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Racism and Invisibility: Race-Related Stress, Emotional Abuse and Psychological Trauma for People of Color

Anderson J. Franklin
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SUMMARY. This article presents an overview of the complex experiences of racism and the invisibility syndrome as they relate to issues of race-related stress, emotional abuse, and psychological trauma for people of color. Racism, through domination, power, and White privilege, is manifested in its individual, institutional, and cultural forms. Race-related stress is discussed as an outcome of perceived racism creating emotional abuse and psychological trauma. Consequences of racism are considered for family and couple relationships. A case example is presented illustrating the issues of racism in the professional and personal development of a staff member in a mental health agency. Examples of

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interventions to combat racism are given, such as identifying resilience and strengths of people of color, and the role of the antiracist movement.
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KEYWORDS. Racism, White privilege, invisibility syndrome, microaggressions, race-related stress, antiracist movement

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This article presents an overview of racism and its complexity. It focuses upon understanding the role that power and White privilege play in the treatment of people of color. The creation of an invisibility syndrome and the experience of emotional abuse and psychological trauma are also explored. Acquiring strategies of resilience and antiracist training are presented as a means of combating racism.

Racism is complex and not easily defined because of the different levels of meaning, beliefs, and acts associated with the concept. Based on erroneous principles of racial superiority, it bestows power and privilege on those who define, enforce, and establish the institutional mechanisms that maintain it. Jones (1997) argues that racism formalizes "the hierarchical domination of one racial group over another" (p. 11). It is an overarching orientation toward people and groups that creates attitudes and sanctions acts that express specific negative views of others. Racism is defined by Harrell (2000) as

> A system of dominance, power, and privilege based on racial-group designations . . . where members of the dominant group create or accept their societal privilege by maintaining structures, ideology, values, and behavior that have the intent or effect of leaving nondominant-group members relatively excluded from power, esteem, status, and/or equal access to societal resources. (p. 43)

Jones (1997) disentangles the confusion in understanding the definition of racism by discussing the centrality of prejudice and discrimination to the concept. He defines prejudice as "a positive or negative attitude, judgment, or feeling about a person that is generalized from attitudes or beliefs held about the group to which the person belongs" (p. 10).

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Implicit in prejudice is the tendency to attach one-dimensional attributes or stereotypes to the person at the expense of all other characteristics. This tendency to hold a fixed view of others results in a failure to see the diversity within groups or the individuality of its members. Moreover, the victim of prejudice often feels indignant because he or she has been classified into a category and not judged according to his/her own characteristics.

The consequences of prejudice become apparent only in exposing patterns of discrimination, which constitute another important facet of racism. Jones' (1997) definition of discrimination "consists of negative behavior toward a person based on negative attitudes one holds toward the group to which that person belongs, or, positive behavior toward a person based on positive attributes one holds toward the group to which that person belongs" (p. 11). The important element in discrimination is its conversion of prejudice into specific behaviors or acts. Those acts, resulting from narrow attitudes and feelings about a group, are an expression of the individual's personal prejudices. Acts can be legalized or organized forms of prejudice through institutional policies, laws, or other group practices. Segregation and inequities in housing or employment are examples. Racism therefore includes prejudice and discrimination as elements that help manifest it.

INDIVIDUAL, INSTITUTIONAL, AND CULTURAL RACISM

Jones (1997) identifies three different domains of racism, which are its individual, institutional, and cultural forms. *Individual racism* includes the attitudes and acts that express a person's prejudices. This form of racism is located in the individual's interpretation of his/her feelings about other people. People draw upon the prevailing attitude of their group toward others utilizing mechanisms within the larger society to support their individual beliefs, and to discriminate in accordance with those beliefs. *Institutional racism* is the process whereby individual racist beliefs, nurtured by convictions of power and authority, are converted into discriminatory policies and procedures of the institution. These policies manifest in the conscious or unconscious prejudicial feelings of the dominant group towards others. Through biased policies, institutions help maintain the advantages of one group and restrict the access of another group to valuable resources and opportunities. *Cultural racism* is the result of the privileged group's power to determine values, beliefs, attitudes, and practices so that they

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become legitimate expressions of its culture. It makes preferences and behaviors of the dominant group an intrinsic part of the social fabric, and sets the boundaries to be observed for acceptance or non-acceptance of others. Thus, cultural racism creates an environment that lets certain prejudices and discrimination appear natural and part of everyday behavior, as occurred with slavery in America and apartheid in South Africa. Individual, institutional, and cultural racism all breed White privilege.

