing studies suggest that police officers, as a whole, tend to show higher levels of SDO than people in other occupations designed to serve the public at large (e.g., public defenders: Sidanius et al., 1994). Given the well-documented tendency for police officers to shoot unarmed Black men in both psychological studies (e.g., Correll, Park, Judd, & Wittenbrink, 2002) and real life, one possibility could involve testing the relationship between SDO and the tendency to shoot unarmed minority targets in a controlled laboratory environment (e.g., in a video game); if the one predicts the other, then it could be tested as a potential way to screen police officer candidates. Along a related vein, existing research has shown that implicit racial biases (e.g., performance on the Implicit Association Test, or IAT) predicts the tendency to shoot (Glaser & Knowles, 2008), but it remains unclear whether the IAT has been used or studied as a screening tool for law enforcement. Thus, future efforts to undercut the stark inequalities in the criminal justice system can involve systematic examinations of whether using these measures could help effectively screen for less biased personnel entrusted with law enforcement (for recent discussion on this topic, see Cox, Devine, Plant, & Schwartz, 2014; Spencer, Charbonneau, & Glaser, 2016).

CONCLUSION

Interesting, one area that remains unexplored is what the consequences of inequality and interventions aimed at reducing inequalities mean for the underlying motivational systems that set the inequalities in place. The literature on the motivational underpinnings of inequity has suggested that human beings have evolved numerous cognitive, social, biological and personality systems that enable us to perceive and perpetuate disparities between social groups. Many of these systems appear to be drive-like, in the sense that the theoretical frameworks surrounding them suggest that as a species, we have a fundamental need for these processes (e.g., toward dominance or counterdominance, or justifying the status quo). Following this logic, this suggests that any efforts to reduce inequalities may run counter to these motivational systems and, as a result, be met with psychological pushback, at least initially.

Thus, given the abundance of ways in which people can maintain inequalities through their beliefs, behaviors, and individual differences, future studies aimed at interventions should also take into consideration

the proximal psychological responses to such efforts. Along these lines, examination of the situational and individual moderators of how people respond to efforts at undermining inequity stands as an important related line of inquiry. Ultimately, both drives and counterdrives are likely at work that contribute to the maintenance of inequity, but given our uniquely human capacity to stand up to nature and defy it (e.g., via the social systems and technological advances we create), we are one of the few species not bound to naturalistic or deterministic fallacies—that is, the myths that what is natural is good or inevitable (e.g., see Dar-Nimrod & Heine, 2011, for a discussion). This means that regardless of the evolutionary basis for hierarchies or the motivational, cognitive, and individual differences that contribute to their existence, we should be able to alter the course of our actions in ways that promote more equitable societies. After all, it likely takes a village to reduce the inequities we have maintained, and understanding the psychological makeup of the villagers remains an important first step.

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CHAPTER 2

Social Privilege

Flipping the Coin of Inequity

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> *Everyone is aware of people who intentionally act out in oppressive ways. But there is less attention given to the millions of people who know inequities exist and want to be part of the solution. Removing what silences them and stands in their way can tap an enormous potential for energy and change. —Allan Johnson,* Power, privilege, and difference, *2006, p. 125*

INTRODUCTION

Therapist: You were telling me that something upsetting happened? Can you say more?

Client: Yeah, I was flying out of the airport and, you know, it was really busy. I pulled out those bins. . . . I put my laptop in, took off my shoes, right? I was dressed normally . . . just like now [*gestures toward self*]. And all of a sudden, they went ahead and pulled me out of line, and they searched my bags before I even went through the whole TSA check. They patted me down, took me to a room, and gave me the whole questioning thing. I kept questioning back, "Why me? Why me?" and they kept on giving me the same phrase over and over again, "It's just routine. . . . It's a random check sir."

Therapist: Oh wow. How stressful! What were you doing?

As psychologists and psychologists in training, we all have the best intentions. We want to listen, understand, validate, and support, especially

at the beginning of treatment. But are there client-therapist dynamics in which our good intentions and fundamental therapeutic skills are simply not enough? Are there times in which our tried-and-true, well-meaning approach invalidates and unintentionally harms both the client and the therapeutic alliance?

Client: Nothing. I wasn't doing anything. . . . I was just standing in line. I'm sick of being targeted all the time. And because of this whole thing, I missed my flight.
Therapist: That must be so frustrating. Those lines can be so horrible. It takes forever to get through them. It's such a hassle to take off your shoes, and people are so slow and disorganized. And people get stopped for no reason at all.
Client: Um . . . but it's really difficult for me.
Therapist: Oh? Well, it is a random check, though; are you sure they were targeting you?
Client: Um, yeah. . . . I mean . . . they must be targeting me; I mean, look at me [*gesturing toward self*].
Therapist: Oh, okay. Well, this is clearly really difficult for you. Do you think there is anything you can do to make the process go a little more smoothly for you?

In this short clinical vignette, the therapist was a White woman in her midforties. The client was an East Indian man in his midthirties, with a darker complexion and a beard. He had grown up in the United States and had an American accent. He was a young professional who typically dressed in business casual attire.

The therapist listened, validated feelings, and tried to help alleviate distress by problem-solving with the client. Although the therapist's technique can always be debated, it is difficult to debate her intention: she wanted to help. Despite the therapist's intentions, though, the client felt dismissed, invalidated, and misunderstood. The client invited the therapist to openly discuss their racial differences, and the therapist, unfortunately, missed this opportunity.

In this vignette, the therapist had received multicultural competency training in her doctoral psychology program. She learned about Asian culture with the ultimate goal of remaining respectful and considerate toward her future Asian clients. She had learned about working with Asian populations and how she should refer to herself as "Doctor," consider the importance of family, and be aware of psychological symptoms presenting somatically. She considered how her Anglo-European American culture differed from others and learned to be mindful of these differences. In the parlance of current American political terminology, she wanted to be "woke": alert to social injustice.

If the therapist was aware of cultural differences and was well-intentioned, what else might have caused the therapeutic rupture? The therapist lacked an awareness of the fundamental differences in power and social privilege between herself and her client. The therapist was unaware that her social

privilege as a White person conferred an unearned advantage of being able to get through TSA check lines without being targeted, to walk through the world without others suspecting her of wrongdoing even when she was simply standing. Had the therapist engaged in self-reflection about her social privilege as a White person, she would better understand her client's reality and be able to offer a better therapeutic experience.

The therapist in this short vignette is likely not alone. For many psychologists, reflection on social privilege and application to the therapeutic process is an unfamiliar strategy in a comprehensive therapeutic approach. Most training programs lack curriculum to address psychologist positionality within historical systems of power, privilege, and oppression (Bartoli, Bentley-Edwards, Garcia, Michael, & Ervin, 2015; Motulsky, Gere, Saleem, & Trantham, 2014; Singh et al., 2010). However, the work of scholars such as McIntosh (1988), Tatum (1997), Helms (1984, 2017), Spanierman and Smith (2017), Goodman et al. (2004), Goodman (2015), and Case (2013, 2017) suggests it is critical for psychologists to begin reflecting on their social privilege awareness to provide ethical and multiculturally competent treatment and services. If the therapist in this vignette had received sufficient training, sought consultation for her social privilege, or otherwise found a space to develop her social privilege awareness, how might the therapeutic interaction have gone differently?

This chapter will address social privilege as a driving construct within psychology and summarize its importance to the future of the field. We will visit the origins of dialogue about social privilege; highlight the understandable and inexcusable resistance and barriers to incorporating social privilege into psychological research, education, and practice; and end with suggestions for a pedagogy of social privilege recommended by Reason and Bradbury (2006) as part of the growing movement toward a pedagogy of social justice (Down & Smyth, 2012).

COURSE CORRECTIONS: APA ETHICAL CODE AND MULTICULTURAL GUIDELINES

The American Psychological Association (APA) provides vision and direction for the field of clinical psychology through aspirational principles, mandatory ethical codes, and pragmatic practice guidelines. These either guide or bind clinicians, educators, researchers, supervisors, and policy makers in responsible conduct. The APA *recommends* psychologists respect people's rights and dignity, which requires awareness of individual, cultural, and role differences (American Psychological Association, 2016). The APA *mandates* psychologists "obtain the training, experience, consultation, or supervision necessary" to understand the integral effect of "factors related to age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or

socioeconomic status . . . [*w*]*here scientific or professional knowledge in the discipline of psychology establishes* [emphasis added]" that this understanding is "essential for effective implementation of their services" (American Psychological Association, 2016, sec. 2). Alternatively, psychologists may "make appropriate referrals" (American Psychological Association, 2016, sec. 2), perhaps if training, experience, consultation, or supervision are not accessible—or of interest—to the psychologist.

In the updated 2017 APA multicultural guidelines, guideline 5 states, "psychologists aspire to recognize and understand historical and contemporary experiences with power, privilege, and oppression" (American Psychological Association, 2017, p. 4). Professional knowledge in psychology has established the necessity of understanding psychologists' social privilege as a factor related to their social identities and the efficacy of their services, yet science has not caught up to this common sense (Helms, 2017).

OVERCOMING INERTIA: A SOCIAL JUSTICE INITIATIVE

Social justice can be viewed as an overarching concept of which awareness of social privilege is at once a process and an outcome. Rawls defined social justice as "equal access to basic liberties and the fair distribution of goods and opportunities" (Thrift & Sugarman, 2019, p. 3). Later, Young expanded social justice from equal access and fair distribution to "recognition of difference and elimination of oppression across institutions" (Thrift & Sugarman, 2019, p. 3). The APA calls on our profession to strive to understand oppression and achieve equity for all. Awareness of social privilege offers a dramatically different perspective in APA's mission to seek justice, shifting focus from those who are deprived of benefit and resource to those who are born with benefit and resource in order to loosen the hegemonic hold of social privilege on society. Scrutiny of social privilege calls into question the invisible systemic mechanisms that manufacture inequity beyond the more visible interpersonal experiences of prejudice and discrimination. Social privilege is an essential, implicit component of an oppressive system, and thus awareness of social privilege can elucidate the mechanisms that scaffold inequity and ultimately serve a social justice mission.

LOOKING UNDER THE HOOD: SOCIAL PRIVILEGE AS ENGINE

Social privilege and oppression are corollary and divergent systems that are "inseparable and codependent structural forces" (Case, 2013, p. 4). In the past several decades, the consequences of oppression, especially racism and sexism, have received attention; however, this focus has

kept the conversation one-sided (Case, 2013; Case, Iuzzini, & Hopkins, 2012; Helms, 1984; Pinterits, Poteat, & Spanierman, 2009). Kurt Lewin (1946) implicated paralysis of "groups in power" (p. 43) in the failure to bring about social change. He drew attention to the new idea that "so-called minority problems are in fact majority problems" and that "to improve relations between groups both of the interacting groups have to be studied" (p. 44).

In her keynote speech at the 2014 Society for Intercultural Education Training and Research (SIETAR) Japan Conference, Diane J. Goodman described oppression and privilege as "two sides of the same coin" (p. 1). Goodman (2015) elaborated, stating, "While it is critical to understand how some groups are disadvantaged by individual behaviors, institutional policies, and cultural norms that is only one side of the coin of oppression. The other side of the coin is understanding how some groups are advantaged. Looking at both sides provides a clearer picture of how systemic inequality operates, and uncovers more opportunities to intervene and create change" (p. 6). Goodman's (2015) speech thus encourages individuals to adjust their focus from oppression to the other side of the coin, social privilege, which has often been ignored. Case (2013) stated, "Understanding dominant group privilege as it functions on a personal level is essential for individuals interested in challenging systemic privilege" (p. 3), and thus highlighted that psychologists' development of social privilege awareness is essential for challenging the status quo of oppression.

THE ISSUE OF SOCIAL PRIVILEGE

Confusion about the distinction between social privilege and diversity, multicultural psychology, and cultural competency, and its relation to oppression have obscured the purpose and place of social privilege in psychology's evolving legacy of social justice and advocacy. Part of the difficulty of defining social privilege is that it is invisible to individuals who have it. Social privilege easily hides behind issues of oppression, discrimination, and injustice because it is inextricable from them. While one side of an issue dominates psychological attention, the other side of that issue escapes notice.

LOOKING IN THE REARVIEW MIRROR: SOCIAL PRIVILEGE AMID MULTICULTURALISM, CULTURAL COMPETENCE, AND HUMILITY

In psychology training, dominant models of multicultural counseling, cultural competence, and cultural humility are related to social privilege but can actually serve to distract from social privilege and the external structures that uphold it. Each paradigm emerged from a particular era

in psychology's history. Although each attempted an emic perspective on oppression, contributing potential solutions to prejudice and interpersonal challenges in therapy, the emic approach somehow neglected the structural elements of the field that perpetuated inequity.

Multiculturalism

Multicultural counseling competence is defined as "the counselor's acquisition of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society (ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds), and on an organizational/societal level, advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all groups" (Sue, 2001, p. 802). Although this aspirational definition encourages praxis at the level of society, the practice of multicultural counseling can focus on the other within the interpersonal dyad and still neglect the contextual and ecological influences of the individual's issues. Multicultural counseling asks us to be aware of our own social identities and positions within the counseling dyad, but it does not explicitly ground this reflection in the historical context of oppression, power, and privilege.

At its core, does multicultural competence exist as it does today to soothe the racial stress so acutely and intolerably felt by White psychologists? Do multiculturally competent skills aim to instill a shallow sense of comfort and confidence in the White psychologist, to quell the fear of working with marginalized others? This is not to say that multicultural competence is ill-intentioned; it does follow the diversity-era ideology that every individual is unique, beautiful, and created equal. However, these values fundamentally dismiss the reality of historical systems of power and privilege, the consequences of which have been borne by oppressed groups. In its current practice, multicultural competence has, perhaps unintentionally, become a psychological tool to deflect "the problem" and responsibility for the problem from socially privileged psychologists; thus psychologists continue to sit, comfortably, in positions of power and privilege.

Cultural Competence

In 2001, D. W. Sue defined cultural competence as "the ability to engage in actions or create conditions that maximize the optimal development of client and client systems" (p. 802). The goals of cultural competence and multiculturalism are closely linked by the premise that mental health providers should know and consider cultural values specific to persons of that culture in order to provide effective interventions (Sue, 2006). Multiculturalism and cultural competence both recognize the ethnocentric

and assimilationist effect on clients from underrepresented cultures of dominant theories and models of care. However, while early multiculturalism was concerned mostly with interpersonal aspects of counseling reliant on specific group differences, such as ethnicity, cultural competence expanded aspects of individual identity to community processes and focused on service delivery outcomes, social justice, and addressing oppression across ecological levels (Cross, 2008).

Cultural Humility

The concept of cultural humility is a cousin of cultural competence and came out of the medical profession, specifically nursing, and was subsequently modified for social workers (Hook, Davis, Owen, Worthington, & Utsey, 2013). Self-awareness and reflection are key to multiculturalism and cultural competence; however, cultural humility further emphasizes introspection and co-learning in order to prevent misdiagnosis. Reflecting on the psychologist's own culture and socialization is an element of social privilege awareness, but culture is not social privilege. Culture does not generally address the historical antecedents to power, nor does it raise the dysconscious element of social privilege, which King (1991) originally denoted as "an uncritical habit of mind (including perceptions, attitudes, assumptions, and beliefs) that justifies inequity and exploitation by accepting the existing order of things as given" (p. 135). In its recent transition from a medical context, cultural humility has incorporated an increasing focus on psychologists' awareness of their own power, privilege, and prejudices as well as the positional power that comes with the role of a professional clinician.

Multicultural counseling and cultural competence generally focus on the client from a marginalized social domain as the object of therapy, rather than on the therapist from a privileged social domain as the subject of therapeutic action. Cultural humility brings psychology one step closer to examining the perpetuation of social inequity that manifests in therapy, yet it does not make explicit the need for consciousness of personal and group social privilege. Although multiculturalism, cultural competence, and cultural humility are important foci in therapy, they minimize the magnitude of the problem of inequity that is often located in dysconscious social privilege.

ASPIRATIONAL APPLICATIONS OF A SOCIAL JUSTICE MOVEMENT

Imagine again the therapist's stance in the opening vignette, prior to the advent of cultural humility. Although the therapist may have accounted for the implications of the difference between herself and the client based on training in multicultural psychology and cultural competence, her

inability to reflect on the implications of her social power as a therapist and her social privilege as a White individual resulted in therapeutic rupture. Psychologists pride themselves in therapeutic repair, but how can practitioners repair such ruptures when their professional field does not provide guidance for how to identify the source of the conflict?

Psychologists need to acknowledge that oppression exists, need to know the cultural aspects of individuals that affect therapeutic effectiveness, and need to work on developing self-awareness. But it is still threatening to consider acknowledging social privilege within oneself, bestowed by the circumstance of birth and invisibly intrinsic to the perpetuation of social oppression. Psychology needs a pedagogy of social privilege.

BRINGING DEFINITION TO THE ISSUE OF SOCIAL PRIVILEGE

The concept of social privilege and its invisibility appears to have been first identified by sociologist and historian W. E. B. Du Bois in his 1903 book, *The Souls of Black Folk*. Du Bois noticed Black persons needed a "double focus" (Du Bois, 2014, chapter 1, location 60), or an ability to see the self as both Black and American but through the eyes of White persons. In 1935, Du Bois identified the notion of White privilege as he argued that although both Black and White laborers received low wages, "[i]t must be remembered that the white group of laborers . . . were compensated in part by a sort of public and psychological wage" (Du Bois, 2007, chapter 16, location 16468). These psychological wages, or privileges, were later called "the wages of whiteness" by historian David Roediger, in the title of his 1991 book. Here was the first allusion to the coin of privilege and oppression.

About 85 years after W. E. B. Du Bois (2007, 2014), Peggy McIntosh (1988) rekindled a critical dialogue about social privilege, this time in the field of women's studies and education. In her seminal work, McIntosh called attention to systems of privilege that advantage White persons and men, defining privilege as "an invisible package of unearned assets" (p. 1) and later adding "that [it] corresponds to unearned disadvantage in society" (McIntosh, 2013, p. xi). From the field of sociology, Alan Johnson writes that "privilege is always a problem both for those who do not have it and those who do, because privilege is always in relation to others. Privilege is always at someone else's expense and always exacts a cost" (Johnson, 2018, p. 8). For example, able-bodied persons "can usually be confident that whether they are seen as qualified to be hired or promoted or deserving to be fired from a job will not depend on their physical ability" (Johnson, 2018, p. 27).

Psychologists have added in many ways to the concept of social privilege. Tatum (1997) recognized privilege as an implicit or unconscious and unearned advantage. Case (2013) then further defined privilege as "automatic unearned benefits bestowed upon perceived members of dominant groups based on social identity" (p. 4). Helms (2017) later reiterated social

privilege as an ability to decide when an individual or group will wield a system of power to their benefit and the detriment of others.

AN INVISIBLE MULTIPLIER

McIntosh (1988), Tatum (1997), Case (2013), and Helms's (2017) definitions underscore several important and problematic aspects of social privilege. First, as McIntosh suggested, social privilege is invisible or unconscious, especially for those with privilege, and is thus difficult to identify and discuss. Second, social privilege is dependent on social identities—both physically visible and invisible—and is not simply related to a person's race or gender but also to other socially constructed identities, including age, ethnicity, able-bodied status, sexual orientation, socioeconomic status (SES), Indigenous heritage, religion, and national origin. Acknowledgment of intersecting privileged social identities thus expands the conversation from White privilege and male privilege to the more comprehensive concept of social privilege. With this expansion also comes the potential for dilution of the most salient aspects of social privilege, and psychologists must be cautious of drawing attention away from the potent effect of Whiteness on all other social privileges.

If oppression is one side of a weighted coin, privilege is the other, weighted side; privilege dictates which side lands up (Goodman, 2015; Johnson, 2018). This intrinsic tying of privilege to oppression can make privilege seem at first like an interpersonal insult. As such, privilege is neither an easy nor a natural topic of conversation. Self-identification with privilege and discussion of its benefits to those who have it could be seen as deliberate risking of that privilege and its associated benefits (Helms, 2017).

Resistance to becoming aware of social privilege is highest among people who identify strongly with a privileged social identity because there is more to lose. Stewart and Branscombe (2015) describe the defensiveness that results from being confronted with the prospect of social privilege as a barrier to awareness of privilege. From birth, many individuals with privilege are socialized to avoid shame. Antibias education insists educators should avoid making young children feel guilty or ashamed of their identity. However, collective guilt is actually a "critical ingredient" for reducing intergroup bias through social privilege awareness (Stewart & Branscombe, 2015, p. 138).

WHERE THE RUBBER HITS THE ROAD: FROM THEORY TO APPLICATION

With the knowledge of what social privilege is—what it looks like, where to find it, how to describe it—psychologists can begin to understand how social privilege operates. How does the invisible force of privilege perpetuate oppression? How can psychologists then self-examine

and self-reflect on privilege to apply the brakes to inequity? Alan Johnson (2018) highlighted the phenomenon that individuals often compare themselves to groups in society that are afforded more of anything that gives those groups greater power and usually neglect to consider groups in society with less. This sort of confirmation bias bolsters the invisibility of social privilege. Seeing the machinations of social privilege takes effort. Slowing them down for long enough to intervene takes humility and courage.

THE MECHANICS OF SOCIAL PRIVILEGE

In order for psychologists to intervene in the dynamics of social privilege, it is necessary to identify the social categories that prescribe these dynamics. Pamela Hays (2001) first conceptualized the ADDRESSING model, an acronym for each social identity domain that influences the dynamics of psychologists' work. ADDRESSING stands for age, disability, religion and spiritual orientation, ethnic and racial identity, SES, sexual orientation, Indigenous heritage, national origin, and gender identity and sex assigned at birth. Hays recognized the need to explicitly identify each social identity domain and discuss how they are related to either dominant or minority groups.

Social Privilege and Rank

The introduction of the ADDRESSING model is critical as it sparked an awareness of how historical and current systems of power categorize individuals into dominant or minority groups. Thus it has become a common cultural practice to categorize clients, friends, and family members by identity domains such as race, sexual orientation, or gender. This systematic classification has become so commonplace that the U.S. Census relies on these categories, without apparent question or concern. However, these categories are problematic not because they highlight differences in race, gender, or any other identity domain but because they highlight and maintain differences in power and social privilege. Adams, Bell, and Griffin (1997) acknowledged the inherent differences in power and privilege within each social identity domain. Adams et al. introduced the concepts of agent and target to denote the possession or lack of social privilege, respectively. Thus, in the identity domain of race and ethnicity, a White person is considered an agent and a Black person is considered a target because White people have social privilege whereas Black persons do not.

Differences in power and social privilege can also be conceptualized as rank and status (Nieto & Boyer, 2006). Rank is analogous to a privileged social identity domain or being an agent; an individual thus has rank in being male, White, with high SES, able-bodied, heterosexual, or Christian. Status refers to social roles and contexts that confer an individual power,

no matter their social privilege or rank. Individuals may, therefore, have a lower rank in that they are persons of color, female, or identify as LGBTQ+ but have a higher status in that they are a doctor of psychology or a professor in a graduate program, both of which endow them with authority and power in different social contexts. Status, however, does not minimize, balance out, or negate individuals' social privilege or lack of social privilege.

These categorical systems assign value at birth and deprive individuals with a fundamental sense of agency, dignity, and worth. However, despite our lack of control in the operation of systems of power, privilege, and oppression, Nieto and Boyer (2006) argue individuals have authority over their awareness of it. Although the ascribed categories of agent and target, or rank and status, are socially constructed, they have real and dire consequences. This creates difficulty and complication in challenging the systems of power, privilege, and oppression itself. Smedley and Smedley (2005) recognized these complications and emphasized that differences in social privilege are socially ascribed and exist because of systems of power created by historically dominant groups. With regard to the domain of ethnicity and racial identity, differences in social privilege do not exist because of biological differences such as phenotype. Smedley and Smedley review the historical social construction of race and reveal that the term first emerged as a means to categorize Europeans, Africans, and Indigenous populations in the late 17th century. During the American Revolutionary War, "race" became a standardized term and a divisive political tool to justify slavery and oppression. Despite the socially constructed nature of social identity domains, such as race and ethnicity, centuries of American history have been built on the categorization of persons as privileged or oppressed, agent or target; the issue of power, privilege, and oppression is, therefore, a real issue that must be addressed.

Intersectionality of Social Privilege

Kimberlé Crenshaw (1989) introduced intersectional theory and stressed the interplay between the social identities. Crenshaw challenged the single-axis framework that delineated and viewed marginalized social identities as mutually exclusive. Crenshaw recognized "multiply-burdened" (1989, p. 140), or persons who have multiple marginalized social identities—specifically, "Black" and "woman"—were relegated to a distorted and partial frame of either "Black" or "woman," a frame that dismissed Black women as whole persons and rendered them invisible.

Scholars have recently advocated for "responsible stewardship of intersectionality" (Moradi & Grzanka, 2017, p. 500), which involves respecting the theory's Black feminist roots. It is, therefore, important to be cognizant of the history of appropriating the intellectual contributions from marginalized persons. However, psychologists such as Case (2013) have begun to

recognize the benefit of applying intersectional theory to individuals with social privilege. Researchers have found that privileged and oppressed social identities overlap and intersect (Case, 2013; Collins, 1990). Thus a person may have an agent identity of White that intersects with the target identity of female; this person, therefore, has intersecting agent and target domains. The interaction of simultaneously overlapping privileged and oppressed social identities within an individual can also be referred to as "social location."

Social location, or the combination of specific identity domains culled out by the ADDRESSING model (Hays, 2001) and the designation of agent or target, allows individuals to explore both sides of the oppression coin. Social location enables individuals to examine how different aspects of their identity change over time, as does age, or remain stable, as do ethnicity and racial identity. Scholars encourage psychologists to engage in self-reflection, personally explore their intersecting social identities, and contrast their personal experiences of privilege and oppression (Case, 2013). In addition, most individuals have both agent and target identities, which can increase empathy and insight across experience. Such reflection fosters an individual's empathy and understanding for the individual's oppressed identity and other oppressed group members, facilitating a recognition of the detrimental impact of social privilege and greater social privilege awareness within the individual.

THE PRICE OF PRIVILEGE

Wise and Case (2013) acknowledged individuals experience discomfort in their development of social privilege awareness. For example, individuals may feel defensiveness, guilt, or shame when recognizing they are members of a privileged group and part of a legacy of oppression. Wise and Case also suggest individuals may experience hopelessness, as they realize the existence and operation of systems of power, privilege, and oppression function beyond their individual control. If the system of power and oppression covertly confers advantages while awareness creates discomfort, it is reasonable for agents to wonder, What is the benefit of social privilege awareness for me? To answer this question, it is necessary to review the many disadvantages and advantages of social privilege awareness for agents and targets.

Costs to Agents

Spanierman and Heppner (2004) recognized negative affective, behavioral, and cognitive consequences of racism to White individuals. For example, affective costs might include feelings of anger, guilt, or fear toward people of color or about one's White privilege. A White person

may also experience anxiety about living in a racialized world. Cognitive costs can include distortions about people of color or oneself. For example, Clark and Spanierman (2019) suggest a White person may have "an individualized sense of entitlement" (p. 143) or believe people of color fit into narrow stereotypes. Behavioral costs involve living a more limited and restricted life, as a White person may expend energy attempting to filter thoughts and communication to be more politically correct. Alternatively, a White person may exclusively spend time in White neighborhoods and spaces, limiting the person's exposure to different belief systems and cultures. Although Spanierman and Heppner (2004) and Clark and Spanierman (2019) discuss the costs of social privilege for White persons, it is important to be conscious of the fact that each of these costs can be translated to other privileged social identity domains.

Aversive Whiteness

The failure of White persons to see themselves within a racialized world, or in the context of social privilege, may also lead to what DiAngelo (2018) called "White Fragility." DiAngelo discusses how White people's refusal to see their privileged positionality has caused challenges in tolerating racial stress and has thus become "highly fragile in conversations about race" (p. 1). DiAngelo speaks to the affective costs of racism and argues White people become defensive, angered, or silenced when the topics of racism and Whiteness arise. However, as American demographics shift and the number of multiracial and people of color grows in the United States (U.S. Department of Commerce Economics and Statistics Administration, 2018), conversations about racism, Whiteness, and social privilege are inevitable.

Whiteness as Predisposition to Disease

While DiAngelo identifies the fragility of Whiteness and provides examples of associated affective, cognitive, and behavioral costs, Metzl (2019) speaks to the harmful effects of Whiteness on health. Metzl (2019) identifies a paradoxical phenomenon in which midwestern lower-class White groups endorse a set of political values to increase their own health, education, and economic disparities. However, Metzl also introduces a dynamic in which White groups adhere to pro-gun legislation in order to restore White men's privilege and balance of power in an increasingly diverse society. Therefore, although White conservative groups preserve and defend political ideologies intended to secure their power, these same ideologies are the source of their current decline in well-being. Metzl highlights, counterintuitively, "firearms have emerged as the leading cause of white, male suicide" (p. 7).

Benefits for Agents

The benefit of social privilege awareness for agents is often obscured. First, given that remaining unaware of social privilege can induce anxiety within today's racialized world, restrict communication and lifestyle, and evoke feelings of guilt and shame, social privilege awareness presents a possible solution (Wise & Case, 2013). If individuals experience an overwhelming sense of hopelessness in their inability to change the systems of power and privilege, social privilege awareness provides a means toward understanding one's positionality within a historical and systemic framework, thus outlining the limits of individual responsibility and control. Second, open conversations about social privilege normalize feelings of guilt, shame, anger, fear, stress, and worry and renders social privilege less threatening.

Agent Authenticity

Developing social privilege awareness offers an opportunity for individuals to live in a more authentic manner. In applying Spanierman and Heppner's (2004) Psychosocial Costs of Racism to Whites model, D.W. Sue (2010) recognized that White persons who deny racism can live with incongruence. Sue argues there are cognitive costs to being "oppressors" (2010, p. 128), as "they must engage in denial and live a false reality that allows them to function in good conscience." While White persons may believe themselves to be a good person, they live with the conflict of knowing they are "losing one's humanity for the sake of the power, wealth, and status attained from the subjection of others" (Sue, 2010, p. 132). Thus Sue suggests that developing social privilege awareness allows individuals to accept uncomfortable truths and begin to live with more congruence and authenticity.

Agent Compassion

Finally, most individuals have social locations with intersecting agent and target domains; and, even those with all agent domains can recall moments of less power and privilege when they were younger than age 18. This inherent developmental experience can facilitate awareness of gained social advantages. Developing social privilege awareness allows individuals to begin a process of self-compassion and forgiveness. By acknowledging their positionality within the larger historical structure of power and privilege, individuals can recognize the system's effect on their own life and, inevitably, the effect on others.

Making Way for Restoration

Helms (1984) initially called for White psychologists to begin examining the opposite side of the oppression coin, to understand their socially

privileged positions and tacit participation in oppressive systems. While there are personal advantages for privileged persons to engage in a practice of self-reflection about their social privilege, there are also crucial systemic advantages. In their development of social privilege awareness, agents can concomitantly aid in lifting the constraints of inequity and cultivate a space for restorative justice.

Costs to Targets

Social privilege awareness has the additional potential to invite both agents and targets to experience less fear and anxiety about difference. In their book, Torino, Rivera, Capodilupo, Nadal, and Sue (2019) discuss the effects of microaggressions, which "are the everyday verbal, nonverbal, or environmental slights, snubs or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership" (p. 129). While the negative effects of aversive racism are indisputable, implicit biases and attitudes about marginalized persons portrayed in the form of microaggressions are more challenging to dispute.

Torino et al. explain microaggressions can be explicit or implicit but are often difficult to identify; although they may be delivered by well-meaning individuals who support anti-racist attitudes, microaggressions reflect the invisible and unconscious nature of social privilege. Thus the aggressors may not recognize they are committing microaggressions, and the victims may not realize they are the recipients of same; however, Torino et al. highlight that even when microaggressions go unnoticed, the victim is typically exposed to a range of uncomfortable experiences, including confusion, anger, range, anxiety, depression, and hopelessness.

Smedley and Smedley (2005) emphasize that while race and ethnicity are social constructions, their consequences are dire and tangible. Similarly, microaggressions may be perceived as subjective, yet they also contribute to real-life consequences. Dovidio, Pearson, and Penner (2019) note that microaggressions occur within the delivery of health-care systems and, when compared to Whites, contribute to poorer health for Black persons across the life span.

POWER IN ILLUSION, NOT NUMBERS

U.S. Census data from 2014 projects that by 2045, about 50 percent of the American population will identify as non-White, while more than 50 percent of younger generations, such as 18- to 29-year-olds, will identify as non-White by 2027. In their study, Cohen, Fowler, Medenica, and Rogowski (2017) found that about 48 percent of White millennials believe discrimination is of equal concern for White persons as it is for Black, Asian, or Hispanic persons. These findings are especially concerning given that in 2016, White psychologists constituted about 84 percent of the

psychology workforce (American Psychological Association, 2018); which suggests that incoming professionals may not fully appreciate the lived experiences of growing marginalized groups and may inflict harm by invalidating, minimizing, and dismissing the reality of marginalization.

Helms (1984) recognized the power of social privilege to place undue burden on oppressed groups to identify, discuss, and address systems of power and privilege. However, as social privilege remains invisible, so, too, does the source of oppression, conveniently removing the responsibility of privileged groups. Echoing Helms, DiAngelo argues, "Whites invoke the power to choose when, how, and to what extent racism is addressed or challenged" (2018, p. 108). Privileged persons have the power to control the conversation. By focusing on oppressed groups, the invisibility of social privilege places "the problem" and the potential solution to the problem within the other. This enables privileged persons to deflect responsibility and maintain their privileged positions.

Take into account the short vignette at the beginning of this chapter. The therapist was uncomfortable about her client's willingness to call attention to their racial differences, which resulted in her anxious avoidance of the topic of race. She asked, "What were you doing?" "What can you do to make this easier?" The therapist had difficulty tolerating racial stress and instead deflected responsibility by placing "the problem" and burden of change on her client.

SHIFTING GEARS: FROM TARGET TO AGENT, FROM AGENT TO ALLY

Social privilege awareness removes the burden of change from targets; social privilege can finally be examined as an agent's problem, as it has been since its conception. As responsibility is reassigned and systems of power and privilege are acknowledged and called into question, oppressive myths begin to shatter. Social privilege challenges the myth of meritocracy, the idea that individuals earn advantages solely by their effort and abilities. Such a notion positions oppressed persons to incorrectly believe their disadvantages are based on their characteristics and personhood. Social privilege awareness, therefore, assists in liberating marginalized group members from oppressive myths of self-worth, stereotypes, internalized oppression, and pervasive feelings of shame.

"Ally": Noun, Verb, or Both?

Despite the APA's call for psychologists to engage in allyship, there are few resources that provide clear standards and guidelines about what responsible and ethical allyship entails. According to Tatum (2007), a White ally is "namely, a White person who understands that it is possible to use one's privilege to create more equitable systems; that there are

White people throughout history who have done exactly that; and that one can align oneself with that history" (p. 37). This role can be expanded outside of a racial framework, and the APA's 2017 Multicultural Guidelines call for psychologists to practice within the boundaries of what Tatum defines as allyship.

Steps to Allyship

Spanierman and Smith (2017) outline the defining features of White allies and six steps toward becoming an ally. The following six steps are modified to speak beyond White allyship and consider allyship in all social identity domains. According to Spanierman and Smith, the six steps involve:

1. Gaining a nuanced understanding of institutional oppression and social privilege
2. Enacting a continual process of self-reflection about one's own racism, biases, and positionality
3. Committing to promoting equity from a position of privilege
4. Taking responsibility for actions against racism, discrimination, and the status quo on multiple levels
5. Participating in solidarity work with people of marginalized groups
6. Encountering resistance from other socially privileged individuals

While the final three steps are dedicated to engaging in specific behaviors, the first two foundational steps suggest allies should understand institutionalized privilege and oppression and engage in a continual process of self-reflection about their privileged social location. Spanierman and Smith (2017) thus argue that all allyship should begin with a fundamental development of social privilege awareness. Without a commitment to this fundamental first step, Spanierman and Smith warn that although well-intentioned, allies are susceptible to adopting "savior attitudes and behaviors" (2017, p. 610); the ally work can become shallow, with the ultimate purpose of fueling the privileged person's desire to live in good conscience instead of enacting and facilitating "deep structural change" (Spanierman & Smith, 2017, p. 610).

Applying Allyship in Practice

In the vignette, despite the therapist's multiculturally competent training, the exchange was tense and stressful for both the client and the therapist, undermining therapeutic rapport and treatment. Further, although the therapist was well-intentioned, without her engagement in Spanierman and Smith's (2017) fundamental first two steps of becoming an ally, her efforts to help her clients can be perceived as empty advocacy, as her effort was primarily directed toward easing her own discomfort. Had the

therapist expanded her nuanced understanding of systems of power and privilege and engaged in self-reflection about her social privilege, she might have been less apt to perpetuate oppressive forms of interaction and enact ongoing racial trauma for the client.

In their six steps toward allyship, Spanierman and Smith (2017) introduce the need for a developmental framework. Each step builds on the other and, without the fundamental first step of self-reflection about one's own social privilege, allyship can manifest as empty, shallow, and harmful work. Sensoy and DiAngelo (2017) and Case (2013) assert that becoming aware of social privilege is no easy task. Malin Fors (2018) astutely states, "There is no doubt that discovering blind spots in oneself is challenging and sometimes quite painful" (p. 4). Unlike the single-axis structure of either agent/target or "privileged" and "not privileged" in which we currently live, social privilege awareness does not exist within a binary or dichotomous framework. Much like the concept of growing pains, the difficulty in developing social privilege awareness alludes to the developmental nature of the process.

A DEVELOPMENTAL PERSPECTIVE

Psychology has long been the source of developmental theory, spanning from the moral and cognitive to the sexual and social. Piaget (1976) established the dynamic cognitive leaps children make from birth to adolescence, which has influenced primary education ever since. Kohlberg (1981) took Piaget's model a step forward, elucidating how our moral and ethical values increase in sophistication over time. Erikson (1968) labeled the essential tensions that define stages across the life span. Bandura (1997) bridged the behavioral and cognitive, positing that social learning results in self-efficacy. These models provide a temporal map that permits individuals to move and grow over time. The developmental perspective allows for progression and growth, accumulation and scaffolding, in which change is natural and normal.

The arena of social privilege is fraught with shame, anger, and isolation. The "call-out culture" results in fear to open up to others about our confusion regarding the latent and inevitable racism, sexism, and ableism that have been ingrained in all of us. The unrealistic demand that individuals immediately become woke versus the process of awakening results in a dichotomy that gives no room for gray, only a demand that we think, say, and act on the ideal values of equity. While aspiring to move from an agent to an ally, we will all struggle to shake the socialization that reinforces implicitly privileged thought, feeling, and behavior. Applying a developmental lens to social privilege can offer permission, relief, and encouragement in the unsettling task of acknowledging our privilege and moving to disrupt the structures and institutions that serve to gate-keep resources. The incremental developmental perspective counteracts the

accusation of intentionality and instead establishes that our lack of social privilege awareness is a common and reasonable starting point. Thus not being aware of our social location does not infer mal intent, despite its negative consequences on others.

There are contributing factors, social interactions, and cognitive frameworks required for the development of effective allyship. Since development is sequential and cumulative, we must give ourselves and others permission to progress instead of demanding that we leap to the desired outcome. Coming to terms with our own social location and privilege is difficult, and the fear of being called out as not woke can be counterproductive. Developmental theory includes the aspect of regression, in which negative experiences can cause an individual to get stuck or revert to a prior stage. A sense of compassion for privileged individuals who are trying to increase their capacity of allyship can be a powerful motivator. Just as we soften when we see a child struggling to learn, we can offer ourselves some forgiveness in not fully understanding the pervasive power of our social privilege.

Psychologists have utilized a developmental perspective to elucidate racial identity development, which often alludes to racial privilege but does not clearly call it out. Developmental models by Cross (1978), Thomas (1971, as cited in Ponterotto, 1988), and Root (1996) supported and guided the shift from a singular to multiple realities and focused largely on the developmental experience of persons marginalized within American society. Models such as these could be resources to practicing psychologists, but the foundational guidelines for implementing such models in culturally competent practice have been mostly theoretical (Sue, 1996). Contemporary critique of these models is that they focus solely on racial target domains and put the burden of liberation squarely on individuals of color.

Psychologists must consider that the use of models focused only on one side of a therapeutic relationship could "reinscribe White hegemony" (Spanierman, Poteat, Whittaker, Schlosser, & Arévalo Avalos, 2017, p. 619) and other systems of power. Other than White Racial Identity Theory (Helms & Carter, 1993), the Psychosocial Costs of Racism to Whites Scale (Spanierman & Heppner, 2004), the Racial Consciousness Development Model (Ponterotto, 1988), and the Model of Intercultural Sensitivity (Bennett, 1986), developmental theories specific to persons with privilege and in positions of power in American society are conspicuously absent from the developmental or clinical psychology literature. Studies specific to training culturally competent therapists have either applied scholar-conjectured models in classroom training (Case, 2015; Ferber & Herrera, 2013; Goodman & Jackson III, 2011) or focused on small cohorts of culturally competent White counselors to explore growth of a culturally competent perspective (Atkins, Fitzpatrick, Poolokasingham, Lebeau, & Spanierman, 2017; Case, 2007; Goodman, Wilson, Helms, Greenstein, & Medzhitova, 2018; Ouellette & Campbell, 2014; Pruegger & Rogers, 1994).

Coming to terms with our own social location and the ascribed privilege, both in the personal and professional sense, requires sustained effort. A developmental perspective can offer permission, acceptance, progression, compassion, and hope. While there are various developmental models exploring racial identity and cultural competency, there are not many resources applied directly to social privilege. We encourage the field of clinical psychology to remedy this gap.

APPLYING THE BRAKES TO SOCIAL PRIVILEGE

To review, social privilege has recently entered the grand forum of psychology discourse through multicultural psychology, cultural competence, and social justice. As a distinct construct within the frame of social justice, social privilege is fraught with political and emotional tenor, which has kept it from the general purview of psychology. Social privilege is allocated by societal institutions such as law, economics, and education in order to benefit those historically advantaged. Social privilege calls us to move beyond our attention on oppression and its survivors to how we are complacently involved in the system of oppression simply by being a part of society. If we confront privilege, we realize that we unintentionally benefit from it despite the fact that we disagree with it. The imperative work of psychologists to continue the legacy of social justice and advocacy that was initiated decades ago requires psychologists to meaningfully translate social privilege reflexivity into research, education, and practice.

Research

Psychologists ought to now join the ranks of "scholars in each field [who] are asked to be accountable for recognizing that privilege exists in creation of knowledge as well as in all other human experience, and should be included in frames of analysis and discourse" (McIntosh, 2012, p. 195). In the heyday of the multicultural psychology revolution, White researchers called attention to the "Eurocentric bias present in the *Diagnostic and Statistical Manual of Mental Disorders*" (Spanierman & Poteat, 2005). Recent qualitative studies in counseling psychology have turned the focus toward this bias (e.g., Atkins et al., 2017; Smith, Kashubeck-West, Payton, & Adams, 2017; Spanierman & Smith, 2017; Spanierman et al., 2017). Although these researchers were well-intentioned, "the authors focused very little attention on the benefits of their internalized whiteness as impediments to fulfilling their scholarly and professional goals" (Helms, 2017, p. 717).

There is minimal momentum in psychological research and even less mainstream literature that aim to understand the experience and effects of privilege on researchers, educators, and practitioners. As many before now have implored, reflexive research of social privilege in psychology

must address the "what," "how," and "why" of research, education, and practice. Such research can inform hypotheses, design, analysis, interpretation, and implementation. A developmental model of social privilege as a general construct could guide educators and clinicians.

Education

Despite the APA's recent call to action, there is a dearth of literature offering approaches, standards, and outcomes for implementing doctoral-level social justice pedagogy in clinical psychology curricula. Literature focuses on social justice philosophies, definitions, and competencies (Ali, Liu, Mahmood, & Arguello, 2008; Motulsky et al., 2014, Singh et al., 2010) without offering practical suggestions for social justice implementation across doctoral psychology curricula.

Among 66 doctoral-level psychology trainees, Singh et al. (2010) found that 85 percent had not taken a course with social justice content, and the trainees reported disparities in their definition of social justice. However, Singh et al., also found that the majority of participants endeavored to integrate social justice into their practice and sought social justice training outside of their academic programs. Vera and Speight (2003) suggest training the next generation of psychologists as change agents. If the field of psychology is to realize the APA's social justice aspirations, doctoral-level psychology programs must begin to consider a comprehensive inclusion of social justice pedagogy.

Practice

Despite best efforts, there is no clear standard for social justice practice in clinical psychology. Current literature seldom incorporates social justice perspectives into clinical practice. However, the lack of social justice initiatives in the therapeutic space is understandable. Psychology has a long-standing history and tradition of remaining therapeutically neutral. Especially with the push for evidence-based practice, the psychologist's personhood is conveniently left out of the therapeutic dyad. Although we are asked to engage in self-reflection and be aware of our racial biases, political attitudes, and personal values, most theoretical orientations discourage us from explicitly bringing these human parts of ourselves into the therapy room. As one of the sole authors addressing power in psychotherapy, Malin Fors (2018) recognized the importance of differences and similarities of social privilege within the therapeutic dyad, and their effects on the outcome of therapy. She provides practical tools for incorporating what she refers to as the "matrix of relative privilege" into clinical practice (Fors, 2018, p. 59).

Thrift and Sugarman (2019) argue that psychology has failed to acknowledge the historical context, evolution, and implications of social

justice. Thus psychology has ignored the wider political and moral debate about "human freedom, individual and collective responsibility, and the role of the state" (Thrift & Sugarman, 2019, pp. 13–14) that necessarily accompanies social justice. Moreover, psychologists such as Goodman et al. (2004) call for professionals to become change agents who pursue challenging "societal values, structures, policies, and practices" (p. 793). The introduction of social justice invites American history and collective responsibility into the therapeutic dyad. We are no longer alone in the therapy room. We are no longer only advocating for our client but for the collective good.

TRANSFERRING MOMENTUM

Let's revisit the opening scenario. When clients are asking for the therapist to recognize and meet their needs, and the therapist has no historical context or internal reference point for recognizing the experience of oppression, how can the therapist be therapeutically effective? Unaddressed power imbalances between therapist and client can be the source of therapeutic ruptures, misinterpretation, and ongoing harm by replicating the silent and invisible oppressive patterns that clients experience throughout life. Without clear research on how a therapist who has cultivated privilege awareness should or would respond, it is a risk to trust that the combination of self-reflection, accountability, and foundational clinical skills would prepare the therapist to validate the client's experience of a legacy of inequity and injustice.

In following the APA's practice guidelines, psychologists are called to first delineate their social location, acknowledging the identity domains in which they hold agent or target rank. Second, psychologists must cultivate ongoing self-awareness about how their positionality influences their cognitive biases, relationships, and life accomplishments. And finally, they must own their positionality in relation to those they serve across the roles of researcher, educator, and therapist.

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CHAPTER 3

Psychology of Liberation

Strategies to Engage in Transformative Practice in Public Schools

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Washing one's hands of the conflict between the powerful and the powerless means to side with the powerful, not to be neutral. —Freire, Pedagogy of the Oppressed

Education is the civil rights issue of our time. . . . We must recommit, as a nation, to programs and policies that close opportunity gaps and help all students reach their potential. —Arne Duncan, U.S. secretary of education, July 2, 2014

BACKGROUND AND HISTORICAL ROOTS OF LIBERATION PSYCHOLOGY

Over the last 30 years, liberation psychology has emerged as a "distinctive way of doing psychology" (Montero, Sonn, & Burton, 2017, p. 149). The roots of liberation psychology can be traced to Latin American liberation theology during the period between the 1960s and 1980s and are found in the context of widespread poverty and social injustice in this region. Gustavo Gutierrez (1971/1988), known as the "father" of liberation theology, argued that the directive to struggle against poverty and injustice emerged from Christian teachings. Gutierrez developed the notion that we should adopt a "preferential option for the poor," which

includes a moral responsibility to take the side of the oppressed and to work with them to create a more just and better world.

Ignacio Martín-Baró, a psychologist and priest in El Salvador, championed Gutierrez's ideas and similarly argued that psychologists should adopt the "preferential option for oppressed majorities" and work with the oppressed to develop strategies for social change. Martín-Baró's words, nearly 30 years ago, still provide a radical call to action for psychologists: "We have to redesign our theoretical and practical tools, but redesign them from the standpoint of the lives of our own people: from their sufferings, their aspirations, and their struggles" (Martín-Baró, 1996, p. 25). Gutierrez's and Martín-Baró's commitment to marginalized people carried a high cost: imprisonment for Gutierrez, and for Martín-Baró, his life, as he was murdered by the Salvadoran army. However, these ideas continue to provide a theoretical lens and moral impetus to inform psychologists' work in challenging structural injustice and inequity in arenas such as the public school system in the United States.

We focus on racial inequity in the U.S. public school system and apply concepts and strategies from liberation psychology to conceptualize and confront this social and systemic injustice. The history of racism and its multiple forms in public school harms students of color of all ages. We believe liberation psychology is best suited to address this oppression. In contrast to traditional psychological perspectives that privilege an individualistic, decontextualized, and "objective" view of the world, liberation psychology frames psychological issues within the context of power, critical *concientización*, and the transformation of oppressive conditions (Martín-Baró, 1996). This model envisions change to occur at both the personal and political levels (Moane, 2003), offers the potential to abolish inequity and promote well-being (Prilleltensky, 2003), and engages people in their own process of liberation. We argue that due to the presence of multiple levels of racism in the U.S. public school system, students of color face unique and persistent adversity that may be remedied through the application of liberation psychology principles and strategies.

Specifically, the historical and conceptual roots of liberation psychology in the development of practices acknowledge the interdependence of psychology with broader sociopolitical contexts in the pursuit of social justice. Racism and racial inequity in schools and classrooms using a liberation psychology pedagogical framework illustrate the history of educational inequity in the public school system. A case example of Micah illustrates specific issues in the application of liberation psychology principles, strategies, and methods to U.S. public schools, which may generalize to other educational settings to incite systemic anti-racism. Obstacles to this process are delineated. We conclude with recommendations for how liberation psychology may be used to form relationships to analyze the causes of marginalization, create conditions that heighten awareness of

dehumanizing social inequities, and unite marginalized communities in transformative practice (Burton & Kagan, 2009). Finally, a list of resources related to educational advocacy and liberation psychology is provided.

TOWARD AN UNDERSTANDING OF LIBERATION PSYCHOLOGY

The meaning of the term "liberation" in liberation psychology refers to a process of transformation of both the conditions of inequality and oppression and the institutions and practices producing them. It is "an ethical-critical-empowering and democratizing process of a collective and historical condition" (Flores Osario, 2009, p. 16). Hence for liberation psychology, the point of departure is the "conscientization" of the people, that is, a process in which the participants become aware of their rights and duties in society and develop a critical perspective on the world in order to transform it. The term "concientización" was first used by the Brazilian educator Paulo Freire and roughly translates to the raising of politicosocial consciousness. Concientización refers to the acquiring of a critical consciousness (Freire, 1970/1993) and supports the notion that lived experiences are inherently related to sociopolitical structures surrounding individuals.

At the same time that liberation psychology works to raise the consciousness and empower the oppressed, the praxis (or unity of theory and practice) (Freire, 1970/1993) of liberation psychology also works to alter the "oppressors," who are also seen as alienated. Hence liberation psychology is inclusive in endeavoring to build a just and egalitarian society for all people (Flores Osario, 2009; Montero & Sonn, 2009). The aim is to change the social identity of both the "oppressed" and the "oppressors" in order to emancipate all and strengthen democracy and society. The point of departure, however, is those in need, the excluded, those suffering from inequity due to historical, cultural, and social conditions and who are often ignored by society (Montero, 2007).

Our focus is the enormous inequity in the U.S. public school system, which, according to a report by EdBuild (2019), is directly connected to a $23 billion gap in funding between White school districts and school districts that predominantly include children and youth of color, even though the two districts serve roughly the same number of children. High-poverty districts serving mostly students of color receive about $1,600 less per student than the national average, with this discrepancy largely related to how much local residents pay in taxes (EdBuild, 2019). This gap means children in resource-deprived schools serving mostly students of color have disproportionately fewer rigorous math, science, and college preparatory courses, fewer academic programs and extracurricular activities, along with lower-paid teachers and staff and crumbling infrastructure. As noted in the opening letter of a Government Accountability Office (GAO)

report, "children who live in neighborhoods with a high minority population and with high levels of poverty tend to go to schools mirroring these demographics" (U.S. GAO, 2016, p. 1).

DEFINING RACISM IN U.S. SCHOOLS

Racism and intersecting classism perpetuate the inequity experienced by students of color (Blanchett, 2006; Dixson & Rousseau, 2005; Riley, 2010). Racism, as defined by Ibram X. Kendi, is a "marriage of racist policies and racist ideas that produces and normalizes racist inequities" (Kendi, 2019, p. 18), which operates on four levels: structural, institutional, individual, and internal. Structural racism refers to a system inclusive of public policies, institutional practices, and cultural norms that promote and perpetuate the inequity of people of color. Structural racism is the means through which racism is diffused and infused into economic, social, and political systems, including the education system, continually producing new and reproducing old forms of racism (Gee & Ford, 2011; Lawrence & Keleher, 2004). Institutional racism manifests in discrimination that occurs within and between institutions such as schools and governmental agencies. Inequitable policies, procedures, and opportunities may represent institutional racism (Griffith et al., 2007; Lawrence & Keleher, 2004). Individual racism refers to racist assumptions, beliefs, or behaviors and is "a form of racial discrimination that stems from conscious and unconscious, personal prejudice" (Henry & Tator, 2010, p. 329).

In the context of the school system, representatives of institutions, such as administrators, faculty and staff members, or parent volunteers, may perpetuate institutional racism through behaviors and beliefs (Lewis & Diamond, 2015). Lastly, internalized racism is the personal conscious or subconscious acceptance of racial hierarchy in which White people are viewed as superior (Perez-Huber, Johnson, & Kohli, 2006). Internalized racism may lead students of color to believe that they are inherently less intelligent, and personally responsible for not being as smart as White peers (Perez-Huber et al., 2006). Our case example will describe the experience of a Black elementary school student who is confronted by racism at the institutional level, which manifests in internalized racism and ultimately compromises his access to education.

Racism in U.S. Schools: White Resistance

Research demonstrates that institutionalized racism in U.S. schools is a by-product of structural racism. Examples of the four levels of racism can be identified in the history and current state of the U.S. public school system. For example, the presence of structural racism in the U.S. public school system can be observed through the reactions of White communities to integration efforts. Nikole Hannah-Jones, investigative reporter

and former integration program student, covered the 2013 story of the Missouri State Department revocation of accreditation from one of the most segregated and lowest-performing schools districts in the state, Normandy School District. As a result of losing their accreditation, the School Transfer Law was enacted, and the Normandy District, with more than 95 percent students of color at the time (Missouri Department of Elementary and Secondary Education, 2013), was required to provide financial support to bus students to a predominantly White school in an accredited district. As Jones describes, Black families rejoiced at the opportunity for Black children to experience higher-quality educational experiences, but families of the predominantly White Francis Howell School District, which would receive Normandy students, reacted in outrage. At a town hall meeting of roughly 3,000, predominantly White attendees, parents spoke to elected school board officials about their fears of including Normandy students, fears that mainly derived from their expectation that children of Normandy would bring violence to their communities (Hannah-Jones, 2015).

This example, decades after school desegregation, demonstrates the same reaction: White resistance (Clotfelter, 2004). This effort to integrate a school district represents an institutional change, as the district was legally required to accommodate the influx of students. However, the resistance of White parents stems from the cultural belief that Black children are prone to violence, a symptom of structural racism and a belief that was proven wrong. Instead, within a short time, the achievement gap between students in the two schools was cut in half at the newly integrated school (Hannah-Jones, 2015). The White resistance in this example demonstrates not only racism but also the absence of the liberation strategy of social orientation, which, as we will describe, can counter oppressive beliefs liberating both for those prone to perpetuating them and those subject to their effects.

Racism in Schools and Black Families

This kind of institutional racism and educational inequity in the education system also enables acts of individual racism against students and families of color. For example, a 1999 case study by Temple University describes the complicated dynamics between Black parents and White school administrators and how these relationships differ from those of White families who are more successful in navigating their children's school systems. The case details Black parents identifying and addressing patterns of racism in the school, including Black boys receiving more severe punishment for the similar behaviors of other children, Black history receiving little to no acknowledgment, and teachers providing more direct academic support to White students than to Black students. Black parents were described as "upsetting" and "angry" by members of

the school when they addressed these concerns and consequently were excluded from volunteer opportunities for their efforts (Lareau & McNamara Horvat, 1999). Black parents were not successful in advocating for their children in this case because their concerns were dismissed as dispositional emotional reactions. The attribution of their outrage with the school to disposition rather than to its source, subtle and covert racist practices in the school, contributed to a delegitimization and invalidation of their concerns and a denial of racism in the institution. The case also reports on Black parents who identified patterns of racism within the school but did not directly address their concerns with administration. Administrators and teachers found these parents more likable, and they received more opportunities for participation. Parents were indirectly encouraged not to advocate for their children when they observed racism. This case details the ways in which racism in schools impacts the family system, as Black parents who tolerate racism experienced better outcomes regarding school involvement.

Acts of racism are frequently insidious or covert in nature and are therefore challenging to notice and confront. The liberation principle of deideologizing reality involves supporting the oppressor and the oppressed in acknowledgment of the presence and reality of oppressive forces, including racism. Further, the principle of conscientización involves the ability of the oppressor and the oppressed to recognize biased beliefs and their consequences. Including these principles in school culture creates opportunities for parents and students to safely identify racism when they see it and requires that these concerns be heard. Additionally, liberation principles in the culture of an institution work to prevent inequity.

Racism in the Classroom

Individual and institutional racism also impacts the dynamics between teachers and students. Teachers report being more likely to call on Black students when they are asking easy questions and more likely to choose White students for difficult questions (Landsman, 2004). When Black students demonstrate behavioral problems—including tardiness, submitting assignments late, arguing with teachers, and fighting with peers—they receive fewer verbal and written warnings and are more likely to be punished than White students showing the same behaviors (Landsman, 2004; Wegmann & Smith, 2019). The U.S. Department of Education reported that in the 2015–2016 public school year, Black students made up nearly a third of all students arrested at school or referred to law enforcement but only 15 percent of overall enrollment. In addition, Black, Native American, and multiracial students were similarly disproportionately likely to be the targets of reported harassment based on race, sex, and disabilities. Students of color, particularly Black and Latinx students, were also significantly

less likely than their White counterparts to be enrolled in STEM courses in high school (Kena et al., 2016).

The racial and economic disparities seen in schooling experiences for young students of color likely interact with and potentially contribute to each other. Fewer students of color in STEM courses may contribute to racist assumptions about their intelligence, and excessive disciplinary action may suggest that students of color are unsafe or dangerous. Both of these messages may contribute to internalized racism. In addition to the obvious social and educational barriers these inequities create for these students, these disparities intensify the overall stress of racism, which from a biopsychosocial perspective is a serious detriment to physical and mental health (Clark, Anderson, Clark, & Williams, 1999). A review of empirical research articles on racism and health in children and adolescents concluded that perceived racism is associated with depression, anxiety, substance abuse behavior, poor conduct, and anger (Pachter & Coll, 2009). Liberation psychology is uniquely suited to address these disparities at multiple levels when incorporated into the training of teachers and other education professionals, school policies and procedures, and curriculum. As we will discuss, incorporation of liberation strategies at multiple levels can contribute to a cultural shift in the school system toward racial equity.

HISTORY AND CONCEPTUALIZATION OF INEQUITY IN SCHOOLS

The complex theoretical roots of racial inequity in schools are longstanding and can be connected to all four levels of racism: structural, institutional, individual, and internal (Kendi, 2019). Historically, these roots can be traced back to the fundamental rulings of the *Plessy v. Ferguson* 163 U.S. 537 (1896) case that led to the "separate but equal" doctrine, or the often-referenced *Brown v. Board of Education*, 347 U.S. 483 (1954) case that led to racial integration in public schools. These rulings marked significant changes in the fight for racial equity from a structural and institutional perspective. However, as will be discussed in the next section, the values associated with structural racism persisted nationally, impeding the potential progress toward racial justice that may have been possible through this policy change.

In 1903, the famous equalist, W. E. B. Du Bois wrote that "the problem of the 20th century is the problem of the color-line" (Du Bois, 1903, p. v). Over 100 years later, institutional racism remains a barrier to every individual's right to equitable education. The introduction of zero tolerance policies adopted as forms of school discipline has contributed to racial disparities in the education system (Daly et al., 2016). Policies such as the Gun-Free Schools Act of 1994, which "mandates specific disciplinary consequences for negative student behavior" (Daly et al., 2016, p. 259), and

the No Child Left Behind Act of 2001, which has been used to justify the expulsion of students of color with problematic behaviors (Klehr, 2009) that can be traced back to the "war on drugs," have inevitably contributed to racial inequity in schools.

Research demonstrates the ways in which these policy decisions result in institutional racism, particularly for young Black males who have the highest likelihood—2.19 times in elementary school and 3.78 times in middle school—of being referred to the office for disruptive behavior compared to White students for similar or more disruptive behavior (Skiba et al., 2011). A higher likelihood of office referrals leads to a higher chance of being suspended or expelled from school (Cardichon & Darling-Hammond, 2019), and negative impacts related to suspension and exclusion include compromised educational outcomes due to lost instruction time, lower academic success, lower graduation rates, and increased likelihood of involvement with the juvenile justice system (Steinberg & Lacoe, 2017; Wald & Losen, 2003). In general, Skiba, Peterson, and Williams (1997) found that White students are typically suspended or expelled for fighting, vandalism, theft, and acts of physical aggression, while Black students are often suspended for discretionary acts such as defiance, misbehavior, and verbal threatening. Essentially, Black students are suspended at the determination of their teachers, suggesting the same presence of the "color line." Strategies from liberation psychology creates the possibility for this history of racism to end, as it forces awareness of and reflection upon the presence of racism in the history of U.S. schooling and requires collaborative action toward equity.

CASE EXAMPLE: MICAH'S STORY

This case comes from the experience of the third author, who worked as an outreach mental health therapist in the public school setting. The third author identifies as an African American male who is of similar background to the client and who also attended a predominantly White public school. This case provides a detailed example of institutional and individual racism and describes the incorporation of several strategies derived from a liberation perspective to support behavioral and emotional remediation. Some of these strategies include representation, positive reinforcement, depathologizing, and cultivating an empowering environment through mutual support and challenge. All identifying information has been changed in order to protect the identity of the individual and maintain confidentiality.

Micah was a six-year-old African American male attending an urban magnet school in the northeast United States. He was referred to a local community-based agency that specialized in the behavioral treatment of children and adolescents by his mother for behavioral concerns while in school. Micah's referral paperwork included descriptive information such

as in-school suspension forms, incident reports written by his teacher, a recent Vanderbilt assessment suggesting issues related to ADHD, conduct disorder, and oppositional behaviors, and a recommendation from the school psychologist suggesting additional testing and alternative placement in a behavioral school setting.

The incident reports written by his teacher provided a detailed, first-hand account of Micah's behavior in school. The reports included recurring incidents of stealing, major class disruptions, fighting, kicking, punching, and physical assault against teachers and aides. The reports also included suggestive statements made by Micah, such as, "I'm going to slap you," "I'm going to kill you," and "I hate you." Despite the school's foundational mission to develop children physically, socially, emotionally, and cognitively, initial reports suggested that Micah had significant behavioral challenges within the school that were extreme and disruptive and that jeopardized the safety of himself and others.

My first encounter with Micah and his mother provided some useful background information into their everyday experience. Micah's mother was a 23-year-old, single, African American parent who worked as a childcare assistant. Micah and his mother received government assistance and lived together in low-income housing while Micah's father was incarcerated. Micah, who couldn't remember his father, was told that he had passed away. His mother was in the process of enrolling in a local community college to work toward her associate's degree. His mother emphasized how much she wanted to provide her son with the highest quality of education that she could and stated, "I work so hard to try and get him to behave in school, but he's just bad, and I'm ready to give up," as Micah sat next to her. "They call me for every little thing and want him to switch schools. He's not really bad at home, though, just at school. He knows what he's doing is wrong and he just keeps doing it."

During our first encounter, Micah was guarded, suspicious, and very active. Micah stood on his chair, sat down, and would talk and giggle to himself. Micah's mother frequently directed him to pay attention while answering questions, but Micah would respond briefly and then continue doing whatever he was doing. Micah appeared to be testing the limits of a new environment. When Micah did not want to answer questions, he would cover his ears, hum, and giggle. Micah's mother eventually persuaded Micah to pay attention and sit still by promising him ice cream following the initial encounter. Micah seemed nice, curious, and playful. Micah did not show any signs of physical or verbal aggression and seemingly paid attention and responded to his mother's requests in a respectful manner. My initial impression, although relatively brief, was that Micah's presentation was significantly different from his school reports. Curiously, I wondered if the striking difference in presentation was because we had just met or if it was because his mother was there. Or was there something just different about Micah's behavior at school?

Following Micah's first session, I decided to meet with the administration at the school to discuss his behavior and get some additional information. The school representatives included the principal, vice principal, school nurse, kindergarten teacher, school adjustment counselor, and the part-time paraprofessional who provided behavioral assistance in the classroom. The school representatives were middle-aged, White American women with the exception of the school adjustment counselor, who identified as a Latina woman. During the meeting, countless stories were shared by the school representatives expressing concerns about Micah's problematic behavior. One member stated that the only solution the school could come up with to manage his behavior was to have Micah speak to the African American male custodian, since he seemed to connect with him. This suggestion led me to question whether the school administrators were simply having difficulty connecting with Micah due to his race and therefore magnifying his behaviors.

The meeting concluded with the school representatives pushing for a diagnosis of oppositional defiant disorder. The principal requested that a behavioral intervention plan be completed in order to address the school's concerns about Micah's behaviors or else the school would recommend Micah be placed in a traditional public school that might be better equipped to handle him. As the principal left the meeting, the principal asserted, "I commend your effort in trying to help this little boy. We all want to see him do well. He's a bright kid, but his behavioral issues aren't normal for our school setting. Maybe he needs medication? He's a strong boy now, and he has a lot of anger. I'm not sure if it's because his father is out of the picture, but he's got a lot of anger pent up. We unfortunately get the brunt of it. We can handle him kicking us now, because he's six, but what about when he gets older? What about next year, or the year after that? He's going to get bigger and stronger, and he's going to hurt someone! We can't have teachers afraid of him. We have to consider him a threat to the safety of others. We don't think he'll be safe in our school, and it might be better if he went somewhere else." This statement made by the principal demonstrated not only individual prejudice and racial bias but also the concept of White resistance (Clotfelter, 2004).

Countless families of color experience similar narratives in the public school system, suggesting the presence of institutionalized racism. During a classroom observation with the school adjustment counselor, I noticed Micah coloring at his desk. His desk was separated from his peers, which was striking. The school adjustment counselor informed me that Micah had been disruptive that day and in response to his behavior, the teacher separated his desk from the rest of his peers to limit distractions. Micah was one of two non-White students in the classroom. The school adjustment counselor began narrating as Micah got out of his seat, went to another student's desk, and took a blue colored pencil. The school adjustment counselor described the incident as "stealing" and stated that this

behavior was what they experience on a daily basis. When Micah finished coloring with the colored pencil, he returned it. Had this been what was previously reported as "major classroom disruptions"? This did not feel right!

Immediately after the school observation, I sought supervision with our clinical director, a former school psychologist in the public school system who discussed case after case detailing incidents of racism that she observed within the public school system. "School administrators who are generally and predominantly White, frequently target and label boys of color because they don't understand them," the director concluded. This was my first experience learning about racism in the public school system, despite having gone through the school system myself. It was surprising but demonstrated the disconnect between not only teachers but other school administrators of different races with non-White students—in this particular case, Black male students. This was an example of institutional racism.

Micah attended individual therapy twice a week and met with a therapeutic mentor once a week to help improve his emotional expression and social skills. Micah was pleasant, funny, intelligent, and charming. It was clear that Micah was misunderstood by his teacher and other school administrators. Micah enjoyed puzzles, coloring, card games, sports, and situational role-playing focused on the development of positive social skills. Micah was goal-directed and up for a challenge, and he enjoyed problem-solving. Micah's engagement improved as our therapeutic relationship grew. Micah felt comfortable, accepted, and most importantly, understood.

After about a month of treatment, Micah had a major breakthrough! Micah's behavioral issues at school stopped completely, and he received a certificate of congratulations awarded by his treatment team. The treatment team expressed how proud they were of his accomplishments and Micah began to cry. "I've never been told I should be proud of anything. No one's ever said that they were proud of me. I don't even think the teachers here [at the school] like me." Surprisingly, Micah may have been right. As Micah's behavior improved and he stopped getting in trouble, the school administrators became less invested and less willing to talk about his progress. Micah's statement was a powerful moment in the therapeutic relationship and provided valuable insight to his experiences. Micah had received so much attention for his misbehavior that his positive behavior was never adequately acknowledged or reinforced. What if more teachers focused on positive behavior and acknowledged the efforts of Black males in the public school system? Could it make a difference? Would these efforts be enough to interrupt the often harsh and racially inequitable disciplinary procedures in schools linked to high levels of incarceration—what has come to be known as the school-to-prison pipeline? Some research indicates that educators play a key role in preventing "students

from entering the pipeline by establishing relationships of mutual trust, building a caring learning environment, and applying positive behavioral approaches" (Wilson, 2014, p. 51). When students are encouraged and feel empowered, a hurdle to the school-to-prison pipeline is constructed.

My work with Micah's mother included providing wraparound services, improving parent-child communication, strengthening positive reinforcement for Micah, implementing an incentive-based behavior modification plan within the home, and also requesting a 504 plan through the school, which is a plan developed to ensure that a child who has an identified disability and is attending an elementary or secondary school receives accommodations that will ensure the child's academic success and access to the learning environment (U.S. Department of Health, Education, and Welfare Office for Civil Rights, 1978). Despite initially feeling stressed with his behavior in school, Micah's mother demonstrated determination, resourcefulness, resilience, and a commitment to supporting Micah in any way possible. Micah's mother reported improvement in Micah's behavior within the home, community, and also within the school. Micah's mother was met with some resistance from the school after requesting the 504 plan, but additional referral services for a school advocate were made to help assist her with the process.

The empowerment process through training and education of services helped Micah and his mother receive the necessary support to help him remain in the school for the next school year. As a provider, it is important to recognize how to empower those such as Micah who are disadvantaged and to work with them to overcome obstacles and barriers. But what if we made it equally our duty to work with the advantaged to help them understand the barriers and obstacles in place for children such as Micah? With liberation-based training, school administrators within the U.S. public school system may be able to better recognize how to connect with and support Micah and other students like him, which may eventually lead to empowerment and continued future success. The role of empowerment can lead to sustainable and systemic change that may prevent future experiences similar to Micah's story. Liberation psychology is a unique opportunity to exercise the psychologist's role of "change-maker" in the public school setting, by lending support to those in positions of power in the education system and help guide the educational experience toward transformative justice.

LIBERATION PSYCHOLOGY STRATEGIES TO ADDRESS EDUCATIONAL INEQUITY

The application of liberation psychology to the U.S. public school system has the potential to illuminate the insidious nature of racism in the United States, liberate students of color from systemic oppression, and liberate school professionals from inadvertently perpetuating racism in schools.

Several principles from Martín-Baró's theory of liberation can be applied to the work of psychologists and other helping professionals in the U.S. education system, including (1) concientización, (2) de-ideologization, (3) social orientation, and (4) a preferential option for oppressed groups. Although the liberation framework is originally designed for application with oppressed people in Latin America, the structural and systemic nature of racism in the United States mirrors the power imbalance of the inequities from which Martín-Baró sought to liberate Latin Americans, and therefore the method of intervention may be similarly applied (Burton & Kagan, 2009; Kirylo, 2006).

Concientización

In liberation psychology, liberation of the oppressed relies upon an understanding of political forces contributing to oppression. In the previous case study, the supervisor providing consultation to support Micah's case equipped himself and his supervisee with tools for the critical analysis of the contextual and identity-based factors that contributed to Micah's challenges at school. This analysis demonstrates an exercising of concientización, which ultimately informed best practices for Micah's behavioral and emotional interventions. Equal opportunity, desegregation, and inequities in educational achievement have received considerable attention in the education system, yet very few schools have incorporated antidiscrimination programming or curricula to teach about racial inequity (Derman-Sparks & Edwards, 2019; Pine & Hilliard, 1990). Incorporating anti-racism into the curriculum creates two important liberation opportunities: for the oppressed and for the oppressor. Facilitating concientización by teaching about racism and racial bias in the classroom creates an intentional, consistent, and safe space for interpreting the mechanisms and structures of racial oppression and for developing a new self-understanding about people in context and the potential of individuals to excel and succeed.

However, liberation psychology emphasizes that awareness is only a first step toward liberation. Individuals must actively transform their understanding of their world, their relationships, and their reality. In Micah's case, administrators noticed his unique relationship with a Black custodian but fell short of understanding why this relationship was uniquely impactful. Teaching anti-racism is not the same as teaching Black history or diversity. Teaching about racism must situate the issues in the present day, emphasize the role of power, and notice the student's individual roles in the racial hierarchy. In Micah's experience, it was important that his counselor understood how racism manifested in his life as a personal experience. This knowledge of social context facilitates the ability of White students and students of color to recover historical memory and to develop autonomous determination of their future (Martín-Baró, 1996). Part of liberation is to incorporate those who are socially positioned

to perpetuate oppression—in this case White students, faculty, and staff—to understand their inherent privilege and to learn anti-racism, which liberates them from promoting oppression, consciously or not. In this way, learning about racism is empowering to students, faculty, and staff of all identities. The professionals consulting on Micah's case may have been responsible for inadvertently perpetuating racism in the school had there not been a counselor with a critical and informed understanding of racism, and had they resorted to removing Micah from their school. Critical race theorists have called on teacher education programs to reform their curriculum toward emphasizing race and racism education with greater depth in order to meet the needs of students of color (Milner & Laughter, 2015). One area for further development is implicit bias training. Implicit bias, along with cultural misunderstanding, can lead teachers to exaggerate disruptive behavior of children of color and/or have low expectations for these children (Warren, 2014). Teacher training efforts, such as implicit bias training, aim to empower those who may be in a position to perpetuate racism at the institutional level with the awareness necessary to interrupt institutional racism and with the tools to raise the conscious awareness of students.

De-ideologization

De-ideologization refers to the process of developing new, more accurate schemata for understanding oneself in the context of one's realities. The dominant class holds the power to create reality that is ideologically compatible with its own best interests. Martín-Baró (1996) calls this reality a "Social Lie" (p. 188) and describes it as a powerful determining factor from which individuals must escape. The Social Lie most harmful to students of color is the belief in White superiority. This lie breeds other harmful lies including a belief that White students are smarter than students of color and that students of color are dangerous. Once people exercise critical consciousness, they are better able to identify the dissonance between reality and a Social Lie, and they may de-ideologize by naming and describing their lived experiences and the ways in which they contradict the ideology of the dominant class (Martín-Baró, 1996). In the case of Micah, the importance of de-ideologization is demonstrated by Micah's powerful emotional reaction toward praise. Even at only six years old, his counselor began to facilitate the process of de-ideologization through validation of Micah's strengths, intelligence, and importance, compromising his previously internalized beliefs of his capabilities.

In the public school system, facilitating de-ideologization may resemble intergroup dialoguing in schools. As an educational method, intergroup dialogues engage students in exploring identity-based differences, inequity, and their personal and social responsibility for promoting justice in society (Zúñiga, Nagda, Chesler, & Cytron-Walker, 2007). Intergroup

dialogues can provide a space for students to discover truths about the realities of others and to develop their ability to articulate the truth of their own realities. In addition, incorporating opportunities for experiential youth civic engagement in school provides students spaces to empower themselves and actionize their new ways of knowing the world. This process is an important part of liberation and one that affirms social power.

Social Orientation

While concientización and de-ideologization are appropriately applied to direct work with students, a social orientation and a preferential option for oppressed groups are incorporated as macro-level interventions. Shifting the public school system toward a social orientation means shifting policies and procedures away from individualized interpretations of students' lives and toward a framework that sees all individual students as a product of their unique sociopolitical, cultural, and historical contexts. Without this social orientation, Micah's care team interpreted his reactions to his environment as inherently bad behavior. With an understanding that students experience reality differently based on individual and cultural differences, "one size fits all" no longer works when creating policies and procedures for schools; intersectionality and positionality must be taken into consideration. Therefore, it is essential that school personnel have an understanding of and a language for the history and systems at play that impact students differently due to their identity and social location. They must also be empowered to use this knowledge of systemic oppression to make individualized decisions on behalf of the best interest of their students. These considerations may be applied to policies related to behavioral problems for which, as previously described, students of color are punished more often, more severely, and with less warning.

A Preferential Option for the Oppressed

Liberation psychology requires preferential options for oppressed groups, meaning the goal is to develop a psychology that is *by* the oppressed group, not for the group. As Freire (1970/1993) notes, our role is "to liberate, and to be liberated, with the people—not to win them over" (p. 95). In applying this principle to the public school system on behalf of students of color, this goal may be interpreted as creating policies and procedures that are *by*, not just for, students. This type of liberation may be possible through more inclusive decision-making processes to create policies and procedures that encourage and create space for input from families, such as holding forums to discuss issues, collecting data from families, and voting. Schools must be expected to include, and be held accountable for including, families, with attention to being accessible to families with different barriers that may be due to transportation, time, or

ability. In addition, feedback may be collected from students within the schools on what is and what is not working for them and what may work better. As noted by Kocon (2018), an increasing number of schools are doing "culture and climate audits, asking students about their experiences and using that data to make changes" (p. 21). Although seeking data from young students may seem trivial and unhelpful, normalizing the notion that even very young people have agency in their education may help children develop the skill and ability to advocate for themselves and others as they grow and contribute to their empowerment.

OBSTACLES TO CHANGE

Institutional racism in schools prevails due to the structural racism at large in the United States. In his book *The Color of Law: A Forgotten History of How Our Government Segregated America*, Richard Rothstein (2018) explicates the continuation of housing segregation in the United States and argues that these patterns do not result from personal choice or preference but from federal, state, and local policies and laws that perpetuate racial separation. Importantly, he argues that after the Federal Housing Act prohibited racial discrimination in private housing transactions in the late 1960s, White Americans have largely interpreted the issue of segregation as resolved. In more recent history, racism at all levels has become more covert or subconscious and therefore more difficult to identify (Fish & Syed, 2019). The shifting manifestation of racism allows Americans to deny racism and misattribute inequities to personal choices or self-induced circumstances, and it creates a barrier to abolishing inequity in schools (Riley, 2010).

Herein lies the need for a psychology of liberation, that is, a framework that requires acknowledgment of the oppression that is perpetuated by sociopolitical structures. A psychology of liberation sets a standard wherein even the most subtle and discrete forms of racism are brought into awareness and are understood for their cause and effects. However, liberation work is not comfortable, and it is not profitable. It is political, sometimes public, relentlessly honest, and selfless. It is brave and vulnerable in its efforts to dismantle oppression. It seems unrealistic. However, individuals in positions of power capable of promoting liberation have much to gain from the work. When individuals in positions of power promote the liberation of the oppressed, they liberate themselves from their adjacency to oppression.

THE ROLE OF PSYCHOLOGY

Psychology as a field interacts with the public school system through research and practice. The field influences curriculum, pedagogy, student support services, and conduct procedures and provides assessments,

diagnostic criteria, and psychotherapeutic interventions. As a field, we hold great power in determining what is pathological and what is psychologically healthy for school children and adolescents. Furthermore, as a field of professionals with social and cultural power across a diversity of settings, we influence students in schools by either participating in structural racism by remaining silent in the face of it or by actively combating it (Kendi, 2019).

Due to our position of power, we cannot be neutral in the face of structural racism: to do so is to deny its existence and support its perpetuation. As noted by Kendi (2019), "To be antiracist is to champion resource equity by challenging the racist policies that produce resource inequity" (p. 180). As a field, we hold an ethical responsibility to define structural racism for what it is: a societal mental health crisis with serious, real, long-term effects on wellness. Psychologists have a particularly unique and important position when embarking on anti-racism work by virtue of holding the unique power and privilege to shed light on what is internalized, implicit, and discrete. Psychologists are entrusted to conduct research and to ultimately explain social processes and behaviors. As professionals, we are uniquely capable of understanding the social role of the oppressed and the oppressor and why the behaviors and beliefs associated with promoting and experiencing racism are generational patterns.

A LIBERATION PSYCHOLOGY OF DESEGREGATION AND RACIAL SOLIDARITY

Since 1954, when the Supreme Court ruled in the *Brown v. Board of Education of Topeka* decision that racial segregation in the public schools violated the 14th Amendment, research has demonstrated the existence of structural, systemic, and individual racism in public schools (U.S. Department of Education, Office of Civil Rights, 2016). We now live in a time when racial "resegregation" in U.S public schools is increasing. The aforementioned 2016 GAO report notes evidence of growing racial divides in public education, with the number of Black and Latino students enrolled in impoverished K–12 public schools increasing 11 percent between 2001 and 2014 (U.S. GAO, 2016).

Addressing this problem begins with revisiting the issue of racial inequity in public schools with a renewed sense of urgency. Generations after *Brown v. Board of Education*, integration continues to fail because of White resistance. Desegregation may be the intervention that creates equity in our school system, but it is not an intervention that dismantles the structural racism that encompasses society. Noticing the inequity and incorporating supportive interventions have been insufficient; these efforts have not effectively dismantled oppressive systems. Similarly, principles of liberation psychology in public schools as anti-racist interventions can be most successful if intervention simultaneously occurs on the structural

level. That work requires a grand cultural shifting of values and priorities in psychology.

Shifting our paradigm toward liberation psychology involves a reorientation toward addressing practical social problems and to engagement with schools. This reorientation is not just an action but a commitment to unending series of actions. Liberation psychology positions the field at large in solidarity with oppressed peoples (Malherbe, 2018). It is not a subfield of its own but a paradigm that equips psychologists to empower oppressed populations toward liberation (Malherbe, 2018; Martín-Baró, 1996). It is not avoiding being a racist psychologist; it is being an anti-racist psychologist. As a paradigm, liberation psychology can be appropriately applied to a multitude of settings for psychological work.

FUTURE DIRECTIONS TO ELIMINATE INEQUITY IN PUBLIC EDUCATION

In considering future directions for the field of psychology, we urge researchers, practitioners, and social justice advocates to significantly expand their engagement in addressing the tremendous inequities found in the U.S. public education system. In issuing this invitation, we recall the work of psychologists Kenneth B. and Mamie Clark, who conducted research using dolls to study children's reactions to race and to what extent race influenced their judgment about themselves and impacted their self-esteem. This research had a groundbreaking role in the U.S. Supreme Court's 1954 decision in *Brown v. The Board of Education* to declare racial segregation in public schools unconstitutional (Pickren & Tomes, 2002). The Clarks' work highlighted the negative impacts of prejudice, discrimination, and segregation for both African American and White children. Additional research following the path established by the Clarks is urgently needed in order to directly expose the mechanisms of racism in K–12 schools. For example, Warikoo, Sinclair, Fei, and Jacoby-Senghor (2016) call for more research on how implicit bias presents itself in schools and how schools can reduce bias. In Kohli, Pizarro, and Nevárez's (2017) analysis of over 4,000 articles from 2005 to 2016 that reported on studies of racial inequity in educational settings, they identified only 186 articles that addressed racism in the K–12 setting, and many of these articles were focused on Black boys, with little research on girls and or undocumented children of color.

The review by Kohli et al. (2017) revealed the existence of a "new racism" in public education that is "evasive, subtle, and challenging to identify because it is normalized and hidden under the guise of multiculturalism, color blindness, and everyday individualized interpretations of policy and practices" (p. 195). This new racism, along with the trend toward resegregation of public schools, ultimately leads to racial

inequality becoming a normalized and accepted part of the U.S. education system. Further, as noted by Brown and Brown (2012), much like what happened in the case study of Micah presented near the beginning of this chapter, the dominant rhetoric blames students of color and their families for a lack of academic success, suggesting a change in their behavior as the solution, instead of recognizing the need to change structures or policies that systematically fail students of color (Kohli et al., 2017). Psychologists need to enter into dialogue and partnership with families, children, and school personnel in order to critically analyze, challenge, and introduce an alternative discourse into efforts toward educational equity and an end to structural racism.

As noted by Singh (2016), psychology needs to move from a place of affirmation to one of liberation in psychological practice with marginalized communities. While Singh applies this concept of liberation to people who are transgender and gender nonconforming, her argument applies equally well to children and youth of color in public education. In order to fully address how racism impacts psychologists, school personnel, and families in K–12 education, we urge psychologists to use the framework of liberation psychology (Martín-Baró, 1996) to engage in work to subvert the existing structures of educational inequity. Using a liberation perspective, psychologists are encouraged to reflect on their own racial experiences, identify how White privilege influences their research and psychological practice, and advocate for children and families of color to be better served in the educational system. In and through their own process of personal change, psychologists are then able to engage in social change on behalf of, and in collaboration with, families of color and educators in ways that simultaneously liberate psychologists from their own racial oppression experiences.

In closing, we envision a broadened focus of psychology to include the most urgent social issues of our day, and most particularly the needs of children and youth in public education. This expansion involves finding new ways to seek knowledge, from the perspective of oppressed communities, which necessitates critical reflection and deconstruction of dominant ideologies to guard against the Eurocentric origins of psychology governing how psychology is applied. Further, a psychology focused on liberation entails "a new psychological praxis" in order to fully commit to the process of transforming both people and societies (Montero et al., 2017, p. 152).

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RESOURCES

Broader, Bolder Approach to Education is a national campaign to advance evidence-based strategies to mitigate the impact of poverty-related disadvantages on education: https://www.boldapproach.org

Ibram X. Kendi. https://www.ibramxkendi.com

Jonathan Kozol. https://www.jonathankozol.com

Liberation Psychology Network, a network to disseminate, discuss and develop Liberation Psychology in English with a list of more resources at http://libpsy.org/sources-on-liberation-psychology

Nikole Hannah-Jones. https://nikolehannahjones.com

U.S. Department of Education Civil Rights Division Data Collection. https://ocrdata.ed.gov

What is Liberation Psychology? Webpage at Pacifica Graduate Institute

CHAPTER 4

Racial Microaggressions and Self-Esteem

Gloria Wong-Padoongpatt
Aldo M. Barrita

Remember that consciousness is power. Consciousness is education and knowledge. Consciousness is becoming aware. . . . Consciousness-raising is pertinent for power, and be sure that power will not be abusively used, but used for building trust and goodwill. . . . Tomorrow's world is yours to build. —Yuri Kochiyama (Kochiyama & Tajiri, 1993)

This empowering quote highlights the key motivation for many race scholars doing work on racial injustices: to build consciousness around racism and racial inequity (Solórzano, Ceja, & Yosso, 2000; Sue, Capodilupo, et al., 2007). Consciousness building is the first step to multicultural competence (APA, 2016) and the centerpiece for the scholarship on racial microaggressions (Sue et al., 2019), the most common form of everyday racism (Pierce, Carew, Pierce-Gonzalez, & Wills, 1977; Sue, 2009). People of color experience racial microaggressions as racism-related slights and insults that happen daily in social exchanges. Findings have suggested that racial microaggressions are daily stressors that can be more damaging than other daily hassles, because these interactions lack clarity and directedness (Pierce et al., 1977; Sue, 2009). Furthermore, racial microaggressions have a greater potential for internalization compared to more acute, blatant forms of racism (Kohli & Solórzano, 2012; Pierce, 1995; Solórzano et al., 2000; Sue, Capodilupo, et al., 2007). The American

Psychological Association (APA) conducted an extensive study (n = 3,361) to explore the impact of discrimination on stress and found that nearly three in four people of color experience everyday discrimination (APA, 2016). Almost all people of color have experienced at least one racial microaggression in their lives, and the cumulative effects of these daily slights and indignities can deplete psychological and physiological resources while damaging self-esteem (Omi & Winant, 1994; Sue, Capodilupo, et al., 2007). These everyday slights can attack core social identities and self-orientations, which can deeply damage self-esteem. Therein lies the impetus for this chapter on racial inequities: the *what*, the *why*, and the *how* racial microaggressions denigrate self-esteem for people of color. We first briefly discuss *what* racial microaggressions are and their relation to self-esteem. Second, we discuss in-depth *why* racial microaggressions can insidiously damage different aspects of self-esteem. We differentiate types of self-esteem as used for microaggression research. We highlight the current state of research on explicit self-esteem and introduce novel implicit measures. Further, we discuss self-esteem discrepancies as mechanisms for the impact of microaggressions on stress. Third, we discuss *how* people of color can arm and protect their self-esteem from microaggressions. We highlight racial socialization and sense of coherence as instrumental protective factors in the microaggression–self-esteem relation. Lastly, we discuss the implications and resources for theory, research, and practice.

THE *WHAT*: MICROAGGRESSIONS AND THE CLASHES OF REALITIES

Racial microaggressions are the most common form of everyday racism, and perpetrators often unknowingly commit these slights and indignities (Pierce, 1995; Sue, Capodilupo, et al., 2007). According to Sue, Capodilupo, and colleagues (2007), microaggressions are brief, commonplace, daily verbal and nonverbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults toward members of oppressed groups. Sue (2010b) explained that ordinary citizens commonly perpetrate this insidious and damaging form of *everyday* racism. White people often unintentionally commit racial microaggressions, which makes it difficult for people of color to address (Solórzano et al., 2000; Sue, Lin, et al., 2009; Sue et al., 2011). Many White people agree with racial equality and condemn blatant racism (Pew Research Center, 2016). Consequently, the majority of White people believe they do not harbor racism-related attitudes or behave in discriminatory ways (Sue, 2010a). The Pew Research Center (2016) showed that the majority of White people believed that people of color had achieved racial equality and that racial issues were no longer critical social issues. In fact, White people see people of color

who do not achieve social mobility as not properly applying themselves (Astor, 1997). The contrast between perceptions of racism by White people and by people of color leads to discrepancies in racial realities. Most people of color perceive racism as a daily reality, while most White people minimize the existence and effects of racism (Astor, 1997). Racial microaggressions often occur within this contrast in racial realities (Sue, 2010a). Racial microaggressions are embedded in everyday interactions and often delivered with minimal awareness (Sue, 2010a; Sue, Bucceri, et al., 2007). Those who deliver microaggressions may perceive their comments and gestures as nondiscriminatory and even well-intentioned (Sue, Bucceri, et al., 2007); therefore, creating a dialogue around racial microaggressions is difficult. Sue, Lin, and colleagues (2009) found that White faculty and university counselors had difficulty engaging in dialogues about racial microaggressions and lacked training on how to effectively support students of color. These conversations produced feelings of anxiety in the professors and university counselors as well as in their students. Without a more thorough understanding of the nature and experience of racial microaggressions, dialogue about everyday acts of racism will remain difficult, and the gap between racial realities will continue to widen.

"Microaggression" was the most used word in 2015, according to the Global English Monitor (Lilienfeld, 2017). The construction and popularity of this term armed many people of color with vocabulary to name their everyday experiences with racism (Sue et al., 2019). According to critical race scholars, the action of "naming" oppressive events is the first step to liberation and empowerment (Freire, 1970; Wong-Padoongpatt & Rider, 2020). These scholars have theorized that racial microaggressions are chronic stressors that adversely affect the daily lives of people of color (Solórzano et al., 2000). Many critics, however, have asserted that racial microaggression researchers are "making a mountain out of a molehill" and have claimed that the severity of this form of racism elicits little to no stress response (Schacht, 2008; Sue, Capodilupo, et al., 2008; Thomas, 2008). Lilienfeld (2017), in his article *Strong Claims, Inadequate Evidence*, interrogates the validity of microaggression research and argues these definitions were not rigorously formed but came from casual armchair discussions. On the contrary, people of color who have experienced more incidences of racial microaggressions also have suffered from more negative health and mental health outcomes (Sue, 2010a, 2010b). Robust findings indicate a strong adverse relationship between microaggressions and self-esteem (Nadal et al., 2014; Thai, Lyons, & Lee, 2017; Wong-Padoongpatt, Zane, Okazaki, & Saw, 2017) with moderate to large effect sizes. A deeper understanding of how microaggressions impact different aspects of self-esteem can bolster rigorous research and support critical theories. Furthermore, this knowledge will help practitioners and educators equip people of color with valuable resources and interventions to protect their self-esteem from microaggressive attacks.

THE *WHY*: REASONS FOR DECREASED SELF-ESTEEM

Robust findings indicate that microaggressions, like other forms of discrimination (Harrell, 2000; Liang & Fassinger, 2008), can be quite damaging to self-esteem (Alvarez, Juang, & Liang, 2006; Wong-Padoongpatt et al., 2017). Microaggressions may be more harmful to self-esteem compared to blatant racism because these slights are subtler and more ambiguous (Yoo, Steger, & Lee, 2010). Due to the lack of clarity of microaggressions, people of color have more potential to take responsibility for these interactions rather than externalizing and blaming the perpetrator (Wong, Derthick, David, Saw, & Okazaki, 2014). Microaggressions also can invalidate and marginalize the identities of people of color and their lived experiences (Sue et al., 2019). The United States has a long history of marginalizing people of color, and findings indicate that marginalization correlates with different aspects of self-esteem. Many of these claims are based on correlational studies relying on recall and self-report measures (Wong et al., 2014). Therefore, temporal precedence is not clear, specifically, the directionality of microaggressions and self-esteem. Critics often focus on this methodological limitation and question the directionality of the effect. Do racial microaggressions cause decrements in self-esteem, or do people of color with lower self-esteem perceive more daily interactions as microaggressive? We discuss our most recent empirical studies that examined the immediate impact of racial microaggressions on different aspects of self-esteem to clarify possible mechanisms by which racial microaggressions can cause stress. In this section we cover three major reasons why microaggressions can harm self-esteem: (1) their ambiguous nature makes them difficult to address, (2) the marginalizing effect can attack self-esteem, and (3) the immediate impact can cause self-esteem discrepancy. Also, we include specific measures of self-esteem that researchers have used to examine microaggressions.

Ambiguity

The ambiguous nature of microinsults and microinvalidations can cause people of color to blame themselves for these incidences (Yoo et al., 2010) instead of blaming the perpetrators. Threats to self-concept can cause stress, because the targets make internal attributions rather than externalizing the blame (Heatherton & Polivy, 1991). Attributional style is defined as the way of inferring a causal explanation for life experiences (Mehl, Vazire, Holleran, & Clark, 2010) either to oneself (internally) or other people and circumstances (externally). According to the attribution theory, people are more likely to make external attributions for blatant situations, such as blatant racism, and internal attributions for more ambiguous situations, such as microaggressions (Spalding, 1999). People of color may feel attacked by microinsults and microinvalidations and, at the same time, feel responsible for these situations. Researchers have examined attributions of responsibility as an important response to stressors (Delahanty

et al., 1997). Studies have consistently indicated that assuming responsibility for negative events causes stress (Noh, Kaspar, & Wickrama, 2007; Tran & Lee, 2014). Crocker and Major (1989) tested the impact of subtle and blatant discrimination and found that targets were able to protect their self-esteem when discriminatory acts were more brazen and direct. Findings suggested that subtle and indirect discrimination elicited more internal attributions and, in turn, were more damaging to self-esteem.

Most of the social-psychological studies on self-concept have focused on explicit self-esteem that is consciously accessible (Spalding, 1999; Woodford, Howell, Kulick, & Silverschanz, 2013). More recent studies have started to examine implicit self-esteem, or self-esteem that is not consciously accessible (Dewitte, De Houwer, & Buysse, 2008; Greenwald & Banaji, 1995; Spalding, 1999). Decrements to implicit self-esteem have been associated with negative mental health (Robins, Hendin, & Trzesniewski, 2001) and health outcomes (Leary & Kowalski, 1995; Steinberg, 2007). Steinberg (2007) found that low levels of implicit self-esteem predicted clinically significant depression. Leary and Kowalski (1995) found a robust association between decrements of implicit self-esteem and high levels of anxiety. Research on attributions and implicit self-esteem strongly suggests that microaggressions have negative effects (i.e., are stressful), but these effects often involve processes that may not be apparent or salient to people of color.

A large body of research has demonstrated the connection between internal attribution and implicit processing (Miller, Burgoon, & Hall, 2007). In one of our experimental studies (Wong-Padoongpatt et al., 2017), we found that microaggressions caused stress because these slights implicitly undermined self-concept. Specifically, we found that implicit self-esteem mediated the microaggression–stress relationship. We experimentally induced microaggressions to which people of color responded with higher physiological stress (blood pressure) compared to those who did not experience a microaggression. Moreover, people of color who experienced a microaggression also showed a decrease in implicit self-esteem, and those who showed this decrease also had higher levels of stress. In other words, microaggressions seemed to cause stress for people of color because these slights decreased levels of implicit self-esteem. Furthermore, implicit self-esteem emerged as a full mediator for this relationship, which strongly supported the claim that these incidences are ambiguous and can happen outside the awareness of the targets. Our most current follow-up study (Wong-Padoongpatt & Rider, 2020) replicated the findings of implicit self-esteem and, interestingly, showed that explicit self-esteem was higher for those who experienced a microaggression. We examined the discrepancy of implicit and explicit self-esteem and found that this discrepancy further explained the microaggression–stress relation. Not only are microaggressions causing internalization but people of color also seem to compensate for these attacks by reporting an inflated explicit self-esteem. Discrepancies in implicit and explicit self-esteem can be distressing for individuals since what they are putting out in

the world is not congruent to how they feel internally (Kim & Moore, 2019). The ambiguity of microaggressions seems to cause disorientation with self-esteem, and this discrepancy can lead to stress.

Marginalization

Racial microaggressions may elicit feelings of marginalization, which also can threaten self-esteem. Social marginalization is the process by which individuals from subordinate groups are prevented from participating fully and normally in the society in which they reside (Tang & Richardson, 2013). White people in the United States have had a long history of marginalizing people of color starting with the Native Americans. Past research also has indicated that feelings of marginalization lead to socioemotional struggles and engagement in risky behaviors (Botticello, 2009; Eitle & Eitle, 2004; O'Malley, Johnston, Bachman, Schulenberg, & Kumar, 2006). Benner and Wang (2015) found that adolescents who were racially marginalized at school reported poorer school attachment, which was linked to more depressive symptoms. Furthermore, more depressive symptoms were associated with higher levels of substance use (Benner & Wang, 2015).

Microaggressions are based on common stereotypes of marginalized groups; therefore, marginalized individuals may feel threatened when these stereotypes are evoked (Steele, 1997), regardless of who perpetrates the stereotype. Steele (1997) has examined extensively the negative effects of stereotypes on people of color, which he has termed "stereotype threat" and can be defined as the fear that one will confirm negative stereotypes, categorizing their social group. Much of the research on stereotype threat has found that negative stereotypes have an adverse effect on performance associated with that stereotype (Armenta, 2010; Shih, Bonam, Sanchez, & Peck, 2007). Steele (1997) found that Black students performed lower than White students on a math exam when they were led to believe that the exam would measure racial differences. Wong-Padoongpatt and colleagues (2017) tested a microaggression toward Asian Americans based on the negative stereotype that they are perpetual foreigners. This slight invalidated their Americanness and communicated that Asian American people cannot assimilate to American lifestyles. These findings suggested that White perpetrators of microaggressions caused stress for people of color because a negative stereotype was evoked in the interaction (Wong-Padoongpatt et al., 2017).

Measures Used to Examine Self-Esteem in the Context of Microaggressions

Construct validity is important to consider when addressing claims about microaggressions (Wong et al., 2014). More recently, critics have

challenged the methodological rigor of microaggression research (Lilienfeld, 2017). To address these concerns, we provide valid and reliable self-esteem measures used by past microaggression-related researchers. These measures include: (1) explicit individual self-esteem, (2) explicit collective self-esteem, and (3) implicit self-esteem. We finish this section with our current microaggression research examining the discrepancy between implicit and explicit self-esteem.

Explicit Individual Self-Esteem

Most research on microaggressions and self-esteem use the Rosenberg Self-Esteem Scale (Rosenberg, 1965) to examine explicit individual self-esteem. This measure is a 10-item scale that measures global self-worth. This scale measures both positive and negative feelings about the self. It has been used with people of color with Cronbach's alphas around 0.90 (Thai et al., 2017). Thai and colleagues (2017) used this scale as a criterion variable for microaggressions and found that racial socialization moderated the relationship between racial microaggressions and self-esteem. Nadal and colleagues (2014) examined the adverse impact of racial microaggressions on college students' self-esteem. Findings indicated that racial microaggressions negatively predicted lower self-esteem (Nadal et al., 2014). Tawa, Suyemoto, and Roemer (2012) explored the relationship between perceived racism and self-esteem among Asian Americans. Findings indicated that interpersonal racism was related to lower personal self-esteem.

Explicit Collective Self-Esteem

Collective self-esteem also has been examined in the context of racial microaggressions and other forms of discrimination. The Collective Self-Esteem Scale (CSES; Luhtanen & Crocker, 1992) is a 16-item measure of collective self-esteem. This scale assesses four different subscales: (1) Membership Collective Self-Esteem (feelings about membership in one's social group), (2) Private Collective Self-Esteem (general evaluations of one's social group), (3) Public Collective Self-Esteem (assessments of others' perceptions of one's social group), and (4) Importance to Identity (significance of one's social group to one's own identity). Thai and colleagues (2017) found that only public CSE was negatively correlated with racial microaggressions. Liang and Fassinger (2008) examined CSE as a mediator and moderator in the relationship between racism-related stress and psychological adjustment. Additionally, they also only found effects for public CSE, specifically public CSE as a mechanism for the relationship between racism-related stress and self-esteem. Tawa and colleagues (2012) also examined CSE and found that structural racism was related to higher collective self-esteem.

Implicit Self-Esteem

Researchers are incorporating more implicit measures to test the effects of discrimination (Wong-Padoongpatt et al., 2017). The most commonly used measure is the Implicit Association Test (IAT; Greenwald & Farnham, 2000), which uses a computerized categorization task to assess implicit self-esteem (Rudman, Dohn, & Fairchild, 2007). The task tests for the relative strength of associations by comparing response times on two combined discrimination tasks. It measures automatic associations of self-relevant (I, me, mine) and non-self-relevant (they, them, theirs) words with pleasant (e.g., smile and vacation) and unpleasant (e.g., pain and disaster) words. People with higher self-esteem tend to pair self-relevant and pleasant words at a higher rate than their pairing of self-relevant and unpleasant words. Researchers have found strong relationships between the self-esteem IAT and other implicit self-esteem measures (Greenwald et al., 2002; Rudman et al., 2007), including the Implicit Self-Esteem Compensation (ISEC; Rudman & Fairchild, 2004) which supports the construct validity of the measure. The self-esteem IAT had the highest test-retest reliability coefficients of all the implicit self-esteem measures. Verkuyten (2005) examined different types of self-esteem among ethnic minorities living in the Netherlands and found that perceived discrimination was related to implicit self-esteem but not other, explicit self-esteem measures. The first author of this chapter is the only researcher to date to examine implicit self-esteem with microaggressions (Wong-Padoongpatt et al., 2017). Findings indicated that microaggressions from White perpetrators, compared to people of color perpetrators, decreased implicit self-esteem for people of color.

Self-Esteem Discrepancy

The relationship between self-esteem and psychopathology has been well documented (Leeuwis, Koot, Creemers, & van Lier, 2015); however, the majority of the scholarship has focused only on explicit self-esteem. This singular approach to self-esteem is also reflected in research with microaggressions (Nadal et al., 2015; Thai et al., 2017). As mentioned before, the first author conducted a social-psychological study where participants of color came into a lab and experienced a microinsult about English abilities (Wong-Padoongpatt et al., 2017). Findings indicated that decreases in implicit self-esteem explained the relationship between microaggressions and stress. Discrepancies in implicit and explicit self-esteem have been associated with internalizing problems (Romero, Sanchez, Vázquez, & Valiente, 2016). We are currently examining self-esteem discrepancy as a mechanism for microaggressions on stress. Since we need to assess self-esteem in the moment of the microaggression, we used the IAT and the State Self-Esteem Scale (SSES; Heatherton & Polivy, 1991). The SSES has

been commonly used in laboratory manipulations to examine state self-esteem (Heatherton & Polivy, 1991). The SSES is a 20-item scale modified from the widely used Janis-Field Feelings of Inadequacy Scale (Janis & Field, 1959). Researchers have used this scale to test situational factors that lead to momentary changes in self-evaluation (Heatherton & Polivy, 1991). The SSES also has high internal consistency with coefficient alphas for the scale reaching 0.90 and above (Heatherton & Polivy, 1991; Rudman et al., 2007). Preliminary findings indicated that the discrepancies in implicit and explicit self-esteem fully mediated the effect of microaggressions on stress (Wong-Padoongpatt & Rider, 2020).

THE HOW: ARM AND PROTECT AGAINST MICROAGGRESSIONS

Once the relationships between microaggressions and the different aspects of self-esteem were established, the logical next step for researchers was to empower people of color with strategies to arm and protect their self-esteem against these everyday slights and indignities (Thai et al., 2017; Sue et al., 2019; Su et al., 2020). Researchers of discrimination have routinely searched for protective factors that can buffer the negative effects of these behaviors on self-esteem (Anderson & Stevenson, 2019; Su et al., 2020). A number of protective factors have been explored; however, findings strongly indicate that racial socialization (Hughes et al., 2006; Hughes, Witherspoon, Rivas-Drake, & West-Bey, 2009; Su et al., 2020) and sense of coherence are instrumental for coping and navigating discrimination (Antonovsky, 1979; Koskinen et al., 2015). Researchers are beginning to incorporate these protective factors into the conceptual framework for the microaggression–self-esteem relation in order to map out coping pathways and provide strategies to navigate these difficult social exchanges (Thai et al., 2017; Lam, 2007).

Racial Socialization

Racial socialization is the process of deliberately or implicitly imparting information about race, ethnicity, cultural values, attitudes, customs, and roles to another person, usually the younger generation (Hughes & Johnson, 2001). A strong consensus exists among scholars that the practice of racial socialization improves awareness and provides coping mechanisms for racial discrimination (Brown & Ling, 2012). Several researchers have incorporated racial socialization into their conceptual framework for understanding the impact of discrimination on self-esteem (Anderson & Stevenson, 2019) since this type of awareness building can buffer the negative effects of racial discrimination on psychological adjustment and self-esteem. The bulk of findings strongly suggest that racial socialization positively correlates with a host of positive outcomes for self-esteem

(Brown & Ling, 2012) and coping strategies (Thai et al., 2017). More recently, researchers have included different aspects of racial socialization to the conceptual framework to understand the relationship between self-esteem and microaggressions. Racial socializations have been commonly categorized into three different types: cultural socialization, preparation for bias, and promotion of mistrust (Hughes et al., 2006). These types can be further divided into protective factors (cultural socialization) and proactive factors (preparation for bias and promotion of mistrust). Cultural socialization emphasizes ethnic and racial pride, traditions, and history. Preparation for bias includes messages promoting awareness of ethnic and racial prejudice and discrimination. Promotion of mistrust includes messages that encourage wariness in interracial interactions and teaches children about racial barriers to success (Hughes & Chen, 1997; Hughes et al., 2006). In this section, we describe in detail the different aspects of racial socialization and how we can incorporate these strategies.

Cultural Socialization

Cultural socialization refers to the promotion of ethnic and racial pride (Hughes et al., 2006) and is perceived as a protective factor. This type of socialization encourages valuing cultural strengths and heritage. For example, cultural socialization can equate to providing exposure and training in cultural practices and values. Researchers have found that use of cultural socialization decreases one's susceptibility to the negative effects of racial discrimination (Neblett et al., 2008). Su and colleagues (2020) found that cultural socialization buffered the effect of racist events on alcohol consumption and problems. Harris-Britt, Valrie, Kurtz-Costes, and Rowley (2007) found that cultural socialization practices that promoted racial pride buffered the effect of racial discrimination among adolescents. Another study indicated that individuals who had lower levels of cultural socialization were more distressed when they experienced racial discrimination compared to those who received more cultural socialization messages (Sellers & Shelton, 2003). These findings strongly suggest that through cultural socialization and the promotion of racial pride can people of color protect their self-esteem from racial microaggressions.

Preparation for Bias

Preparation for bias promotes awareness of potential barriers or hostilities that people of color may encounter. These messages encourage individuals to anticipate racial discrimination by increasing awareness of potential discriminatory events (Hughes & Johnson, 2001). Scholars have argued that this proactive socialization can be an effective strategy for coping with and overcoming discrimination (Hughes et al., 2006). Findings for preparation for bias are mixed and the relationships that have

emerged are more complex. For example, Thai and colleagues (2017) found that moderate levels of preparation for bias were associated with higher levels of individual self-esteem, whereas extremely high or low levels of preparation for bias were negatively associated with individual self-esteem. Overemphasis on bias may make folks feel helpless and lacking control over their environment. Overpreparation for bias may intensify the result from discriminatory experiences. People of color with levels of preparation for bias seem to moderate the relationship between perception of discrimination and self-esteem. Specifically, greater perception of discrimination was associated with lower self-esteem for people of color at low levels of preparation for bias. In other words, people of color who were less prepared for bias were more vulnerable to discrimination.

Promotion of Mistrust

Promotion of mistrust includes warning about other groups and promoting distance from out-group members (Hughes et al., 2006). These messages encourage wariness in interracial interactions and highlight racial barriers to success. Findings for promotion of mistrust varied between blatant discrimination and microaggressions when the impact on self-esteem was examined. Thai and colleagues (2017) found that promotion of mistrust moderated the microaggressions–private self-esteem relation. At high levels, there was no relationship between microaggressions and self-esteem, whereas microaggressions and self-esteem were negatively related for low and moderate levels. People of color who were more wary of out-group members seemed to be more protected from microaggressions compared to those less cautious. However, Thai and colleagues (2017) found that promotion of mistrust exacerbated the effect of racial microaggressions on alcohol problems. Furthermore, the overall promotion of mistrust seems to correlate with lower self-esteem and more depressive symptoms; however, relations may be temporary since Gartner, Kiang, and Supple (2014) found that these messages did not have a longitudinal effect on psychological well-being.

Sense of Coherence

Sense of coherence is a mixture of optimism combined with a sense of control (Antonovsky, 1979; Koskinen et al., 2015). Antonovsky (1979) devised the sense of coherence concept to indicate an individual's general orientation to life that reflects high self-esteem and perceived control over life events. Findings have indicated that a sense of coherence is strongly related to good health and well-being (Koskinen et al., 2015). Furthermore, higher self-esteem was related to a stronger sense of coherence, which in turn was related to lower levels of depression and anxiety (Lam, 2007). Several researchers have proposed that a sense of coherence

can mediate the association of perceived racial discrimination to psychological distress, anxiety, and depressive symptoms (Koskinen et al., 2015). Lam (2007) found that higher levels of perceived racial discrimination were associated with a reduced sense of coherence. Overall, findings strongly suggest that sense of coherence is a valuable coping mechanism for racial discrimination and can buffer the effects on self-esteem (Lam, 2007; Koskinen et al., 2015). Therefore, we included the cognitive, behavioral, and motivational aspects of this life orientation when discussing different coping mechanisms for racial microaggressions. Specifically, people of color with a strong sense of coherence behold their environment and the events in their everyday life as comprehensible and manageable (Koskinen et al., 2015).

Comprehensibility is the cognitive aspect of coherence that reflects the extent to which a person perceives both internal and external stimuli as being understandable in some kind of rational way (Eriksson & Mittelmark, 2017). In other words, microaggressions are structured, predictable, and explicable and can be easily understood and rationalized. This reflects the ability to see things as orderly, coherent, and clear. The ability to make something structured out of a chaotic situation makes it easier to handle. Manageability is the behavioral aspect of coherence that highlights adequate resources available to deal with everyday issues. Building self-confidence in the form of efficacy may help buffer the demands of microaggressions. Furthermore, perceiving microaggressions as challenges rather than threats may change the pathways of these daily stressors.

IMPLICATIONS AND RESOURCES FOR THEORY, RESEARCH, AND PRACTICE

A major misconception about microaggression scholarship is that advocates want to simply correct how perpetrators communicate (Wong-Padoongpatt & Rider, 2020). For instance, Asian Americans are often perceived as perpetual foreigners and are commonly asked, "Where are you really from?" Microaggression advocates do not merely want to change this microinvalidation to a more politically correct statement such as "What is your ethnic heritage?" The first step to addressing inequity is forming critical consciousness about different racial realities (Sue, Bucceri, et al., 2007). Only with critical racial awareness can we take steps toward bridging the social gap between White people and people of color. Not addressing race relations and social hierarchy are patterns across the majority of scholars who critique not just microaggression research (Lilienfeld, 2017) but research on discrimination in general. In this section, we provide suggestions for theory, research, and practice that include: (1) continue advancing theories around microaggressions, (2) provide guidelines for microaggression research, and (3) offer strategies and resources to protect the targets.

Support for Microaggression Theory

Sue, Capodilupo, and colleagues (2007) redefined microaggressions and encouraged the field of psychology to explore the impact of these everyday slights and denigrations. Since then, researchers have steadily generated basic, translational, and applied research on microaggressions while interrogating validities of studies and reliabilities of measures (Nadal et al., 2015). Researchers investigating microaggressions have placed strong values on scientific rigor and, for a decade, have been building on the construct, identifying patterns in findings, and addressing impact, mechanisms, and individual variations of microaggressions. Given the current state of research on microaggression and self-esteem, it is evident that researchers value feedback and critiques, which are important to strengthen scientific investigations. Alarmingly, there is a call for the abandonment of the term and a demand for a moratorium on microaggression training programs (Lilienfeld, 2017). Although these critics have stated that microaggressions do occur, they often question the veracity of microaggressions research: for example, they make recommendations to shift the focus from the voices of the targets to the perpetrators, which consequently can be perceived as a microinvalidation. Recentering the focus on the perpetrators communicates exclusion and negates the psychological thoughts, feelings, and experiential reality of the targets (Sue, 2010a). Consequently, calling for the abandonment of the term "microaggressions" is ultimately denying the necessity to take action against oppression.

Another major implication involves the insidious impact of microaggressions. Findings strongly suggest that microaggressions often operate outside the conscious awareness of the targets. Research on microaggressions and self-esteem verifies that microaggressions do operate as daily stressors. Furthermore, findings indicate that these stressors are race-related and reflect the sociopolitical hierarchy of the United States. Race is usually the first social categorization people notice and is critical in determining how individuals interact (Helms, 1990). Much of the critiques on microaggression research focus on questioning whether these slights and indignities are racism-related. For example, Lilienfeld (2017) accuses microaggression advocates of going against Martin Luther King's famous "I have a dream" speech, which essentially communicates that color blindness is the solution. Lilienfeld stated that dwelling on subtle discrimination that is race-based creates more group tension and ultimately works against the main mission of microaggression scholarship to minimize discrimination. Moreover, he argues that the effects of microaggressions are trivial and "weak" situations compared to blatant discrimination. In response, the main focus of microaggression research is not to ascertain which type of discrimination, blatant or subtle, is worse and augurs a more negative impact. Instead, the main objective of microaggression advocates has been to reveal the reality of marginalized people

and empower them with terminology to explain their lived experiences with everyday discrimination.

Guidelines for Microaggression Research

In response to the recent critics of microaggression research, we provide the following guidelines for future studies.

Do not recenter the microaggression scholarship on perpetrators' perspective. We think it is a good scientific practice to examine microaggressions from the perpetrators' perspectives, but to focus the program on the realities of the perpetrators is invalidating to marginalized people. The recent suggestion to rename "microaggressions" to "inadvertent racial slights" refocuses the entire construct on the perpetrators' experience, which invalidates the lived experiences of marginalized people.

Do not let the argument of "scientific rigor" mask Whiteness, privilege, Eurocentrism, power, and hegemony. There is a long history of using scientific rigor to challenge research on experiences of the marginalized, specifically on experiences of discrimination. We need to address social power and hierarchy when discussing the dynamics of microaggressions.

Not seeing social categories is not the answer to discrimination as color blindness is not the answer to racism. Addressing microaggressions without considering social hierarchy is a denial of power and an invalidation of the marginalized's realities. Marginalized people spend much of their existence navigating a world that has othered them. The constant predicament of targets is whether to address the marginalization and risk confrontation or to remain silent and risk self-blame. Terms such as "microaggressions" help marginalized people name and label their experiences on their own terms. Moreover, creation of these terminologies allows marginalized people to reach out for support and know they are not alone in their experiences.

Protection for Targets of Microaggressions

Scholarship on microaggressions and self-esteem has implications for diversity programs and mental health interventions. One possible way counselors and therapists may help people of color cope with the adverse effects of microaggressions could be to build their self-efficacy. Bandura (1986) defined self-efficacy as the belief in one's ability to succeed in difficult situations and tasks. People who are low in self-efficacy doubt their capabilities and shy away from challenging situations and tasks that they perceive as personal threats. According to Bandura (1986), cognitive processes are vital to increasing self-efficacy. Counselors and therapists can use these findings to explain the social dynamics of racial microaggressions and help clients of color recognize and identify these incidents as racial discrimination or racial bias. Crocker and her colleagues (Crocker &

Blanton, 1999; Crocker & Major, 1989) have used experimental studies to examine the impact of discrimination and have found that the process of recognizing negative interactions as discrimination can have a protective effect on the self-concept and can increase self-efficacy of marginalized individuals. These findings suggest that enhancing people of color's ability to identify microaggressions may be an effective way to cope with the stress generated by these acts.

The response to microaggressions includes different strategies and levels depending on how such experiences are received as well as the impact such aggressions have on self-esteem. Microinterventions are tactics suggested to reduce the harm of microaggression and include: (1) make the "invisible" visible, (2) educate the offender, and (3) seek external support (Sue et al., 2019).

Make the "Invisible" Visible

Social media platforms such as Facebook have been used to create virtual communities such as the "Microaggressions Project," whereby people of color share their daily experiences with racial microaggressions in a space that has over 20,000 members. The influence of support groups has been shown to positively counter some of the effects stigma and stereotypes have on the individual while also shielding one's self-esteem (Crabtree, Haslam, Postmes, & Haslam, 2010). In social media groups such as this, a sense of group identity is shared by their users; some studies have suggested that group identity, especially on social media, has a positive relationship with collective self-esteem (Kim & Kim, 2019), which could explain the benefit of seeking support in spaces such as these when one experiences discriminatory attacks.

Educate the Offender

Training programs may both help White people and people of color identify microaggression-related acts and educate them about such acts' insidious effects on marginalized individuals. White people and people of color may also engage in intergroup dialogue about their experiences of microaggressions and discuss the different perspectives as perpetrators and targets. Empirical studies on intergroup dialogues show that participation in these exchanges leads to greater personal awareness, changes in attitudes on issues of identity, and increased motivation for social justice action (Aldana, Rowley, Checkoway, & Richards-Schuster, 2012; Dessel & Rogge, 2008; Nagda & Zúñiga, 2003). Public agencies such as the APA or the National Alliance on Mental Health have made available free resources to counter the negative effects of microaggressions on self-esteem, including virtual training, on-call centers, and assistance to find local support.

Seek External Support

Dealing with the effects of microaggressions involves different processes, many of them internal (Wong-Padoongpatt et al., 2017) which is why it is necessary for the clinical field to be better prepared to address the effects of these slights on mental health. According to a census done in 2013 by the APA, about 86 percent of the active psychology workforce is White, showing a lack of diversity and access for people of color. Thompson and Alexander (2006) found that when race between client and clinician matched, clients rated higher therapeutic understanding. Initial steps to close this gap include organizations such as the National Queer and Trans Therapist of Color Network or communities such as Therapy for Black Girls, which give access to directories that match their users with licensed mental professionals based on culture, race, or experiences.

Microaggressions affect people of color's self-esteem adversely but in a covert way, which may prevent people of color from taking protective steps against these attacks on the self. Counselors and therapists may clarify these incidents for people of color so they can become more aware of how such events are adversely affecting them. Training programs can increase racial sensitivity among White people by using these findings to explain how these common, everyday incidents are stressful and can insidiously undermine the self-concept of people of color.

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CHAPTER 5

Poverty and Mental Illness

Motivation, Beliefs, and the Cycle of Inequity

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Poverty and mental illness are deeply intertwined and fuel a wide range of disparities and inequities in health, education, income, incarceration rates, employment, and housing. The term "disparity" is neutral and implies a "value-free" difference, while the term "inequity" is "value-laden" and implies unfairness and injustice; to this end, disparities are not always inequitable, while inequities reflect systemic conditions that limit equal access and/or opportunities (Meghani & Gallagher, 2008).

Examples of disparities that are value-free include racial and gender disparities in health that result from genetic differences, such as the fact that male neonates are heavier at birth than female neonates. Another example of a disparity that is not the result of inequities includes genetic polymorphisms affecting drug metabolism (e.g., poor versus extensive metabolizers). For instance, there is evidence that approximately 10 percent of Caucasians are poor metabolizers of codeine; they are unable to convert codeine to morphine and are thus generally unresponsive to its pharmacologic effects (Meghani & Gallagher, 2008). This is a disparity that has implications for race-specific pain management, but it is in contrast to health inequities, which are reflections of systemic social injustice. Consider maternal mortality: the United States is one of the only countries experiencing increasing rates of maternal mortality, especially among Black, Native American, and Alaska Native women (Robeznieks, 2019).

These differences arise from multiple factors, including stress caused by racial discrimination, which can lead to hypertension, heart disease, and gestational diabetes; poor quality of care driven by health-care providers' discriminatory behaviors; and inequities in social determinants of health (e.g., education, employment), all driven by systemic racism (Robeznieks, 2019).

In this chapter, we will describe how most of the disparities associated with the poverty–mental illness cycle, which are often implied to be value-free, are actually the result of profound social inequities and systemic racism. The first section of this chapter will explore the poverty–mental illness cycle and its compounding effects. The second section will examine the motivation and beliefs that perpetuate the poverty–mental illness cycle, including mental health stigma, explicit and implicit biases, the school-to-prison pipeline, and the belief in the American dream and meritocracy. The third and final section will highlight systemic approaches that can help break the poverty–mental illness cycle and promote a more equitable society.

THE POVERTY–MENTAL ILLNESS CYCLE AND ITS COMPOUNDING EFFECTS

Children growing up in poverty (both transiently and chronically) have a higher risk of developing a mental illness (Dearing, 2008). Studies have demonstrated that childhood poverty increases the risk of developing mental illness by up to three times, and individuals who develop mental illness are more likely to remain poor or drift into poverty. Poverty fuels mental illness through disparities in perinatal risks, malnutrition, trauma, violence, and social marginalization. Although these disparities can be perceived as value-free, they are often the result of systemic and individual inequities (e.g., lack of universal health care, low quality of care provided by physicians who hold negative biases against the poor, social discrimination, and hate crimes against the poor). The poverty–mental illness cycle is also fueled by the fact that mental illness is associated with disparities in income, unemployment, and higher health-care expenses (Reiss, 2013). Once again, even though these disparities are inferred to be value-free, they are also often the result of systemic and individual inequities (e.g., employers' denial of advancement opportunities due to stigma surrounding mental illness, discrimination against people who have mental illness, lack of universal health care).

Unfortunately, childhood poverty is very difficult to overcome, and as a result, it fuels a larger host of disparities and inequities throughout a person's life. Indeed, children whose family incomes were below the poverty line before the children turned five completed two fewer years of education, worked 451 fewer hours per year, earned over $21,000 less per year on average, and accepted over $800 a year more in food stamps as adults

than children whose families earned a minimum of two times the official poverty line (Duncan, Ziol-Guest, & Kalil, 2010). Moreover, a brief published in 2013 by the Pew Charitable Trust showed that 43 percent of people whose childhood household income was in the last quintile remained in the bottom quintile of income as adults. In fact, only 4 percent of people born into the bottom 20 percent made it into the top 20 percent income bracket as adults. African Americans experience even worse outcomes. While 68 percent of White Americans born into the fifth quintile experienced at least some upward mobility (including moving into the fourth quintile), only 45 percent of African Americans did the same. Additionally, approximately 10.8 percent of non-Hispanic White Americans live below the poverty level, in contrast to 27 percent of African Americans (U.S. Census Bureau, 2016).

The economic disparities experienced by African Americans today are known to be largely the result of centuries of systemic racism in the form of extreme oppression, colonization, slavery, forced migration, segregation, and discriminatory policies. A clear example of how centuries of systemic racism continue to prevent African Americans from creating wealth relates to real estate ownership. Real estate generates more wealth more consistently than other types of assets due to a number of factors, including cash flow, appreciation, tax advantages, and forced equity (Greene, 2018). Most of the land owned by Whites has been passed down through generations via inheritance, a privilege that was denied to hundreds of thousands of Black families. In the report *Who Owns the Land*, the U.S. Department of Agriculture indicated that African Americans own less than 1 percent of the land (approximately 1.5 million acres) in the United States while Whites own about 98 percent (Moore, 2017). At the beginning of the 20th century, however, Blacks owned 16 million to 19 million acres. Most of that land was not sold freely by Blacks. Records indicate that over 600,000 Black farmers were forcibly displaced through lynchings, extreme violence, and intimidation. The financial and emotional consequences of those crimes have been and will continue to be felt throughout generations.

A report released by Brandeis University's Institute on Assets and Social Policy further analyzed the compounding factors that have widened the wealth gap between Blacks and Whites over the years. The report states that lack of inheritances and family gifts leads Blacks to wait about eight years longer than Whites to make down payments on homes, which results in fewer available years in which to build equity (Fletcher, 2013). For many years, Black families had to move to undesirable areas due to unfair housing practices (e.g., lending companies refusing to give loans to Black clients; landlords refusing to rent or sell to Black clients). Despite the fact that the Fair Housing Act made these practices illegal in 1968, a 1989 report showed high levels of discriminatory housing practices against Blacks and Latinos across the country. A report by the Urban Institute showed that even though explicit forms of housing discrimination have declined, real

estate and housing providers still show a lower number of homes to Blacks and Latinos than to equally qualified Whites (Urban Institute, 2019). In addition, research indicates that Whites feel aversion to the presence of Blacks in neighborhoods, even if those neighborhoods meet their needs. Indeed, most Whites surveyed about their housing preferences indicated that they would be unlikely to move into a home in a predominantly Black neighborhood, even if such home met their requirements (e.g., price, size) in a neighborhood with high-quality schools and low crime rates (Brown, 2012). Since Whites continue to be the majority of the population in the United States, their attitudes influence property values. Thus houses in predominantly Black neighborhoods accrue significantly less equity over time than houses in predominantly White neighborhoods.

Ingrained individual biases paired with centuries of systemic racist policies have resulted in substantial economic disparities that affect adults and children of color in the United States. Currently, 35.5 percent of Black children and 30.7 percent of Latino children in America are growing up in poverty (Thomas & Fry, 2020). Furthermore, when children who grow up in poverty go on to develop mental illnesses, they can fall into a cycle that further hinders their ability to achieve financial or mental wellness. Using data from the U.S. National Comorbidity Study, researchers found that men with a history of mental illness were 14 percent less likely to be employed (Chatterji, Alegria, & Takeuchi, 2011). It has also been documented that people with mental illness have high rates of absenteeism (missed work) and presenteeism (working while sick), both of which signal a loss of productivity. Mental illness is the third most expensive medical condition for employers, behind hypertension and heart disease (Goetzel et al., 2004). Kessler et al. (2006) found that people with bipolar disorder miss 27.7 days of work in a year on average and lose the equivalent of an additional 35.5 workdays through presenteeism. People with major depressive disorder were found to lose 18.2 workdays a year from absenteeism and presenteeism combined.

There are several mechanisms through which mental illness impact individuals' work performance and employment opportunities. First, there are symptoms that may come with mental illness. For example, decreased motivation, sociability, concentration, and energy may reduce productivity and result in fewer opportunities for advancement or difficulty keeping a job. Second, while employers often make accommodations for employees with physical disabilities, there are potential barriers for employees getting effective accommodations for psychiatric disabilities. These barriers include employers either not knowing what accommodations would be appropriate or being unwilling or unable to provide them. Additionally, the stigma of mental illness and disability could result in discrimination and could prevent people from securing employment in the first place (Chatterji et al., 2011). According to the American Psychiatric Association (2017), while the rates of mental health disorders are

similar among Whites and minority groups, the consequences of these disorders tend to be worse in non-White populations. These consequences worsen due to a wide range of racial and ethnic disparities and inequities. Minority groups tend to be uninsured or underinsured, experience more stigma against mental illness, lack access to diverse and culturally competent health-care providers, and have inadequate access to mental health services (American Psychiatric Association, 2017).

Educational Inequities

The impact of the poverty–mental illness cycle often first becomes evident in children's educational trajectories. Studies indicate that children who are persistently exposed to poverty throughout their childhood are 77 percent less likely to graduate from high school than children who were not exposed to poverty (Lee, 2014). The factors that impact those statistics include issues at the micro level (individual difficulties) as well as the macro level (social issues).

In terms of individual difficulties, studies suggest that children living in poverty are more likely to have cognitive, behavioral, and socioemotional difficulties (National Research Council & Institute of Medicine, 2009). Although such individual difficulties can make educating these children more challenging, there are social issues that can further prevent these children from achieving educational success. For example, people who live in poverty in the United States receive lower-quality education. Public schools in poor communities are often crowded with insufficient space, have poor physical environmental quality, fewer school supplies, and less-qualified teachers who also hold lower academic expectations (Evans, 2004; McKown & Weinstein, 2008). Although Americans expect school conditions in low-income neighborhoods to be worse than in high-income neighborhoods, that is not the case in other countries where resources are equally distributed among all schools. For example, in Finland, the country with the best educational system in the world, it is illegal to charge school tuition. Moore (2015) posited that since all Finnish children have to attend public schools and all schools must offer the same quality of education, rich and powerful families invest money and promote policies to ensure that all public schools receive the best resources. On the other hand, children who live in poverty in the United States, the majority of them being children of color, have to study under conditions that make them significantly less likely to graduate and achieve financial success. Inequities that impact children of color in the United States also include being exposed to less rigorous curricula and having teachers who expect less of them academically than they expect of White students with similar abilities (McKown & Weinstein, 2008). The setback for these children is clear, particularly in the context of economic prosperity and academic achievement.

Students of color are also at a greater risk of being disciplined through suspensions and expulsions. African American children are 31 percent more likely to receive a school discretionary action than peers of the same gender who commit the same offenses and have the same family income (Fabelo et al., 2011). Moreover, African American students who have disabilities are three times more likely to be subjected to removal from their schools than are White students with disabilities (Rausch, 2006). In a recent analysis of school disciplinary action, it was found that suspensions account for approximately one-fifth of Black–White differences in academic achievement (Morris & Perry, 2016). Racial biases play an undeniable role in children's punishments. Studies indicate that teachers' negative biases against Black children start in preschool and that Black children as young as five years of age can be perceived as violent and dangerous (Todd, Thiem, & Neel, 2016; Young, 2016). These negative biases lead to excessive and unfair punishments that take children out of school and delay their learning. These practices result in a decreased likelihood of graduation and postsecondary educational attainment, and they help solidify the poverty–mental illness cycle.

Minority children get labeled as "learning disabled," "emotionally disturbed," or "intellectually disabled" at markedly higher rates than White children (Losen & Orfield, 2002; U.S. Department of Education, 2014). Minority children are overrepresented in these special education services, and they are underrepresented in postsecondary education (Reid & Knight, 2006). In one study that explored the ways a "disability" label is used to justify the exclusion of minority students, it was postulated that any deviation from the societal perception of normalcy is punished. The perceived standard of White, upper or middle class, and ability opens the door to think of minority children who engage in different cultural or linguistic habits as abnormal or deviant (Reid & Knight, 2006).

Children with mental health disabilities have higher rates of enacted discipline, including suspensions and expulsions (Patel, Flisher, Hetrick, & McGorry, 2007; U.S. Department of Education, 2014). Students with disabilities are twice as likely to be suspended and 75 percent more likely to be expelled than their peers are (Rausch, 2006). They make up about 25 percent of all suspensions although they are only about 12 percent of the student population (U.S. Department of Education, 2014). Suspensions are associated with negative outcomes, including lower academic performance, higher rates of dropping out, failure to graduate on time, decreased academic engagement, and future disciplinary exclusion.

Health Inequities

People living in poverty and those with mental illness are both at risk of having worse health outcomes, including higher rates of chronic disease and increased mortality, than the general population is. These disparities

are largely driven by systemic racial and ethnic inequities. Steep healthcare costs prevent people from breaking the poverty–mental illness cycle, leaving these vulnerable populations trapped.

People with mental illness experience higher mortality rates for both natural deaths (e.g., due to heart disease and cancer) and unnatural deaths (e.g., due to suicides and accidents) than the general population. Mortality is highest for those with psychotic disorders and lowest for those with anxiety, with mood disorders in the middle. However, given the relative prevalence of psychotic disorders versus mood and anxiety disorders, more deaths are attributable to mood disorders and anxiety disorders than to psychoses (Walker, McGee, & Druss, 2015). People with mental illness are estimated to die 10 to 30 years earlier than people without mental illness, depending on the psychiatric diagnosis and gender of the patient (De Hert et al., 2011; Lawrence, Hancock, & Kisely, 2013; Parks, Svedensen, Singer, Foti, & Mauer, 2006; Thornicroft, 2011).

There are several proposed reasons for these disparities. First, it is well documented that people with both current and past mental illness report higher rates of smoking, with estimates indicating that people with mental illness are two to three times more likely to smoke (Lasser et al., 2000; Parks et al., 2006). Consequently, people with mental illness account for more than 200,000 of the 520,000 tobacco-related deaths in the United States every year (Colton & Manderscheid, 2006). Smoking and mental illness are both associated with lower socioeconomic status. However, the correlation between smoking and mental illness cannot be explained by socioeconomic status alone (Lawrence, Hafekost, Hull, Mitrou, & Zubrick, 2013). Researchers have also found that some clinicians engage in "diagnostic overshadowing," which means that they erroneously attribute patients' physical symptoms to their mental health diagnoses (van Nieuwenhuizen et al., 2013). This practice, which is driven by physicians' biases about mental illness, is an example of the type of inequities that can prevent mentally ill patients from receiving adequate treatment for their physical conditions.

Other inequities that impact patients with mental illness include receiving lower-quality care, being misdiagnosed due to racial biases, and receiving less preventive care. For example, in a study of intravenous thrombolysis (IVT) use in patients with acute ischemic stroke, it was found that patients with any mental illness (including psychosis, mood disorders, and anxiety) were 20 percent less likely to receive IVT than patients without psychiatric disorders, with outcomes being the worst for patients with schizophrenia (Bongiorno, Daumit, Gottesman, & Faigle, 2018). Among patients presenting to the emergency department with a primary diagnosis of diabetes, patients who also suffered from mental illness were less likely to be hospitalized. This effect was strongest in patients with nonpsychotic disorders (e.g., depression and anxiety) than in patients with psychotic disorders (e.g., schizophrenia) (Sullivan, Han,

Moore, & Kotrla, 2006). In addition, people with mental illness receive less preventive health care, which can result in greater morbidity and mortality in the future (Druss, Rosenheck, Desai, & Perlin, 2002). These findings are even stronger in African Americans. For example, it has been found that African Americans receive poorer quality of care independent of mental health status (American Psychiatric Association, 2017). Those who experience mental illness have lower utilization rates of outpatient and prescription medication services (less preventive care) but higher utilization of inpatient services (American Psychiatric Association, 2017). African Americans with mental illness are also more likely to be misdiagnosed with schizophrenia and less likely to be diagnosed with mood disorders compared to non-Hispanic, White patients presenting with similar symptoms (American Psychiatric Association, 2017). Misdiagnosing patients with schizophrenia and prescribing them inappropriate medications can lead to serious consequences and side effects, including worse symptomatology, weight gain, diabetes, and increased risk for suicide (Pedersen, 2019).

As previously discussed, minorities experience higher rates of poverty. Unfortunately, socioeconomic status is linked to poorer health outcomes in multiple ways. People living in poverty have higher rates of obesity, cancer mortality, and diabetes mortality (Freeman, 2008; Pickett, Kelly, Brunner, Lobstein, & Wilkinson, 2005). Poverty during childhood is associated with worse health as an adult, and studies point at chronic stress being one of the most important causal mechanisms (Evans & Kim, 2007). Another problem that impacts the health of minorities and individuals living in poverty is receiving lower-quality care. According to the *National Healthcare Disparities* report (Agency for Healthcare Research & Quality, 2018), Blacks, American Indians and Alaska Natives, and Native Hawaiians/Pacific Islanders receive worse care than Whites do for about 40 percent of quality measures.

Poverty and poor health create a perpetual vicious cycle. Even though the United States spends more on health care than any other country does, it has the lowest rates of insured persons and ranks worst in health care in the developed world. Data from 2013 to 2016 show that the United States spends almost twice as much per capita on health-care costs than the average of ten other high-income countries with similar demographics. The prices faced by consumers are a serious barrier to access for people in poverty; in fact, a 2018 study showed that 22.3 percent of Americans surveyed claimed to have missed a health-care appointment because of the cost, while the average for the other countries in the study was only 9.4 percent (Papanicolas, Woskie, & Jha, 2018). Although Americans have learned to see the health-care disparities faced by the poor in the United States as the norm and as value-free, the disparities are actually the result of profound socioeconomic inequities. The main reason for the high cost is not higher utilization (in fact, Americans see doctors less often) but a manufactured,

profit-driven system that benefits powerful corporations and harms marginalized communities. The United States is the only highly industrialized country in the world that does not offer universal health care. The profit-driven system has allowed medical costs to become the number one cause of bankruptcy in the United States, while health insurance companies enjoy record profits (e.g., United Health ranks fifth in the Fortune 500 list, and the average pay of health-care CEOs is 20 million dollars a year).

Adding to the problem of health-care cost is reduced access, particularly to preventive services. A primary care physician shortage has been a problem for many years, and it is expected to continue. While the number of primary care physicians was expected to grow 11 percent by 2020 (U.S. Department of Health and Human Services, 2016), the circumstances of the pandemic that followed have suggested a low estimate shortfall of 17,800 and a high estimate of 48,000 by 2034 (Association of American Medical Colleges, 2021). This situation is worse for minority groups, who already struggle to find culturally competent care and minority providers (American Psychiatric Association, 2017).

Decreased access to primary care increases the cost of health care. Most commonly noted, in the absence of affordable clinics, uninsured patients frequently utilize emergency rooms (Gertz, Frank, & Blixen, 2011). This problem places an enormous burden on an already overburdened health-care system. The cost of the median, nonurgent emergency room visit in 2013 was $740 for an upper respiratory infection and $3,473 for a kidney stone, and the median cost for all outpatient conditions was $1,233 (Caldwell, Srebotnjak, Wang, & Hsia, 2013). This amount is approximately 10 times higher than a community health center visit (U.S. Senate, 2011). Furthermore, emergency room visits were the only type of visit to increase in utilization every year between 2013 and 2017—and though utilization only increased 10 percent, average prices increased by a whopping 24 percent (Health Care Cost Institute, 2017).

As previously mentioned, the high costs of medical care significantly contribute to bankruptcy. Jacoby, Sullivan, and Warren (2001) estimated that almost half of all families who filed for bankruptcy in 1999 had a medical problem, and they identified female heads of households and the elderly as being especially likely to experience a health-related bankruptcy. In 2007, 62 percent of people who filed for bankruptcy claimed medical problems as a cause, despite the fact that three-quarters of those filing had health insurance (Himmelstein, Thorne, Warren, & Woolhandler, 2009).

Incarceration Disparities

Estimates of the prevalence of mental illness in prison populations vary based on how mental illness is measured and defined, but an international systematic review of 62 studies and 23,000 inmates concluded that 3.7

percent of male prisoners and 4.0 percent of female prisoners suffered from a psychotic disorder, with a substantially higher percentage of American male prisoners diagnosed (4.5 percent). Ten percent of incarcerated men and 12 percent of incarcerated women met criteria for major depressive disorder. These rates are two to four times higher than those of the general population (Fazel & Danesh, 2002). A more recent study put the rates of serious mental illness (which included schizophrenia and other psychotic disorders, major depressive disorder, and bipolar disorder) among the incarcerated as 14.5 percent for men and 31 percent for women (Steadman, Osher, Robbins, Case, & Samuels, 2009); higher rates for women is a consistent finding (Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010). In fact, due to the scarcity of inpatient mental health facilities, as of 2004 there were three times as many people with serious mental illnesses in the criminal justice system than in hospitals and medical facilities (Torrey et al., 2010).

As we discussed, racial and ethnic disparities contribute to both poverty and mental illness. Unfortunately, they also independently affect incarceration rates. For example, African Americans are much more likely to not only be arrested but also convicted, with longer prison sentences (The Sentencing Project, 2018). The statistics are sobering: African American adults are six times more likely than non-Hispanic Whites to be incarcerated, and they constituted 27 percent of all arrests—approximately two times the percentage of the total population (The Sentencing Project, 2018). The Sentencing Project reports that one in three Black boys and one in six Latino boys can expect to go to prison during their lifetime, compared with one in seventeen White boys (2018).

Beyond racial discrimination, people experiencing poverty are at a higher risk of incarceration than people of higher socioeconomic status. Studies have found that boys who were raised in the bottom 10 percent of the income distribution had a 9.6 percent chance of being incarcerated in 2012, whereas boys who grew up in the top 10 percent of the income distribution had a 0.49 percent chance (Looney & Turner, 2018). Further, a study published by the Brookings Institution in 2018 found that 56 percent of people incarcerated for at least a year reported an annual income of $500 or less two years before entering prison, with an additional 30 percent earning less than $15,000 (Looney & Turner, 2018). Moreover, incarceration harms a person's economic prospects, increasing the chances of that person falling into or returning to poverty. Western, Kling, and Weiman (2001) found that estimates on the wage penalty for the formerly incarcerated ranged from 10 percent to 30 percent, without taking into account the years of lost wages and wealth from time spent in prison. Looney and Turner (2018) show that in the first year after release from prison, only 20 percent of former inmates earn more than $15,000. People with mental health disorders report even lower rates of employment after prison than ex-inmates without reported mental illness (Visher, Debus-Sherrill, & Yahner, 2011).

While mental illness and poverty increase one's chances of going to prison, prison also increases the chances of one developing mental illness and experiencing socioeconomic decline. Incarceration deepens the marginalization of already marginalized populations. For example, indicating a criminal record on a job application makes it less likely an applicant will receive a call back from a potential employer. White male applicants are half as likely to receive a call from a potential employer if they have a criminal record compared to other White men without a criminal record. Black male applicants are penalized even more: their chances of getting a call back are about a third of that of their peers without a record (Pager, 2003). It should be noted that Pager's study also indicated that employers were more interested in White men with criminal records than Black men without criminal records, underscoring the impact of race in systems of inequity.

Being incarcerated is often considered a traumatic event. Inmates experience loss of autonomy, hypervigilance, interpersonal distrust, isolation, diminished sense of self-worth, and intense pressure to control all emotions. In addition, a large number of inmates enter prison with an extensive past history of trauma, and their experiences of incarceration can intensify their traumatic memories and exacerbate their trauma-related symptomatology (Haney, 2003). Moreover, inmates with mental health disorders are significantly more likely than their peers to be victimized by other inmates and correctional officers (Blitz, Wolff, & Shi, 2008). A prior history of trauma, the trauma of incarceration, and being victimized while incarcerated increase inmates' risk of developing post-traumatic stress disorder (PTSD). Research has found that people with PTSD are less likely to be employed, especially if symptoms are severe (Smith, Schnurr, & Rosenheck, 2005; Zatzick et al., 1997). Thus people of a lower socioeconomic class and those with mental illness are more likely to be incarcerated, are at risk for trauma once incarcerated, and have poor mental health and economic outcomes after being released. In this way, the poverty–mental illness cycle continues.

MOTIVATION AND BELIEFS THAT PERPETUATE THE POVERTY–MENTAL ILLNESS CYCLE

There are specific motivations and beliefs that perpetuate the poverty–mental illness cycle. In this section, we will examine how explicit and implicit biases, mental health stigma, the school-to-prison pipeline, and the belief in the American dream and meritocracy solidify the poverty–mental illness cycle.

Explicit and Implicit Biases

A key player in the advent of stigmatized attitudes and discrimination against those with mental illness is bias. Bias is a tendency to hold positive

or negative prejudice toward one individual, group, or issue compared with another. Biases are usually considered unfair, misleading, or not accurate, and they can be implicit and explicit.

Explicit biases are the biases that we consciously recognize (Greenwald & Krieger, 2006). Implicit biases, on the other hand, are the unconscious, automatic associations that we carry toward a specific group (FitzGerald & Hurst, 2017). While we are not always aware of our biases, everyone has them. Examples of these biases include seeing those with mental illness as more aggressive or considering mental illness to be a character flaw or personal weakness. Both implicit and explicit biases can have large impacts on human behavior and can fuel the active stigmatization of mental illness.

Mental Illness Stigma

There are three types of stigma: social, self, and structural. Social stigma is what perpetuates the beliefs and attitudes surrounding a certain group or topic in society and drives people within that society to act on these beliefs through discrimination, violence, and social exclusion. Structural stigma refers to the exclusion of certain groups from opportunities on an institutional level and contributes to inequities in housing, jobs, and health care (Hatzenbuehler, 2016). Self-stigma is the internalization of this discrimination at both societal and systemic levels, which often leads to social isolation and shame (Corrigan & Rao, 2012). All three stigmas impact individuals who have mental illness, contribute to the marginalization of this population, and have devastating effects on the perception of mental illness in society.

The attribution theory details the sequence of events that leads to discrimination and can be used to explain the basis of social stigma. In the attribution theory, a primary label and the attribution of a stereotype are placed on a specific group (e.g., everyone with a mental illness is violent). Stereotypes are widely accepted as true, are commonly exploited in the media, and often lead to negative attitudes, such as fear and hatred, toward the marginalized group. This negative attitude could lead to discriminatory behaviors (Stuart, 2013) such as hostility and violence. For example, a 2010 study showed that when compared to the general population, men and women with severe mental illness were at a higher risk of being the victims of physical violence. Similar research has also revealed gender discrepancies. Women with severe mental illness are more likely to experience both physical and sexual violence than are men with severe mental illness (Khalifeh & Dean, 2010; Khalifeh, Oram, Osborn, Howard, & Johnson, 2016).

Social stigma flourishes under the notion that those with mental illness are part of a "different" group. The concept of "otherness" has been used countless times in history as a way to marginalize minority populations

(Takaki, 2008). The social stigma that comes from the propagation of these false narratives and negative stereotypes surrounding certain populations, especially those with mental illness, is the root of social exclusion. This social exclusion is often worse for those with mental illnesses who belong to other marginalized groups based on socioeconomic, racial, or ethnic characteristics (Dinos, 2014). Additionally, the same stereotypes that perpetuate marginalization of those suffering from mental illness exist on an institutional level in the form of structural stigma.

Structural stigma is often difficult to identify because it is embedded in the covert language of laws and policies. For example, a recent study demonstrated that those with mental illness were less likely than their peers to be informed of available housing (Hammel, Smith, Scovill, Campbell, & Duan, 2017), leaving those with mental illness at a higher risk of homelessness. In fact, it is estimated that about 25 percent of the homeless population has a serious mental illness (Harvard Health Publishing, 2014). Again, negative outcomes for mentally ill persons due to structural stigmas are worse for those with additional health-care inequities. For example, the National Alliance to End Homelessness (2020) found that African Americans, American Indians and Alaskan Natives, and Pacific Islanders experience homelessness at disproportionate rates compared to the White population and that these are the effects of long-standing disparities in poverty, health care, and housing.

Discrimination in the workplace also makes it difficult for those with mental illness to find and keep jobs (Wheat, Brohan, Henderson, & Thornicroft, 2010). Thus individuals with mental illness often feel the need to hide their diagnoses because they fear negative responses and discriminatory attitudes from both employers and coworkers (Stuart, 2006). Not surprisingly, this fear extends beyond the workplace and can have damaging effects on the general well-being of those with mental illness, particularly in the form of self-stigmatization.

Self-stigma can have damaging effects on self-esteem. Sanchez and colleagues (2018) found a relationship between internalized stigma and feelings of being "less competent" and "unworthy." Shame has accompanied a diagnosis of mental illness for many years and contributes to the pressure felt by many to conceal mental health issues from everyone they know (Byrne, 2000) and avoid seeking mental health treatment. Self-stigma is particularly prevalent in Asian American and Hispanic populations and contributes to disparities in mental health service utilization among these groups (Wong, Collins, Cerully, Seelam, & Roth, 2017).

In the United States, White Americans are most likely to seek mental health care, followed by African Americans and U.S.-born Latinos, while immigrant Latinos have the lowest rates of access to care (Nadeem et al., 2007). Furthermore, discrimination within the mental health service sector has been demonstrated, as African American and lower socioeconomic status patients are less likely to be offered appointments compared to

White, middle-class patients when seeking mental health services (Kugelmass, 2016). Although rates of mental health treatment increased after the implementation of the Affordable Care Act, there was no decrease in the racial/ethnic disparities in mental health care (Creedon & Lê Cook, 2016) suggesting that more needs to be done to reach minority populations. This lack of consistent and adequate mental health treatment has created a mental health crisis in the United States.

School-to-Prison Pipeline

The "school-to-prison pipeline" is a process by which children, particularly children of color, who are subjected to school-based punishments become more likely to get incarcerated in the future (Mallett, 2017). Zero tolerance policies in school seek to prevent certain behaviors by punishing all similar infractions harshly, no matter how minor. This philosophy was initially adopted in schools to combat drugs, gangs, and violence in the late 1980s and early 1990s, culminating into national law with the Gun-Free Schools Act of 1994 (American Psychological Association [APA], 2008; Skiba & Knesting, 2001). Since then, these zero tolerance policies have expanded to punish smoking, making threats, and disrupting class. The enforcement of harsh punishment, even in the case of first or minor offenses, has made schools unforgiving places for minors who break the rules. The criminalization of education is felt now more than ever, as seen with the addition of metal detectors, cameras, and police officers patrolling the halls of many educational facilities (Mallett, 2017). Despite their goal in improving the school learning environment, zero tolerance policies show no clear benefit in improving student learning, behavior, or school safety (APA, 2008; Mallett, 2017; Skiba & Knesting, 2001).

Suspension and expulsion are the two main punishments that result from a zero tolerance policy. These practices disproportionately affect marginalized minors, including students of color, students in poverty, abused or neglected youth, members of the LGBTQ community, and students with disabilities (Mallett, 2017). Rather than improving academic outcomes, these disciplinary actions have been shown to decrease class engagement, lower academic performance, and result in increased dropout rates (APA, 2008; Darensbourg, Perez, & Blake, 2010; Mallett, 2017). This academic gap only widens as time passes, as these students are less likely to graduate high school, less likely to go to college, and more likely to live at or below the poverty line (Dearing, 2008; Musu-Gillette, de Brey, McFarland, Hussar, Sonnenberg, & Wilkinson-Flicker, 2017; Reid & Knight, 2006). There is widespread evidence supporting the connection between students who receive exclusionary discipline and those who will eventually enter the prison system, with no group being impacted more severely than African American males (APA, 2008; Darensbourg, Perez, & Blake, 2010).

Since the 1980s and President Reagan's declaration of the War on Drugs, the United States' incarceration rates have doubled, and the number of people incarcerated in America has more than quadrupled, increasing from roughly 500,000 to over 2.2 million (National Association for the Advancement of Colored People, 2019). Additionally, private prisons require their beds to be at 90 percent capacity in order to stabilize their profit margin. It has been argued that the need to profit has led private prisons to lobby for policies that increase incarceration rates and recidivism, such as zero tolerance policies (In the Public Interest, 2016). Importantly, the War on Drugs discriminates based on race and ethnicity and is a large contributor to the disproportionate numbers of minorities in the prison system. For example, in seven states, between 80 percent and 90 percent of prisoners convicted with drug charges are Black (ACLU, 2003). The American Civil Liberties Union (ACLU) also found that in 1999, Latinos comprised 46 percent of the population convicted with drug charges despite constituting only 12.5 percent of the population and despite evidence indicating they used and sold drugs less than Whites (2003). The climate surrounding the War on Drugs has not improved since then. For example, deportations for drug possession increased by 43 percent between 2007 and 2012 (Human Rights Watch, 2015). These drug laws and enforcement policies are harmful, discriminatory, and ineffective; they serve to perpetuate the inequities faced by those already impacted by poverty, mental illness, and racial injustice.

The American Dream and Meritocracy

America has often been described as the land of opportunity and a place where anybody could rise from nothing and achieve great success: the so-called American dream. This dream became a reality for many, namely White European immigrants who fled turmoil in their home countries and found prosperity in America (Hochschild, 1995). However, the dark side of American history shows a pattern of inequity, inequality, and oppression of minority groups that often prevents members of these groups from achieving the American dream.

Central to the doctrine of the American dream is meritocracy, or the belief that one's individual effort is directly proportional to the level of success that person can achieve (McNamee & Miller, 2009). Meritocracy assumes that all people have equal, and equitable, access to resources (Bell, 1972) to achieve social mobility and to reach a higher socioeconomic class. Equality assumes that everyone within a population is afforded the same opportunities (Kabanoff, 1991). Equity recognizes that certain populations begin in more disadvantaged positions than others and therefore may require extra assistance in order to be successful. Meritocracy oversimplifies the idea of social mobility by implying a level playing field, when in fact, there are many issues that impact whether one climbs the

proverbial economic ladder. Unfortunately, many of the factors that play a role in social mobility, including education, household income, and health (Nunn, Johnson, Monro, Bickerstaffe, & Kelsey, 2007), are factors where inequities among marginalized populations have been identified (Starfield, 2011).

In the United States, the lower socioeconomic class is disproportionately composed of individuals who belong to racial and ethnic minorities (Harris, 1996), as well as people with mental illness (Chow, Jaffee, & Snowden, 2003). As discussed throughout this chapter, the poverty–mental illness cycle is very difficult to break due to individual factors as well as systemic issues, such as disparities in job opportunities, incarceration rates, education, and health care. Belonging to a historically marginalized group, in addition to living in poverty and having a mental illness, can make the poverty–mental illness cycle almost impossible to break. Thus, promoting the idea that minority individuals who are trapped in the poverty–mental illness cycle have the same opportunities to achieve the American dream as everyone else is not only inaccurate but harmful, as it can be used to ignore the factors that solidify the cycle and shame those who cannot "pull themselves up by the bootstraps."

SYSTEMIC APPROACHES THAT CAN HELP BREAK THE POVERTY–MENTAL ILLNESS CYCLE

In this chapter, we have described the poverty–mental illness cycle, the social and health-related costs, and the motivations and beliefs that perpetuate these inequities. We have explained how both individual and social issues keep people trapped in the poverty–mental illness cycle. In this final section, we will review the systemic approaches that we believe are needed to help break the cycle and promote a more equitable society.

As discussed throughout this chapter, both people in poverty and people with mental illness face a wide range of disparities and inequities, including increased incarceration, mental illness, and substance abuse rates, and decreased educational achievements, health-care access, and productivity (Eisenberg & Neighbors, 2007). Studies have shown that mental illness contributes to more missed days of work and work impairment than any other medical problem, including back pain, diabetes, hypertension, heart disease, arthritis, and asthma (Druss & Rosenheck, 1999; Kessler, Greenberg, Mickelson, Meneades, & Wang, 2001; Stewart, Ricci, Chee, Hahn, & Morganstein, 2003). Importantly, these factors affect not only the people who are mentally ill but also their families, who may have increased absenteeism and shorter work hours to take care of their sick family members (Keck, 2017), thus maintaining the cycle of poverty and creating an enormous economic burden. In addition to the indirect costs of untreated mental illness, such as increased teen pregnancy, higher unemployment rates, and increased disability, direct, long-term economic

costs include reductions in annual incomes by 20 percent, seven fewer weeks worked per year, loss of up to $18,000 in family assets, and total lifetime costs of $300,000—culminating in approximately $2.1 trillion losses for the U.S. economy annually (Smith, Monica, & Smith, 2010). Strikingly, however, Kessler and colleagues (2008) estimate that the direct costs of health care for mental illness are only 1/37th the direct *and* indirect costs of untreated mental illness (Kessler et al., 2008). Thus providing adequate mental health care to those who need it can not only help them improve their individual financial situation but can also give a boost to the overall economy.

Studies have found that 65 percent to 90 percent of people with mental illness improve when provided with appropriate care (Evans et al., 2005; Hosman & Jane-Llopis, 2005; Lipsey & Wilson, 1993). Unfortunately, the number of people accessing mental health care remains low. In 2005 and 2007, only 1 in 8 patients with depression and 1 in 10 patients with substance abuse and a comorbid mental illness, respectively, received even minimally adequate treatment in a primary care setting (Kessler, Chiu, Demler, Merikangas, & Walters, 2005; Wang et al., 2005). Furthermore, each year, up to 80 percent of youths with mental illness do not receive the treatment they need (Merikangas et al., 2011). Several issues compound this problem: (1) an increasing number of uninsured or underinsured persons, especially among minorities and low socioeconomic status persons, (2) a shortage of primary care physicians and psychiatrists, and (3) stigma surrounding mental health. In 2017, the number of people without insurance increased for the first time since the implementation of the Affordable Care Act. These numbers, similar to those with untreated mental health disorders, are higher among minorities and people from low socioeconomic backgrounds (Eisenberg & Neighbors, 2007). African Americans, for example, are more likely to be uninsured and have up to 20 percent higher rates of severe mental illness, fewer same-race providers, less access to health care, and more problems with the care they receive (Kugelmass, 2016; Substance Abuse and Mental Health Data Archive, 2001).

Dismantling the poverty–mental illness cycle completely will require large-scale, systemic change that takes into account racial and ethnic inequities. For example, there needs to be better integration of mental health into primary care, especially in areas with limited mental health facilities. In fact, the World Health Organization (WHO) recognized mental health as a public health challenge at both national and international levels and specifically recommended redesigning the primary care model to include mental health under universal health coverage (WHO, 2018). This solution is necessary because the current for-profit insurance model in the United States fuels the poverty–mental illness cycle. First, low socioeconomic status and minority individuals are more likely to either be uninsured or have insurance that "carves out" needed mental health services. Furthermore, these individuals experience a number of stressors, such as

systemic racism, that can lead to epigenetic changes that in turn contribute to mental illness in subsequent generations (Hodgkinson, Godoy, Beers, & Lewin, 2017). Second, most mental health services operate at hours inaccessible to those in low-wage positions. These employees cannot afford long wait times, business hour appointments, and multiple follow-ups (Levy & O'Hara, 2010). Third, state-level financial support for mental health care has decreased despite increasing demand for mental health services; patients may instead be redirected to jails, receiving little to no treatment at all (Honberg, Diehl, Kimball, Gruttadaro, & Fitzpatrick, 2011). Universal health care and the integration of mental health services into primary care can help attenuate these issues.

Another systematic change that can be helpful is implementing Housing First models. As previously described, mental illness can be an insurmountable obstacle for those in poverty, especially in the presence of other comorbidities that can push those stuck within the cycle of poverty into homelessness. Traditional housing programs have tried to address the issue of homelessness but have often fallen short due to restrictive housing prerequisites, such as requiring individuals to be drug-free (Ellen & O'Flaherty, 2010). Due to historically high rates of substance abuse, these stipulations become severe barriers to too many people in need of housing (National Alliance to End Homelessness, 2016), and perpetuate the poverty–mental illness cycle.

To help combat this issue, Housing First models use a harm-reduction paradigm in order to provide permanent housing along with supportive services, such as access to social workers, psychiatric management, and substance abuse treatment (Padgett, Henwood, & Tsemberis, 2016), free of the harmful stipulations found in conventional housing approaches (Pearson, Montgomery, & Locke, 2009). Comparative studies have shown that programs using the Housing First approach to combating homelessness in persons with severe mental illnesses are more successful than traditional programs in being able to provide individuals housing earlier and help them maintain their housing status (Tsemberis, Gulcer, & Nakae, 2011). In addition, a recent article in the *Journal of the American Medical Association* concluded that expanding Housing First interventions with intensive case management can have economic benefits due to the interventions' cost-effectiveness (Latimer et al., 2019).

Opening school-based health centers (SBHCs) is another option to work toward increasing access to mental health care, particularly for low-income children. SBHCs are often run by nurses, nurse practitioners, and mental health providers, and they allow students to receive comprehensive health care on school grounds. The majority of SBHCs are in low-income areas where there is high risk for children facing toxic, often chronic, stressors. Having SBHCs in schools dramatically increases the chances that a student exhibiting high-risk behaviors, struggling with complex mental illness, or lacking insurance would utilize mental health

services (Bains & Diallo, 2016). Students who have the highest need of care are the most likely to seek it through these SBHCs. Many students seeking school-based services also have lower grades, suggesting that SBHCs are treating students with issues that may be impacting them academically (Bains & Diallo, 2016).

Given the widespread shortage and relative inaccessibility of mental health providers, utilizing all available resources is crucial. One meta-analysis of school-based mental health interventions found that school personnel (teachers, staff members) can have a positive impact on children who are struggling with mental illness, even in the absence of a formal mental health provider (Sanchez et al., 2018). These school-based mental health programs include forms of cognitive behavioral therapy and mindfulness-based cognitive therapy, all offered during school hours, on school grounds. Such programs result in decreases in depressive and anxious symptoms and show improvement in the school's ability to prevent depression or anxiety from developing (Werner-Seidler, Perry, Calear, Newby, & Christensen, 2017). In addition, using mindfulness-based stress reduction techniques in school has been shown to increase attentiveness and improve learning (Zenner, Herrnleben-Kurz, & Walach, 2014). Programs that target social skills training, anger management techniques, and how to replace inappropriate behaviors with appropriate responses have been proposed to help decrease rates of exclusionary discipline (Darensbourg, Perez, & Blake, 2010). Resiliency training, where children learn positive social skills and self-regulation techniques, can decrease the emotional disturbances many children face that contribute to their receiving disciplinary actions (Darensbourg, Perez, & Blake, 2010; Reid & Knight, 2006).

The use of technology can also help reduce costs and facilitate access to care. This solution may be particularly beneficial for individuals who do not have access to mental health services due to high health-care costs, provider shortages, mental health stigma, or lack of proximity to services. Importantly, technology allows for the information to be transmitted in different languages, saved, reviewed, and accessed by patients at any time, which can improve patients' understanding of the material and be of particular benefit to patients who have low educational levels, cognitive disabilities, limited English proficiency, and limited health literacy.

Finally, reducing mental health stigma is a very important step that has to be taken in order to break the poverty–mental illness cycle. Community education programs have been used in the fight against mental illness stigma. These education programs have been aimed at dispelling the negative stereotypes that are often associated with those who are mentally ill, and they have been shown to reduce negative attitudes toward those with mental illness (Rüsch, Angermeyer, & Corrigan, 2005). While community education is an important facet of antistigma initiatives in mental illness, these education programs are not without their limitations and therefore should be used synergistically with other forms of antistigma programs.

Corrigan and colleagues conducted a study in 2006 that aimed to measure differences in outcomes between two types of antistigma programs: education and contact. Results of this study showed that there were more positive outcomes, including an increase in positive attitudes and a decrease in discriminatory behaviors, associated with the contact group, while the education group showed minimal improvement (Corrigan, Larson, Sells, Niessen, & Watson, 2006).

One way that contact has been used to reduce stigma against those with mental illness has been through imagined intergroup contact. Past research has demonstrated that imagining a social scenario can elicit similar cognitive responses to actual social experiences (Garcia, Weaver, Mosokowitz, & Darley, 2002), and this idea has become the basis for an antistigma initiative through the use of imagined intergroup contact (Crisp, Stathi, Turner, & Husnu, 2009). In imagined intergroup contact, the participant, a member of the "in-group," imagines a social scenario involving a person in the "out-group." In this context, the person in the in-group would be someone without mental illness, while the person in the out-group would be a person with mental illness. The social scenario mimics a positive experience between the participant and the out-group, which leads to more positive attitudes toward the out-group and can influence behavior toward the out-group. The concept of imagined intergroup contact has been shown to decrease negative stereotypes and discriminatory behavior toward those with mental illness, thus reducing mental illness stigma (Pinfold, Thornicroft, Huxley, & Farmer, 2009; Stathi, Tsantila, & Crisp, 2012). Another important part of fighting mental illness stigma is switching from using "handicapped" to "nonhandicapped" language—for example, referring to one as "a person with schizophrenia" rather than as a "schizophrenic." This slight change in language has been associated with more positive attitudes toward those with mental illness (Granello & Gibbs, 2016).

While there has been much progress in recent years with the advent and implementation of antistigma programs, there is still a need for more research into stigma as well as broader dissemination of antistigma programs (Stuart, 2013). These programs are particularly needed in minority communities, where stigmatizing attitudes and behaviors toward those with mental illness are most apparent (Wolff, Pathare, Craig, & Leff, 2018).

CONCLUSIONS

Throughout this chapter, we have discussed how the cycle of poverty and mental illness fuels a wide range of disparities and inequities in health, education, income, incarceration rates, employment, and housing. We have argued that most of the disparities associated with the poverty–mental illness cycle, which are often implied to be value-free, are actually the result of profoundly unjust systems promoted by the dominant culture in the United States. We have also reflected on the motivation and cultural

beliefs that maintain these systems, ranging from the micro to the macro level, and proposed more equitable approaches. Future research should focus on understanding the ways in which dominant cultural beliefs in the United States shape our views of poverty and mental illness and on identifying successful strategies used by other countries around the world to promote a more equitable society.

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CHAPTER 6

Perceived Discrimination in Health-Care Settings among Filipino Americans

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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.

INTRODUCTION

The United States has an extensive history of inequality in, for example, education, employment, and housing, but the most persistent manifestation of inequality is the increasing disparity in health and health care. There have been an increase in acknowledgment of this social injustice and a surge of initiatives to better understand and ultimately eliminate health disparities (e.g., IOM Unfair Treatment, Healthy People 2010, Affordable Health Act). Health disparities refer to unfair distribution in health status (i.e., morbidity, mortality) and health care (i.e., access, utilization, retention rates, quality, satisfaction of service) across different groups. There is a plethora of literature revealing that people of color have less access to adequate health care, receive poorer-quality services, and lack culturally appropriate care (Smedley, Stith, & Nelson, 2003; U.S. Department of Health and Human Services, 2001). Despite the fact that the Asian American and Pacific Islander (AA/PI) community is one of the fastest-growing groups in the country (Budiman & Ruiz, 2021), the health inequity research into this community is not sufficient.

Health disparities must be contextualized with inequities across other sectors of American life. Historic oppression from legalized segregation and discrimination against people of color has contributed to racial inequities in income, employment, housing, education, incarceration, responses to natural disasters, and projected impact from climate change (e.g., Blanchett, 2006; Henkel, Dovidio, & Gaertner, 2006; Hilton, 2016; Mohai, Pellow, & Roberts, 2009; Pager & Shepherd, 2008; Western & Pettit, 2005). These institutional racial inequities embedded within all aspects of society place people of color at disproportional rates of health disparities (Smedley, Stith, & Nelson, 2003). While there have been efforts to improve other societal institutions, inequities in health care are still vastly unrecognized across public and professional communities even though this is a matter of life and death for people of color and other marginalized groups. Emerging research has begun to bring to light structural racism within health care (Bailey et al., 2017; Feagin & Bennefield, 2013; Gee & Ford, 2011; Paradies, 2006).

Most explanations of differences in health care typically focus on individual-level variables, such as an individual's attitude, knowledge, or behavior that leads a person to engage in (or not engage in) health and health-care behaviors (Kazak, Bosch, & Klonoff, 2012). Individual-focused models for explaining health disparities include the health belief model (Becker, 1974), the transtheoretical model of change (Prochaska, DiClemente, & Norcross, 1992), and motivational interviewing (Hettema, Steele, & Miller, 2005). There has been a call to move toward a complex and multidimensional approach in conceptualizing and addressing the causes of health inequity among vulnerable communities, including investigating social determinants of health. Social determinants of health are social factors with important direct or indirect effects on health (Braveman, Egerter, & Williams, 2011), such as socioeconomic conditions, housing, economic opportunities, transportation options, food availability, public safety, access to health-care services, and racial discrimination (Commission on Social Determinants of Health, 2008).

Racial discrimination, specifically in the context of health care, is a social determinant of health that warrants further investigation (Braveman et al., 2011; Paradies et al., 2015; Ramaswamy & Kelly, 2015). The most overt forms of racial discrimination are hate crimes: actions that are bias motivated and can involve physical assaults, harassment, or threats. While cases of hate crimes may not be as common, discrimination may emerge in more subtle and covert forms. These microaggressions are described as "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, Bucceri, Lin, Nadal, & Torino 2007, p. 271). For example, Asian Americans may be assumed to be foreigners (Sue, Capodilupo, et al., 2007). Microaggressions have been found to be a common experience for people of color and have been identified as an important correlate

of health (Krieger, 1999; Nadal, Griffin, Wong, Hamit, & Rasmus, 2014; Williams, Neighbors, & Jackson, 2003). The biopsychosocial model suggests that experiencing ongoing microaggressions elicits a stress response that contributes to poor physical and psychological health (Clark, Anderson, Clark, & Williams, 1999). More specifically, stress from discrimination triggers a release of cortisol, cytokines, and other substances that impact immune responses and physiologic systems and can lead to a rapid onset or progression of chronic illnesses. Chronic stress from perceived racial discrimination has been associated with cardiovascular disease, hypertension, asthma, depression, substance use, and higher rates of mortality (Barnes et al., 2008; Coogan et al., 2014; Dolezar, McGrath, Herzig, & Miller, 2014; Paradies, 2006; Williams & Mohammed, 2009). For AA/PIs, chronic stress from discrimination has been tied to increase risk of heart disease, pain, respiratory illnesses, substance misuse, and depression (Alvarez, Juang, & Liang, 2006; Gee, Spencer, Chen, Yip, & Takeuchi, 2007; Lee & Ahn, 2011; Noh & Kaspar, 2003; Tran, Lee, & Burgess, 2010).

Access to quality health care is arguably one of the most important determinants of health, and racial discrimination immersed in this system poses significant health risk for people of color. The U.S. health-care system has historically engaged in systematic segregation and discrimination of patients based on race and ethnicity that continue to have lasting impact on delivery of care today (see Feagin & Bennefield, 2013, for a comprehensive historical and contemporary review). While discrimination within health care is no longer legal, discrimination emerges still through insurance status, where rates of limited insurance plans or no insurance disproportionately impact people of color (Majerol, Newkirk, & Garfield, 2015). Patients' perceptions of discrimination within their health-care systems predict a variety of adverse outcomes, including overall health status, diabetes, heart disease, and mental health concerns (Brondolo et al., 2011; Lee, Ayers, & Kronenfeld, 2009; Paradies et al., 2015; Pascoe & Smart Richman, 2009; Piette, Bibbins-Domingo, & Schillinger, 2006; Troxel, Matthews, Bromberger, & Sutton-Tyrell, 2003). Patients who report experiences of discrimination with their providers are more likely to postpone treatment, underutilize services, and avoid preventive care, which can contribute to higher morbidity and mortality rates (Burgess, Ding, Hargreaves, van Ryn, & Phelan, 2008; Gonzales, Harding, Lambert, Fu, & Henderson, 2013; Hall et al., 2015; Trivedi & Ayanian, 2006; Van Houtven et al., 2005). Unsurprisingly, these patients experience less satisfaction with their providers and overall care (Benkert, Peters, Clark, & Keves-Foster, 2006; Bird, Bogart, & Delahanty, 2004), greater mistrust of health-care institutions (Benkert et al., 2006), and less likely to follow providers' recommendations (Haywood et al., 2014).

This chapter will examine the role of discrimination in health care and its impact on health-care outcomes among Filipino Americans, one of the most invisible communities within the field of health research. This chapter will present recent findings of a mixed-method study examining the

health-care experiences, including perceived discrimination in services, among Filipino Americans.

OVERVIEW OF HEALTH INEQUITY OF ASIAN AMERICAN AND PACIFIC ISLANDERS

AA/PIs constitute approximately 5 percent of the total U.S. population and are one of the fastest-growing racial groups in the United States, growing four times faster than the total population (U.S. Census Bureau, 2010). AA/PIs are often considered a homogeneous population and therefore remain largely invisible in current research and, consequently, in efforts to understand and address their health needs. AA/PIs represent over 30 countries of origin and include a variety of cultures, beliefs, religions, years in the United States, acculturation levels, English proficiency, and socioeconomic status between and within groups (Liu, Murakami, Eap, & Hall, 2009). While some AA/PIs have achieved good education, employment, and financial stability, these experiences have contributed to the "model minority myth" that assumes that all AA/PIs are successful in life and have positive health. AA/PIs as a whole have a number of strengths in social and health factors; certain AA/PI groups and specific members (e.g., refugees), however, are at risk of poor health outcomes (Yi, Kwon, Sacks, & Trinh-Shevrin, 2016). Compared with other people of color, there has been even less research on the health-care inequity among AA/PIs, perhaps due to the model minority myth. Emerging research has found that while AA/PIs are vulnerable for a variety of health conditions, such as heart disease and diabetes (Centers for Disease Control and Prevention, 2010), they have the lowest rate of health-care utilization compared to other people of color and Whites, regardless of gender, age, and geographic location in the United States (U.S. Department of Health and Human Services, 2001). Additionally, AA/PIs report engaging in significantly fewer preventive services compared with other groups (Centers for Disease Control and Prevention, 2010; Liao et al., 2004). Furthermore, AA/PIs have extremely low rates of seeking behavioral health services compared with other groups (Abe-Kim et al., 2007; Tewari, 2009; Yang & Worpat-Borja, 2007). Similar to other people of color, AA/PIs receive poorer quality of health care compared to Whites (Virnig et al., 2002). They are also less satisfied with their health care, do not trust their providers, and believe that their providers do not understand their cultural background (Ngo-Metzger, Legedza, & Phillips, 2004).

OVERVIEW OF HEALTH INEQUITY OF FILIPINO AMERICANS

Filipino Americans are the second-largest AA/PI group in the United States (Barnes & Bennett, 2002), numbering 3.4 million members in 2010,

and are the fastest-growing portion of AA/PI immigrants in the United States (U.S. Census Bureau, 2010). Despite their long history and growing population in the United States, research on Filipino Americans' health and health-care needs is insufficient. The Filipino American experience in the United States is unique compared to other AA/PI groups due to the history of U.S. colonialism in the Philippines. As a result of this colonial past, the Philippines is the only Asian country where English is the second national language (Posadas, 1999). U.S. presence in the Philippines established Western-centric values and ideals in Filipino society. This led to discrimination against non-Christian, non-English-speaking, darker-skinned, and non-Westernized Filipinos (David & Nadal, 2013). Propaganda in school, media, and government systems emphasized U.S. and White superiority (David & Nadal, 2013). Many Filipinos and Filipino Americans may internalize messages of devaluing Filipino culture due to their long and complex history of colonialism (David & Nadal, 2013). Since Filipino immigrants have had American cultural influences in the Philippines, the majority of Filipino Americans and immigrants identify themselves as "Americans" and have high rates of assimilation to the American culture (David, 2011). Filipino Americans have been described as the most "Americanized" of the AA/PI groups (Nakanishi & Lai, 2003). Given this complex history, Filipino Americans have been identified as the most "invisible" AA/PI group and the least understood and studied ethnic groups in the United States (Dela Cruz & Agbayani-Siewert, 2003).

Although research is limited on Filipino Americans, researchers have identified some preliminary patterns of health disparities, including but not limited to heart disease, hypertension, diabetes, and obesity (Abesamis-Mendoza et al., 2007; Araneta, Wingard, & Barrett-Connor, 2002; Dalusung-Angosta, 2010; Dalusung-Angosta & Gutierrez, 2013; Giyeon et al., 2010; Klatsky, Tekawa, & Armstrong, 1996; Lee, Brancati, & Yeh, 2011; Montano, Acosta-Deprez, & Sinay, 2009; Palaniappan et al., 2010; Ryan et al., 2000). In addition, Filipino Americans experience high rates of depression (David, 2008; Tompar-Tiu & Sustento-Seneriches, 1995), suicidal ideation and suicide attempts (President's Advisory Commission on Asian Americans and Pacific Islanders, 2001), stress and anxiety (Abesamis-Mendoza et al., 2007), alcohol use (Nadal, 2000), and cigarette smoking (Chen & Unger, 1999).

Filipino Americans have been found to have the lowest rate of health-care utilization among AA/PI groups (Tompar-Tiu & Sustento-Seneriches, 1994). Filipino Americans often delay care, do not engage in preventive care, and only seek services in cases of emergency (Abesamis-Mendoza et al., 2007; David, 2010). In addition, Filipino Americans have low rates of seeking behavioral health services (Abe-Kim et al., 2007; Barnes et al., 2008; David, 2010; Gong, Gage, & Tacata, 2003; Ying & Hu, 1994). When faced with stressors or health concerns, Filipino Americans typically seek out important family or friends prior to seeking out health services (Gong

et al., 2003). Filipino Americans experience higher rates of chronic health conditions and do not use health-care services as often as other communities do, even though on average they have higher rates of health insurance and income compared to the total U.S. population and other AA/PI groups (U.S. Census Bureau, 2015). As insurance and income are not significant barriers to care for most Filipino Americans, cultural factors and issues within health-care systems may be more salient barriers for this community.

Filipino Americans face discrimination in their daily lives (Alvarez et al., 2006). Compared to other AA/PI groups, Filipino Americans reported the highest levels of perceived discrimination (Alvarez et al., 2006; Gee, Spencer, Chen, & Takeuchi, 2007). The long history of colonization may contribute to Filipino Americans to be uniquely sensitive to experiences of discrimination compared to other AA/PI groups without a colonial past (Alvarez & Juang, 2010). David and Okazaki (2006) have pointed out that many Filipino Americans may experience "colonial mentality," the experience of colonization and sense of internalized oppression this community faces in response to discrimination. The dynamic interplay of historical oppression, daily microaggressions, and colonial mentality may enhance Filipino Americans' vulnerability to chronic stress, distress, and health conditions. Filipino Americans' experience of perceived discrimination has been linked to greater levels of psychological distress (Mossakowski, 2003; Syed & Juan, 2012) and chronic health conditions, including heart disease, diabetes, and high blood pressure, and substance misuse (Alvarez & Juang, 2010; De Castro, Gee, & Takeuchi, 2008; Gee, Delva, & Takeuchi, 2007; Gee et al., 2006; Mossakowski, 2003). More effort is needed to better understand the important social determinant of health that are racial discrimination and its impact in Filipino Americans' interactions with health-care systems. The current study is an attempt to assess these dynamic processes among Filipino Americans and corresponding impact on their overall health and satisfaction of care.

CURRENT STUDY

In light of the literature discussed above, the current study aimed to better understand the health-care experiences of Filipino Americans. In order to understand the nature of inequities in health care among Filipino Americans, this study employed a mixed-methods design. More specifically, this study examined Filipino Americans' experiences within patient-provider interactions and identification of themes in narrative data on health behavior and health-care experiences. The study aims to:

1. Identify interrelationship of perceived discrimination, cultural factors (enculturation, religion, generation status, language), patient-provider interaction, and health outcomes (health status, satisfaction of provider, satisfaction of health care)

2. Examine predictors of patient-provider interactions and health outcomes
3. Identify themes in narrative data on health and health care

METHOD

Participants were recruited nationally through advertisements and online recruitment with community organizations affiliated with Filipino Americans. Participants had to identify some or all of their ethnicity as Filipino in order to qualify for the study. Of a total sample of 141 participants, 137 completed the entire set of questionnaires through an online survey (see table 1 for descriptive statistics). Adult participants' ages ranged between 18 and 80 years old, with the mean age of the sample at 39.04 years old. The sample included 69 women (50.4%) and 65 men (48.2%), and one participant self-identified as gender nonconforming. Of the entire sample, 100 percent of participants identified their race as Asian American/Pacific Islander and some or all of their ethnicity as Filipino. Additionally, 30.7 percent identified being biracial or multiracial. The majority of participants were born in the United States (69.9%), while 27.7 percent were born in the Philippines and 2.2 percent were born in another country. There were three generation groups identified in the sample, including first-generation (29.2%), second-generation (43.1%), and third-generation (27.7%) Filipino Americans. All participants indicated that they were citizens or permanent residents of the United States. Most participants reported that they were bilingual or multilingual (64.7%). Participants self-reported a number of chronic health conditions, including chronic stress (80.9%), obesity (22.9%), anxiety (39.2%), diabetes (22.9%), hypertension (22.9%), and depression (16.9%). (Full demographic data are presented in table 1.)

Procedure

Participants were recruited through advertisements through community organizations affiliated with Filipino Americans (e.g., Filipino American cultural organizations, Filipino student organizations). Filipino American organizations were contacted by mail, email, or phone. Once permission was received by the organizations, study recruitment letters and survey links were shared with Filipino American community members. Participants were recruited from states and cities with large Filipino American communities as shown on U.S. Census reports (e.g., Hawaii, California, New York City, and Los Angeles). Once consent was obtained, participants completed the online self-report questionnaires and open-ended questions. The total procedure took approximately 30 minutes to complete. Participants had the option to enter into a lottery to win a $25 gift card to Amazon for participation in the study. Institutional approval was obtained prior to recruitment and data collection.

Table 1
Demographics (N = 137)

	N	%	Mean (SD)	*Range*
Age of participants in years			39.04 (*18.48*)	18–80
Gender				
Female	69	50.4		
Male	65	47.4		
Other	1	0.7		
Prefer not to answer	2	1.5		
Racial Background				
Asian/Pacific Islander	137	100		
Biracial/Multiracial	42	30.7		
White	37			
African American/ Black	4			
Hispanic/Latino	3			
Native American	2			
Other	1			
Ethnicity				
Filipino	137	100		
Place of Birth				
United States	95	69.3		
Philippines	38	27.7		
Other Country	3	2.2		
Prefer not to answer	1	0.7		
Citizenship				
Citizen/Permanent Resident	137	100		
Generation Status				
1st Generation	40	29.2		
2nd Generation	59	43.1		
3rd Generation	38	27.7		

Qualitative data were used to identify themes pertaining to the health-care experience and barriers of Filipino Americans using the consensual qualitative research (CQR) method. The CQR method was used for coding narrative data. Four vignettes were used to assess participants' perceptions and views of health-care services, interaction with providers, cultural beliefs, needs, and barriers to care.

Measures

Perceived Discrimination in Health-Care Settings. The multi-item measure of perceived discrimination in health-care settings (Bird & Bogart, 2001; Peek, Nunez-Smith, Drum, & Lewis, 2011) was an adaption of Williams's validated and widely used Everyday Discrimination measure (Taylor, Kamarck, & Shiffman, 2004; Williams, Yu, Jackson, & Anderson, 1997). Items are measured on a five-point Likert scale of never (1) to very often (5). Higher values indicate greater frequency of unfair treatment. This measure has been used with Filipino American samples, with Cronbach's alpha coefficient ranging from 0.86 to 0.91 (Gee et al., 2006; Gee, Spencer, Chen, & Takeuchi, 2007; Mossakowski, 2003). An adapted version has been used to assess race-based unfair treatment encountered within health-care settings (Bird & Bogart, 2001; Peek et al., 2011). The adapted version includes statements such as "Received poorer services than other people" and "Felt that a health provider was not listening to what you were saying." The health care–adapted version has shown excellent reliability in a variety of diverse patient populations, including Asian Americans in general and Filipino Americans (Bird & Bogart, 2001; Hausmann, Kressin, Hanusa, & Ibrahim, 2010). In the current study, the Cronbach alpha coefficient was 0.96.

Interpersonal Process of Care—Short Form. The Interpersonal Process of Care—Short Form (IPC-18) is a patient-reported, multidimensional, 18-item instrument that assesses the domains of communication, patient-centered decision-making, and interpersonal style (Stewart, Nápoles-Springer, Gregorich, & Santoyo-Olsson, 2007). The conceptual framework assesses three domains and seven scales: communication (provider lacked clarity, provider elicited concerns, and provider explained results), patient-centered decision-making, and interpersonal style (provider compassionate/respectful, discrimination by provider, and disrespect by health-care staff). Due to the nature and scope of this study, we included in our analyses two domains of patient-centered decision-making and interpersonal style. Questions include,*How often did doctors take your health concerns very seriously?* and *How often did you and your doctors work out a treatment plan together?* All items on the scale are rated on a five-point Likert scale, ranging from *Never* (1) to *Always* (5). Scale scores are calculated as a mean of their responses to the items of each scale, resulting in scale scores with a possible range of 1 to 5. The ICP-18 has been applied to patients from diverse groups and demonstrated good internal reliability above 0.70 for all scales (Stewart et al., 2007). In the current study, the Cronbach alpha coefficient for the scales was between 0.88 and 0.98.

Enculturation Scale—Filipino Americans, Short Form. The Enculturation Scale for Filipino Americans (ESFA) was developed to assess the degree to which a person adheres to values and behaviors of the Filipino culture

(Del Prado & Church, 2010). The short form consists of 30 items that are measured using a six-point Likert scale that ranges from *Strongly disagree* (1) to *Strongly agree* (6). The items in this measure include statements such as: *I visit the Philippines often; I always listen carefully to those in positions of authority; A personal failure is a letdown for the entire family;* and *I leave things to God's will*. Internal consistency reliability estimates for the subscales were high, and construct validity was supported by the other enculturation/acculturation measures as well as immigration, generation status, and cultural identity variables (Del Prado & Church, 2010). The short form showed high internal consistency, with Cronbach's alpha of 0.88–0.89 and compared well with the longer form of the measure (Del Prado & Church, 2010). In the current study, the Cronbach alpha coefficient for the total scale was 0.95, and between 0.93–0.94 for the subscales. Table 2 represents the means, standard deviations, and internal consistency of study measures.

Perceived Health Status. Perceived health status is one's subjective evaluation of personal health. Perceived health status is measured by one item

Table 2
Means, Standard Deviations, and Internal Consistency for Study Measures

Measure	*Possible Range*	M (SD)	α
1. PD	7–35	19.56 (*6.82*)	0.96
2. ESFA	30–180	128.30 (*28.76*)	0.95
3. ESFA-H	10–60	36.89 (*10.58*)	0.94
4. ESFA-I	10–60	45.95 (*9.72*)	0.94
5. ESFA-C	10–60	45.60 (*10.70*)	0.93
6. PSQ	1–5	45.77 (*13.35*)	0.95
7. PSQ-GS	1–5	2.64 (*1.03*)	0.85
8. PSQ-PS	1–5	2.56 (*0.75*)	0.91
9. IPC-PCDM	1–5	2.18 (*1.06*)	0.93
10. IPC-I1	1–5	2.04 (*1.01*)	0.92
11. IPC-I2	1–5	2.75* (*0.82*)	0.95
12. IPC-I3	1–5	2.74* (*0.91*)	0.98

Note: PD = Perceived Discrimination in Health-Care Setting. ESFA = Enculturation Scale for Filipino Americans. ESFA-H = ESFA Connection with Homeland subscale. ESFA-I = ESFA Interpersonal Norms subscale. ESFA-C = ESFA Conservativism subscale. PSQ = Patient Satisfaction Questionnaire. PSQ-GS = PSQ General Satisfaction of Health-Care subscale. PSQ-PS = PSQ Provider Satisfaction subscale. IPC = Interpersonal Process of Care. IPC-PCDM = IPC Patient-Centered Decision-Making subscale. IPC-I1 = IPC Provider Interpersonal Style Compassionate/Respectful. IPC-I2 = IPC Provider Interpersonal Style Discrimination. IPC-13 = IPC Provider Interpersonal Style Disrespect.

*Negative directionality for scale: higher scores indicate worse processes.

question: *In general in the past 12 months, would you say your health is . . . ?* Participants rate their health on a five-point Likert scale from *Poor* (1) to *Excellent* (5). A single-item measure of self-reported perceived health is accepted widely as a valid and reliable measure of actual health, especially when predicting illness states, negative health, use of health services, and mortality rates (Bowling, 2005). Participants' self-ratings of health are subjective but are a strength as they reflect on their personal evaluation of overall health.

The Patient Satisfaction Questionnaire—Short Form. The Patient Satisfaction Questionnaire—Short Form (PSQ-18; Marshall & Hayes, 1994) is an 18-item scale that assesses participants' attitudes toward their health-care providers and their satisfaction with the health care they receive. We utilized the following two subscales: General Satisfaction and Satisfaction of Provider. Items include *My doctor treats me in a very friendly and courteous manner*, and *I am dissatisfied with the medical care I receive*. All items on the scale are rated on a five-point Likert scale, ranging from *Strongly Disagree* (1) to *Strongly Agree* (5) such that higher scores indicate greater patient satisfaction. The PSQ-18 has been reported to have a high internal consistency that exceeded 0.90 among population samples with diverse groups, including Asian Americans (Marshall & Hays, 1994). In the current study, the Cronbach alpha coefficient for the total scale was 0.95, the internal consistencies for General Satisfaction subscale were 0.85, and the Patient Satisfaction subscale was 0.91.

Vignettes. Vignettes have long been used in social sciences. Gould (1996) notes that the increasing popularity of vignettes stem from the increasing recognition of the limitations of questionnaires in studies of attitudes, beliefs, and norms. Vignettes have been used in health research in a number of ways, including eliciting views and opinions from people receiving health-care services (Ouslander, Tymchuk, & Krynski, 1993). For the current study, a series of four hypothetical vignettes were used. Each vignette depicted a Filipino American patient interacting with a provider in a health-care setting. Participants were instructed to read the four vignettes and answer questions on their opinion of the patient-provider interaction, patient response, provider recommendations, and the extent to which they related to the situation described in the vignette. The purpose of these questions was to better understand participants' perspectives on the patient-provider interaction, cultural beliefs on health, and barriers to health care. A pilot study of vignettes was conducted, and data analysis had been completed to verify these themes prior to the current study. Themes of patient characteristics, patient-provider interaction, and treatment adherence were obtained from pilot data. The pilot study was done in partnership with three volunteers who were Filipino American community leaders, including Filipino American health providers, researchers, and advocates, in order to develop valid vignettes and

appropriate themes. After specific domain and subdomain themes were identified with definitions and examples, data was coded by two independent research assistants using coding guidelines. Intercoder reliability of 85 percent was obtained for responses on all four vignettes.

Open-Ended Questions on Filipino American Health-Care Disparities. Participants' perspectives on the issue of health-care disparities among Filipino Americans were assessed through open-ended questions. The following statement was presented to participants: *Research shows that although Filipino Americans on average have higher rates of health insurance, income, and education, they experience higher rates of chronic health conditions and do not use health-care services as often compared to other communities*. Three open-ended questions were then presented, including: *What might be some factors that may be contributing to Filipino Americans' low rate of health-care services? What might be some obstacles to the use of health-care services for Filipino Americans? What might be some first steps to begin addressing this important issue?* The purpose of these questions was to generate participants' opinions on health-care inequities among Filipino Americans.

RESULTS

This study was an exploration of various factors contributing to health-care inequities among Filipino Americans. This study examined the role of perceived discrimination, enculturation, language, and religiosity with patient-provider interactions and health outcomes (perceived health status, satisfaction of health care, satisfaction of provider) among Filipino Americans using univariate and multivariate statistical analyses. Qualitative data were also obtained on themes of health-care experiences from responses to vignettes. Additionally, themes of barriers to health care and next steps to address health-care disparities were gathered from participants' responses to open-ended questions. A post hoc power analysis was conducted using G*Power Software (Faul, Erdfelder, Lang, & Bucher, 2007) in order to determine the necessary sample size for the proposed analyses. Power was determined with an alpha level of 0.05, assuming a medium effect size (f^2) of 0.15 and a power level of 0.95 for analysis for the total sample (N = 137) and including up to four factors for analysis. Prior to conducting quantitative analyses, study variables were examined through visual inspection of the data. Frequencies and descriptive statistics were used to identify and address out of range variables, outliers, and missing data. These variables were found to have less than 5 percent missing data. Data from four participants were excluded as being substantially incomplete. The data were suitable after the transformation of variables. Preliminary analyses confirmed no assumptions were violated.

Perceived Discrimination in Health-Care Settings. Results for the overall sample indicated moderate levels of perceived discrimination in health-care settings (M = 19.56, SD = 6.82) (see table 3).

Table 3
Descriptive Statistics for Total Sample (N = 137)

Variable	*Mean* (SD)	*Range*
Perceived Discrimination in Health-Care Settings	19.56 (*6.82*)	7–35
Interpersonal Process of Care		
Patient-Centered Decision-Making	2.18 (*1.06*)	1–5
Patient-Provider Interpersonal		
Compassionate/Respectful Care	2.04 (*1.01*)	1–5
Discrimination by Providers	2.75* (*0.82*)	1–5
Disrespect by Health-Care Staff	2.74* (*0.91*)	1–5
Enculturation		
Enculturation to Filipino Culture	128.30 (*28.76*)	30–180
Connection to Homeland Subscale	36.89 (*10.58*)	10–60
Interpersonal Norms Subscale	45.95 (*9.72*)	10–60
Conservatism Subscale	45.60 (*10.70*)	10–60
Religiosity	3.42 (*1.37*)	1–5
Comfort Speaking English with Doctor	3.62 (*1.06*)	1–5

**Negative directionality for scale, higher scores indicate worse processes.*

Patient-Provider Interaction. Patterns of patient and provider interactions were examined for the entire sample (see table 3). Participants on average indicated low levels of patient-centered decision-making in their health-care experiences (M = 2.18, SD = 1.06). In patient and provider interpersonal interactions, participants indicated on average low levels of experiences in which their provider was compassionate and respectful (M = 2.04, SD = 1.01), moderate levels of perceived discrimination by their providers (M = 2.75, SD = .82), and moderate levels of perceived disrespect by health-care staff (M = 2.74, SD = .91).

Enculturation to Filipino Culture. Results for the overall sample indicated moderate levels of Enculturation to Filipino Culture (M = 128.30, SD = 28.76) (see table 4). Participants on average had high levels of the enculturation subscales of interpersonal norms (M = 45.95, SD = 9.72) and conservatism (M = 45.60, SD = 10.70) and moderate levels to subscale of connection to homeland (M = 36.89, SD = 10.58). Results for enculturation to Filipino culture total score and its relationship to health behavior and health outcomes through univariate and multivariate analyses are presented later. Preliminary analyses indicated that there were high correlations between enculturation to the Filipino culture variable and the three enculturation subscales (bivariate correlations above 0.80); therefore, the

Table 4
Descriptive Statistics of Participants' Health Outcomes for Total Sample (N = 137)

Health Outcomes	*Mean* (SD)	*Range*
General Health Status	2.56 (*2.61*)	1–5
Satisfaction of Health Care	2.64 (*1.03*)	1–5
Satisfaction of Provider	2.56 (*0.74*)	1–5

subscales were not included in univariate or multivariate analyses to investigating relationships with health behaviors and health outcomes due to violation of the assumption of multicollinearity.

Health Status. Results for the entire sample indicate a lower rate of overall health over the 12 months prior ($M = 2.56$, $SD = 2.61$).

Patient Satisfaction. Results for the overall sample for general satisfaction of health care indicated that Filipino American participants on average had lower levels of satisfaction ($M = 2.56$, $SD = 1.03$). Additionally, participants on average indicated lower levels of satisfaction with their provider ($M = 2.56$, $SD = 0.74$).

Interrelations of Variables

Discrimination by Provider. Perceived discrimination by provider (see table 5) was positively related with perceived discrimination in health care ($r = 0.79$, $p < 0.001$) and negatively associated with health status ($r = -0.49$, $p < 0.001$), satisfaction of provider ($r = -0.68$, $p < 0.001$), and satisfaction of health care ($r = -0.68$, $p < 0.001$). Perceived discrimination by provider was negatively associated with patient-centered decision-making ($r = -0.56$, $p < 0.001$), compassionate/respectful care ($r = -0.54$, $p < 0.001$), and positively associated with disrespect by health-care staff ($r = 0.76$, $p < 0.001$). Effect size ranged from moderate to strong in these interrelations. Perceived discrimination was negatively related to enculturation to Filipino culture ($r = -24.$, $p < 0.001$), and positively related to comfort speaking English with a provider ($r = 0.46$, $p < 0.001$) and religiosity ($r = 0.46$, $p < 0.001$), and these effect sizes were small.

Discrimination within Health-Care Settings. Perceived discrimination within health-care settings was negatively associated with health status ($r = -0.50$, $p < 0.001$), satisfaction of provider ($r = -0.72$, $p < 0.001$), and satisfaction of health care ($r = -0.73$, $p < 0.001$). Perceived discrimination within health-care settings was negatively associated with patient-centered decision-making ($r = -0.65$, $p < 0.001$), compassionate/respectful care ($r = -0.54$, $p < 0.001$), and positively associated with disrespect by health-care staff ($r = 0.77$, $p < 0.001$). Effect size ranged from moderate to strong in these interrelations. Perceived discrimination was positively related to

Table 5
Interrelations among Health Outcomes, Health Behaviors, and Individual Characteristics (N = 137)

Scale	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*
1. Health Status	–	0.44**	0.44**	0.50**	0.45**	–0.49**	–0.43**	–0.26**	0.58**	–0.50**	0.44**
2. Satisfaction of Health Care		–	0.79**	0.70**	0.68**	–0.70**	–0.69**	–0.28**	0.51**	–0.73**	–0.16
3. Satisfaction Provider			–	0.75**	0.72**	–0.68**	–0.70**	–0.21**	0.47**	–0.72**	–0.17**
4. Patient-Centered Decision-Making				–	0.77**	–0.56**	–0.61**	0.40**	–0.62**	–0.65**	0.40**
5. Compassionate/Respectful					–	–0.54**	–0.62**	–0.24**	–0.24**	–0.54**	–0.15
6. Discrimination by Provider						–	0.76**	–0.26**	0.46**	0.77**	0.29**
7. Discrimination by Health-Care Staff							–	–0.29**	0.60**	–0.61**	–0.26**
8. Enculturation to Filipino Culture								–	–0.65**	0.39**	0.65**
9. Comfort Speaking English									–	–0.42**	–0.67**
10. Discrimination in Health Care										–	0.65**
11. Religiosity											–

**$p<0.001$.

enculturation to Filipino culture ($r = 39.$, $p < 0.001$) and religiosity ($r = 0.65$, $p < 0.001$), and negatively related to comfort speaking English with a provider ($r = -0.42$, $p < 0.001$), and these effect sizes were low to moderate.

Predictors of Health Behavior and Health Outcomes

We explored the relative contribution of participants' individual characteristics as significant predictors of health behavior and health outcomes among Filipino Americans. Additionally, we explored the relative contribution of participants' health behavior as significant predictors of health outcomes. A total of 10 standard multiple regression analyses were conducted on the data for the entire sample ($N = 137$).

Individual characteristic predictors of health behaviors. We explored the relative contribution of participants' individual characteristics (enculturation to Filipino culture, comfort speaking English to provider, discrimination in health-care settings, and religiosity) as significant predictors of health behaviors (patient-centered decision-making, compassionate and respectful care, perceived discrimination by provider, and disrespect by health-care staff). We hypothesized that higher rates of enculturation to Filipino culture, lower rates of comfort speaking English with provider, higher levels of religiosity, and higher levels of perceived discrimination will be significant predictors of poorer health behaviors. Our hypothesis was partially supported due to not all individual characteristics being significant in the multiple linear regression models.

Predictors of Patient-Centered Decision-Making. A standard multiple linear regression analysis revealed that individual characteristics accounted for 57.5 percent of the variance of patient-centered decision-making, $R^2 = 0.56$; $F(4, 133) = 28.10$, $p < 0.001$ (see table 6). The level of comfort speaking English with a provider ($\beta = 0.65$, $t\ (133) = 6.06$, $p < 0.0001$) was found to make the largest unique contribution and is a statistically significant positive

Table 6
Summary of Standard Multiple Regression Analyses for Predictors Patient-Centered Decision-Making (N = 137)

Predictor	*Unstandardized* B	*SEB*	*Standardized* β
Perceived Discrimination in a Health-Care Setting	−0.072	.012	−0.466*
Comfort Speaking English to Doctor	0.652	0.108	0.650*
Enculturation to Filipino Culture	−0.008	0.004	−0.225
Religiosity	0.118	0.081	0.149

* $p < 0.001$.

predictor of the patient-centered decision-making. Perceived discrimination in health-care settings ($\beta = -0.47$, t (133) = –5.67, $p < 0.001$) also makes a statistically significant contribution. Comfort speaking English accounts for a unique contribution of 17 percent to the variance in patient-centered decision-making. Perceived discrimination in health-care setting uniquely explains 19 percent of the variance in patient-centered decision-making, with greater levels of perceived discrimination in health care related to lower levels of patient-centered decision-making.

Predictors of Compassionate and Respectful Care. Regression analysis revealed that individual characteristics accounted for 56.47 percent of the variance of the compassionate and respectful care $R^2 = 0.57$; $F(6, 133) = 27.12$ $p < 0.001$ (see table 7). Perceived discrimination in health care ($\beta = -0.60$, t (133) = –7.346, $p < 0.001$) was found to make the largest unique contribution and is a statistically significant negative predictor of the perceived level of compassionate and respectful care. Comfort speaking English with provider ($\beta = 0.52$, t (133) = 4.75, $p < 0.001$) also makes a statistically significant contribution. Perceived discrimination in health care accounts for a unique contribution of 28 percent to the variance, while comfort speaking English uniquely explains 12 percent of the variance.

Predictors of Discrimination by Provider. Regression analysis revealed that individual characteristics accounted for 70.1 percent of the variance of discrimination by provider $R^2 = 0.70$; $F(4, 132) = 48.62$ $p < 0.001$ (see table 8). Not surprisingly, the individual characteristics of perceived discrimination in health care ($\beta = 0.80$, t (132) = 11.91, $p < 0.001$) were found to make the largest unique contribution, constitute a statistically significant positive predictor of the discrimination by provider, and account for a unique contribution of 51.1 percent to the variance.

Predictors of Disrespect of Health-Care Staff. Regression analysis revealed that individual characteristics accounted for 70.4 percent of the variance

Table 7
Summary of Standard Multiple Regression Analyses for Predictors of Compassionate and Respectful Care (N = 137)

Predictor	*Unstandardized* B	*SEB*	*Standardized* β
Perceived Discrimination in a Health-Care Setting	–0.088	0.012	–0.599*
Comfort Speaking English to Doctor	0.491	0.103	0.515*
Enculturation to Filipino Culture	–0.013	0.004	–0.372
Religiosity	0.056	0.078	0.075

* $p < 0.001$.

Table 8
Summary of Standard Multiple Regression Analyses for Predictors of Discrimination by Provider (N = 137)

Predictor	*Unstandardized* B	*SEB*	*Standardized* β
Perceived Discrimination in a Health-Care Setting	0.097	0.008	0.805*
Comfort Speaking English to Doctor	−0.046	0.070	−0.059
Enculturation to Filipino Culture	0.001	0.002	0.027
Religiosity	−0.012	0.053	−0.020

*$p < 0.001$.

Table 9
Summary of Standard Multiple Regression Analyses for Predictors of Disrespect by Health-Care Staff (N = 137)

Predictor	*Unstandardized* B	*SEB*	*Standardized* β
Perceived Discrimination in a Health-Care Setting	0.108	0.009	0.810*
Comfort Speaking English to Doctor	−0.024	0.077	−0.028
Enculturation to Filipino Culture	−0.001	0.003	−0.011
Religiosity	0.047	0.058	0.069

*$p < 0.001$.

of disrespect by health-care staff $R^2 = 0.70$; $F(4, 130) = 49.36$ $p < 0.001$ (see table 9). Perceived discrimination in health-care settings ($\beta = 0.81$, $t(130) = 12.05$, $p < 0.001$) was found to be a statistically significant positive predictor of the disrespect by health-care staff, accounting for a unique contribution of 51.8 percent to the variance.

Individual Characteristic Predictors of Health Outcomes. We explored the relative contribution of participants' individual characteristics (enculturation to Filipino culture, comfort speaking English to doctor, religiosity, and perceived discrimination in a health-care setting) as significant predictors of health outcomes (health status, satisfaction of health care, satisfaction of provider). We hypothesized that higher rates of enculturation to Filipino culture, lower rates of comfort speaking English with provider, higher levels of religiosity/spirituality, and higher levels of perceived discrimination will be related to poorer health outcomes. Our hypothesis was partially supported. Of the three standard multiple linear regressions, all models were significant.

Table 10
Summary of Standard Multiple Regression Analyses for Predictors of Satisfaction with Health Care (N = 137)

Predictor	*Unstandardized* B	*SEB*	*Standardized* β
Perceived Discrimination in a Health-Care Setting	−0.097	0.011	−0.642*
Comfort Speaking English to Doctor	0.477	0.096	0.488*
Enculturation to Filipino Culture	0.004	0.003	0.124
Religiosity	0.202	0.073	0.262

*$p < 0.001$.

Predictors of Health Status. Regression analysis revealed that individual characteristics accounted for 42 percent of the variance of health status, $R^2 = 0.43$; $F(4, 130) = 17.08$, $p < 0.001$ (see table 10). Comfort speaking English with a provider ($\beta = 0.65$, t (130) = 5.34, $p < 0.001$) was found to make the largest unique contribution and is a statistically significant positive predictor of health status. Perceived discrimination in health-care setting ($\beta = -.34$, t (130) = −3.65, $p < 0.001$) also makes statistically significant contribution and is a negative predictor. Comfort speaking English with a provider accounts for a unique contribution of 19 percent to the variance in health status, while perceived discrimination uniquely explains 8 percent.

Predictors of Satisfaction with Health Care. Regression analysis revealed that individual characteristics accounted for 64 percent of the variance of satisfaction with health care $R^2 = 0.64$; $F(4, 131) = 37.56$, $p < 0.001$ (see table 10). Perceived discrimination in health-care settings ($\beta = -0.65$ t (131) = 5–8.71, $p < 0.001$) was found to make the largest unique contribution and is a statistically significant negative predictor of satisfaction with health care. Comfort speaking English with a provider ($\beta = 0.49$, t (131) = 4.97, $p < 0.001$) also makes a statistically significant contribution. Perceived discrimination in health-care settings accounts for a unique contribution of 32 percent to the variance in satisfaction with provider, while comfort speaking English with provider uniquely explains 11 percent.

Predictors of Satisfaction of Provider. Regression analysis revealed that individual characteristics accounted for 60 percent of the variance of satisfaction with provider $R^2 = 0.60$; $F(4, 130) = 31.61$, $p < 0.001$ (see table 11). Perceived discrimination in health-care settings ($\beta = -0.66$ t (130) = −8.52, $p < 0.001$) was found to make the largest unique contribution and is a statistically significant negative predictor of satisfaction with provider. Comfort speaking English with a provider ($\beta = 0.42$, t (130) = 4.09, $p < 0.001$) also makes a statistically significant contribution. Perceived discrimination in health-care settings accounts for a unique contribution of 35 percent to

Table 11
Summary of Standard Multiple Regression Analyses for Predictors of Satisfaction with Provider (N= 137)

Predictor	*Unstandardized* B	*SEB*	*Standardized β*
Perceived Discrimination in a Health-Care Setting	−0.073	0.009	−0.663*
Comfort Speaking English to Doctor	0.300	0.073	0.424*
Enculturation to Filipino Culture	−0.006	0.003	−0.213
Religiosity	0.081	0.055	0.146

* $p < 0.001$.

the variance in satisfaction with provider, while comfort speaking English with a provider uniquely explains 8 percent.

Health Behavior Predictors of Health Outcomes. We explored the relative contribution of participants' health behaviors (*patient-provider interactions*: patient-centered decision-making, compassionate and respectful care, discrimination by provider, disrespect by health-care staff) as significant predictors of health outcomes (health status, satisfaction of health care, satisfaction of provider) among Filipino Americans. It is hypothesized that more positive patient-provider interactions will be significant predictors of better health outcomes. Our hypothesis was fully supported. Of the three standard multiple linear regressions, all models were significant.

Predictors of Health Status. Regression analysis found that health behavior predictors accounted for 32.6 percent of the variance of health status, $R^2 = 0.33$; $F(4, 131) = 13.67$, $p < 0.001$. Discrimination by provider ($\beta = -0.46$ t (131) = −2.97, $p < 0.01$) was found to make the largest unique contribution and is a statistically significant negative predictor of the Health Status. Patient-centered decision-making ($\beta = 0.27$, t (131) = 2.14, $p < 0.05$) also makes statistically significant contributions. Discrimination by provider accounts for a unique contribution of 5 percent to the variance in health status, while patient-centered decision-making uniquely explains 3 percent.

Predictors of Satisfaction of Health Care. Regression analysis revealed that health behavior predictors accounted for 66 percent of the variance of satisfaction of health care $R^2 = 0.66$; $F(4, 130) = 57.89$, $p < 0.001$ (see table 12). Discrimination by provider ($\beta = -0.39$ t (130) = −3.64, $p < 0.001$) was found to make the largest unique contribution and is a statistically significant negative predictor of the satisfaction of health care. Patient-centered decision-making ($\beta = -.28$ t (130) = 3.22, $p < 0.01$) and compassionate and respectful care l ($\beta = .23$ t (130) = 2.63, $p < 0.01$) also made significant contributions. Discrimination by provider accounts for a unique

Table 12
Summary of Standard Multiple Regression Analyses for Predictors of Satisfaction with Health care (N = 137)

Predictor	*Unstandardized* B	*SEB*	*Standardized* β
Patient-Centered Decision-Making	0.273	0.085	0.280*
Compassionate/ Respectful Care	0.235	0.089	0.230*
Discrimination by Provider	−0.490	0.135	−0.389**
Disrespect by Health-Care Staff	−0.046	0.130	−0.042

*<0.01. ** $p<0.001$.

contribution of 4 percent to the variance in satisfaction of health care, while patient-centered decision-making and compassionate and respectful care uniquely explain 3 percent and 2 percent, respectively.

Predictors of Satisfaction of Provider. Regression analysis revealed that health behavior predictors accounted for 69 percent of the variance of satisfaction of provider, $R^2 = 0.59$; $F(4, 133) = 68.28$, $p < 0.001$ (see table 13). Patient-centered decision-making ($\beta = 0.36$ t (133) = 4.42, $p < 0.001$) was found to make the largest unique contribution and is a statistically significant negative predictor of the satisfaction of provider. Compassionate and respectful care ($\beta = 0.23$, t (131) = 2.28, $p < 0.01$) and discrimination by provider ($\beta = -0.24$, t (131) = −2.38, $p < 0.05$) also make statistically significant contributions. Patient-centered decision-making accounts for a unique contribution of 5 percent to the variance in satisfaction of provider, while compassionate and respectful care and discrimination by provider uniquely explain 2 percent and 1 percent, respectively.

IDENTIFICATION OF THEMES IN NARRATIVE DATA ON HEALTH-CARE EXPERIENCES

We identified themes on Filipino Americans' health-care experiences based on participants' responses to questions related to four hypothetical vignettes. Qualitative data was coded following the approach of consensual qualitative research data analysis (Hill, Thompson, & Williams, 1997). Two independent coders, one an undergraduate and the other a graduate student, were used to identify narrative domains, and agreement was obtained around the coding of core ideas. Inter-rater agreement was above 85 percent, indicating excellent reliability for all coding categories. Qualitative data obtained from participants were coded to identify themes, including patient characteristics and patient-provider interaction.

Table 13
Summary of Standard Multiple Regression Analyses for Predictors of Satisfaction with Provider (N= 137)

Predictor	*Unstandardized* B	*SEB*	*Standardized β*
Patient-Centered Decision-Making	0.257	0.058	0.364***
Compassionate/ Respectful Care	0.172	0.061	0.231**
Discrimination by Provider	−0.219	0.092	−0.249*
Disrespect by Health-Care Staff	−0.132	0.086	−0.161

Note: All predictors checked for multicollinearity. $R^2 = 0.69$.
* $p < 0.05$. ** $p < 0.01$. *** $p < 0.001$.

Participants made a total of 1,585 statements about patient characteristics. Analysis of responses from the patient characteristic domain indicated a predominance of family, family medical decision-making, collectivism, or *kapwa* (interconnectedness and social harmony; 31%), followed by passive patient (29.3%), stigma (16.3%), respect for authority (12.7%), and spirituality and religiosity (11.8%) subdomains. One participant highlighted the value of kapwa in the context of health care, describing it thus: "Having family involved in medical decisions is pretty much the norm."

Participants made a total of 3,350 statements about patient-provider interaction. Analysis of responses from the patient-provider interaction domain indicated a predominance of dissatisfaction with provider and health care (69.4%), followed by satisfaction with provider and health care (13.9%), cultural insensitivity (8.2%), patient-provider mismatch (7.1%), and patient-provider match (1.3%) subdomains. One participant's response highlighted cultural insensitivity: "The doctor was so disrespectful and made assumptions about me based on the way that I speak."

In addition to vignettes, participants responded to open-ended questions on barriers to health care. Participants responded to these questions with a total of 282 statements. The majority of responses indicated individual and contextual barriers (N = 70), with limited time due to work, school, or family obligations as the predominant subdomain (28% of individual and contextual barriers responses); while 22.7 percent of responses indicated patient-provider interaction barriers, with lack of culturally sensitive care as the predominant subdomain (25.9% of patient-provider interaction barriers responses) followed by mistrust (20.3%) and discrimination (12.5%). For lack of culturally sensitive care, a participant explained, "Doctors don't know anything about Filipino health or culture or how to work with minorities or immigrants." Another participant

explained, "My grandparents are always suspicious of providers here." In highlighting experiences of discrimination, a participant shared this: "[Providers] look down at you, think lesser of you, and you don't get the care you deserve."

Participants generated a total of 85 statements on community recommendations. The top five response domains identified from participants' statements for initial starting places to address health-care disparities among Filipino Americans include the following: (1) health fairs in the Filipino American community (18.4%), (2) diversity and culturally sensitive training for health-care providers (14.1%), (3) increase representation of Filipino Americans in health care, policy, and research (11.8%), (4) Filipino American community meetings and forums to discuss health-care disparities (11.8%), and (5) education on the importance of preventive care and lifestyle changes (10.6%). One participant recommended the need for implementing "health fairs at places of work for men and women and also places where grandparents and mothers spend with children at parks or community centers." To improve current health-care institutions, one participant recommended the "need to train doctors about Asians and Filipinos, their health, their culture," and another participant recommended that the community should "encourage more of us to become doctors and leaders and advocates for our health."

DISCUSSION

Although Filipino Americans are vulnerable to a variety of treatable chronic health conditions, they have the lowest rates of utilization of health services among AA/PI groups. Research on health-care inequities among Filipino Americans is insufficient. This study intended to bring to light these inequities among Filipino Americans.

Overall, we found that Filipino Americans reported extremely poor-quality interactions with their health-care providers. More specifically, participants indicated low levels of patient-centered decision-making, experienced less compassionate and respectful care, perceived high levels of discrimination by their providers, and felt disrespected by health-care staff. These results are consistent with previous literature indicating that AA/PIs and Filipino Americans report poor interactions with their providers (Hughes, 2002; Saha, Arbelaez, & Cooper, 2003). Discrimination from providers and overall health-care systems were significant negative predictors in all health outcome models, including health status, satisfaction of health care, and satisfaction of provider. These findings emerged within the narrative data, where participants identified specific experiences of discrimination and disrespect by providers, lack of culturally appropriate care, and mistrust of health-care systems to be major barriers to care.

Regular negative experiences with providers and health-care systems may explain research that found that Filipino Americans prefer to seek

support through lay care, spiritual leaders, and alternative medicine (Gong et al., 2003). Tucker and colleagues (2007) call for patient-centered and culturally responsive care within Western health-care systems where diverse patients can "feel comfortable with, trusting of, and respected in patient-provider healthcare interactions" (p. 660). Health-care systems must invest in care that is respectful and compassionate. Strengthening shared decision-making and interpersonal skills of health-care providers will enhance the quality of care for Filipino Americans, people of color, and other diverse communities. To elevate services to be culturally responsive, hospitals should prioritize hiring and retaining racially, ethnically, and linguistically diverse staff and offer appropriate medical interpretation and translation services. Health-care systems that serve large Filipino American communities must partner with local community leaders and health advocates to cocreate cultural humility training and health initiatives that capitalize on the strengths of the community and better meet health needs. Such a partnership will facilitate better quality and culturally responsive care, increase engagement in health-care services, and improve the health and wellness of the Filipino American community. Furthermore, health-care providers must become aware of and address implicit provider bias through comprehensive and ongoing diversity training, since discrimination and disrespect impede patient-centered care. Too often, training of health-care providers focuses on medical skills, techniques, and knowledge rather than interpersonal skills and diversity issues. When Filipino Americans come out of appointments feeling supported, respected, and empowered to make decisions on their health, they will be better equipped to face their health concerns, engage in care, and have better health outcomes.

Filipino American participants identified solutions to improve health-care systems to better address their community's health and wellness. The most noted recommendation was hosting health fairs in community settings. The existence of health-care inequities is still largely unrecognized, and public awareness is an essential starting point for efforts at reduction. Targeted steps to increase awareness of inequities among Filipino American community members can be done through community-based health fairs. Health fairs held at community centers, churches, or cultural events would facilitate more direct access to services, reduce stigma and shame, and strengthen trust between Filipino American community and health-care systems. A major asset of Filipino Americans is their strong cultural value of kapwa, and this can be used to engage Filipino Americans in community participation to work together to promote the health and wellness of their community.

Participants also identified a need for health-care institutions to develop culturally informed interventions specifically for Filipino American and immigrant community members. The incorporation of cultural factors and use of language interpretation services should be promoted within health initiatives with the Filipino American community. One recent

example of a promising, culturally informed intervention is the "Healthy Heart, Healthy Family" initiative. This program was developed in 2008 by the National Heart, Lung, and Blood Institute in collaboration with Filipino American and immigrant organizations and includes culturally and linguistically appropriate, evidenced-based health educational materials for community health workers to use to reduce the risk of heart disease in the Filipino American community. The key element of the program was the incorporation of community health workers—nonmedical personnel with shared identity (e.g., racial background, health condition) who help patients navigate the health-care system. These important allies can better reach out to and engage vulnerable and hard-to-reach communities (e.g., elders, immigrants). Community health workers are essential in increasing patient education and empowering community members in enhancing their ability to access care and fully participate in treatment decisions. Community health workers have been identified by the Institute of Medicine as an important component in reducing health inequities among people of color (Smedley, Stith, & Nelson, 2003) and should be considered in community health initiatives to better improve Filipino Americans' health.

Participants expressed the need to increase representation of Filipino Americans within direct health services, policy, and research, and this has been echoed in the literature (David, 2010). Three-quarters of practicing physicians are White (Association of American Medical Colleges, 2010), and most likely there are higher rates of White physicians in medical specialties and leadership roles in hospitals and health research institutes. In one study, higher rates of discrimination experience among patients were found to be associated with a stronger preference for working with a provider of similar race or ethnicity (Chen, Freyer, Phillips, Wilson, & Pathman, 2005). Thus, increasing provider representativeness may increase Filipino Americans' engagement with services via shared cultural beliefs and language. While Filipino immigrant women are highly represented in the health-care industry as nurses (Ming & Jang, 2015), it is unclear whether Filipino Americans or immigrants are involved in specialty care in health and behavioral health concerns specific to this community. Moreover, the lack of diversity in health-care systems influence the nature of structure policies and delivery systems that may not serve the needs of Filipino Americans, AA/PIs, and other diverse groups. Increased representation in research, policy, and administration leadership roles within health-care programs will be essential in bringing to the table Filipino-identified priorities and needs to health initiatives. These important solutions identified by participants in this study align with other Filipino community-defined solutions to improve health delivery (UC Davis Health Center for Reducing Health Disparities, 2018).

There are several limitations to the study. The self-selecting nature of the study limits the generalizability of the results. Single-item measures may not be adequate to obtain detailed information. Other important cultural variables relevant to health behaviors and health outcomes (e.g.,

colonial mentality, acculturation, acculturative stress, Filipino ethnic identity development, geographical location, and number of years living in the United States) need to be incorporated in future studies. This study focused on individuals' experiences in patient-provider interactions and health-care systems, while more insights are needed from other important stakeholder groups (i.e., providers, health-care administrators, health advocates) to inform strategies to improve systems of care that directly impact the health and wellness of Filipino American communities.

Finally, further inquiry in understanding and ultimately eliminating discrimination and structural inequities within health-care systems are important public health initiatives. More qualitative research will allow for in-depth investigation of health-care inequities among Filipino Americans. In-person individual interviews and focus groups will increase insights into the impact of discrimination in health care and identify additional systemic inequities in health. This will inform further research, training, and institutional changes. Additionally, partnering with Filipino Americans and capitalizing on their strengths and values will lead to richer and more culturally informed outreach initiatives and health services. Partnership with Filipino Americans in research, advocacy, and policy will be vital for dismantling health-care inequities for this community.

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CHAPTER 7

Political Extremism in the Wake of Charlottesville

The Motivations and Ideologies of the White Power Movement

Tina R. Lee

INTRODUCTION

Hate groups and the visibility of extremist groups in the United States have reached record highs. The Southern Poverty Law Center (SPLC) defines a hate group as an organization that, "based on its official statements or principles, the statements of its leaders, or its activities–has beliefs or practices that attack or malign an entire class of people, typically for their immutable characteristics" (SPLC, 2019). There are currently 1,020 hate groups operating in the United States, organized under several categories: Neo-Nazi, Anti-Immigrant, Anti-Muslim, Anti-LGBT, Christian Identity, Racist Skinhead, and Ku Klux Klan, among others. Since the 2008 election of former president Barack Obama, hate groups have risen to 755 percent. Since the 2016 election of Donald Trump, there has been a 30 percent increase nationwide (SPLC, 2019). As the United States becomes increasingly diverse (Vespa, Armstrong, & Medina, 2018; U.S. Census Bureau, 2020), public resentment over immigration patterns has grown. America continues to endure a crisis of political legitimacy (e.g., distrust in existing democratic institutions), with political parties polarized, democratic processes paralyzed, and an American public increasingly divided over issues of race, gender, and class (Foa & Mounk, 2016).

Although the SPLC defines extremist groups under specific categories, a more holistic way of understanding extremism is under the framework of the White Power Movement (WPM). The WPM has been conceptualized by American historian Kathleen Belew as the progression of an international social movement premised on White nationalism[1] and White supremacy,[2] with deep historical roots uniting "members of the Klan, militias, radical tax resisters, White separatists, neo-Nazism and Dualism between 1975 and 1995" (Belew, 2018). It strongly opposes a centralized government, globalism, immigration, and multiculturalism. The WPM provides an effective framework for understanding how extremist groups act in concert and how they are unified by a coherent ideology. Although discussing all of these groups is beyond the scope of this chapter, this chapter will reference one modern outgrowth of the WPM as a primary example—the most visible extremist group in recent years, the Alternative Right ("Alt-Right").

The Alt-Right came to prominence in late 2015 and spearheaded the largest White supremacist rallies and race riots in recent history: the 2017 "Unite the Right" rally in Charlottesville, Virginia. The events of Charlottesville have been considered a major turning point in American history as they not only followed in the footsteps of the 2016 presidential election of Donald Trump[3] but also involved widespread media coverage due to the unification of hundreds of White power activists and their open expressions of racism and violence.[4] Moreover, the visibility of the WPM in mainstream America stood in stark contrast to long-standing narratives of racial progress and the achievements of a color-blind society in a post–Civil Rights era.

PURPOSE OF CHAPTER

In understanding the scope of the WPM, it is important to first define "extremism." First, extremism is not limited to a particular race, religion, nationality or political party. Extremist movements, for example, have occurred during the Spanish Inquisition and Nazi Germany. Second, although hate crimes are tied to extremism, violence itself is not inherently extremist; hate crimes are one tactic out of many that extremist groups can endorse (Berger, 2018). An essential characteristic of extremism is the transmission of ideologies that clearly differentiate in-groups from out-groups through common narratives or rationales. Moreover, extremist groups must seek to obtain legitimacy or to change society in some fundamental way (Berger, 2018). Thus, extremism is, above all, rooted in a belief system or an ideology.[5] Finally, extremist movements use polarized narratives about how the out-group's existence is inherently harmful to the in-group, eventually leading to the dogmatic belief that eradicating the out-group remains the only and final solution.

The rise of political extremism is a serious social concern that is in urgent need of analysis by social scientists and intervention by policy makers.

According to a study by the Department of Homeland Security from 2000 to 2016, "White supremacists killed more people in the United States than any other group of domestic extremists" (Monaco, 2017, p. 23). In less than a decade, right-wing and antiestablishment groups have achieved institutional success comparable to the left-wing New Deal in the 1930s. The Alt-Right has achieved mainstream recognition through its shared goals with the Freedom Caucus and Trumpism in the Conservative party. To that end, this chapter seeks to better understand the psychological mechanisms underlying the WPM and the factors that have led individuals to believe in and adhere to the movement's dangerous ideologies. As White power ideologies continue to enter mainstream discourse, understanding the mechanisms that lead individuals to identify with the movement in the first place is the urgent task of our time.

CHARLOTTESVILLE

On August 11 and 12, 2017, a crowd of predominantly White men began to march toward the University of Virginia campus. Adorned in polo shirts and khaki pants, they had organized a march to stop protestors from taking down the statue of Robert E. Lee, a commander of the Confederate State Army during the American Civil War.[6] Beginning in 2016, Charlottesville city officials and residents requested that the statue be removed due to the commander's role in defending the Confederacy.[7]

As the primary organizer of the rally, the Alt-Right managed to successfully unite a range of right-wing extremist groups, including the Rise Above Movement, Vanguard America, Nationalist Front, Klansmen, Proud Boys, neo-Nazis, neo-fascists, and more. While bearing "Make America Great Again" (MAGA)[8] caps and holding lit torches, the crowd angrily chanted "Jews will not replace us," "blood and soil,"[9] and "White lives matter" (Nelson, 2017).

Tragically, the confrontation between protestors and counterprotestors culminated in the violent death of Heather Heyer, a 32-year-old White female counterprotestor, and the injuries of many others when a car driven by an extremist crashed into a crowd of people.

HISTORY OF THE ISSUE

Racial Classifications

Group-based hierarchies have been justified since the days of Ancient Greece, when philosopher Aristotle argued that humanity is divided into masters and slaves: "those who have the right to command and those who are born to obey" (Kendi, 2016, p. 17). Aristotle created a theory of evolution to justify Greece's rule over the Mediterranean alongside notions of racial superiority, arguing that extreme climates had produced intellectually, physically, and morally inferior people (Kendi, 2016).

Although Aristotle's theory helped to justify racial hierarchies across different eras and societies, race as a social concept has also been formed, defined, and contested through both collective action and personal practices (Omi & Winant, 1994). Much pertaining to racial formation and categories has thus been determined by the social, economic, and political forces in a given historical moment or period. In America, citizenship has been shaped against the concept of Whiteness, with populations and perceptions of groups shaped by immigration policies and by definitions of who is White (DeGenova, 2006). The evolution of the Census serves as one illustration of how identity and race have been continually redefined (Hattam, 2005). In the 1800s, for instance, the Census did not differentiate between Whites and Mexicans; the latter was legally classified as White until 1930, when states passed laws applying *Plessy v. Ferguson*'s one-drop rule, requiring anyone with African ancestry to be classified as Black and further distinguishing between race and color (Gross, 2003). The unique histories of non-White minority groups and their respective paths to or their exclusions from citizenship have been critical not only to the real experiences of these groups but also for the groups' perceptions around their sense of national belonging (Suleiman, 1999). The presence of immigrants naturally challenges a nation's established racial order and, in many ways, highlights the rigidity of the White-Black divide. Overall, public perceptions of non-White minority groups have been shaped by policies around citizenship and immigration, establishing certain social constructs as accepted knowledge (Swidler & Arditi, 1994).

Despite shifting standards of race and the dearth of sound biological evidence regarding racial differences, the WPM deeply adheres to an ideology that all White people face an existential crisis due to growing diversity. The belief in an existential threat to the in-group and the necessity of acting to prevent these threats are central characteristics of extremist movements (Berger, 2018). In the WPM, the in-group is categorized as the pure Aryan race while the out-group is any non-Aryan individual. Alt-Right founder Richard Spencer expressed his vision in the unification of a pan-European race resembling the Roman Empire: "It would be an empire that would be welcome to Italians, to Scots, to Russians, to White Americans, to Finns, etc. To have a safe space for all Europeans around the world" (Lombroso, 2016).

Societal Threat

Studies have shown that when the public experiences high societal threat (e.g., war, economic decline), it tends to move toward authoritarian populism (Costello & Hodson, 2010; Pratto, Sidanius, Stallworth, & Malle, 1994). Populism refers to public reactions juxtaposing the interests of the majority population against the elite. It is combined with other ideologies, such as nationalism, liberalism, or socialism. In authoritarian populism,

political leaders can come to symbolize a group's distrust or loss of trust in democratic institutions[10] (Altemeyer, 2006; Feldman & Stenner, 1997). Furthermore, group status threat has been shown to lead to greater identification with conservative ideologies and political beliefs (Craig & Richeson, 2014). Scapegoating of minority groups is further used to generate support for populist leaders.[11] The recent populist movements of both the Left and Right have been united in their contempt for crony capitalism, corporate welfare, big pharma, and the Supreme Court decision of *Citizens United v. Federal Election Commission*.[12] As public faith in democratic institutions has plummeted over the past few decades, Reich (2015) has predicted that America will likely move toward authoritarian populism or engage in fundamental democratic change in the long term.

The loss of trust in democratic institutions is a major reason that extremist movements primarily operate outside of mainstream politics. Political scientists and legal scholars have debated whether, although the Democratic Party appears to be socially liberal, the economic policies of the Democratic and Republican Parties have essentially been the same since the Bill Clinton administration. While the Democratic Party used to represent the middle and working classes, it has largely abandoned that identity and has worked for the financial interests of its major donors (e.g., Wall Street banks). In 1999, for example, the Clinton administration repealed the Glass-Steagall Act,[13] which Congress enacted following the Great Depression of 1929 in order to regulate the big banks and to prevent another depression; the repeal of Glass-Steagall later led to the disastrous 2008 financial crisis.

Economic Crises

Beyond ideological divisions, the United States and other countries around the world have suffered a prolonged period of low economic growth and high income inequality spurred by the 2008 global financial crises (Lindsey & Teles, 2017). After the financial crisis, there was widespread debate on the issue of wealth and resource distribution as well as anti-immigration sentiment surrounding job security.[14] While the ultraconservative Tea Party has remained in mainstream conservatism, promoting fiscal conservatism and constitutional government, WPM groups like the Alt-Right[15] have targeted ethnic minorities for the national problems of unequal wealth disparities, often encouraging an emotional discharge of White rage to be displaced and providing an effective outlet by promoting the status of dominant groups (Anderson, 2016).

The enduring coexistence of low economic growth and high income inequality have raised doubts around the conventional economic principle: that economic growth necessarily entails a "tradeoff" between development and inequality (Okun & Summers, 2015). Political scientists have explained this paradox as the result of either regulatory capture

(e.g., wealthy individuals or corporations influencing the government to reduce business competition to rig the market in their favor) or globalization and technological advancement (e.g., automation). Regardless of its causes, the combination of low growth and high inequality historically results in political instability and increases the likelihood of insurrection, rebellion, and reactionary political forces (Geddes, 1999; Valenzuela & Valenzuela, 1978). Moreover, low economic growth, a shrinking middle class, and authoritarian populism are factors associated with increased political polarization and the rise of extremism (Moghaddam, 2018).

This rise also reflects populations that have experienced the lowest levels of economic growth in the 21st century (Lindsey & Teles, 2017). Market reforms have increasingly redistributed wealth away from the middle class (Skocpol, 2019). This may be one reason that members of extremist groups are predominantly from the middle rather than the working class. As the economy has struggled, and as unemployment and underemployed have remained high, American nationalism has appealed to a larger demographic and, most saliently, to college-educated White men (Hawley, 2017). Although a college degree was once considered a road to the middle class, it is now the equivalent of a high school degree. Furthermore, a generation of young Americans are graduating with enormous school debt. In 2019, for instance, 42 million student borrowers collectively owed $1.5 trillion (Friedman, 2019). Disenchanted by the false promise of a college degree, public resentment and anger against American policies have grown. According to *Counter-Currents Publishing*, a White nationalist publishing house: "They [students in debt] are intelligent, educated, and ambitious. They are also unemployed, idle, angry, and searching for answers. For White Nationalists, they are a vast, increasingly receptive audience, for they are the only ones offering honest explanations of what is happening to them" (Hawley, 2017, p. 79).

The White Power Movement

Belew (2018) describes the Vietnam War as the main cultural framework uniting different factions of the WPM from the late 1970s to early 1980s. Movement members often served in the military. Louis Beam, author of *Essays of a Klansman*, served in Vietnam. His essays describe a culture of stymied grief and betrayal by the American government among war veterans. Similar narratives played a role in structuring paramilitary activists in the WPM and generating new groups like the Alt-Right. Unlike World War II, which centered around moral narratives against the rise of Nazism, Vietnam symbolized a morally ambiguous war. Anti-war protests were widely held against the government's imperialistic policies, intensified by public fears of rising globalism and communism (Belew, 2018).

Following the Vietnam War, the WPM experienced a profound shift at the 1983 Aryan Nations World Congress conference when movement

leaders formally declared war on the federal government. At the conference, different factions and ideological camps affirmed their shared commitment to undermining the American government (Belew, 2018). Unlike earlier groups—such as the KKK, which adhered to and fought on behalf of the state—the WPM now rejected major premises of the conservative movement (e.g., moral traditionalism, economic liberty, strong national defense) and began to construct a new national identity within the movement (Hawley, 2017).

NATIONAL IDENTITY

National identity is a socially constructed category based on subjective feelings one shares with a group about one's nation (Huddy & Khatib, 2007). Americans generally share a strong national identity based on the idea that the nation is an egalitarian, moral, and democratic superpower (Huntington, 2004). Unlike patriotism, which is a benign attachment to one's country, nationalism encompasses an orientation toward superiority and dominance over other nations (Adorno, Frenkel-Brunswik, Levinson, & Nevitt, 1950; Kosterman & Feschbach, 1989). American identity has further been portrayed as the successful assimilation to Anglo-Protestant values, and White identity has been positively correlated with American identity (Huntington, 2004; Sidanius & Pratto, 1999).

When nationalism focuses on ethnicity, studies reveal greater prejudice toward immigrant groups (Mukherjee, Molina, & Adams, 2012). Since Congress passed the Immigration Act of 1990, anti-immigrant hate groups have been at their most extreme (SPLC, 2019). For over 150 years, the U.S.-Mexico border has been rooted in White power vigilante groups and border patrol agents collaborating to detain immigrants (Devereaux, 2019). From 1910 to 1920, hundreds of Mexicans were murdered and lynched at the Texas borders. Following the Vietnam War, paramilitary training camps (e.g., Klan Border Watch) trained activists to capture migrants in South Texas (Belew, 2018). In 2019, the WPM captured hundreds of immigrants along the border and publicized the event online (Devereaux, 2019).

The WPM has strongly advocated for anti-immigration policies. During Charlottesville, KKK leader David Duke expressed this: "We are determined to take our country back. Fulfill the promises of Donald Trump. That's why we voted for Trump" (Nelson, 2017, p. 1). The Trump administration has vowed to remove "millions of illegal aliens" using Immigration and Customs Enforcement (ICE) and Customs and Border Protection (CBP), portraying immigrants as economic and cultural threats (Miroff & Sacchetti, 2019). Furthermore, rather than understanding the fluctuation of economic opportunities as the result of either regulatory capture, global or technological advancements, many Americans believe that immigrants take away job opportunities rather than helping to improve the national economy (U.S. Gallup Polls, 2019). Yet evidence shows that immigrants

stimulate the economy by creating new jobs, spending income on American goods and services, paying taxes, and raising the overall productivity of businesses (American Civil Liberties Union, 2019). Undocumented immigrants also pay an estimated $11.6 billion a year in taxes and take on jobs that boost other parts of the economy (Frazee, 2018).

In addition to anti-immigrant sentiment, national identity can also be "constructed as a masculine space, which may exclude and devalue nonstereotypically masculine ideas and ways of being" (Van Berkel, Molina, & Mukherjee, 2017, p. 360). Both men and women were found to consider male-associated traits more American than female traits (Van Berkel et al., 2017). As men have greater access to political power, they likely experience greater ownership over national material and symbolic resources.

TOXIC MASCULINITY

The anthropological, sociological, and psychological literature converge on the finding that masculinity requires constant differentiation from femininity (Kimmel, 2008; Weaver & Vescio, 2015). Unlike femininity, masculinity must be earned through rituals and life stages (Thompson & Pleck, 1995). Gender norms are initially learned in the context of family or school life, and gender socialization continues into adulthood where men who identify with hegemonic norms believe they must engage in "compensatory manhood acts" when their masculinity or gender identity is threatened (Cassino, 2018, p. 50). The WPM effectively draws on the men's rights movement, premised on the idea that White men are the true victims of neo-liberal and government policies. The men's rights movement attracts religious extremists, Tea Party advocates, and anti-Semitic conspiracy theorists (Thompson, 2018). The ultraconservative Tea Party often uses scapegoating tactics against minorities and women who they accuse of "gaming" the system to gain undeserved advantages (Belew, 2018).

Conforming to masculine norms has been associated with greater psychological distress and less willingness to seek psychological help (Mahalik et al., 2003). WPM factions have provided an effective response to such distress through the notion that "advances in equality by women and minorities are a violation for White masculinity and demand a violent response" (Thompson, 2018, p. 2). SPLC reported how "the first Alt-Right killer" voiced his hatred of women in a manifesto before murdering six people in the 2014 Isla Vista massacre (Cai & Landon, 2019). Attackers who fit similar profiles followed in subsequent years.

Toxic masculinity refers to this "dark side" of masculinity with complex dimensions such as dominance, self-reliance, exclusion of out-groups, pursuit of status, and violence. Experimentally induced threats to masculinity have been shown to lead to aggressive cognitions (Vandello, Cohen, & Ransom, 2008), physical aggression (Bosson & Vandello, 2011), and aggression toward competitors (Cohn, Selbert, & Zeichner, 2009).

One study demonstrated that when men were told they scored more like women on a masculine knowledge test, the men derogated the women by rating them as less competent (Hitlan, Pryor, Hesson-McInnis, & Olson, 2009). Jason Kessler, an Alt-Right organizer, was originally a Democrat who voted for Barack Obama in the 2008 and 2012 presidential elections but became a firm Trump supporter during a long period of unemployment. Although Kessler wanted to work for a social services agency, he reportedly lost out to female candidates and began to form political views against affirmative action, women, and minorities.[16]

ETHNIC-RACIAL IDENTITY

Identity refers to the sort of person one believes oneself to be based on information obtained from the external world (Moghaddam, 2018). Yet no matter how distinctive one may be, Helms (1990) argues that all individuals share a sense of historical experience with their racial groups. Moreover, individuals are more likely to align themselves with their in-groups and differentiate against out-groups when they need to create a strong sense of identity (Hogg, Kruglanski, & Van den Bos, 2013).

Richard Spencer describes himself as an identitarian, believing that where people come from ultimately defines who they are (Hawley, 2017). According to Spencer, "To be White is to be a striver, a crusader, an explorer, and a conqueror. We don't exploit other groups. They need us and not the other way around" (Lombroso, 2016).

Ethnic-racial identity is a core part of the movement's political philosophy. The WPM believes that race is the most important issue of our time and should be the foundation for all policy-making decisions. Although factions diverge on how to implement specific policy ideas, they share a racial animus against non-White minorities and an unwavering belief in their perceived loss of power in society (Hawley, 2017). The primacy of race in the movement's philosophy is further evidenced in their rejection of the major premises of the mainstream conservative party, subversion of the Constitution and federal government, and endorsement of ethnic cleansing by its most radical factions. For White power activists, nothing could be less self-evident than the notion that all people are created equal.

Multiculturalism is also branded as a failed social experiment imposed by political elites (Johnson, 2014). Extremist members, such as Jason Kessler, who choose to leave mainstream political parties, likely experienced cognitive dissonance between the societal messages they heard about their in-groups' privileges and the rise of progressive social movements (e.g., Black Lives Matter, #MeToo). Helms (1990) further describes racial dissonance as the moment when one's schema for making meaning of racial interactions no longer makes sense or violates a moral principle. For WPM members, that moral violation has been the rise of out-groups at the expense of their own.

However, this logic inverts the history of the world and blames non-White minorities for the perceived grievances of Whites. It rationalizes extremism by claiming that minorities are the true instigators of social ills. In reality, there has been a long history of state-sanctioned violence implemented against non-White populations: Black codes, Jim Crow, Massive Southern Resistance, public school segregation, housing segregation, internment camps, anti-immigration policies, anti-miscegenation laws, public lynchings, laws against citizenship and voting rights, employment discrimination, gerrymandering, police brutality, and mass incarceration (Alexander, 2010; Hoggard, Jones, & Sellers, 2016; Paradies et al., 2015; Rothstein, 2017).

Identity politics was originally a mode of organizing groups that were most vulnerable to state-sanctioned violence. Although identity politics is still used to protect the rights of these groups, its rhetoric has also morphed into a tool for political bait and expediency, with some politicians exploiting it to respond to White Americans' anxieties over changing demographics. Identification with dominant or cohesive groups has been shown to regulate feelings of anxiety and distress (Hogg, 2007). For Black Americans, strong identification with their racial groups has been shown to be a protective factor against the negative psychological effects of discrimination (Sellers, Rowley, Chavous, Shelton, & Smith, 1997). Likewise, for Whites, strong identification with their racial group may act as a protective buffer against perceived discrimination.

According to Greg Johnson, editor-in-chief of *Counter-Currents* Publishing, once the WPM dominates mainstream politics, it will be easy to implement race separation policies and to achieve the dream of Whitopia or an all-White nation (SPLC, 2019). Until then, *Counter-Currents* creates a metapolitics for White political identity (SPLC, 2019). In one article, Johnson writes, "The White race is threatened with simple biological extinction, compared to which all other political issues are trivial distractions. . . . The only tenable solution to the threat of White extinction is White Nationalism: the creation of homogeneously White homelands for all White people, which will require the alteration of political borders and the mass resettlement of non-Whites" (Johnson, 2014).

The existential threat of the White race is a long-standing narrative that is circulated within the WPM. The movement's collective fear is exemplified in *The Turner Diaries,* a 1974 utopian novel written by William Pierce who was leader of the National Alliance, a neo-Nazi group. *The Turner Diaries* describes a future all-White utopia where people of color are forced out of North America and individuals in interracial relationships are publicly lynched for committing "White genocide" (Belew, 2018). The necessity of mass violence is rooted in the belief that the out-group's existence impedes the in-group's ability to survive (Berger, 2018). Furthermore, White women play critical roles as organizers, caretakers, and the mothers of future White power activists.[17] To maintain a majority-White state, the WPM strongly

emphasizes their duty to reproduce White children[18] (e.g., "fourteen words" is a popular slogan/propaganda). Reproduction of the race is also one reason polygamy is encouraged among its members. Different WPM factions focus on a range of social issues, including abortion and marriage.

The Turner Diaries is the bible of the WPM, providing a rough road map for implementing and executing terrorist attacks (Belew, 2018). The book was discovered in the collection of Timothy McVeigh, who bombed an Oklahoma City federal building in 1995. Additionally, the 2019 El Paso, Texas, shooter posted a manifesto titled "An Inconvenient Truth" on the online platform 8chan; it ranted about a "Hispanic invasion" and the extinction of the White race (Arango, Bogel-Burroughs, & Benner, 2019). The Christchurch mosque shooter in New Zealand also published conspiratorial theories about the replacement of the White race on 8chan.

Underlying the motive of these manifestos is a relentless, shared belief that mass public violence will "wake" all White people up to the reality that their race faces imminent annihilation (Belew, 2018). The WPM believes that Whites must be saved from the dangers of multiculturalism and rising globalism. Thus, publicly circulating these manifestos is one strategy to recruit the Aryan race on a global scale.

CIVIL RIGHTS REVISITED

Racial Progress and Racist Progress

The progression of mainstream narratives about race relations in America has followed one linear timeline. The original narrative described the nation as a racist, oppressive society that freed all its slaves and transformed into a "color-blind" nation after the civil rights era. During this period, Kim (1999) argues that racialized stereotypes merely became coded in language, particularly in the liberal parts of the urban North where racist beliefs manifested in subtler and more insidious forms than in the South. For instance, "criminals" became synonymous with "dangerous Black men." The disavowment of racism by liberal Whites further allowed their Whiteness to become more invisible, legitimizing them as the standard group and defining "Others" as exotic and different (Bonilla-Silva, 2003; Frankenberg, 1993).

As a result, rather than focusing on the effects of decades of discriminatory policies, references to "cultural differences" or "economic problems" for the prevalence of social inequality disguised racist attitudes and beliefs. American policies were also redefined as race-neutral (e.g., housing, gerrymandering). In recent years, the explanation of cultural differences has changed into narratives about implicit bias. Implicit bias, or prejudice that is outside of one's conscious awareness, has frequently been used to explain the continuing prevalence of racism and discrimination today (Greenwald & Banaji, 1995).

Bonilla-Silva (2004) explains that narratives are important as they can become the foundation for new ideologies which can reinforce the status quo or reproduce power relations. As much as we have been taught and have come to believe in a history of racial progress in America, there has always been a parallel history of racist ideologies propelled by the WPM that have submerged and reemerged over time (Belew, 2018). In fact, Anderson (2016) argues that political elites have always pushed back against Black progress. Furthermore, when studying the baseline structure of White power in America, it is important to understand that Black subjugation has always been a necessary foundation in maintaining White power and privilege across generations. While all non-Black groups experience varying racialization processes, such experiences are primarily shaped around a narrow definition of "Whiteness" and "Blackness," symbolizing a dichotomy of power and subjugation. Non-Black minorities are thus positioned to either fit or maintain this Black–White binary (Kim, 1999). For instance, if new immigrants are perceived as economic or political threats, they are positioned more toward "Blackness" and conferred less privilege.

Kendi (2016) further argues that racist ideologies have never been the result of implicit bias or ignorance. Rather, they have been used to justify discriminatory policies rooted in economic, political, and cultural self-interest.[19] Myths about racial superiority have thus been necessary foundations to sustain the ways in which self-interested actors operate in this world (O'Neal, 2017).

Public Perception

Even with the rise of non-White minorities and projections of a majority-minority nation by 2042, racialized attitudes among the public have not changed significantly since the Civil Rights era (Craig & Richeson, 2014). Although the civil rights movement led to significant policy changes at the state and national levels,[20] resentment around these gains led to the scapegoating of minorities by the political right. Dehumanizing descriptions of minorities translated to powerful right-wing propaganda in response to the national stresses of war, farm foreclosure crisis, stagflation, and job loss. Consistent with group threat theory (Blumer, 1958), studies have revealed that the larger a minority population, the more negative the racial attitudes of the White population (Nadeau, Niemi, & Levine, 1993). According to group threat theory, members of dominant groups use their perception of the size of minority groups to examine if they are threats to existing social arrangements and thus threats to informal and formal social controls (Jacobs & Carmichael, 2002; Tolnay, Deane, & Beck, 1996). Paradoxically, interracial contact and globalism may also strengthen intergroup hostilities. Kim (1999) further argues that negative perceptions between and against non-White minorities persist while the

understanding of racial power and White supremacy largely go unnoticed and unchallenged by the public.

The public may perceive the WPM as a fringe movement that has little chance of succeeding in mainstream politics and thus not to be taken seriously. However, this would be a serious misunderstanding of the movement's efficacy. Although factions like the Alt-Right are fringe groups, the ability of the larger movement to organize on a grand scale and to carry out mass violence through leaderless resistance or cell-style terrorism are highly sophisticated (Belew, 2018). Leaderless resistance is a strategy in which small, independent groups or lone-wolf individuals act without centralized leadership; such strategy allows the WPM to remain invisible to government prosecution as well as unaccountable to the public. We also see the movement's efficacy in the visible rise of terrorist attacks. Belew (2018) warns that it would be inaccurate to gauge the impact and capacity of the WPM by the mere size of its factions.

What has not been fully brought to light in public discourse are the narratives of social and historical forces deeply rooted in White power ideology. The WPM is not only ethnocentric and intolerant but it is also fundamentally antidemocratic. This movement aims to overthrow the current American government and to create a radically different future (Belew, 2018). Inspired by *The Turner Diaries,* White power activists intentionally use incremental direct action to foster conditions that could potentially lead to a revolutionary race war (Berger, 2018). In *Eugenics and Other Evils*, Chesterton (1922) reminds us that "sound historians know that most tyrannies have been possible because [people] moved too late" (p. 3). However tempting it may be to disbelieve the dangers inherent in the WPM and the possibility that it could become a legitimate force in society, we ignore understanding the movement at our own peril and that of our world's future.

OBSTACLES TO STOPPING THIS MOVEMENT

The Internet as a Breeding Ground

Polarization between the Left and Right is sharpened by the tendency of political parties to communicate in echo chambers, in which exposure to information and ideas serve to reinforce preexisting worldviews (Garrett, 2009; Iyengar & Hahn, 2009). These echo chambers are exacerbated on the internet, where entirely new and intangible communities can be created (Bennett, 2016). Political groups use online platforms to organize rallies, create virtual communities, and engage with public figures as well as political opponents. The WPM operates under clandestine, decentralized networks (e.g., the dark web) and spreads its ideologies through blogs, podcasts, forums, and webzines. The Alt-Right has recruited members and gained media attention through legions of Twitter users using the

hashtag #AltRight, proliferating their ideas and successfully pushing them into mainstream discourse. While the literature on media effects discusses the ways in which media has reconstituted social interactions, privacy, presentation of identities and civil discourse (Dill-Shackleford, Vinney, & Hopper-Losenicky, 2016), little has been written on how mechanisms specific to the internet may normalize extremist views. To that end, there is a need for the creation of internet-specific principles regarding media literacy and the understanding of the internet as a potential breeding ground for extremist ideologies.

The scope and depth of the WPM can be witnessed on a global scale online. The international far-right community utilizes online subcultures to organize and share their strategies (Hussain, 2019; Mujanovic, 2019). Extremists have been inspired by the Holocaust, Bosnian genocide, and apartheid regimes in South Africa and Zimbabwe (Hussain, 2019). A manifesto published by the 2019 New Zealand mosque shooter revealed his idolization for Radovan Karadzic, a Serbian politician and convicted war criminal who led the 1990s Bosnian genocide; the manifesto expressed fears of a Muslim demographic shift and the necessity of enacting violence against non-White invaders.[21] Anders Breivk was a Norwegian terrorist who killed 77 people in 2011; his 1,500-page manifesto referred to Karadzic as a hero (Mujanovic, 2019). The WPM claimed that Breivik "inspired young Aryan men to action" by showing the massive scale of violence that could be accomplished by one White power activist (Cai & Landon, 2019).

Government Programs and Resources

In the United States, domestic terrorism[22] has not been taken as seriously as the threat of international terrorism; greater funding has been provided for Islamic terrorism, left-wing extremism, and immigration activism.[23] Furthermore, there is no federal criminal charge for domestic terrorism; extremists are generally charged under hate crimes, gun or conspiracy statutes (Tavernise, Benner, Apuzzo, & Perlroth, 2019). Since the Trump administration, the Department of Homeland Security (DHS) Office of Intelligence and Analysis has been significantly less active, disbanding its domestic terrorism unit in 2018 (Benner, 2019). The administration has also downplayed the role of White supremacy, focusing public discourse on immigrants and falsely arguing that domestic terrorism is a fringe issue perpetuated by the Left and the mentally ill.

In 2009, the DHS Extremism and Radicalization Branch published a report titled "Rightwing Extremism: Current Economic and Political Climate Fueling Resurgence in Radicalization and Recruitment." The report warned that the 2008 Obama presidential election and economic crises would make White nationalism a greater security problem[24] and predicted that Americans suffering economically would be most vulnerable

to recruitment.[25] However, political backlash followed alongside public pressure to minimize the discourse on domestic terrorism as many believed it was a diversion from international terrorism efforts. In particular, the report raised civil liberties concerns about American extremists, whose freedom of speech and expression, unlike international terrorists, is still protected by the First Amendment. Concerns about the surveillance of citizens were raised by both political parties, and there was no strong constituency pushing to address domestic terrorism efforts (Benner, 2019). The overall lack of public support meant the withdrawal of many programs and partnerships that focused on preventing extremism.

ACTIONS UNDERWAY TO MOBILIZE CHANGE

The Anti-Fascist Movement

The Anti-Fascists ("Anti-Fa") represent the movement opposed to the Alt-Right during Charlottesville. Anti-Fa is a network of groups that believe in aggressive and sometimes violent opposition to right-wing movements. Although Anti-Fa may have a propensity toward violence, SPLC (2019) does not consider it a hate group since it does not promote hatred based on race, religion, ethnicity, sexual orientation, or gender. Moreover, unlike the murder rate for the Alt-Right, the death count for Anti-Fa remains at zero. Left-wing extremism by others who are not members of Anti-Fa accounts for 3 percent of murders compared to 73 percent by right-wing extremism (SPLC, 2019). Thus, it would be deeply inaccurate to equivocate the two groups in terms of their levels of violence.[26]

Anti-Fa's political platform encompasses anti-capitalism, anti-racism, pro-immigration, and equal rights for all. The movement has antecedents in Europe, where its early followers fought Nazis in the 1930s and against Benito Mussolini's Blackshirts. Its ideology is partially based on the belief that Nazism and fascism would never have risen to power if citizens had aggressively opposed them. Anti-Fa reached America by the 1970s and has roots in the straight-edge punk rock music scene, 1990s anti-globalization protests, and 2011 Occupy Wall Street movement. Rather than depending on government authorities or mainstream politics to enact change, Anti-Fa believes that there must be an extreme Left using direct action to counter the WPM. The Anti-Fa movement strongly believes that fascist ideas cannot be reasoned with and will never go away on their own.

To that end, Anti-Fa members are willing to use violence as a defense tactic against White power activists as long as such violence is used in the name of eradicating hate. Both Anti-Fa and the Alt-Right train in physical combat to prepare for confrontations during protests and rallies. One Anti-Fa member explained, "You have to put your body in the way, and you have to make it speak in the language that they understand. And sometimes that is violence" (Suerth, 2019).

What Can the Public Do?

After World War II, political theorist Hannah Arendt published a report on the Nuremberg trial of German Nazi leader, Eichmann, where she sought to understand how individuals could come to commit the most extreme crimes against humanity. Contrary to her assumptions, Arendt found that Eichmann was a low-ranked colonel who diligently worked to the top of a well-organized bureaucracy. Psychological assessments further revealed that Eichmann did not have strong anti-Semitic views; at most, he was indifferent to minorities. In *Eichmann in Jerusalem: A Report on the Banality of Evil,* Arendt (1963) concludes that, in any other era, Eichmann would have been considered a law-abiding citizen who merely took advantage of his political and economic opportunities by obeying orders from his state.

It was precisely this diffusion of personal responsibility, lack of critical questioning, and acceptance of societal norms which led to Eichmann's crimes. Diffused from individual principles, Arendt reveals that our tendency to accept group norms and our complacency to achieve personal success at the expense of others are factors that can lead anyone to become an Eichmann. Through his story, Arendt states that we not only better understand ourselves but also come to understand the interplay of social forces, political bureaucracy, and group pressure in shaping core parts of our identities and choices.

The story of Eichmann is a timeless warning on how the banality of evil can permeate any society. The American public, mainstream media, law enforcement, and government have failed to take the consequences of White supremacy and political extremism seriously. What started off as a fringe movement has become a central social issue of our time. A major goal of the WPM is to become a dominant force in mainstream politics. Thus, public awareness, education, and the dissemination of accurate information about the WPM are critical first steps in bringing about change. Unlike the traditional conservative party,[27] the WPM does not believe in the principles of the Constitution or the government. It thus represents a threat to all political parties and the basic tenets of democracy (Hawley, 2017). Moreover, a race war or nuclear arms catastrophe no longer seems nonsensical in the face of impending climate change, international wars, refugee and immigrant crises, and the rise of authoritarianism. In fact, FBI investigations document that the WPM has sought opportunities to take over the state and to enact violence in its goal to catalyze social and civil unrest.

The following list some ways that the public can engage in mobilizing change: (1) advocating for the creation of public programs that prevent the formation of extremist groups; (2) increased outreach with individuals and communities that are vulnerable to recruitment by extremist organizations; (3) advocating for governmental resources to be directed toward

domestic terrorism efforts; (4) placing pressure on online platforms to vigilantly monitor and censor hate groups or divesting from companies that refuse to do so; (5) placing pressure on the mainstream media to investigate and report on the causes of extremism, rather than myopically portraying public violence as the irrational choices of lone-wolf actors.

The events of Charlottesville have reflected a profound shift in mainstream media coverage and public awareness of the WPM. Since 2017, there has been a rapid rise in mass shootings and acts of domestic terrorism. In prior years, the media portrayed these events as the result of lone-wolf actors suffering from mental illness. Muslim-perpetrated attacks were also covered by the media 4.5 times more than non-Muslim attacks, and perpetrator religion was the largest predictor of news coverage (Kearns, Betus, & Lemieux, 2017). Yet, the frequency of gun shootings tied to extremist ideologies, political polarization, and open expressions of racial hatred have also allowed the media to become more bold in its coverage. The renewed use of terms such as "White nationalist" and "domestic terrorism" in the mainstream media can arguably be traced back to Charlottesville, when the world witnessed the stark rage of hundreds of White Americans at the rally. Undoubtedly, investigative journalism and media coverage will continue to play critical roles in uncovering extremist ideologies.

What Can Scholars Do?

In the field of psychology, Grzanka, Gonazalez, and Spanierman (2019) state that professionals must confront Whiteness as a moral issue and an ethical imperative. Specifically, rather than conceptualizing racism and White supremacy as interpersonal problems based on "cultural differences" or "poor judgment," there is a need for research and training on how they manifest as systemic issues (Grzanka et al., 2019). In a nation strongly defined by racialized hierarchies, rarely is the playing field level among the races. Therefore, framing remains important because the understanding of racism as an interpersonal process fails to underscore the cyclical nature of oppression and the systemic effects of White supremacy on individuals. To that end, psychologists may want to engage in interdisciplinary work with fields such as sociology, politics, history, law, and philosophy in order to have a broader framework and to become attuned to system dynamics.

One of the most fundamental ways that psychologists can foster change is to actively turn White students, clinicians, and educators away from a lifelong, self-absorbed experience of Whiteness. Decentralizing attitudes about supremacy and learning that our emotions are sociologically inherited can be fostered in institutions. For instance, what if the history of White supremacy was visibly placed at the conceptual center to be actively

dismantled by students? (Grzanka et al., 2019). Psychologists must also be willing to challenge the political apathy within the field and the notion that empathy alone is sufficient for allyship and anti-racist work (Alexander, 2010). Most importantly, decentralizing Whiteness requires delving deep into learning about the true history of America as well as the painful and often violent ways that our government has continuously kept minority groups down.

As White nationalist organizations gain legitimacy, it is critical that social justice scholars take the rise of right-wing academia seriously. Greg Johnson, who holds a PhD in philosophy, has published over 40 books including *The White Nationalist Manifesto*. Richard Spencer left his PhD studies in European intellectual studies at Duke University where he became radicalized by reading White nationalist literature in order "to pursue a life of thought-crime"; he founded the Alt-Right a few years later (Williams, 2017). In their attempt to rebrand after Charlottesville, extremist groups have recruited in ways that are more palatable to the public (SPLC, 2019). Organizations and think tanks, such as the National Policy Institute[28] and New Century Foundation, regularly hold conferences and lobby for White supremacy ideologies (Hawley, 2017). To that end, social justice scholars must understand how to effectively assess and counter the pretextual arguments being put forth by WPM leaders.

The ideologies of the WPM and our phenomenon of subhumanizing are not new. We have a gory history showing us the consequences of racism and racialized domination as well as parallels between our current movements and the destructive ones of our past. The line that separates our daily prejudices from those of extremists is one of degree, not of content. Although the WPM remains a threat to the future of democracy, we should never forget that there have been other social movements fighting for equality and the principles of democracy. Narratives about racial progress are therefore not inevitable but neither are those about racial inequity. Which pathway we now take depends on how we organize and mobilize as a collective society.

RESOURCES: FOR MORE INFORMATION

Associations and Organizations

- *Southern Poverty Law Center*: nonprofit legal advocacy organization specializing in civil rights and public interest litigation.
- *American Civil Liberties Union*: nonprofit, nonpartisan organization that works through litigation and lobbying to support civil liberties.
- *Showing Up for Racial Justice*: national network that aims to undermine White supremacy and to work toward racial justice.
- *Equal Justice Initiative*: nonprofit organization committed to ending mass incarceration and challenging racial/economic injustice.

- *Anti-Defamation League*: organization that focuses on fighting extremism.
- *Center for Democratic Renewal (Anti-Klan Network)*: multiracial organization that combats movements and government practices promoting bigotry.
- *John Brown Anti-Klan Committee*: anti-racist organization that protested against the KKK and other White supremacist organizations.
- *Veterans For Peace*: international organization of military veterans, family members, and allies who are dedicated to building a culture of peace, exposing the true costs of war, and healing the wounds of war.
- *Life After Hate*: nonprofit consultancy of reformed extremists who provide long-term solutions to combat all types of violent extremism; works in collaboration with several sectors, including the military, international security/intelligence, policy makers, and the like.
- *Against Violent Extremism*: global organization made up of former extremists and survivors of extremism that counter extremist narratives and prevent the recruitment of at-risk youth.
- *Century for Security Policy*: nonpartisan, educational public policy organization that focuses on national security.
- *Council on American-Islamic Relations*: Muslim civil rights and advocacy group that promotes social, legal, and political activism among Muslims in America.
- *Anti-racist White Educators Group*: affinity group for White educators to support each other in confronting and working to undo racism in schools.
- *Educators for Justice*: White leaders committed to dismantling systems of oppression in schools through reading groups, convenings, and collective action.
- *Gifford Law Center to Prevent Gun Violence*: policy organization dedicated to researching, enacting, and defending laws and programs to save lives from gun violence.
- *National Immigration Forum*: advances immigration solutions through outreach, partnerships, and policy expertise.
- *Human Rights Watch*: works on behalf of refugees, migrants, political prisoners, and others who are subject to human rights abuse.
- *Brennan Center for Justice*: nonpartisan law and policy institute that fosters democratic participation, voting rights, campaign finance reform, and ending mass incarceration.
- *Indivisible*: grassroots organization to resist efforts to erode democracy in the United States.
- *Democratic Socialists of America*: the largest socialist and grassroots organization in America that works on transforming government structures in order to achieve greater economic and social democracy for all.
- *ProPublica*: independent, nonprofit investigative journalism that exposes abuses of power, informs the public about complex issues, and uses journalism to spur reform.

Books

- *Stamped from the Beginning*, by Ibram X. Kendi
- *Bring The War Home*, by Kathleen Belew

- *Racecraft*, by Karen and Barbara Fields
- *Making Sense of the Alt-Right*, by George Hawley
- *Understanding Racist Activism: Theory, Methods, and Research*, by Kathleen M. Blee
- *Dangerous Crossings: Race, Species, and Nature in a Multicultural Age*, by Claire Jean Kim
- *Eichmann in Jerusalem: A Report on the Banality of Evil*, by Hannah Arendt
- *Race, Rage, and Resistance: Philosophy, Psychology, and the Perils of Individualism*, edited by David M. Goodman, Eric R. Severson, and Heather Macdonald
- *Eugenics and Other Evils*, by G. K. Chesterton
- *Race Matters*, by Cornel West
- *On Western Terrorism*, by Noam Chomsky
- *Marx, Race, and Neoliberalism*, by Adolph Reed Jr.
- *The Rise and Fall of the White Republic*, by Alexander Saxton
- *Dark Money*, by Jane Mayer
- *When Affirmative Action Was White: An Untold History of Racial Inequality in Twentieth-Century America*, by Ira Katznelson
- *White Rage: The Unspoken Truth of Our Racial Divide*, by Carol Anderson
- *Feminism for the 99%: A Manifesto*, by Cinzia Arruzza, Tithi Bhattacharya, and Nancy Fraser
- *Rules for Radicals: A Practical Primer for Realistic Radicals*, by Saul D. Alinsky
- *The Undercommons*, by Stefano Harney, Fred Moten

Articles

- "The Master's Tools Will Never Dismantle the Master's House," by Audre Lorde
- "Heteropatriarchy and the Three Pillars of White Supremacy," by Andrea Smith
- "Fascism: What It Is and How to Fight It," by Leon Trotsky
- "Identity Politics and Class Struggle," by Robin D. G. Kelley
- "Demarginalizing the Intersection of Race and Sex," by Kimberlé Crenshaw
- "Intersections, Locations, and Capitalist Class Relations: Intersectionality from a Marxist Perspective," by Joanna Brenner
- "Feminism and the Politics of the Commons," by Silvia Federici
- "Social Reproduction, Surplus Populations, and the Role of Migrant Women," by Sara Farris
- "But Some of Us Are Brave: A History of Black Feminism in the U.S.," by Hanna Bechtle
- "Dig Deep: Beyond Lean In," by bell hooks

NOTES

1. White nationalism is one component of White supremacy that advocates for racial segregation, racial purity, and racial nationalism (Daniels, 2009).
2. White supremacy is the ideology that Whites are superior to members of all other races and should dominate society across all institutional and social settings (Ansley, 1997).

3. Some factions in the Alt-Right termed Trump their symbolic leader.

4. Trump's remarks following Charlottesville also generated negative responses from the public; he stated that there were "very fine people on both sides" (Lombroso, 2016).

5. FBI defines a hate crime as a criminal offense motivated in whole or in part by an offender's bias against a race, religion, disability, sexual orientation, ethnicity, gender, or gender identity (SPLC, 2019). Personal bias is not necessarily motivated by an ideology, although it may be indirectly shaped by one.

6. Sculptor Henry Shrady created the statue in 1917 after philanthropist Paul McIntire commissioned it as a gift to the city; upon Shrady's death, it was completed by Leo Lentelli. The statue has remained in Charlottesville since 1924.

7. In 2017, Charlottesville City Council voted in favor of the statue's removal, along with the removal of Stonewall Jackson's statue. In response, conservative organizations and descendants of the statue's donor filed a lawsuit to block the removals, seeking a temporary injunction and arguing that the council's decision violated a state law protecting Civil War memorials. On April 25, 2019, Judge Richard Moore of Charlottesville Circuit Court ruled that local authorities could not remove the statues because they were considered war memorials protected by state law.

8. MAGA was a politically contentious slogan used by Donald Trump during his 2016 presidential campaign, referencing prior policies that largely resulted in benefits to White American men. Former Republican president Ronald Reagan used a similar slogan in his 1980 presidential campaign: "Let's make America great again."

9. "Blood and Soil" is an ideology created in 1930 by Nazi theorist Richard Darré. This phrase espoused the notion that race/ethnicity was solely derived from blood descent and that only native inhabitants can be national citizens.

10. Przeworski (2019) argues that it is the hope of regaining entitlements and power for constituents in the near future that allows democratic institutions to endure. If Przeworski is correct, then the loss of trust in democratic institutions carries serious implications for the future of democracy in Western society.

11. 2016 and 2020 presidential candidate Bernie Sanders represents left-wing populism, while Donald Trump represents right-wing populism.

12. *Citizens United* allowed political campaigns to accept unlimited monetary contributions from corporations, unions, and other groups. It also spawned the creation of super PACS and triggered a boom in political influence by tax-exempt, right-wing, dark money organizations (Mayer, 2016).

13. The Glass-Steagall Act made it illegal for the same bank to both issue mortgages to homebuyers and to turn around and sell those mortgages as bonds to investors. Rather, it required that a commercial bank (a bank that takes deposits from you and me and issues mortgages and commercial loans) be separated from an investment bank (a bank that issues bonds/derivatives/any other types of risky ventures). When financial experts talk about "breaking up the big banks," this is what they refer to.

14. During the 2008 Great Recession, nine million jobs were lost, and the salaries of remaining jobs were cut. The stock market fell by 50 percent (most people put their retirement savings in the stock market, so they lost their funds); home prices fell by 30 percent on nationwide average. Yet taxpayers were forced to pay

over $100 billion dollars to bail out AIG. In the midst of the government bailout, the big banks still had money to pay out millions in bonuses to executives and received billions in their bank accounts through derivatives. In other words, there occurred a massive transfer of wealth from the middle/working class to the top 0.1 percent wealthiest individuals.

15. The Alt-Right is partly an outgrowth of the Tea Party (Hawley, 2017).

16. Kessler also self-published a book of poems with themes of existential angst, describing how he spent his 20s searching for a mission he could call his own, revealing the extent to which he wanted to achieve success and validation from the world.

17. In the 2016 presidential election, the majority of White women voters supported Trump.

18. In order to not advertise the slogan, it is not explicitly stated here.

19. For example, eugenics policies in the early 20th century were driven by scientific consensus that non-Whites were biologically inferior.

20. For instance, the Civil Rights Act of 1964 and the Voting Rights Act of 1965.

21. The New Zealand shooter tweeted and livestreamed his "internet activism" before killing 49 people at a mosque (Cai & Landon, 2019). His video was promoted on 8chan, broadcast live on Facebook, and replayed on YouTube, Twitter, and Reddit.

22. The U.S. Department of State defines domestic terrorism as "premeditated, politically motivated violence perpetrated against noncombatant targets by subnational groups or clandestine agents, usually intended to influence an audience" (Jackson, 2012, p. 235).

23. A humanitarian aid volunteer faced 20 years in prison for providing food and shelter to undocumented immigrants along the U.S.-Mexico border in 2018.

24. White nationalist websites such as Stormfront experienced higher traffic rates; online users also discussed launching a potential race war if Obama was elected.

25. A 2008 FBI report revealed that 203 individuals with military experience were members of extremist groups (Benner, 2019).

26. Despite this contrast, the Trump administration diverted funds away from addressing White nationalist violence, emphasizing the violence of "Black nationalists" and the "alt-left." In 2019, Trump tweeted a demand to place Anti-Fa on the terror list. The Daily Stormer, a neo-Nazi site, publicly praised his tweet.

27. The mainstream conservative party had kept extremists, such as anti-Semites and conspiracy theorists, out of its party in the 1950s (Hawley, 2017).

28. NPI was founded by Spencer and promotes academic racism through pseudoscientific arguments about Black inferiority and White superiority (Weiland, 2017).

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CHAPTER 8

Asian Americans Rising Up, Speaking Out for Greater Equity

Matthew R. Mock

Our work must respect the power of law and defend the most vulnerable, the poorest, and the least powerful. —Sharon C. Ngim, pro bono attorney and founder, Asian Women's Legal Assistance Services, San Francisco

Asian Americans have encountered many inequities throughout history. While progress has been made, the current context of political times serves as a reminder of the discrimination, stereotyping, and blaming that continue for people of color, specifically Asians. Historical injustices that are indelible in the history of Asian Americans include Chinese exclusion, Japanese American internment, and anti-Asian hatred and violence. Political rants and social dehumanizing of Asian Americans through stereotypes and references, such as "perpetual foreigner," "model minority," "looking all the same," continue. A new climate of attacks blaming and targeting people considered minority has evolved. As a ready example, mistrust has been cast on Chinese scientists as threats to national security, with subsequent calls for investigations and arrests. Affiliations with China, even when it is for scholarship or research, have been met with suspicion. The coronavirus outbreak as a public health emergency has opened Asians to be targets of microaggressions and renewed racism. Asians, specifically Southeast Asians who arrived as refugees, have

been detained and deported. Some Asians have been targets of violence or blame and depicted mistakenly, wrongly, as threats or terrorists.

Decades of work by historians, social activists, and Asian American studies scholars serve as solid grounding for the inequities among Asian Americans. While it is beyond the scope of this chapter to list and fully examine all of the inequities encountered by Asian Americans, descriptions of several disparities, injustices, and inequities serve as a significant reminder of what inroads have been made as well as the challenges that remain. It is of paramount importance that we never forget history, that we remember and convey to future generations what is known from the past. We must also examine what we do not know, perhaps assume to be true, or even have a distorted or incorrect view of due to hegemony. "Hegemony" essentially is the dominant influence of one more powerful group over another. A related concept, "epistemology," refers to the way individuals construct knowledge as well as meaning or an understanding of the world. Therefore, epistemological hegemony is manifested most commonly in the United States by the dominant cultural-racial group (i.e., those considered White), which is consciously as well as unconsciously socialized to assume its interpretations of reality are unquestionably universal truths, ones that are rarely if at all questioned (D'Andrea, 2006).

This chapter will describe some of the multiple inequities experienced among Asian Americans. The history of inequities along with their effects on the social, psychological, relational, and even economic health of Asian individuals, families, and communities will be examined. The ways in which Asians are subsequently portrayed and treated have served different purposes depending on minority versus majority or oppressed versus in-power vantage points, and these will be examined and discussed. Current and potential strategies to mobilize change toward increased equity, including future directions, will be offered. Some strategies may be large, such as a framework to use for examining and confronting, while others will be individual and specific, including dynamic initiatives the author is undertaking. Finally, the complexities of the social and psychological change process to reverse inequities as continuing commitments to social justice will be explicated. Constructive resources as well as additional references key to lasting transformation will be provided.

HISTORICAL INEQUITIES

Most people will agree that Asian Americans have endured discrimination, prejudice, racism, and social marginalization. Entire books, such as *Strangers from a Different Shore*, by Ron Takaki (1989); *The Making of Asian America: A History*, by Erika Lee (2015); *Asian Americans*, by Sucheng Chan (1991); and *Asian American Dreams: The Emergence of an American People*, by Helen Zia (2000), as well as other prominent publications, are dedicated

to detailing Asian backgrounds of triumphs amid struggles so that they will never be erased or forgotten. It is almost overwhelming to itemize, deconstruct, and examine all of the histories and social as well as cultural events in the United States that have been discriminating, unjust, unfair or unequal with regard to our diverse Asian American communities. Examining some events more in depth as they relate to inequities provides insights to address them.

While most would likely understand that inequities for Asian Americans remain, there is also likely some dispute in terms of how they began and how they are manifested in society and overtly or insidiously, structurally, maintained. It is critical for researchers, scholars, and health providers, including psychologists and all mental health practitioners, to understand these inequities and their pernicious dynamics and impact on the psychological health and wellness of Asians past, present, and future. As will be described, small as well as large societal inequities, historical as well as current, affect individual identity and development throughout the life course. The formation of family and community as well as cohesive, social and community relationships are impacted. Consequences may be intergenerational, like an earthquake with aftershocks of different magnitudes.

While our histories and dynamic identities are not to be forgotten, some may dispute or even deny that Asian Americans are profoundly affected by social inequities. The pernicious stereotypes of model minority as well as invisibility attempt to support a discourse that claims, "We're all the same" or "Anyone can arrive and thrive as an immigrant." But these are untruths, distortions, and complicit denials of realities that serve a colonizing mindset. Psychologist Richard Lee noted, "Elevating Asian Americans as a model minority essentially absolved white systems from taking real accountability for the inequities they've created" (from Greenbaum, 2019, p. 27).

INEQUITIES: SPECIFIC HISTORIES REMEMBERED AND DECONSTRUCTED

Specific events of past inequities illustrating as well as contributing to present inequities for Asian Americans are all too numerous. An initial listing of some inequities from the past and then referencing present-day disparities and injustices are illustrative. The identification of some of the more readily accessible experiences of Asian Americans include:

- The building of the transcontinental railroad. While Chinese laborers were significant throughout its arduous construction, the photographed documentation of the historic place and time commemorating its completion purposely showed no Asians. While present in the United States for decades, Asians are often decentralized or misremembered in the history, construction, and foundation of this country.

- The Chinese Exclusion Act of 1882. This major legislation with surrounding laws has been noted as racist legislation targeting Asians. It specifically barred Chinese from entering the United States and seeking citizenship. This legislation remained in effect until 1943, when it was replaced with restrictive quotas. With economic challenges in the United States, Asians are among those who are blamed, resulting in legislation to back up the scapegoating of the group.
- The internment of over 120,000 Japanese Americans during World War II in 1942 via Executive Order 9066. This has been deemed an unfair, unjust presidential act based in racial and prejudicial fears. While an apology was passed with inadequate compensation, the consequences of this presidential act remain a historical trauma. Present-day detention of undocumented individuals and mixed status families separated and languishing without due process serves as a reminder of unequal rights and treatment based in perpetuated fears.
- The murder of Vincent Chin in 1982 and an unjust verdict for the perpetrators. The reasons behind the violence were hatred against Asians and economic threat. More recent anti-Asian violence, such as the targeting of a Sikh temple in Wisconsin or of those thought to be Muslim, are reminders of targeting perceived "others," including Asians, for hate.
- The current targeting and discrimination against Asians, especially Chinese scientists. There have been escalating concerns under the Economic Espionage Act and the prosecuting of Chinese "spies" (e.g., scientists Xiaoxing Xi and Sherry Chen) through targeted investigations. In 2015, the National Council of Asian Pacific Americans (NCAPA), a coalition of over 35 Asian American advocacy organizations, joined with more than 70 other organizations to investigate the profiling of Asian American scientists. Charges against scientists Xi and Chen were dropped but not before irreparable damage had been done to their reputations, careers, and lives (NCAPA, 2015).
- The current political situation, where there is unchecked language and vile references calling out Asians and other immigrants. This plays into the undesirable, passive, perpetual foreigner stereotype; scapegoating of people deemed different; and "othering" images, even though Asians have been in America as long as, if not even longer than, some Americans.
- There have been ongoing and now increased detention and deportation of Southeast Asians. While many came initially as refugees, their past records have led to some being arrested and/or deported for legal reasons and circumstances they thought they addressed earlier in their lives.
- The novel coronavirus (COVID-19) health concern underscored the existence of another societal virus: racism. Apparently originating in China before sweeping across Europe to the United States, the COVID-19 health crisis arose with alarming rapidity by March. Even with no exposure to the virus, Asians and Asian Americans reported incidents of microaggressions and even overt acts of racism, such as shouting, "Go back to your country" (Wang, 2020). Without hesitation, President Trump made reference to the "Chinese virus" despite being aware of incidents of scapegoating, bullying, and acts of violence against Asian Americans. With the country and the world focused on news of the pandemic, he continued to perpetuate negative rhetoric targeting Asians, despite being challenged by reporters and

legislators. By doing so, he perpetuated anti-Asian and anti-Asian American xenophobia and hostilities.

- During a national briefing led by legislators such as Judy M. Chu, Kamala Harris, and Ted Lieu, all members of NCAPA reported that within a two-week period, there were over 1,000 reports of anti-Asian incidents related to COVID-19 blaming. Award-winning journalist and CNN reporter Lisa Ling reported receiving threats of bodily harm and death in extremely derogatory ways. She had not shared any remarks in defense of China. This was solely attributed to her being Chinese American. Ironically, she had appeared only three months prior to proudly open an exhibit in Sacramento. During her commemorating speech, she shared how she initially grew up being ashamed of being of Chinese descent because her family was the "only," therefore "lonely," being singled out for appearing different.
- In a coordinated response, several national organizations readily coalesced, as they had during the 2019 Public Charge Rule, and spoke out against Asian discrimination and social injustices. These leading civil rights and racial injustice organizations included the Asian American Health Forum, the NAACP, the National Congress of American Indians, and the National Urban League, among others. It is significant to note that speaking out went beyond Asian organizations, such as the NCAPA, to others allied in unified protest, standing up for equity and social justice.

A more in-depth explication of several of these events will serve as ongoing illustrations of their ongoing negative impact on Asian Americans surrounding inequities.

The Transcontinental Railroad

The month of May is observed nationally as Asian American and Pacific Islander Heritage Month (formerly Asian Pacific American Heritage Month). If asked, few would be able to state why this month and why the designation was updated. May marks the month when the first documented Asian immigrant arrived from Japan: May 7, 1843. Early Asian arrivals, mainly Chinese, sacrificed themselves for the betterment of the country. Chinese laborers would contribute to gold mining, agricultural labor, the construction of dangerous flumes for the transport of cut lumber for buildings, and even the stacking of stones for miles and miles to demarcate properties. Their work would be accompanied by growing resentment and overt anti-immigrant hatred that culminated in violence. Vigilante justice and mob lynchings were not uncommon.

Every month of May also honors the official completion of the Transcontinental Railway on May 10, 1869. The Chinese played a significant, pivotal role in this incredible accomplishment. However, the commemorating photograph of this momentous national event speaks loudly. The photo taken depicts men—but only White men—during the commemoration. While Asians—primarily Chinese—slaved over the railway completion, they were intentionally omitted from public acknowledgment.

Asians were responsible for the building of this essential transportation, resulting commerce, and migrations of people, yet they were made invisible from this enormous accomplishment. Why would this be so? One answer is obvious: for those in power and dominance (i.e., White men), giving official documented credit to Chinese laborers would in some ways acknowledge them as equal human beings who were important for development and as significant contributors even economically to the backbone of the country.

The contributions of workers would not be forgotten but deeply remembered as a direct threat to Whites. In 1871, in Los Angeles, California, there was an infamous race riot. Some 500 men, primarily White, attacked, robbed, and murdered Chinese residents. It was one of the largest recorded lynchings, with 17 Chinese men and boys being killed. Not a single person would ever be brought to justice for this heinous act. In part, the violence was fomented by local print news media portraying Asians as inferior and immoral. Viewed as subhuman, there would be no justice for Chinese Americans.

The Chinese Exclusion Act of 1882

Race, racial consciousness, and race relations are embedded in the founding and existence of America. Determined to be a social-political rather than false biological concept, race was used to determine the "haves" and "have-nots"—those more privileged with power versus those marginalized and oppressed. White colonizers would assert their dominance on the backs and at the costs of those struggling to find a place in this country. The Chinese Exclusion Act of 1882 has been deemed the only federal legislation in U.S. history to name as well as specifically exclude a race and nationality from immigration and citizenship. The documentation of 15 related laws enacted by the federal government along with those passed at state and local levels is a painful reminder of intentional acts—in this case, legislation—to bar an entire group of immigrants based on ethnicity and race. Being referenced as "orientals" sets us distinctly apart from the dominant group. Images of a group representing "yellow peril" clearly conveys a threatening message. Parenthetically, as a child, the author never understood why we were considered to be "yellow" yet different from the color of the yellow crayon schoolchildren would use. I soon came to understand that being seen as non-White had its purpose, especially when it came to viewing Asians as perpetual foreigners, a form of yellow peril never to be fully trusted—to be treated as different, even inferior, to White classmates.

There have been subsequent waves of Asian newcomers in America since the 1880s. For each, there have been struggles to gain a secure foothold. The histories of Asian Americans in America are rich, multilayered,

and complex. The development of Asian American and ethnic studies in California gave rise to our communities being seen, heard, and acknowledged. Becoming more prominent, visible, and settled communities to be reckoned with would mean forming stronger coalitions of unity and pan-Asian recognition, such as the Asian American and Pacific Islander (AAPI) or more recent Asian American Native Hawaiian Pacific Islander (AANHPI) designations. While unity would be important, so would individual distinctions of specific history, country of origin, culture, traditions, and prominence. While sometimes lumped together as the same, Asian Americans are clearly not so. Rather than homogenous, we must be correctly treated as heterogeneous with our complexities acknowledged. The significance of this to confront inequities will follow.

The Internment of Japanese Americans

Another significant historical injustice that contributes to Asian inequities was the incarceration and detention of Japanese Americans during World War II. Japanese American internment represents a powerful, enduring example of race-based discrimination, war hysteria, and acts of outright injustice.

This Japanese Americans wartime experience is an indelible example of race-based trauma with enduring consequences. Research has shown that Japanese Americans received undeserved stigma from unjust incarceration, leading to additional psychological burdens. Even before the war, there were perceptions of Japanese Americans as untrustworthy and unassimilable foreigners. Laws restricted rights to citizenship, land ownership, immigration, and miscegenation, or mixed-race marriages. Psychological trauma was manifested in individual, race-based, historical, as well as cultural forms. Historical trauma is one that is still shared among those with Japanese backgrounds, with impacts spanning multiple generations, including those in the future. Cultural trauma focuses on the way a specific traumatic event or experience impacts identity and group consciousness. This may take the form of self-blame; holding on to negative, unprocessed feelings; compromised mental and physical health; and even premature death attributable to silence (Nagata, Kim, & Wu, 2019).

Vincent Chin Beating and Injustice

An additional example of an historic event contributing to inequities among Asian Americans was the murder of Vincent Chin, a 27-year-old Chinese American man. In 1982 in Detroit, Mr. Chin was accosted in a bar by two unemployed, White men who blamed him along with his friends for the success of the Japanese auto industry. The two

subsequently bludgeoned him with a baseball bat until he died from head injuries. The men, a Chrysler plant supervisor along with his stepson, never denied the acts but minimized what tragically happened as a barroom brawl that ended badly. The outcome of the resulting trial was that the men were sentenced to three years of probation and each fined $3,000. This killing catalyzed political activism among Asian Americans but also across other ethnic and racial communities encountering similar violence. In this situation, the justice system was declared inequitable by strong legal advocates as well as Asian community coalitions noting that Vincent Chin would be alive if he were not Asian and that the sentencing of those who killed him would have been more just were there not biases due to Vincent being Chinese. It's important to note the context of the times: the nation was experiencing an economic malaise. There was competition for jobs, in this case in the auto industry, with White flight depicted as the result of foreign encroachment. This echoes current sentiments.

Each specific, historic example above of Asian American mistreatment as well as injustice serves as a painful reminder of what is being replicated in current times. There are parallels to be drawn. In the context of current times, accomplished Chinese scientists, who have contributed to worldwide knowledge, ironically have been targets of mistrust. Portrayed as threats to U.S. security, there have been investigations and arrests of Asians having affiliation with China (NCAPA, 2015). This continuation of making Asians invisible or inscrutable, as well as the "Send her back" rants by Donald Trump when he was president targeting Congressperson Ilhan Omar, is deeply concerning. They foment ongoing racism, hate, and discrimination. Native Americans have been told to go back to the reservation. Negative sentiments toward Latinx are evident in immigrant detention centers at the border. The blaming of economic downturn on those who are not White—Latinx and Asian as examples—targets them for microaggressions and microassaults as well as outright violence. In other words, scapegoating of those considered "other" is not a new phenomenon but one that gets repeated to lift the privileged up and keep historically marginalized others down.

The United States is a nation of immigrants. Yet the current targeting and separation of Latinx immigrant families at the border have been serious concerns requiring protests and activist response. More and more Asian-origin families, including those from Southeast Asian, have been increasing targets of similar destruction of family unity as well as deportation. The current political atmosphere of detention and deportation of undocumented immigrants has a negative impact on Asians. Deferred Action for Childhood Arrivals (DACA), for immigrants who arrived as children, is currently under scrutiny by the Supreme Court. While Latinx individuals and families have been the primary focus of deportation, Asians have been targeted as well. In fall 2019, Southeast Asians,

specifically Cambodian and Vietnamese with legal issues, faced increased detention for expulsion.

STRUCTURAL, SOCIAL, AND SYSTEMIC DRIVERS OF INEQUITIES

While one would hope that the disturbing histories of unequal treatment of Asians would be dismantled and not be repeated, many would argue that the opposite is true. A consideration of some of the structural drivers of inequities for Asian Americans in such areas as employment, housing, and justice must be seen. These structural determinants in society have led to unequal playing fields in the forms of walls, barriers, and impasses that are difficult to surmount or even negotiate.

Some of the underlying systemic causes and reasons behind inequities unfortunately remain. Structural, societal, and systemic inequities are many. Some examples and their contributions to inequities serve as illustrations:

- There is an ongoing lack of Asian representation in the media. This lack of accurate "reflection in the mirror" has an adverse impact on Asian Americans. The TV show *Fresh Off the Boat* and incredibly popular movie *Crazy Rich Asians* demonstrate the desire for Asians to be portrayed within the general populace. Critiques for each underlie the need for more diverse, intersectional Asian role models.
- The number of Asian American political leaders and legislators remains small, limited in size and diversity.
- Asian Americans are portrayed as uniformly successful, but there are great income as well as education disparities. Some communities overall are doing well while others are struggling for economic survival, overrepresented in poverty, and limited in their educational success—for example, those who are Hmong, Cambodian, Laotian, Vietnamese, Native Hawaiian, and Pacific Islander.
- While some Asians are well educated and well qualified for employment advancement up to leadership positions, there is still the experience of a glass ceiling, or "bamboo ceiling." Asian Americans may rise based on qualifications, but they continue to be the least likely group promoted to management positions in the United States.
- Intersectional identity struggles lead some to question authenticity, as in the inquiry: "Are you really Asian?" and "To what degree are you Asian? Can you speak your home language?" (i.e., Asian first, American second, or vice versa; hyphenated or not, and what exactly does that mean?). Related to this is another perspective: "Are you really American?" and "To what degree do you know English?" or "Do you speak without a noticeable foreign accent?"
- There are also additional identity and social complexities of diversity questioning, including race, culture, class, sexual orientation, gender, immigration status, dis/abilities, and appearance (i.e., standards of beauty, for example).

- There has been increased pressure in the context of politics and opinions, with increased suspicion and subsequent scrutiny of Chinese as loyalists to the People's Republic of China (PRC). Divides seem to be increasing over opinions based on protests happening daily in Hong Kong along with democratic stances being taken.
- Research reveals that there is a disproportionate distribution of "pieces of the pie," meaning Asians are not getting their fair share, for example, in funding for AAPI programs, research in certain health areas, and more. Doan, Takata, Sakuma, and Irvin (2019) cite unequal funding from major federal sources, such as the National Institutes of Health (NIH), for AAPI health research.
- Still hotly debated, there is seeming overrepresentation of Asian Americans in some areas (e.g., admissions at certain colleges and universities) and absence or less representation in others.
- There remain untold stories, such as Asian Americans lacking in representation in social security services and SNAP (Supplemental Nutrition Assistance Program) (NIMHD, 2017). In other words, those needing social services—including elders, those with different abilities, the poor, and the disenfranchised—are not being reached.

The pernicious depiction of Asian Americans as a "model minority" adversely impacts individuals as well as relationships, especially with other minority groups. This term attempted to capture the successes of Asians in America. But in doing so, the stereotype serves as a wedge pitting us against other ethnic and racial groups. As Dr. Vivian Tseng, with the W. T. Grant Foundation, remarked, "The nature of all stereotypes is that they dehumanize people and prevent us from seeing them in their whole humanity" (from Greenbaum, 2019, p. 27). After all, if Asians could be successful, then why couldn't other racial minorities? Within Asian communities and families, why is it that not all are successful? Perhaps it is because families were not being model enough. The pressures of reaching externally defined pinnacles of success have also had a deleterious effect on wellness and happiness. Given the concept of "saving face," some have suffered silently, believing lack of success as entirely personal or family failure. This contributes to depression and even thoughts of suicide (Mock, 2013).

The model minority image of Asians also contributes to stress and conflicts in community racial relations. The deleterious argument is that if Asians as a minority can do so well, then other ethnic/racial minority groups should also be able to do so. This falsely pits Asian Americans against others. The 1992 riots after the Rodney King verdict in Los Angeles depicted African American and Korean communities battling each other. This civil unrest minimized the context of economic struggle experienced by both communities.

Being viewed as model implies that Asians do not have needs relative to other racial groups or intraethnically among other Asian communities.

This compounds a posture that Asians do not need attention, special focus, or an affirmation to address inequalities and systemic inequities.

MULTIPLE EFFECTS OF INEQUITIES

The effects of inequities are many and multifold. They are seen in forms of psychological, social, health, economic, and family functioning. With inequities clearly continuing among Asian Americans, one must understand their impact within multiple facets of life. These include effects along psychological, social, health, and economic as well as relational dimensions including individual, family, and interactions with other communities. Each of these bears further explication specific to Asian Americans.

Economic

Helen H. Hsu, a psychologist and the president of the Asian American Psychological Association, says it succinctly: "When we look at specific subpopulations, we see that for almost every health and economic indicator, there are Asian Americans who are struggling" (Greenbaum, 2019, p. 27). The college completion rate for Southeast Asians and Native Hawaiians as well as Pacific Islanders is low in relation to not only other Asian groups but other racial groups as well. This impacts later employment opportunities and economic success. These groups languish in poverty, needing different sources of support and intervention than other Asian groups, such as Chinese, other East Asians or South Asians.

Among all groups, income inequality is rising most rapidly among Asian Americans. Income inequality from lowest to highest increased most among Asians from 1970 up to 2016 (Pew Research Center, 2018). While this is in part due to a majority of Asian adults being foreign born, it is also driven by needs for inexpensive labor, Asians arriving as refugees, and ongoing struggles of acculturation and enculturation.

Health and Help Seeking

Inequities in life show up in health and help seeking among Asian Americans. While experiences of microaggressions may be manifested in increased stress and anger turned inward, such compounded emotional reactions are often set aside. Microaggressions, daily indignities, dehumanization, and repeated, mounting, or insidious trauma based in differential social treatment through dynamics of power differentials effect health negatively. Those who are targets may have higher blood pressure, obesity, diabetes, and even a reduced life span.

References to stigma and shame as barriers to seeking out psychological assistance inevitably arise. It is known and documented that Asians

do not seek out mental health services as others do (Lee & Mock, 2005). They tend to wait longer until symptoms are more severe. Suicide among Asian Americans is a serious, ongoing concern. Loss of personal or family "face" with resulting shame is one of the primary barriers. Lack of workforce diversity, including linguistic competence and the necessity of cultural responsiveness through a process of cultural humility, are additional factors.

The model minority stereotype is a dual-edge sword relating to health. Being a "model" means having fewer problems, being better adjusted, and, by caveat, being healthier. Internalizing this message, Asians may not seek out care when needed and may pursue outside help with a doctor, for example, only when symptoms are severe. While help seeking may be due to different attributions of illness, it may also relate to some denial, because we are supposed to be healthy. Enduring in the face of life challenges, not burdening others, trusting in outside help when the government itself has been a source of betrayal are additional contributors.

From the health providers' perspective, if Asians are viewed as the model minority, their needs may be minimized or discounted. Asian Americans have a high incidence, for example, of diabetes and various cancers. However, they are often undiagnosed, neglected, and not afforded necessary, timely treatment.

Social Processes of Acculturation and Enculturation

Much has been written about the acculturation and enculturation of Asian families. "Acculturation" refers to the phenomenon during which groups of individuals from different cultures come into direct contact, with changes resulting in the original cultural patterns of one or both groups. For some, acculturation describes the process of adapting and changing to the norms of the dominant U.S. culture in which one is immersed (Kim, Ahn, & Lam, 2009).

Enculturation, a closely related concept, gives reference to the process of socialization and maintenance of the values and norms of the individual's indigenous or original culture. This may include tangible and salient ideas, values, concepts, and ways of being. In other words, enculturation in many ways embodies maintenance of one's root culture or becoming socialized into and sustaining the norms of one's Asian culture (Kim et al., 2009).

Numerous studies have focused on the relationship of acculturation and stress among individuals and their families. Sources of psychological stress for new arrivals include understanding social and behavioral norms in a new context, learning a new language to communicate and negotiate interactions, developing additional work skills for being productive, and coping with loss, social isolation, and likely racism. For some for which relational issues are paramount, there may be an experience of

"attachment anxiety" that references fears of being alone and worries or anxieties about being separated from significant figures such as family or community (Suinn, 2009).

Several studies have yielded concrete information for specific Asian groups regarding psychological stress and the acculturation process. Sodowsky and Lai (1997) studied immigrants representing Asian Indian, Chinese, Filipino, Japanese, Korean, and Vietnamese families. They found that among these groups, a lower level of acculturation was associated with higher levels of distress. Among these groups there would be notable differences to consider. For example, to what degree did individuals from each group experience racism or discrimination?

In an Asian American psychology course taught for over two decades, graduate students interviewed individuals from different Asian backgrounds. The degree to which individuals reported an experience of racism or discrimination differed dependent on a variety of factors, including level of acculturation, context and diversity in which the person lives, English-speaking ability, and even the racial background of the interviewer in terms of truthful response (Mock, 2008). Some questions that might be posed were: Among each intraethnic Asian group represented, what was their degree of "attachment anxiety," and what buffers existed to counter such stress? What are the psychological consequences of naming that differential treatment? What does denial or minimization of such events represent, positive or not?

In Relationships and across Groups

Asian Americans have often found themselves placed in the middle or between groups. In some ways they are "in between" because they are pushed or pulled between American and Asian affinity. In race relations they are often sandwiched within the polarization of Black and White opposing relationships. Among some, African Americans may see Asians as more affiliated with Whites (i.e., the model minority concept). Whites may see Asians as minority because they will always look different and maintain cultural traditions in some form (i.e., the perpetual foreigner). This social and relational being put and caught in-between position arises also because some Asian Americans have higher educational attainment and incomes akin to the aspiring majority and the myth of meritocracy. This is compounded by stereotypes and assumptions that what appears to be for some, is true for all Asians. The psychological dehumanization of Asian Americans is achieved via the stereotypes of foreignness and the racial lumping of us as all the same. Asians get used and abused as a relational wedge with other marginalized populations.

There has been a limited history of Asian Americans working in coalitions with other people of color. This may be due to our being portrayed as "inauthentic" (i.e., not really people of color). Racial stereotyping of

Asians persists. Asians are sometimes not trusted by other ethnic groups. Many Asians come from countries colonized by Whites, meaning they were already influenced in their home countries by Western, White thinking. This may be the source of stereotypes being perpetuated by Asians against other races. This dynamic, combined with fewer Asians in politics, power, and prominence, contributes to Asians working less collaboratively in cross-community relationships.

An example of both social and relational barriers related to inequities is illustrated by an experience in a college class. With a focus on gender, a discourse arose about privilege and identity. Strong and then opposing perspectives became charged and then overheated with a Latinx student shouting at a Chinese American declaring: "You don't understand because you and your community are not people of color!" The White male instructor felt at an impasse, having not experienced such accusations leveled at Asians before and at a loss to unravel the intersectional complexities presented in the moment. This was a teaching and learning opportunity that was missed.

Individual Identity

Inequities have a profound impact on individuals in several ways. Some were referred to earlier. There may also be doubting of the self, with conflicting views about one's racial, cultural, and ethnic identity. Our cultural identity is a sort of collective culture, what we think about ourselves, a shared true self. It is influenced by history, ongoing social, cultural influences, and power dynamics, as well as enduring narratives from our past. Our Asian identity is our inherited background, also shaped by social, economic, political circumstances, and outside influences (Dividio, Hewstone, Glick, & Esses, 2010). As referenced earlier, these forces can be conflicting, with some adding to pride and others contributing to internal questioning.

In order to fit in and achieve some semblance of equity, some Asians may deny their heritage. Asian Americans may have internalized racial oppression (Trieu & Lee, 2018). Critical exposure to ethnic and racial history, as previously exemplified, and ethnic organization involvement can help this. Coethnic ties may also lead to subsequent empowering critical consciousness, replacing thoughts and behaviors that perpetuate internalized racial oppression.

Additionally, individuals may vary in their processes of acculturation and adjustment. For example, many Southeast Asians were forced to leave their home countries during the Vietnam War exodus. Many experienced multiple, unforgettable traumas that continue intergenerationally (Chin, 2019; Lee & Mock, 2005). Some had loss of family members. Upon arrival as refugees, they experienced socioeconomic deprivation contributing to dire needs in employment, housing, transportation, and community

safety, as well as social needs and support. Perhaps initially receiving some upon new arrival, such supports might very well have diminished or been removed.

Family System

Social needs and structural inequities are often apparent within the Asian family system. With a collective sense of self often being the focus of upbringing, the impact of social inequities often manifests itself within the family. As described earlier, processes of socialization and acculturation as well as enculturation occur within the home, with parents impacting the process of succeeding generations. For some, this is guidance; for others, this may be pressures and internalized messages of success. Conflicts may occur in families, eroding family cohesion, a sense of collective identity, and relational health between generations (Lee & Mock, 2005; Mock, 2013).

STILL FIGHTING FOR EQUITY AND SOCIAL JUSTICE

In order to address continuous inequities for Asian Americans, there must be strategies to break the cycle of pernicious stereotypes, misperceptions, and outright ignorance within and across divides.

Privilege and oppression within race, culture, class, and other systems continue to not be fully acknowledged. As long as there is a denial of inequities for Asian Americans, inequities will persist. Within education, for example, Asian American, immigrant, and American Indian as well as students with disabilities are not given equitable resources to facilitate success. Bullying toward refugee and immigrant youth continues, with harassment or microaggressions based on nationality, race, ethnicity, language, and religion.

Among educators, the concept of intersectionality can assist in deepening an understanding of marginalization. Intersectionality describes the merging intersection of multiple identities that are marginalized. Possessing one identity that is viewed as "less than" results in encountering discrimination. When multiple identities intersect, the potential for discrimination and oppression increases exponentially. These experiences are commonly more intense than those where there is a single marginalized identity. The result may be an increase in social and economic disadvantages. Someone Asian—for example, a Vietnamese refugee—may already be struggling to adjust to the United States. Someone who is gay, lesbian, transgender, differently abled, poor, or challenged in terms of mental health will find the struggle magnified.

Each person has multiple identities. If we can identify our marginalized identities, we can increase our abilities to have empathy and compassion for others, including Asian Americans. We must work within our Asian

communities to address inequities and disparities. For example, East Asians who want to ease tensions among others of the Asian American community need to listen thoughtfully and with empathy to the concerns of others outside of their own specific community. We must also work across ethnic and racial lines. Less recognized but even some in-common issues, such as the new arrival experience, generational trauma, colorism, limited access to public health and educational opportunities, and the school-to-prison pipeline, are relatable issues not only for other Asians but also other racial minorities. Common threads when woven together are a stronger, more enduring tapestry.

In order to combat invisibility and forge a semblance of unity, the overarching terminology of AAPI or AANHPI have been adopted in various contexts. Each validates a shifting focus, from one that is all-inclusive to another that references cohesion across multiple Asian communities. The impact of an overarching reference has a danger of being homogenizing, that is, turning us into people who are all the same. Being seen as "all the same" detracts from being seen, heard, and acknowledged. In actuality, Asian Americans are heterogeneous with origins from over 50 different countries and with diverse and complex backgrounds. Nuances of language, histories, traditions, conflicts, and survival enrich our understanding of self as well as relational connection. When identifying inequities, it may be a mistake to lump all the groups under an Asian American umbrella.

Confronting inequities means specifically identifying them in order to effectively confront them. Dr. Tseng comments: "Being invisible is damaging in itself because the way in which you're suffering goes unseen, largely ignored and overlooked." And this invisibility Asian Americans encounter is "pernicious on its own and can ultimately cause even more suffering" (Greenbaum, 2019, p. 27).

While a pan-Asian approach may be strategic to being bigger, stronger, visible, better heard, more visible, and so forth, there must be distinctions of experiences and needs. Disaggregating and looking at the nuances of each Asian community is significant. To not do so would contribute to perpetuating stereotypes or supposing that what is meaningful to one is the same for all. In other words, given the multiple factors and contributors to the cultural adjustment process among Asian immigrants of different generations and contexts, professionals must be cognizant of the disparities in the experiences of the specific groups and communities (Chen & Park-Taylor, 2006).

The disaggregation of data for Asian Americans, Native Hawaiians, and Pacific Islanders remains a significant necessity. In order to adequately address specific and unique needs within AANHPIs, there must be critical depictions of each. Economic disparities impact Native Americans, African Americans, and Latinx. Despite stereotypes that attempt to depict otherwise, economic disparities impact Asian Americans. While some studies note Chinese Americans, Korean Americans, and South

Asians as economically successful when grouped, incomes for Southeast Asians, Native Hawaiians, and others from South Asia struggle at levels closer to poverty (Kaholokula, Okamoto, & Yee, 2019). While most would agree that educational success is often tied to a positive economic future, many are not aware how some Asians have not accomplished such success. Some studies (Ahmad & Weller, 2014) show that approximately half of Asian Americans hold a bachelor's degree or higher. When examined more carefully, only 27 percent of Vietnamese Americans and 17 percent of Cambodian and Hmong Americans—many who came originally as refugees—possess a bachelor's degree. In countering the model minority myth, Asian Americans look to affirmative action to address lower educational attainment, poverty, lack of access to high-quality K–12 education, barriers to high attendance and retention, and more.

MOBILIZING FOR SOCIAL ACTION AND STRATEGIC CHANGE

Addressing ongoing inequities for Asian Americans must be multifaceted, consistent, and persistent. As is often stated, if we do not remember history, we are destined to repeat it. We must be willing to act and mobilize for calling out disparities and inequities, as described, exemplified, and explicated throughout this chapter. Inequities continue to exist due to systemic and structural factors. No matter how small or incidental, situations involving unequal treatment often due to prejudice, stereotyping, bias, and discrimination must be interrupted and identified. To not do so, to be silent, colludes with a sense of tacit agreement or endorsement.

As with most historically sustained and systemic problems, there are often no easy or quick solutions. As I have espoused elsewhere, White supremacy and colonialism cannot be erased, as they constitute the legacy upon which our country was founded. However, there are multiple stances, actions, and strategies that we can undertake to continue the progress toward greater equity (Mock, 2008, 2019).

Some additional recommended strategies or levels of advocacy are instructive.

TEACHING AND ADVOCACY FOR CHANGE

Education, advocacy, and developing social change agents can be done in many ways. Such significant action can take many forms.

Remembering Those Who Came before Us

We must keep the memory of those among us and those who came before who dedicated their lives to confronting inequities. I am continuously aware of heroes within our community, such as Yuri Kochiyama,

Grace Lee Boggs, and Fred Korematsu. These are national heroes that we all must know, regardless of our backgrounds. They each experienced oppressive and unequal situations, often over a lifetime. But they endured to have their voices heard, to raise awareness, and to not give in to systemic marginalization. Rather than being viewed as "exceptions," I see these leaders as exceptional in the ways they advocated for Asian American equity.

In "Hearing Our Elders," Parham and Clauss-Ehlers (2017) provide an excellent description for how remaining vigilant in times of unfairness and antagonistic environments can yield opportunities for eventual social justice. While they were respectful, law-abiding, contributing members to society, Gordon Hirabayashi, Minoru Yasui, and Fred Korematsu were each not only interned but also served time in federal prison. It was only through their perseverance, endurance in seeking the truth, and serendipity that justice would eventually triumph. While it was eventually concluded that the rationale for placing over 120,000 Japanese Americans was wrong, the convictions of these three men still remained. Decades of their pursuing the truth finally uncovered that the government had altered reports, thereby committing fraud. It was this discovery that led to the overturning of the three men's convictions. One of their allies and supporters, Peter H. Irons, helped them uncover the truth. This sustained act of pursuing truth for eventual justice is a restorative one to Japanese Americans and others.

Remembering Role Models in Present Day

In addition to large reminders from such national heroes of how they dedicated their lives to equity movements, we should all develop personal heroes in our own lives whom we can invoke whenever necessary. This strengthens our resolve for continuing social justice. Their contributions also provide insights for reversing inequities. For me, for example, there is Sharon C Ngim, a public law attorney. After completing Hastings Law School, Sharon founded the Asian Women's Legal Assistance Services program at Cameron House in San Francisco. Focusing on Asian women experiencing family violence, she recognized that there were disparities and inequities in these victims' search for legal and mental health services. She, along with others, went on to establish a network of services including the Asian Women's Shelter, with related legal support services. Subsequently, as a program developer with the State Bar of California, Sharon dedicated her life to have programs provide pro bono legal services to those most in need, including those socially, culturally, and economically marginalized. Her early inspiration was the riots among Korean and African American communities in Los Angeles in the aftermath of the Rodney King verdict. In hindsight, both communities suffered while White ones prospered.

Recognizing inequities and disparities among all, including Asian communities, Sharon turned what she saw into opportunities to further pro bono legal services to help ravaged communities. In recognition of her dedicated life contributions, the State Bar honored her posthumously through the very first pro bono service award, potentially to be referred to in future awarding years as the "Serving Community Needs" (SCN) Award. Sharon is one of my heroes, one whom I will continuously reference while addressing inequities and fighting for justice.

Forming Collaborations among Organizations

Another obvious strategy to address inequities and promote ongoing social justice for Asian Americans is to make linkages with and among key organizations and coalitions, many but not all Asian focused. While by no means a complete list, I provide names of organizations that I have engaged, in "Resource Contacts," below. Our linking with and utilizing such organizational strategies depends on the question to be asked or the inequity to be confronted as well as the opportunities that may be provided. For example, in 2020, the U.S. national census recognized for the first time that Asian Americans are not monolithic but represent complex heterogeneity (Hasnain, Fujira, Capua, Bui, & Khan, 2020). Becoming involved and mobilizing key organizations representing different Asian groups will demonstrate how diverse we are in reality. While our collective voice must be heard, so must those who have historically been unheard or marginalized. These include, for example, Vietnamese-, Cambodian-, Laotian-, Pacific Islander–, Native Hawaiian–, and Burmese-origin families and individuals with needs yet to be successfully addressed.

In order to continue the fight for social justice, the existence and continued persistence of inequities for marginalized communities must be documented, discussed, and strategically dismantled. Communities that have been historical targets of discrimination and oppression, including Asian Americans, African Americans, Latinx, Native American; gay, lesbian, transgender; women; new immigrants; the uneducated, poor, or disabled, as well as oppressed others, face an ongoing climate of attacks and exclusion. The psychological impact and sequela of historical, societal, and relational inequities can be obvious but also subtle and pernicious. We must stand up and speak up for our communities yet at the same time remain undivided alongside others. We must build and maintain collaborations across racial, ethnic, and cultural communities.

Formulating Personal Strategies

Via my teaching of future psychologists and mental health professionals, I am passionately committed to confronting and dismantling Asian

American stereotypes, discrimination, and the model minority myths and attempts to make the inequities faced by Asian Americans invisible.

As a professor, I have undertaken a meaningful strategy specific in this role to contribute to increasing equity. It is a course that I have effectively taught for over two decades with powerful results. I will describe some of the key aspects of that course here in order stimulate similar ideas among readers. Trained as a clinical psychologist, I also teach doctoral graduate students in California's Bay Area. Along with their comprehensive training, students are required to take a course focusing specifically on one specific cultural, ethnic, racial community. Approximately 20 graduate students, with perhaps one-third being Asian American of diverse backgrounds, enroll in this course titled "Asian Americans: Socio-Cultural and Psychological Perspectives." It is taught in a dynamic and engaging way focusing on history, social experiences, psychological, and related health issues. From the outset, students are immersed into the context of what it means to be Asian American. Forming a foundation for understanding Asian American as well as some Native Hawaiian and Pacific Islander experiences means intensively delving into meaningful history. Terms and events underlying the Asian American experience are readily presented, deconstructed, and discussed. Words and concepts such as model minority, perpetual foreigner, whiter than White, hyphenated American, "Orientals," glass ceiling, impostor syndrome, and more are proactively presented. Students are made responsible for an in-depth examining of these terms, including their deleterious effects on identity development and self-esteem. Racial, ethnic, cultural, and linguistic identity issues are reviewed through specific Asian communities as examples.

The course is thoughtfully immersive and intensive. My passion as a third-generation Chinese American, heterosexual man who is also a practitioner, consultant, trainer, writer, and professor is apparent throughout the three weekends of 8 hours each day for a total of 45 hours. The self-of-the-therapist-in-development is a perspective taught and adopted by students during their education. They are made to take responsibility for their learning, which initially begins in the safe surrounds of the classroom. Learning agreements for meaningful discussions are clearly established so that all students are invested in their learning short term and long.

Historical and portrayed narratives of some of the experiences of Asian Americans are presented. There may be guests, including psychologists representing our diverse communities. Students have one major assignment where they comprehensively interview someone from a different Asian background than their own. The interview format includes asking about multigenerational immigration experiences as well as memories of incidents where the individual felt they were treated differently due to being Chinese, Japanese, South Asian, Vietnamese, Pacific Islander, biracial, Korean, and so on. This engenders delving into experiences of racism and discrimination. Ultimately, students gain appreciation of how such

experiences have impacted their interviewees. For example, their interviewees may disclose how their self-esteem was affected or what resulting decisions they made that were less than optimal. These informants may also share how they overcame potential psychologically related obstacles through perseverance, resilience, and personal strengths often drawn from familial or cultural sources.

Sociocultural and psychologically meaningful films depicting the range of Asian diversities along with inequities are also viewed in the class. Some examples of these, most available from the Center on Asian American Media (CAAM, see "Resource Contacts") with their community focus include *All Orientals Look the Same*(multiple Asian identities), *My Brown Eyes* (Korean American), *The Chinese Exclusion Act* (Chinese American), *Rabbit in the Moon* (Japanese American), *Healing the Spirit* (diverse Asian elders), *A Village Called Versailles* (Vietnamese American), *Off the Menu: Asian America* (focusing on the aftermath of a fatal hate crime shooting at a Sikh temple in Wisconsin), *Happy* (visiting Okinawa, where the oldest elders with a background of historical trauma live), *The Slanted Screen* (diverse Asians portrayed in Hollywood films). Psychologically related films may be shown, such as *The Culture of Emotions*, *Saving Face: Recognizing and Managing the Stigma of Mental Illness in Asian Americans*, *Unnatural Causes . . . Is Inequality Making Us Sick?* (with a specific segment on "Collateral Damage," focusing on Marshall Islanders), *The Color of Fear*, *Voices: Cultural Perspectives on Mental Health*, and more.

Concurrent with developing a strong foundation for learning, students are exposed to contributors to health and mental health disparities for Asian Americans and Native Hawaiians or Pacific Islanders. They learn more in depth via psychological research done individually or in assigned teams. Through a process I refer to as C-H-E-C-K (Cultural Humility, Empathy, Compassion, and Kindness), I strategically form bridges between my students and the local communities of Asian Americans. We may go to Angel Island (the port entry to the West) to examine the immigration process and sources of political and/or social exclusion based solely or principally on race and racism or discrimination. The National Japanese Historical Society of America is the site for sharing powerful depictions of the intergenerational impact of Executive Order 9066 and the legacy of the internment camps. Stories are told of what families endured and what they experienced as a result: miscarriages, shame in being from Japan, intraethnic disdain (the "no-no boys" judged to be disloyal by the U.S. government due to their answers on a questionnaire), mistrust in government, ongoing feelings of betrayal and anger, increased out-marriage, and the suppression of Japanese culture and language because it is not valued or may even be considered suspect. Students are taught diagnostic assessment and then are taken to a Chinese apothecary or Ayurvedic medicine practitioner or a Hmong shaman. References to stigma and shame as barriers to seeking out psychological assistance inevitably arise. It is known and documented

that Asians do not seek out mental health services as readily or frequently as others do. They tend to wait until symptoms are more severe. Loss of personal or family "face" is one of the issues behind the wait. So are inequities. While experiences of microaggressions may be forms of stress and even violence, they are often set aside. Physical and mental health are impacted by microaggressions, daily indignities, dehumanization, and repeated, mounting, or insidious trauma based in differential social treatment through dynamics of power differentials. Those who are targets may have higher blood pressure, diabetes, or even a reduced life span.

Students are trained to see how misperceptions and stereotypes also contribute to larger, systemic inequities even in the fields they will be working in or contributing to. For example, this appears true even in funding from a national health perspective. A recent review (Doan et al., 2019) of funding allocated to AAPI communities by NIH from 1992 to 2018 was found to be at a paltry 0.17 percent. This is alarming on multiple levels. This lack of monetary support for necessary research promotes a message that there have been few health needs among AANHPI populations requiring institutional support.

Graduate students are taught sociocultural and psychological perspectives impacting a diversity of Asian populations. In the end, these future psychology practitioners, researchers, policy makers, program supervisors, and advocates are armed with tools to confront the roots of inequities for Asian American communities. They are more prepared clinically and strategically to contribute to Asian wellness and resilience.

Existing Frameworks to Confront Disparities

Personal, local, and national strategies may be linked with larger ones. The National Institute on Minority Health and Health Disparities Research Framework (NIMHD, 2017) has established a way to address disparities that are the result of inequities. As an example, this framework is useful for posing a multilevel intervention strategy for addressing disparities among Asians. NIMHD poses this as an effective vehicle for confronting disparities and inequities. Different domains of influence over the life course are biological, behavioral, and environmental (both physical/built and sociocultural), including one's health-care system. The levels of influence are individual, interpersonal, community, and societal. Within the domain of sociocultural environment, discrimination appears within each level of influence. At an individual level, response to discrimination and cultural identity contributes to health outcomes. At the societal level, under the primary domain of behavioral influence are policies and laws. The outcome measure would be population health—in this case, with a focus on Asian-specific communities. This is one example of a larger framework being undertaken within the health-care realm. It can also be used with other strategies, such as teaching future advocates of change.

FINAL PASSIONATE CALL: UTILIZING RELATIONAL SOCIAL JUSTICE TO CONFRONT INEQUITIES FOR ASIAN AMERICANS

Within our various walks of life and in the different contexts in which we interact, we must see truth-telling as a part of our commitment. As a therapist, I find there is no such thing as neutrality. We have our ethics, values, and professional standards for upholding social justice, in this case for Asian Americans. But inquiries may persist for how to best move those who are unseeing, unhearing, or even in denial regarding Asian American inequities and their need for elimination. Protesting is telling the truth in public. And the importance of stories and sharing of narratives cannot be emphasized enough. Validating the ways discrimination, prejudice, and stereotyping have impacted the psychology and health of Asian Americans contributes to identifying resilience in the face of adversity and to our eventual wellness.

Asian Americans have risen up, organized, and spoken out. The perniciousness of systemic inequities attempts to silence or make invisible our standing up against injustices. We continue to step up and step out to combat inequities. The list includes making our overarching needs as AAPIs known but also understanding specific Asian communities; disaggregating data so that we are not treated as all the same; naming the injustices as they are occurring or recurring, to stop the cycle of repetition; mobilizing with other racial or ethnic communities similarly discriminated against so that our rising up and speaking out will be recognized. In my work, I have found that facilitating kinds of reenactments where injustices have occurred can have profound and lasting impact. Examples described earlier include all that I do in my classes to mobilize my students. These calls to action enable them to be potential future advocates, leaders, and powerful healers in their communities.

Speaking up and out, for and with, Asian Americans to confront generations of inequities is not taking on the voice of the voiceless but rather eliciting and bringing to light the voice of the unheard for a more connected and just world. Given all of the issues faced by marginalized people on a daily basis, lending our voices on behalf of these communities while also amplifying our own is both liberating and transformative. The past reminds us that rising up and speaking out for equity and social justice for Asian Americans has to be maintained and sustained for generations to come. This is the legacy for each and every one of us.

RESOURCE CONTACTS

Asian American Center on Disparities Research (UC Davis)
https://aacdr.ucdavis.edu
Asian American Psychological Association (AAPA) and Divisions
https://aapaonline.org

Asian Health Services
https://asianhealthservices.org
Asian Law Alliance
https://asianlawalliance.org
Asian Law Caucus: Asian Americans Advancing Justice
https://www.advancingjustice-alc.org
Center for Asian American Media (CAAM)
https://caamedia.org
National Asian American Pacific Islander Mental Health Association (NAAPIMHA)
https://naapimha.org
National Asian Pacific American Bar Association (NAPABA)
https://napaba.org
National Asian Pacific American Families against Substance Abuse (NAPAFASA)
https://napafasa.org
National Council of Asian Pacific Americans (NCAPA)
https://ncapaonline.org
Southeast Asian Resource and Advocacy Center (SEARAC)
https://www.searac.org

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CHAPTER 9

Psychiatry and the African American Community

A History of Diagnosis and Treatment for Social Control

H. Russell Searight
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On March 24, 2011, an African American woman named Maryanne Godboldo, holed up in her apartment with her daughter, had a 12-hour standoff with Detroit police, who organized SWAT teams and armored personnel carriers in their effort to gain custody of Ms. Godboldo's 12-year-old daughter, Arianna. The scene resembled a military assault. The standoff came after a child protective services worker attempted to take custody of Arianna based on a charge of medical neglect. Ms. Godboldo had discontinued Arianna's antipsychotic drug, Risperdal, because she was concerned about the side effects of the medication, including uncontrolled motor movements, such as facial grimaces. Ms. Godboldo, instead of returning to the physician who had prescribed the antipsychotic medication, had consulted a holistic medicine practitioner. While some of the details of the standoff have been debated, Ms. Godboldo was accused of firing a shot at one officer. Ms. Godboldo, after surrendering, was held on a half-million-dollar bond with charges that included discharge of a weapon, three counts of felonious assault, and three counts of resisting and obstructing a police officer. A judge dismissed these charges amid public criticism of the state interfering with a mother's right to decide what is best for her child (Bukowski, 2011). However, the prosecution contested the judge's ruling and the case went through two subsequent

appeals. The final appeal was never heard because Ms. Godboldo had become incapacitated and eventually died of a brain aneurysm.

The Godboldo case suggests that the therapeutic state described by psychiatrist Thomas Szasz (1984) was still alive and well. The therapeutic state represents a collaborative relationship between mental health professionals and the government, in which citizens' socially disapproved actions are controlled and punished through a therapeutic rationale (Szasz, 1984). Mental illness is not, from Szasz's (1984) perspective, a biological or psychosocial illness but is instead a political, economic, moral, and social problem given a medical veneer.

This chapter describes a series of historical examples of social control agendas, based upon mental health rationales targeting the African American community. In addition to overt actions such as those in Detroit, therapeutic language has a 200-year history of being employed in the United States to rationalize racial discrimination and paternalistic social welfare programs directed toward the African American community. With respect to this community, Szasz (1984) frequently invokes antebellum psychiatrists who argued that slaves desiring their freedom were exhibiting evidence of a mental aberration.

ANTEBELLUM PHYSICIANS AND PSYCHIATRY

Medical Research

During the pre–Civil War era in the southern United States, some physicians developed a specialty practice: treating and performing research on nonconsenting slaves. From an economic perspective, female slaves' reproductive capacity was an issue around which physicians and slave owners had a particular interest. In the 1840s, Alabama physician J. Marion Sims established the first women's hospital in the United States, specifically for the treatment of and research on slave women (Owens, 2017). In recent years, Sims, often called "the father of American gynecology," has been the subject of critical historical revisionism. Sims developed gynecological surgical procedures, as well as medical devices such as the vaginal speculum, using female slaves, some of whom were directly purchased by Sims for his research at the nearby Montgomery slave market (Owens, 2017). A relatively common gynecological problem was that of intravaginal fistula: an abnormal opening in the vagina into the rectum, bladder, or intestines (Owens, 2017). Sims developed a surgical technique to repair these malformations, and in order to develop this procedure, Sims deliberately induced fistulas in slave women and then repaired them; these surgeries were performed without any form of anesthetic (Owens, 2017). This cruelty was rationalized with a belief among southern Whites that people of African origin did not experience pain (Washington, 2006).

Experimentation on African Americans without consent did not end with death. As more U.S. medical schools were established in the 19th century, there was a growing need for cadavers for teaching anatomy. Medical schools often hired porters for acquiring cadavers from grave robbers—often known as resurrectionists, or night doctors. A dramatic illustration of this practice was discovered in 1989, when the Medical College of Georgia initiated a plan of building renovation (Blakely & Harrington, 1997). Workers came across thousands of human bones in the basement of a building used between the 1830s and early 1900s for laboratory instruction in anatomy. Up to 70 percent of the remains were determined to be of African American origin (Blakely & Harrington, 1997). There were indications that many of these remains were from bodies taken from a nearby African American cemetery (Blakely & Harrison, 1997). While there is documentation that Scottish night doctors may have deliberately abducted and killed innocent people for anatomical study, rumors of this practice have also been common in the U.S. African American community (Washington, 2006).

Samuel Cartwright's Taxonomy of Slave Diseases

J. Marion Sims's practice was intentionally directed toward slaveholders' economic interests. Physicians were seen as a valuable source of information for obtaining the most financially viable outcomes from the slave population (Willoughby, 2018). Any intervention that improved slaves' productivity was welcome (Owens, 2017). Providing a medical and moral justification for maximum labor output may have reduced any qualms of conscience that lingered.

In an 1851 medical journal article, the Louisiana physician Samuel Cartwright described a new taxonomy of psychiatric illnesses unique to the Black slave population. Cartwright's article echoed the paternalism often invoked as a rationalization for slavery. Cartwright used his medical platform to justify Black slavery by asserting that African Americans were temperamentally docile, which made them "psychologically and physiologically fit for slavery." Blacks' supposed cognitive deficits stemmed from Cartwright's erroneous conclusion that the average Black cranium was 10 percent smaller than that of Whites (Washington, 2006). Since, as Cartwright believed, Blacks were childlike and in need of adult supervision, he invoked both his own biblical interpretation as well as contemporary scientific theory, arguing that "slaves . . . required tight control" (Willoughby, 2018, p. 585).

In his apparently widely read article, Cartwright catalogued several behavioral illnesses unique to the Black slave population. As Washington (2006) notes, "the principal symptoms seemed to be a lack of enthusiasm for slavery" (p. 36). Arguably, Cartwright's best-known diagnosis was drapetomania, a condition said to be caused by excessive kindness on the

part of White slave owners and characterized by slaves' attempts to run away from their White masters. In justifying his diagnosis, Cartwright invoked the divine Christian social order in which Blacks were to be subservient to Whites (Washington, 2006). Attempts by misguided White liberal masters to treat their slaves with some degree of equality was an important etiological factor in drapetomania (Metzl, 2010; Washington, 2006). Cartwright's recommended treatment of choice for drapetomania was a harsh beating (Metzl, 2010).

Cartwright believed that constitutional weaknesses among Blacks accounted for drapetomania as well as for other conditions, such as dysaethesia aethiopis, that were unique to the slave population. Dysaethesia aethiopis, characterized by an irresistible impulse to destroy slave owners' property, was also treated with physical punishment (Willoughby, 2018). Cartwright's etiological explanation for these conditions reflected an early diathesis-stress conceptualization: Black slaves had unique constitutional features that were elicited by their masters' overly permissive attitudes. Cartwright even went so far as to conclude that there were visible bodily lesions associated with these behavioral syndromes that were detectable by trained physicians (Washington, 2006).

In a similar vein as J. Marion Sims's gynecologic procedures for slave women, Cartwright's treatments for these behavioral syndromes unique to Black slaves were certainly consistent with slaveholders' economic interests. These antebellum physicians were valued as a useful source of information for obtaining the greatest financial benefit from the slave population (Willoughby, 2018).

While whippings and beatings may not seem to require professional guidance, Cartwright's framing of physical assault as therapy for behavioral disorders indicated a need for professional guidance. For example, Cartwright counseled that corporal punishment, when administered too frequently or too rarely, could adversely impact the psychological well-being of slaves, which in turn could prevent optimal productivity (Willoughby, 2018).

In a historical period in which medical practice was largely unregulated, Cartwright promoted his psychiatric practice by announcing that he had studied with Dr. Benjamin Rush, considered the founder of American psychiatry; Rush, who advocated extensive bloodletting as a medical treatment, believed that Black skin was the product of leprosy (Washington, 2006).

Cartwright's medical racism was not limited to slave behavior. He also argued that African Americans were constitutionally predisposed to dysentery. Because of their unique biological status, slaves required similarly distinctive treatment. For dysentery, Cartwright encouraged slave owners to send the slaves "back to an imitation of African barbarism in the neighboring fields, woods and wilds, to lead a savage life, exposed to the open air and weather, and unprotected by houses" (Cited in Willoughby, 2018, p. 598). Cartwright also described a form of pica among slaves, in

which they ingested clay and dirt. While the physician's view was that this behavior was simply a common characteristic of persons of African background, it is more likely that in this case, rather than reflecting some endemic desire behavior pattern, pica was more likely to be at least partially caused by inadequate nutrition (Washington, 2006).

While Cartwright's articles on psychopathology among Black slaves predated Szasz's (1984) description of the therapeutic state by nearly 100 years, diagnoses such as drapetomania certainly reflect the use of psychiatric illness as a rationale for social and economic control, including legally sanctioned physical abuse.

THE POST—CIVIL WAR ERA

According to some physicians of the era, emancipation brought new threats to the psychological health of African Americans. Indeed, freedom itself was described as an etiological factor in the growing incidence of psychopathology in the African American community. Southern physicians often waxed nostalgic about the carefree life under slavery: "While the Negro had a master he had not thought for the morrow; not a single care burdened his mind, there was nothing to disturb his equilibrium" (Buchanan, 1886, p. 68, as cited in Jarvis, 2008). Cartwright's opinion that African American slaves needed tight supervision can be found in the medical writings of many 19th- and early 20th-century physicians. Indeed, the "enforced self-restraint" (Jarvis, 2008, p. 212) provided by slave owners was the only deterrent to a life of drunkenness, overeating, sexual promiscuity, and poor hygiene (Jarvis, 2008). The psychiatric community often shared the opinion of former slaveholders—that African Americans' inherent psychological makeup prevented them from functioning as competent citizens. Writing in the *New England Journal of Medicine*, psychiatrist Edward Jarvis predated the adverse effects of emancipation. In comparing free Blacks in the North with slaves, he reported that psychiatric illness was 10 times more common among those who were free (Jarvis, 1842). A diagnostic study in 1872 reported that sudden emancipation was a cause of "insanity" among some of the residents of Virginia's Central Lunatic Asylum (Gonaver, 2019).

Even several decades after the end of the Civil War, psychiatrist Arrah Evarts (1914) expressed concern about a soaring incidence of dementia praecox (schizophrenia) among ex-slaves as a reaction to the stresses of emancipation. She believed that because of their African origins, Blacks had never developed social control and that their relatively brief period of socialization under White-dominated slavery was not adequate to remedy these deficits. Evarts and other late 19th- and early 20th-century psychiatrists continued the "blissful" account of life under slavery: "This bondage in reality was a wonderful aid to the colored man. . . . It has been said . . . that a crazy Negro was a rare sight before emancipation . . . we know he is by no means rare today" (Evarts, 1914; cited in Metzl, 2010, p. 31).

During the 50 years post-emancipation, Freudian theory offered explanations of conditions such as depression or suicide. Freud visited the United States in 1909 and received a good deal of publicity. From the Freudian perspective, Black Americans had minimal ego strength and lacked the necessary capacity for preventing instinctual sexual and aggressive impulses from breaking though their shoddy defenses (Gambino, 2008). While some former slaves might demonstrate periods of self-control, a "savage heart [lurked beneath] . . . a civilized exterior" (Lind, 1917). As Metzl (2009) notes, a similar rationale was invoked by European administrators of African colonies. British psychiatrists' and anthropologists' accounts of "mass hysteria" emphasized how susceptible the "African mind" was to these collective, uncontrolled emotional outbursts (Mahone, 2006). Their argument was that persons Indigenous to these countries were not competent for self-rule and were unconsciously grateful for the civilizing effects of colonization.

Beginning around 1925, rates of increased psychosis among African Americans were reported by psychiatric researchers. Many of these investigations were conducted in northern cities, which were experiencing a large influx of Black migrants from the rural South. Many studies found that rates of psychosis for Blacks were higher than that for Whites (Jarvis, 2008). Causes of this differential rate of psychosis were at best nonspecific; as in the immediate post-slavery period, Blacks as a group were described as being more emotionally unstable (Jarvis, 2008), while still other explanations included the psychological stress of living in White majority cities (Jarvis, 2008).

The "primitive" psychological makeup attributed to Black patients in the early to mid-1900s was seen as rendering them inaccessible to treatments that were becoming increasingly common among middle-class Whites, such as psychodynamic therapy. However, among Blacks, only debilitating psychiatric illnesses such as schizophrenia, syphilitic paresis, or severe neuropsychological sequelae of years of alcohol abuse qualified for psychiatric care. Afflicted with these severely debilitating conditions, Blacks were often institutionalized in segregated facilities that were hospitals in name only.

PSYCHIATRIC HOSPITALIZATION

Most of the large psychiatric hospitals in the United States were initially constructed in the early 19th century (Rothman, 2017). In their early years, many of these institutions incorporated many of the elements of moral treatment. The moral treatment movement, associated with reform-minded Quaker physicians, emphasized the humane treatment of patients with psychiatric illness. As much as possible, a family atmosphere was encouraged. Patients typically worked on adjacent farmland as part of their therapy. Prayer and Bible reading was encouraged. Using chains

or similar methods to restrain patients was typically not permitted or at minimum frowned upon.

Influenced by this approach, Dr. John Galt oversaw one of the few racially integrated asylums in the United States. Eastern Lunatic Asylum in Virginia accepted slaves as patients, with reimbursement being provided by their owner. Free Blacks were also hospitalized at Galt's facility, though the state paid 50 percent to 75 percent less for their care than for Whites. Slaves also worked directly with patients—including Whites and free Blacks (Gonaver, 2019). Galt actively worked to provide positive experiences for patients; he included a game room, library, and even afternoon tea for the female patients (Gonaver, 2019).

However, by the mid to latter part of the 19th century, the U.S. population and the corresponding census of asylums increased substantially (Rothman, 2017). In addition, reform-minded superintendents—who were in the minority—died and were replaced by administrators emphasizing efficiency and control. Galt, considered by his fellow hospital superintendents to be a maverick, died by a deliberate overdose of opiates when the Union Army surrounded Williamsburg.

By the end of the 19th century, large state asylums became overcrowded institutions that provided little more than custodial care. In addition, in both the northern and southern United States, these facilities were racially segregated and had differing standards of care for Whites and Blacks. While viewed today as a quaint, medically primitive treatment, hydrotherapy and "wrapping" (encasing the patient in wet sheets) were considered among the best therapies that late 19th- and early 20th-century psychiatric hospitals could offer. At the Eastern Lunatic Asylum, these "progressive" therapies were, in the late 1890s, only provided to White patients; they were unavailable for African American patients until the mid-1920s. It is likely that this race-based treatment pattern contributed to the 50 percent greater use of restraints on Black, as compared with White, patients (Gonaver, 2019).

Even liberal reformers such as Galt held the belief that slavery had protective mental health effects for Blacks and encouraged slave owners to send their charges to his facility. He suggested that because slaves did not experience "anxiety relative to loss of property" and that slaveholders' economic investment in the patients' health encouraged hospital treatment at an early stage of illness, slaves recovered quickly (Gonaver, 2019). The view that Blacks had different types of mental illness than Whites did was invoked as one reason for the racial segregation that characterized most psychiatric hospitals soon after the Civil War's conclusion. The illness course of Whites was more optimistic than for Black patients. In particular, emancipation led to a state of emotional and physical anarchy within the Black community; "neurotic conditions, such as major depressive disorder, were becoming increasingly common among Whites. However, these less severe illnesses were seen as rare among Blacks. Instead,

the stresses of emancipation contributed to a surge in psychosis in the newly freed southern slave population" (Jarvis, 2008). While many White patients were suffering the effects of emotional repression, Blacks, without the structure of slavery, experienced few constraints on their "primitive passionate nature," leading to moral and physical deterioration (Gonaver, 2019). The need to maintain order in the face of these challenges was another factor invoked to support segregated asylums. After Galt's death, the Eastern Lunatic Asylum became a Whites-only facility, with all of its Black patients moved to another facility, then called the Central Lunatic Asylum.

Another well-known segregated asylum in the region was Crownsville State Hospital, in Maryland. The facility was actually constructed by Black patients as a form of therapy. Originally named "The Hospital for the Negro Insane," Crownsville opened in 1911. The institution's census escalated from 521 patients in 1920 to 2,719 in 1955. An exposé for the *Baltimore Sun* in 1949 described an overcrowded facility in which little treatment was provided: 2,700 patients were cared for by eight physicians with one nurse and one "low caliber attendant" per 270 patients (Nuriddin, 2019). The wards were a heterogeneous mixture of diagnoses and ages; pedophiles, persons with schizophrenia, and Alzheimer's patients shared hospital units with children with Down syndrome. During the 1940s and -50s, patients were more likely to leave the facility as a result of their death than from improving enough to be discharged.

Crownsville has received recent attention by its association with the story of Henrietta Lacks. Lacks, an African American woman, died of complications in 1951 related to cervical cancer. However, before her death, a cell culture was taken without her consent that has proved to be very biologically robust and continues to serve as the basis for cellular research (Skloot, 2010). One of Lacks's daughters, Elsie, was placed in Crownsville at the age of 11. While Elsie's diagnosis is unclear, there are suggestions that she demonstrated cognitive limitations stemming from a developmental disability (Skloot, 2010). During her four- to five-year hospitalization, Elsie, like a number of other Crownsville patients, was reportedly subjected to more than one experimental procedure that was conducted without family consent. Elsie was subjected to a precursor to contemporary brain imaging, pneumoencephalography, in which cerebrospinal fluid is drained and replaced with air or helium. Described as a very painful procedure often associated with days of nausea and vomiting, pneumoencephalography resulted in some patients' deaths, and Elsie may have succumbed to the procedure's sequelae (Skloot, 2010). Crownsville was integrated in the early 1960s and closed in 2004.

Cities just beyond the borders of the former Confederacy, such as Washington, DC, and Baltimore, experienced an increase in the Black population

as migration to the North became common in the late 1800s. Saint Elizabeth's psychiatric hospital, a federal facility in Washington, DC, was also segregated. Black patients performed unpaid manual labor as therapy. These menial tasks were considered appropriate for Blacks but beneath the social status of White patients: "Most . . . [of the Black patients] . . . were just one generation removed from the experience of slavery, and black men in particular recognized that ownership of one's labor was a crucial component of their freedom" (Gambino, 2008, p. 400). A 1907 government report highlighted the racial issues regarding labor for patients, indicating that Whites were "averse" to manual labor, and believed that Black patients should perform these tasks. Blacks, however, often seemed to see through the therapeutic ruse and, to the dismay of hospital officials, requested pay for their efforts. As one Black patient stated, "The onliest time I got good sense is when I'm working for nothing, but when I ask for pay like you would, then I am out of my mind and insane" (Gambino, 2008, p. 400).

In 1946, President Truman signed the Hill-Burton Act, which provided federal funds to states and municipalities for hospital construction. The Act included a proviso that in order to receive federal funding, hospitals should be responsive to the needs of local citizens and establish a certification/licensing protocol. Hospitals could be denied federal funds if the institution failed to demonstrate responsiveness to the local citizenry or did not maintain quality specifications (Quadagno, 2000). However, through the efforts of some southern legislators, it was established that these provisions could not be applied to private health-care institutions—and that hospitals met this definition. Even after passage of the Civil Rights Act in 1964, both medical and psychiatric hospitals in many jurisdictions had implicit or explicit policies of racial segregation. For example, some southern hospitals maintained separate entrances for "colored" and "White" staff, visitors, and patients (Quadagno, 2000). Some municipalities had hospitals significantly designated for "Negroes," and within local hospitals, wards were often segregated and medical equipment was specifically labeled by race (Quadagno, 2000). However, with the implementation of Medicare in 1966, the "private" status of hospitals that could discriminate dissolved. In order to receive Medicare funds, hospitals were required to abide by Title VI of the nondiscriminatory policies of the Civil Rights Act. Since hospitals depended on this funding for operations, the economic well-being of the hospitals required compliance with federal law. For some southerners, the final lost battle was the actual integration of individual hospital rooms. Alabama's health-care institutions were particularly recalcitrant on this issue, with only 5 percent of rooms being integrated (Quadagno, 2000). The Ku Klux Klan reportedly threatened to bomb a Mississippi hospital if patient rooms were integrated (Quadagno, 2000).

PATHOLOGIZING PROTEST: THE 1960s AND 1970s

A reassertion of psychiatry's social control function was evident during the 1960s and 1970s as peaceful civil rights demonstrations as well as race riots became common in the United States. In some instances, typically triggered by perceived unfair police treatment of an African American, rioting broke out in many large cities. Martin Luther King's assassination was associated with both rioting and peaceful demonstrations. Additionally, there were several movements within the African American community that encouraged separation from White society. Examples included the Nation of Islam (Black Muslims), who publicly stated that Whites were "the devil," and Black nationalism, which encouraged greater recognition of and participation in African culture.

Relatively quickly, applied psychology and psychiatry (glossing over issues such as income inequality, residential segregation, unemployment, and discrimination) medicalized these movements with psychiatric jargon. By doing so, the locus of these social problems became dysfunctional personality traits, a predisposition for certain types of mental illness, or neurological dysfunction endemic to the African American community (Metzl, 2010; Raz, 2013).

Personality research in psychology, focusing on common variations of traits in nonclinical populations, examined "normal" African American personality and also compared their characteristics with those of Black activists; multiple studies conducted in the 1960s concluded that African Americans were more likely than Whites to have an external locus of control (Baistow, 2000; Shaw & Uhl, 1969). This construct was invoked to explain the reasons for economic deprivation among African Americans. This view of inherent fatalism and learned helplessness among the African American population provided a psychological rationale that minimized the idea that discrimination and other social forces contributed to poverty (Baistow, 2000). The implication was that if African Americans could develop greater "internality" in the form of a belief that they had control over the important dimensions of their lives, these long-standing social problems would be alleviated.

In the late 1960s and early 1970s, several studies focused on the psychological characteristics and mental health of African American civil rights activists to determine psychological correlates of civil rights activity. Evans and Alexander (1970) found that African American college students who were more active in the Student Nonviolent Coordinating Committee (SNCC) and the Congress on Racial Equality (CORE) demonstrated higher levels of psychological repression than members of Black sororities and fraternities, and a White student group. It is suggested that "in the face of the recurring frustrations and disappointments of the civil rights movement, only Negroes with strong repression could function actively" (Evans & Alexander, 1970, p. 904). In their discussion, the authors note the

increasing "militancy . . . among Negro activists" (p. 905) and suggest that this factor, along with a "heightening of black racial pride" (p. 905) are likely to contribute to the pattern of findings obtained (Evans & Alexander, 1970).

While not focusing on racial issues, Lasswell (1931) published a frequently cited study concluding that political activists exhibited higher levels of psychopathology. Marcus (1969) compared the prevalence of psychopathology among those involved in "innovative" political activity—specifically African American civil rights—with members of more "traditional" community organizations. Innovative organizations were defined by their mission of "challenging the existing institutions of the ghetto" (Marcus, 1969, p. 921). Based upon questionnaire and interview data, Marcus (1969) reported that compared with White community leaders and African American members of "traditional" political organizations, local African American civil rights leaders exhibited greater psychopathology. In discussing these findings, Marcus (1969) concludes, "For radical political activity to accept cultural values and norms, on one hand, while acting and creating new institutions, on the other, would seem to be a form of social schizophrenia" (p. 930). The term "schizophrenia" as a description of social tensions experienced by Blacks who lived in a society that was perceived as oppressive was a common theme in the civil rights movement (Metzl, 2010). Black writers such as Frantz Fanon and Ralph Ellison as well as civil rights activists including Martin Luther King and Stokely Carmichael, referred to schizophrenia as an adaptive response to a racist society in which Black identity had to be submerged in order for Blacks have any chance of economic success in a culture dominated by White European norms and values (Metzl, 2010).

During the 1960s and 1970s, paranoia became a defining feature of psychosis among African Americans. As schizophrenia was increasingly diagnosed in Blacks relative to Whites, the experience of racism and discrimination among Black patients was reframed as a delusion by the mental health establishment. Metzl (2010), in his account of the demographic changes in the patient population of Ionia State Hospital in Michigan, describes a shift from White females who were not functioning effectively as homemakers in the 1950s to angry, suspicious African American men in the mid-1960s and early 1970s. In reviewing patient records from the mid-1960s to early 1970s, Metzl (2010) highlights how the description of Black patients with schizophrenia differed from that of White patients with the same diagnosis. While White schizophrenic patients were more likely to be described as withdrawn, suicidal, or depressed, Blacks with schizophrenia were described as hostile, aggressive, threatening, and as having problems with authority figures. The clinical histories of some Black patients reveal the psychiatrists' view that their patients stated political or social affiliations that were in and of themselves, pathological: "Very disturbed, feels outside of society"; "aggression projected onto others . . . states,

'White men are against me'"; "supports 'Black Power,' agitated, threatening" (Metzl, 2010, pp. 148–149).

The Nation of Islam, originating in Detroit in the 1930s, combined Islamic tenets with a view that Blacks needed to separate entirely from White society. During the 1960s and early -70s, there was an upsurge of activity as the sect underwent changes, with the organization splintering into subgroups. While some of these offshoots were less radical in their views, the perception of ongoing discrimination by Whites persisted. Identification with the "Black Muslims" was, however, often interpreted as a quasi-delusional symptom by Ionia's psychiatrists, as these excerpts from patient records suggest: "Outbursts, belligerent, . . . authority figures challenged including ALL WHITE PEOPLE *[note caps—in original]* . . . seeks Black identification through interest in Islam" (Metzl, 2010, p. 150); "his identification with the Black Muslim group is a projection of his inadequacy" (Metzl, 2010, p. 143).

Echoing back to the antebellum era of Cartwright, Blacks' collective assertiveness regarding their fundamental rights was interpreted by some mental health professionals as both a cause and a manifestation of African Americans' distinctive psychopathology. In 1968, a psychiatrist and psychologist described a new psychiatric condition: the "Protest Psychosis." Bromberg and Simon (1968) attributed the condition among African Americans to the stress of "asserting civil rights" and "the corresponding nationalistic fervor of Africo-Asian nations" (p. 155). Other factors eliciting this psychosis included the Black Muslims and "African subcultural ideologies" (p. 155). Symptoms included "a denial of Caucasian values . . . [and a] virtual repudiation of 'white civilization'" (Bromberg & Simon, 1968).

Other mental health professionals were more direct in their view that participation in civil rights activities alone was enough to cause schizophrenia. Writing from a psychodynamic perspective, Pierce and West (1966) described how participating in civil rights demonstrations led to delusions and magical thinking. However, these symptoms could be controlled with pharmacotherapy. Metzl (2010) describes an advertisement for the antipsychotic drug Haldol that appeared in a 1974 issue of the *Archives of Psychiatry:* "An angry, hostile African American man with a clenched, inverted, Black Power fist. The James Brown–like figure literally shakes his fist at the assumed physician viewer while the orange, burning, urban setting appears to directly reference civil unrest in cities such as Los Angeles, Detroit and Newark" (Metzl, 2010, p. 102).

THE PATHOLOGICAL AFRICAN AMERICAN FAMILY

While civil rights activists were describing an American culture that generated adaptive schizophrenia among Black Americans, government-sponsored research concluded that the pathology of African American life was not confined to the psychiatric clinic or to those joining protests for equality. Instead, according to the research, pathology was endemic to

African American families. In the mid-1960s, President Lyndon Johnson—in a speech to Howard University graduates—described the breakdown in families as a pervasive force that radiated into all aspects of the African American community. Moreover, this family pathology was a major obstacle to economic equality for Black Americans (Rainwater & Yancey, 1967). Johnson's pessimistic portrayal of African American family life was largely based upon the efforts of his assistant secretary of labor, Daniel Patrick Moynihan. In his report, Moynihan argued that despite civil rights legislation and employment programs directed to the African American community, economic progress had been very limited. He asserted that a fundamental contributor to racial economic inequality was "the weaknesses of the family structure which is . . . the center of the tangle of pathology" (Moynihan, 1965, p. 30). Early in his report, Moynihan invoked psychoanalytic theory to explain the repeated cycle of hopelessness among African Americans: "The child learns a way of looking at life in his early years through which all later experiences are viewed and which profoundly shapes his adult conduct" (Moynihan, 1965, p. 5).

The root of this self-perpetuating cycle, in Moynihan's view, was a pathological family structure—the female-headed household. The list of the adverse consequences of this pattern of family dysfunction was lengthy: children with lower IQs, poor academic performance, school dropout rates, living in households with mothers left behind with their children when their male partner deserted the family, and having to rely on welfare payments for food, clothing, and shelter. Moreover, citing psychological research, Moynihan describes the enduring adverse impact from growing up in a fatherless home on the developing personality, including a "hunger for immediate gratification" (p. 39) which is a "critical factor in immature, criminal, and neurotic behavior" (p. 30). Even if the father remains in the household, his inferior earning power relative to his female partner leads "older children to become resentful" as they watch their father reduced to the status of "errand boy to and from the relief office" (Baake, 1940, cited by Moynihan, 1965, p. 19).

Moynihan's description of the adverse impact of geographic mobility from the rural South to industrialized northern cities echoes that of psychiatrists such as Evarts 50 years earlier. Rather than provoking psychosis, Moynihan links the change from "the simple family organization and folk culture which the Negro has evolved in the rural South" (p. 65) to northern urban centers as an etiological factor in parental desertion of the family.

As would be expected, the *Moynihan Report* generated a good deal of public commentary. Several critics invoked the report's mental health language. For example, the federal conference scheduled as a follow-up on the report was described as being "aimed at developing a national policy to strengthen the ego of the Negro male in the United States" (Rovere, 1965; cited in Rainwater & Yancey, 1967). Writing in the magazine *Commonweal*, sociologist Herbert Gans raised concern about the psychiatrization of

African American poverty that the *Moynihan Report* appeared to espouse. As Rainwater and Yancey (1967) note, Gans's article highlighted reservations about the "clamor for pseudo-psychiatric programs," and the implied solution of counseling and therapy implied by the report, along with the language of pathology, could be used by conservative opponents of Johnson's civil rights initiatives and the War on Poverty (Rainwater & Yancey. 1967). As civil rights leaders and public intellectuals began to criticize Moynihan's conclusions and etiological descriptions, the Labor Department became more equivocal about the report.

Two years after the appearance of Moynihan's report, Elliot Liebow, a researcher with the National Institute of Mental Health, conducted an anthropological study and compiled his findings into the book *Tally's Corner*. *Tally's Corner* was, for an academic book, widely read and became a frequently assigned text in 1970s university sociology and cultural anthropology courses. Liebow described a group of "Negro street corner men" that he studied through participation observation. Liebow's (1967) in-depth description of this cultural group seemed to support and provide further explanation for Moynihan's psychodynamically punctuated, statistical conclusions.

Liebow's (1967) monograph provides an account of Moynihan's missing men in the matriarchal family. Liebow engaged in participant observation with a group of Black men who spent much of their days and nights socializing on a street corner in Washington, DC. With a "Carry Out" shop and a liquor store on opposite sides of the street and being within walking distance of the White House, the corner was an informal open air social club for 10 to 20 men who frequently congregated there. Being a member of the street corner society is described as an exercise in psychological impression management designed to shore up shaky self-esteem among men who did not maintain regular employment nor contribute to the families that they had helped create. In Liebow's account, the street corner provides a context for having an identity other than that of a "loser." Regular, stable work and relationships were not part of the street corner life (Liebow, 1967). However, accounts of interactions with women were a key part of the life narrative that the men frequently updated for their street corner peers. These stories often centered around successful exploitation of women—either sexually or economically. Liebow (1967) describes how the men are drawn to women who have stable employment: One of the men describes a woman he has recently started seeing and who paid for all their dates: "She just got herself a government job. . . . She never misses a day of work. She's a real mule." Liebow responds: "Hell, who wants to live with a mule?" Leroy defends his position: "Man that's the best thing to live with. . . . When you got somebody who can pull that wagon, you really got something" (Liebow & Lemert, 2003, p. 90).

The men's limited employment prospects are seasonal or other time-limited, menial jobs. While sympathetic to the men, Liebow (1967) also

describes the "broken" family structure that was the major etiological factor of the *Moynihan Report*. However, from Liebow's perspective, the solution is far more complex than gaining regular employment. Given their level of education and spotty work history, jobs available to these men would not pay well enough to support a family, with few prospects of job advancement.

THE KERNER COMMISSION AND PSYCHOSURGERY

In response to the mid-1960s race riots in Detroit, Newark, and Los Angeles, President Johnson established the Kerner Commission to examine the causes of this unrest and provide recommendations for preventing future uprisings. In attempting to account for the surge of racial civil unrest, the Commission recycled many of Moynihan's descriptions of Black family structure (National Advisory Commission on Civil Disorders, 1967). New York mayor John Lindsay asked the Commission to investigate whether rioters had come from one- or two-parent homes (Raz, 2013). In addition to hearing about pathological, female-headed households, the Commission listened to experts addressing the question of whether early childhood education programs could offset the harm caused by deviant African American family structure and therefore reduce the likelihood of future civil unrest (Raz, 2013). In their testimony before the Commission, several experts addressed the question of whether employment should be required for low-income mothers. This requirement would necessitate a large government investment in day care or preschool (Raz, 2013). According to some of the experts, large-scale early education for African American children might offset their inadequate maternal care as well as the cognitive deprivation of ghetto life. As such, a comprehensive early childhood education program could address two of the possible etiologies and eliminate factors contributing to urban rioting.

Liebow, in his testimony to the Kerner Commission, described the street corner men's approach to life as an adaptation to their economic circumstances rather than a direct cause of civil unrest (Raz, 2013). In their final report, the Commission placed the blame for the riots on a long history of racism that had created persistent social inequality.

One of the more controversial responses to the Kerner Report came from the field of neuropsychiatry. Mark, Sweet, and Ervin (1967) suggested that the Commission had overlooked a key factor contributing to violence: brain dysfunction. Moreover, there was an available intervention: psychosurgery. In the 1940s and 1950s (prior to the availability of antipsychotic medication) an estimated 40,000 lobotomies—involving deliberate damage to the frontal lobes—were performed in the United States. The success rate of these procedures was, at best, equivocal (Raz, 2013). Lobotomies' benefits are difficult to assess since a common objective was to reduce behavioral agitation—making the patient easier to manage in a hospital

setting. Lobotomies' adverse effects included apathy, significant memory loss, and overall decline in executive function. Given the procedure's risks and the availability of effective alternative treatments, lobotomies became rare.

However, in the late 1960s and early 1970s, two neurologists—Vernon Mark and José Delgado—collaborated with the psychiatrist Frank Ervin on studies examining the influence of the amygdala on aggression (Casey, 2015). Case studies of patients with seizure disorders indicated an association between increased electrical discharge by the amygdala and seizures that included sudden aggressive outbursts (Faria, 2013). Delgado had experience with implanting electrodes in the brain and observing behavior associated with electrical stimulation. In one of their patients, surgical ablation of the right amygdala significantly reduced aggression, although the seizures persisted.

Mark and Ervin conducted research on a total of 20 patients with histories of seizures accompanied by "uncontrolled violence." Once these patients had undergone amygdalectomy, the majority reportedly exhibited less aggression. In a frequently cited letter in the *Journal of the American Medical Association*, Mark and colleagues (1967) suggested that use of psychosurgery could possibly reduce civil unrest and decrease the burden on the criminal justice system. The letter, along with their book *Violence and the Brain*, generated considerable controversy, with many critics attacking Mark and colleagues' use of surgery as a form of "mind control"—a phrase evoking associations with totalitarian governments (Casey, 2015).

Critics analogized Mark, Sweet, and Ervin's description of those participating in civil disturbances as "violence prone" personalities as analogues to the drapetomania label of the antebellum era. Applying a medical diagnosis to explain the results of social inequality and racism protected the White status quo from having to address issues such as discrimination and poverty (Casey, 2015). One commentator contrasted psychoanalysis—the costly introspective treatment available to middle-class Whites ("a safer empowering means of self-exploration," [Casey, 2015, p. 113])—with the invasive surgical intervention of amygdalectomy proposed for economically disadvantaged African Americans.

THE PERSISTENCE OF PSYCHIATRIC SOCIAL CONTROL

Psychotropic medications, often associated with attempts to control behavior and encourage compliance with the values of White society, have raised pronounced suspicion among minority patients. The recent increase in diagnosis and treatment of ADHD has been seen as a contemporary approach to medicating social problems such as underfunded schools and overcrowded classrooms and inflicts the view that Black males have little self-control (Carpenter-Song, 2009; Searight & McClaren,

1998). In a study of parents' views and experiences with childhood ADHD, Carpenter-Song (2009) found that even when their children were taking stimulant medication for ADHD, parents maintained suspicion about whether their child really had a problem and suggested implicit racism as a factor in diagnosis: "It's a lot harder for the boys though because in our society, they already have negative views on boys, period. . . . But to be an African American boy is twice as hard. So if you don't sit still in class—you're considered—Oh, he has problems. He needs to be tested for ADHD. . . . I feel that a lot of the young Black men that are acting out or in jail at this time it's because of these influences they had in school" (Carpenter-Song, 2009, p. 76).

Treatment of ADHD was seen as directed disproportionately to African American children: in one of her encounters with a pharmacist, a parent was told that the pharmacies frequently run out of stimulant medication because "all the little Black boys need their medication" (Carpenter-Song, 2009, p. 80).

As is evident from the discussion of ADHD, concerns about psychiatric social control are still with us—albeit more subtly than in the antebellum past. The use of psychiatric intervention to help persons adjust to their diminished social status has not completely disappeared. The earlier use of lobotomies in the 1940s and 1950s on apathetic housewives with the reported goal of returning them to carry out their household duties without complaint has been characterized as a political application of psychosurgery (Casey, 2015; Raz, 2013). An adult daughter's testament to the benefits of her mother's lobotomy highlights these treatment benefits: "She has developed into a pretty reliable dishwasher and accomplishes this chore with more thoroughness and precision than she used to" (Raz, 2013, p. 127). The benefits of lobotomy were often cast in a moral or religious light, as in this report by a husband about his wife: "She performs the housework very well and has been an indispensable part of the home. . . . For the most part, the home has been a congenial, Christian one, with the children provided for as such. Mrs. May, the children, and myself go to Sunday School each Sunday" (Raz, 2013, pp. 127–128). As accounts of the benefits of psychosurgery as well as medical journals' psychotropic drug ads during this period would attest, a positive treatment outcome is the cheerful acceptance of the drudgery of housework.

Much as antipsychotic medication was prescribed to address the anger and "paranoia" of unemployed or underemployed African American men in the 1960s and 1970s, social inequality continues to be treated as a psychiatric syndrome. The theme of psychiatric treatment as a tool for helping patients blissfully accept life's unfortunate circumstances emerges again in a recent report from the United Kingdom: a recent study found that 25 percent of the UK population had been prescribed an opiate or antidepressant during 2018 (Taylor et al., 2019). Of particular note was that the regions of the country with the highest levels of social deprivation also had the highest proportion

of patients prescribed these medications. Hamilton (2019) acknowledges that the medication does not cure problems of unemployment, poor housing, or access to quality education; however, he suggests that they can effectively numb or inoculate against helplessness and hopelessness of inequality and that painless acceptance may be particularly attractive.

An issue in the popular press has been the difficulty that patients have withdrawing from antidepressant medication. Reducing the dosage of selective serotonin reuptake inhibitors has been associated with nausea, agitation, dissociation, and agitation. Hamilton (2019) argues that the only way that one can determine if antidepressants are no longer needed after an adequate therapeutic trial of 6 to 12 months is whether reducing the medication results in rebound depressive symptoms of sadness or poor sleep and appetite. However, when hopelessness is based upon social reality, it is difficult if not impossible to determine whether accompanying dysphoric mood stems from major depressive disorder or a clearer view of one's unfortunate social circumstances (Hamilton, 2019).

CONCLUSION: INTEGRATING SOCIAL HISTORY WITH CLINICAL PRACTICE AND POLICY

It is estimated that at present, 17 percent of the U.S. population has an active prescription for psychiatric medication (Miller, 2016). However, African Americans appear to be underrepresented in this figure. Whites are nearly three times as likely as African Americans to be taking antidepressants, and an estimated 43 percent of African American patients prescribed psychiatric medication are nonadherent (Pratt, Brody, & Gu, 2011)—a figure higher than that for White or Asian Americans (Lanouette, Folsom, Sciolla, & Jeste, 2009). Within the African American population, negative attitudes toward pharmacotherapy for psychiatric conditions are more pronounced; patients report greater levels of distrust of organized medicine and, in particular, a specific mistrust of psychiatry (Christie-Mizell et al., 2015).

The Tuskegee syphilis study, the legacy of J. Marian Sims, and Cartwright's drapetomania have all contributed to an atmosphere of suspicion of medicine among African Americans that continues up to the present. President Clinton's belated 1997 apology for Tuskegee did not put an end to revelations of the Public Health Service's history of scientific misconduct. A decade after Clinton's apology, Reverby (2016), who had provided detailed information about Tuskegee, uncovered new information that the PHS had been simultaneously conducting similar research in Guatemala. From 1946 through 1948, over 1,300 Guatemalan prisoners, military personnel, and psychiatric patients were intentionally and unknowingly infected with syphilis, gonorrhea, and chancroids (Reverby, 2011; Rodriguez & Garcia, 2013).

Within the African American community, this mistrust has extended to a belief that health-care professionals are conspiring to reduce the Black

population. For example, Klonoff and Landrine (1999) found that 27 percent of African Americans agreed with the statement that "HIV/AIDS is a man-made virus that the federal government made to kill and wipe out Black people." Other AIDS/HIV conspiracy-related views among African Americans include a belief that the AIDS virus was manufactured in a government laboratory (White, 2005) and that the federal government was withholding a secretly created AIDS vaccine (Ball, 2016).

This atmosphere of suspicion is likely to be present in African Americans' encounters with White mental health professionals. It is important to recognize that clinical mental health, even when not directly oppressive to minorities, reflects the values of the dominant White American culture. For example, therapists implicitly expect that when asked directly, clients will readily disclose deeply personal information to a stranger (Snowden, 2001; Wallace & Constantine, 2005). In addition, mental health professionals relying on rational, evidence-based treatment approaches would expect patients to comply with recommended psychotropic medication. However, mistrust of physicians' relationships with pharmaceutical companies (Nicolaidis et al., 2010) and concerns about medication side effects, including the alteration of one's fundamental identity (Carpenter-Song, 2009), have all been cited as factors in reducing use of and adherence with psychotropic medications among African Americans. As noted in the discussion of ADHD, the perceived effects of these medications may reflect White society's norms for compliant and minimally expressive behavior (Carpenter-Song, 2009; McGill & Pearce, 2005; Searight & McClaren, 1998)—leading Szasz (2000) to refer to pediatric psychopharmacology as "a chemical straightjacket."

While training in cultural diversity has been emphasized in both mental health and medical education, data suggest that enhanced cultural knowledge has not led to consistent increased use of behavioral health services among ethnic and cultural minorities. Diversity has often been taught as a body of knowledge about cultural differences with less attention to the long-standing burden of discrimination, oppression, and economic disadvantage. At the clinical level, recent approaches to patient assessment include attention to the heightened social vulnerability of minority patients.

Writing from the perspective of medical education, Stonington and colleagues (2018) suggest that health sciences students' clinical instruction in taking a patient's social history should include attention to broader social forces, such as health risks associated with poverty, discrimination, and inequality. In this regard, Bourgois, Holmes, Sue, and Quesada (2017) developed a structural vulnerability assessment tool for systematically assessing the impact of larger social forces on patients' health. In addition to inquiring about food security, adequate housing, and exposure to violence, the structural vulnerability social assessment also includes questions about the experience of discrimination ("Have you experienced discrimination based upon your skin color, your accent, or where you are

from?") (Bourgois et al., 2017, p. 12). The structural vulnerability protocol also encourages clinicians to reflect on their own reaction to patients by (silently) asking themselves, "May some service providers (including me) find it difficult to work with this patient?" with specific follow-up, self-directed, reflective questions: "Could the interactional style of this patient alienate some service providers, eliciting potential stigma, stereotypical biases, or negative moral judgments?"; "Could aspects of this patient's appearance, ethnicity, accent, etiquette, addiction status, personality, or behaviors cause some service providers to think this patient does not deserve/want or care about receiving top quality care?"; "Is this patient likely to elicit distrust because of his/her behavior or appearance?"; "May some service providers assume this patient deserves his/her plight in life because of his/her lifestyle or aspects of appearance?" (Bourgois et al., 2017, p. 302).

Bourgois et al. (2017) also challenge clinicians to go beyond the individual patient and provide medical leadership by addressing policies that impact the health of vulnerable populations. In addition to enhancing clinical care of individual patients, proponents of including structural vulnerability as part of health care encourage clinicians to address the underlying social inequalities contributing to the patient's medical and mental health concerns. In the 1960s, recognition of unequal access to health care led to the establishment of federal funding for community health centers. More recently, one of the originally stated objectives of the Affordable Care Act ("Obama Care") was to address health-care disparities, with particular attention to uninsured African Americans. The ACA, despite being repeatedly challenged by Congress and in the courts, has been successful in this regard—particularly among African Americans. In his recent analysis, Metzl (2019) found that as a group, African Americans viewed the ACA much more favorably than his comparison group of White lower- and middle-income males.

It was expected that the ACA would make mental health care more accessible to minorities through the expansion of Medicaid government subsidies for insurance premiums as well as additional provisions to the Domenici-Wellstone Act establishing parity for mental health and general medical insurance coverage (Creedon & Cook, 2016) While early data indicate that the ACA's implementation was associated with increased mental health service use among White, Hispanic and Asian Americans, African Americans' utilization of behavioral health services remained the same (Creedon & Cook, 2016). With increased access, greater sensitivity to minority issues, use of health-care navigators as advocates (Searight, 2019) and the increased attention to cultural diversity, the ACA, if it survives, could eventually lead to greater use of mental health services among African Americans.

However, given the lengthy history of medicine and mental health intervention as tools of social control, a substantive, public process may

be required to reduce African American distrust in the medical community. A policy approach that is gaining political support is the concept of government-funded reparations for slavery and its psychosocial sequelae (Graf, 2017). While the psychiatric coercion described in this chapter can, in many cases, be seen as the sequelae of slavery, many of these issues are not well known to the general U.S. population. A program of restorative justice provides support to victims of discrimination and immediate family members but is also an opportunity for victims to educate the public. Perkiss (2008) describes restorative justice as including two basic dimensions: "(1) the victims must have the opportunity to share their experiences and to tell their stories, and (2) the perpetrator (s) must both acknowledge that experience and atone for it" (Perkiss, 2008, pp. 86–87). Perkiss (2008) uses the Tuskegee syphilis study as an example, suggesting that President Clinton's belated apology was insufficient as a response, and raises the possibility of a restorative justice program, including a public acknowledgment of the abuse of trust, harm caused, and a venue for educating the greater population about the study and its historical significance. A similar process was carried out in South Africa to address the abuses of apartheid. Similarly, the Canadian government supported a restorative justice program with multiple televised hearings to address the abuse of Indigenous children occurring in the Indian Residential Schools (Park, 2016). These examples could form a loose blueprint relevant to addressing the U.S. history of medical and psychiatric harm perpetrated on the African American community.

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Index

Acculturation, 128, 134, 150, 197–201. *See also* Enculturation
ADHD, 57, 228–229, 231
Advocates, 54, 60, 64, 67
Alcohol, 82–83, 129, 218
Allies, ix, 37, 149, 177, 204; alliance(s), x, 9, 22, 87, 107, 112, 168, 210
American: African, 4–5, 97, 102, 104, 107, 111, 199, 202, 205, 215–218, 222–225, 228, 230–232; Asian, 78–79, 84, 126, 129, 133, 135, 187–207, 209–210, 230, 232; Black, xi, 168, 218, 224–225; Chinese, 191, 193, 200, 206–207; dream, 96, 105, 109–110; Filipino, 125, 127–137, 140–141, 143–150; Hispanic, 35, 97, 102, 104, 107, 132, 169, 232; Japanese, 190, 193, 204; Korean, 202; Latina(o/x), 3–4, 54, 58, 65, 98, 104, 132, 194, 200, 202, 205, 238; Pacific Islander, 125, 131–132, 191, 193, 195, 205–206, 210. *See also* Indigenous; Myth(s), of meritocracy; White
American Psychological Association (APA), 23–24, 73–74, 87–88
Antebellum, 214, 216, 224, 228–229
Anti-fa(cists), 173, 180
Antipsychotic. *See* Psychosis
Anxiety, 4, 6, 33–35, 55, 75, 77, 83–84, 101, 113, 129, 131, 168, 199, 219
Apartheid, 172, 233
Arendt, Hannah, 174, 178
Assessment, 57, 231; diagnostic, 207; screening tool, 13
Asylum(s), 217, 219–220
Authoritarianism, 2, 10, 174

Bankruptcy, 103
Bias(es): explicit, 106; implicit, 35, 96, 105–106; racial, 13, 41, 100–101. *See also* Prejudice
Biracial, 131–132, 206. *See also* Multiracial
Boggs, Grace Lee, 204

Cartwright, Samuel, 215–216, 224
Charlottesville, 159–161, 165, 173, 175–176, 179
Chin, Vincent, 190, 193–194
Chinese Exclusion Act, 187, 190, 192, 207
Civil Rights. *See* Rights, civil
Civil War, 161, 179, 214, 217
Clark, Kenneth and Mamie, 66
Cognitive processes, 6, 86; cognitive dissonance, 1–2, 6–7, 14, 167; cognitive miser, 1–2, 6–7; self-serving biases, 1, 6, 8; system justification, 1–2, 6–7, 11

Colonial, 129–130, 150
Color blindness, 66, 85–86
Community(ies), xi, 27, 51, 53, 56–57, 60, 67, 87–88, 99, 103, 113, 126–127, 130, 136, 171, 174, 188–189, 199; African American, 204, 213–215, 217, 219, 222–223, 225, 230, 232–233; Asian American, 125, 189, 193, 194–196, 200, 202–203, 205–208; diverse, 148, 194, 197, 205–206, 209; far-right, 172; Filipino American, 130–131, 135, 147–150; hard-to-reach, 149; health center, 103; Korean American, 204; LGBTQ, 108; minority, 114; Pacific Islander, 125, 208–209; psychiatric, 217; virtual, 171; White, 52. *See also* Neighborhood(s)
Concientización, 50–51, 61, 63
Connectivity, x–xi
Coronavirus, 5, 187, 190; COVID-19, x, 190–191. *See also* Pandemic
Counseling, 40, 226; multicultural, 25–27. *See also* Therapy
Cultural: competence, 25–27, 40; diversity, 231–232; humility, 25, 27, 148, 198, 207

Depression, 35, 55, 77, 83, 101, 111, 113, 127, 129, 131, 163, 196, 218; suicide, 33, 102, 129, 196, 198, 218
Disability, x, 8, 23, 30, 60, 98, 100, 110, 179, 220
Disparity(ies): economic, 33, 55, 97–98, 202; education, 2, 195; health, 9, 12, 95, 125–126, 129, 149, 207–208. *See also* Incarceration; Inequity
Drapetomania, 215–217, 228, 230
Du Bois, W. E. B., 28, 55
Duke, David, 165

Education. *See* Schools; Students
Egalitarianism, 2, 8–9
Emancipation, 217–220. *See also* Slavery
Empower, 51, 60, 62–63, 66, 81, 86; empowerment, 60, 64, 75
Enculturation, 130, 133–134, 136–144, 197–198, 201. *See also* Acculturation
Ethnic, identity, 150, 200
Ethnicity, ix–x, 1, 3, 5–6, 23, 27, 29–32, 35, 81, 109, 127, 131–132, 149, 165, 173, 179, 192, 201, 232; ethnic minorities, 5, 7, 80, 110, 163. *See also* Race
Eugenics, 171, 178, 180
European(s), 2, 162
Evolutionary, 1–2, 8–9, 14; environment of evolutionary adaptiveness, 8
Extremism, x, 159–160, 164, 168, 172–175, 177. *See also* Hate groups; White, power

Family, 22, 30, 54, 96–97, 100, 110–111, 129, 134, 146, 149, 166, 177, 189, 191, 194, 196–201, 204, 208, 218, 220, 224–227, 233; structure, 225, 227

Galt, John, 219–220
Gender, x, 1, 4–5, 7, 9–10, 12, 23, 29–30, 100–101, 106, 128, 132, 159, 173, 179, 195, 200; feminism, 178; feminist, 31; identity, 30, 166, 179; inequality, 3; masculinity, 166; nonconforming, 67, 131; stereotypes, 3; transgender, 67, 201, 205, 238
Godboldo, Maryanne, 213–214
Guatemala, research in, 230. *See also* Tuskegee Syphilis Study

Hannah-Jones, Nikole, 52–53
Hate groups, 159, 165, 175. *See also* Extremism; White, power
Hays, Pamela, 30
Hierarchy(ies), 8–9, 11, 14, 84–86, 161; racial, 52, 61, 162, 175
Hirabayashi, Gordon, 204
Holistic, x, 160, 213
Homelessness, 107, 112; Housing First, 112
Hopelessness, 32, 34–35, 225, 230
Hsu, Helen, 197

Immigrant(s), 109, 129, 146, 149, 162, 165–166, 170, 172, 180, 190, 192, 194, 199, 202, 205; immigration, 134, 159–160, 162–163, 165, 168, 172–173, 177, 192–193, 195, 206–207. *See also* Refugee(s)

Implicit Association test (IAT), 13, 80
Incarceration, 59, 95, 103–105, 109–110, 114, 126, 168, 176–177, 193; incarcerated, 57, 104–105, 108–109. *See also* Trauma, of incarceration
Indigenous, 29–31, 198, 218, 233; Alaska Native(s), 95, 102; American Indian(s), 102, 107, 191; Native American(s), 54, 78, 95, 132, 194, 202, 205; Native Hawaiian(s), 102, 193, 195, 197, 202–203, 205–207
Inequity(ies): cycle of, 95; educational, 99; health, 95, 100, 125–126, 128, 149; racial, 8, 50, 55–56, 61, 65–66, 73, 176; resource, 65; socioeconomic, 102; wealth, ix
Insurrection, 164
Internment, Japanese Americans, 168, 187, 190, 193, 207
Intersectionality, x–xi, 31, 63, 178, 201

Jarvis, Edward, 217
Jim Crow, 168
Justice: criminal, 10, 13, 104, 228; social, ix, xi, 23–25, 27, 40–42, 50, 66, 87, 176, 188, 191, 201, 204–205, 209

Kerner Commission, 227
King, Martin Luther, Jr., 125, 223
King, Rodney, 196, 204
Kochiyama, Yuri, 73, 203
Korematsu, Fred, 204

Lacks, Henrietta, 220
Leader(s), 135, 147–148, 163, 195, 209, 223; civil rights, 204, 223, 226; leadership, 4, 149, 171, 195, 232; white supremacy, 159, 165, 168, 174, 176–177, 179
Lynching(s), 97, 168, 191–192

Marginalization, 36, 50, 76, 78, 86, 96, 105–107, 188, 201, 204
Martín-Baró, Ignacio, 50, 61–62
Masculinity. *See* Gender
Media, xi, 12, 106, 129, 160, 171–172, 174–175, 192, 195, 207, 210; social, 87
Medical: care, 103, 135; racism, 216; school(s), 215
Mental illness stigma, 106–107, 114. *See also* Psychiatry; Psychology
Microaggressions, x, 35, 73–88, 126–127, 130, 187, 190, 194, 197, 201, 208; microinsults, 76; microinvalidations, 76
Miscegenation, 168, 193
Moynihan Report, 225–227
Multiracial, 33, 54, 131–132, 177. *See also* Biracial
Myth(s), 9–10, 14, 36; of meritocracy, 7, 36, 96, 105, 109, 199; model minority, 128, 187, 189, 196, 198–199, 203, 206; of racial superiority, 170. *See also* American, dream

Nationalism, 162, 164–165, 168, 172, 178, 222. *See also* Populism
Neighborhood(s), 52, 98–99; Black, 98; White, 33

Obama, Barack, 159, 167, 172, 180, 232
Omar, Ilhan, 194
Oppression, 23–29, 31–32, 34, 36–37, 40, 42, 50–51, 60–64, 67, 85, 97, 109, 126, 130, 175, 177, 200–201, 205, 231

Pandemic, x, 103, 190. *See also* Coronavirus
People of color, ix–x, 32–33, 52, 73–84, 86–88, 125–128, 148–149, 168, 187, 199–200
Personality, 2, 9, 11, 13, 222, 225, 232
Police, 10, 13, 108, 213; brutality, 168, 222; law enforcement, 13, 54, 174; shootings, 13
Populism, 162–164, 179. *See also* Nationalism
Post-Traumatic Stress Disorder (PTSD), 105
Poverty, x, 49, 51–52, 71, 95–102, 104–105, 107–115, 159, 176, 195, 197, 203, 222, 226, 228, 231
Prejudice, ix–x, 3, 10, 24, 26, 52, 58, 66, 82, 106, 165, 169, 188, 203, 209. *See also* Bias
Privilege, ix–xi, 8, 21–42, 50, 62, 65, 67, 86, 97, 170, 200–201; entitlement, 33

Psychiatry, 213–214, 216, 222, 224, 230; psychiatric, 98–99, 101–103, 112, 215–219, 221–222, 224, 226, 228–230, 233; psychotropic medication, 228–229, 231
Psychological: bandaging, x; consequences, xi, 11, 199
Psychologists, 21, 23–32, 36–37, 39–42, 50, 61, 65–67, 175–176, 189, 205–206; White, 26, 34–35
Psychology: clinical, 23, 39–41; counseling, 40; developmental, 34, 38–40, 220; liberation, x, 49–51, 55–56, 60–61, 63, 65–67, 71; multicultural, 25, 27, 40; personality, 2
Psychosis, 101, 218, 220, 223–225; antipsychotic(s), 213, 224, 227, 229; protest, 224; psychotic, 101, 104. *See also* Schizophrenia
Psychosurgery, 227–229

Race, ix–x, 1, 4, 7, 10, 12, 23, 29–31, 33, 35–36, 54, 58, 62, 66, 73, 81, 85, 88, 95, 105, 109, 111, 127, 131, 133, 149, 159, 160, 162, 167–169, 171, 173, 178–179, 192–193, 195, 199, 201, 207, 219, 221–222; critical race theory, 62, 75; racial socialization, 74, 79, 81–82; relations, 84, 169, 192, 199; riots, 160, 227; war, 171, 174, 180. *See also* Ethnicity, ethnic minorities; Hierarchy(ies), racial
Racism: insidious nature of, 54, 60, 74, 85, 87, 169; institutional, 52–56, 59, 62, 64; media-based, xi. *See also* Medical, racism; Xenophobia
Railroad, 189, 191
Refugee(s), 128, 174, 177, 187, 190, 197, 200–201, 203. *See also* Immigrant(s)
Religion, x, 23, 29–30, 128, 130, 160, 173, 175, 179, 201
Resilience, ix, xi, 60, 207–209; resiliency training, 113
Restoration, 34
Rights, 7, 23, 51, 166, 168, 173, 190, 193; civil, ix, 49, 71, 160, 169–170, 176–177, 180, 191, 221–226; human, 177; voting, 168, 177, 180

Schizophrenia, 101–102, 104, 114, 217–218, 220, 223–224. *See also* Psychosis
Schools, x, 3, 12, 49–57, 59–66, 98–100, 108, 112, 177, 215, 228; administrators, 52–54, 58–61; Indian Residential, 233; teachers, 3, 51–59, 62, 99–100, 113. *See also* Students
Self-esteem, x, 66, 73–88, 107, 206–207, 226
Self-fulfilling prophecy, 1–3, 5–6
Sexual orientation, x, 4, 6, 8, 12, 23, 29–30, 173, 179, 195; gay, 201, 205; lesbian, 201, 205
Slavery, 31, 97, 215, 217–221, 233
Social: cognition, 1, 7–8; determinants of health, 96, 126; dominance, x, 2, 9
Socioeconomic: class, 105, 109–110; status, x, 1, 24, 29, 101–102, 104, 107, 111, 128
Southern Poverty Law Center, 159, 176
Spencer, Richard, 162, 167, 176
Stereotype, threat, 1–6, 78
Stress, 26, 33–34, 36, 55, 74–81, 87, 96, 102, 105, 113, 127, 129–131, 150, 196–199, 208, 216, 218, 224
Students, 3–5, 12, 49–65, 67, 75, 78–79, 99–100, 108, 112–113, 164, 175–176, 201, 222; academic success of, 56, 60, 67; first-generation, 12; graduate, 199, 206–209; health sciences, 231. *See also* Schools
Sue, Derald Wing, 26, 34
Suicide. *See* Depression

Tea Party, 163, 166, 180
Technology, 113
Terrorism, domestic, 171–173, 175, 178, 180. *See also* White, power; White, resistance; White, supremacy
Testing. *See* Assessment
Therapy, 26–27, 41–42, 59, 226; for Black girls, 88; cognitive behavioral, 113; family, 240; physical assault as, 216; psychodynamic, 218; psychotherapy, 41; work as, 218, 220–221. *See also* Counseling
Transgender. *See* Gender, transgender
Trauma, 96, 105; cultural, 193; historical, 190, 193, 202, 207; of

incarceration, 105; insidious, 197, 208; psychological, 193; racial, 38, 193
Truman, Harry, 221
Trump, Donald, 159, 165, 167, 172, 179–180, 190, 194
TSA (Transportation Security Administration), 21, 23
Tseng, Vivian, 196, 202
The Turner Diaries, 168–169, 171
Tuskegee Syphilis Study, 230, 233. *See also* Guatemala, research in

Violence, 53, 96–97, 106, 108, 160, 166, 173–175, 180, 187–188, 190, 208, 227–228, 231; anti-Asian, 190–192, 194; anti-immigrant, 191, 194; family, 204; gun, 177; mass, 168–169, 171–172; murder(ed), 150, 165, 173, 190, 192–193; state-sanctioned, 168; white nationalist, 180

Well-being, ix, 6, 11, 33, 50, 83, 107; economic, 221; psychological, 83, 216; wellness, ix, 65, 98, 148, 150, 189, 196, 208–209
White: fragility, 33; hegemony, 39; millennials, 35; power, x, 159–161, 165, 167–168, 170–173; resistance, 52–53, 58, 65; superiority, 62, 129, 180; supremacist(s), 160–161, 177; supremacy, 160, 171–172, 174–176, 178, 203. *See also* Terrorism, domestic

Xenophobia, 191

Yasui, Minoru, 204
"Yellow peril," 192