WHITE PRIVILEGE

By the preeminence of cultural racism, White privilege becomes a presumed benefit of group membership. Since it is greatly determined by skin color, White privilege begins at birth and accrues benefits throughout the life span. White privilege therefore refers to unearned resources and/or power held by Whites. It results from acts of individual, institutional, and cultural racism that keep the advantage of Whites while marginalizing people of color. These unearned resources and power tend to be unacknowledged and bolstered by notions of superiority versus fairness. The disparities in advantage are only revealed, for example, when employment, educational, and health statuses of non-Whites are compared to Whites. McIntosh (1998) states that, "Whites are carefully taught not to recognize White privilege, as males are taught not to recognize male privilege" (p. 148). Similarly, Bowser and Hunt (1996) note that some Whites see racism as a "Black" problem, and thus they do not claim any personal ownership in the creation of the aforementioned disparities. The superiority of Whites, therefore, is often consciously, or unconsciously, assumed and promoted as their right. Since so many privileges are taken for granted, their expectation and benefits are often not stated explicitly and can easily be denied. Non-Whites, with less power and resources, are often put in the position of protesting unfair standards created by institutions controlled by Whites. Their protests are often dismissed as unworthy, or ignored because of the underlying challenge to White privilege. This process further excludes people of color from the privileges that Whites enjoy. When they are repeatedly placed in situations of this type, people of color can feel that their true talents and abilities are overlooked and undervalued as if they are invisible.

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THE INVISIBILITY SYNDROME

Cumulative experiences of confronting race-related stress, emotional abuse, and the psychological trauma of racism can lead to the development of the invisibility syndrome (Franklin, 1999, 2004; Franklin & Boyd-Franklin, 2000). Symptoms of the syndrome are an outcome of psychological conditions produced when a person perceives that his or her talents and identity are not seen because of the dominance of preconceived attitudes and stereotypes. Persons of color experience this as a slight or microaggression (Franklin, 2004; Pierce, 1995). Unresolved psychological injury from slights can create debilitating symptoms. According to Franklin (2004), such debilitation from slights "limits the effective utilization of personal resources, the achievement of individual goals, the establishment of positive relationships, the satisfaction of family interactions, and the potential for life satisfaction" (p. 11).

Microaggressions and Everyday Racism

Slights are fundamental to the invisibility syndrome. They provoke indignation and emotional upset because they are acts based upon biased attitudes and beliefs. These acts are considered "microaggressions" (Pierce, 1995). Interpersonal interactions that take no genuine notice of the other person are unsettling, and can create disillusionment or confusion. Microaggressions, therefore, are acts of disregarding the person of color based on biased beliefs. Recipients of these acts of slight, as with other racist treatment, feel invisible in its rejection and disrespect of their personhood (Franklin & Boyd-Franklin, 2000; Pierce, 1995). People of color experience microaggressions as consistent with previous treatment of disrespect and injurious to their self-esteem. Repeated experiences of such slights, which come periodically but inevitably, require anger management and the resolution of the emotional upset from the incident. Inability to successfully resolve the upset from perceived recurring slights can cause mental health problems such as race-related stress, chronic indignation, depression, or substance abuse (Franklin, 2004).

Another problem related to such slights is internalized racism, wherein people of color begin to believe in their own inferiority and accept negative views disseminated in society about their racial group (Kelly, 2004). Kelly's data have shown that a variety of internalized racist views held by some African Americans are associated with increased symptoms of psychological distress.

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Essed's (1991) research has further documented the experiences of "everyday racism" in the lives of people of color. On a daily basis, ethnic minorities must cope with overt as well as covert manifestations of racism on institutional, individual, and cultural levels (Jones, 1997). Overt and covert forms of everyday racism in the lives of people of color include ethnocentrism, harassment, humiliation, and institutional practices that restrain their goals and aspirations (Essed, 1991; Sanchez-Hucles, 1998). These constant experiences wear away at the psyche and can result in a cumulative experience of psychological trauma and emotional burnout over time.

PERCEIVED RACISM

Researchers and scholars have identified perceived racism as a major contributor to the race-related life stress experienced by people of color (Clark, Anderson, Clark, & Williams, 1999; Essed, 1991; Harrell, 2000; Jones, 1997; Sue, 2003; Thompson, 2002; Utsey, Chae, Brown, & Kelly, 2002). Harrell (2000) has indicated that these experiences with racism can be pervasive because they are embedded within the "interpersonal, collective, cultural-symbolic and sociopolitical contexts" (p. 44). As Jones (1997) points out, however, the vestiges of modern racism are often manifested on an institutional level and are so pervasive and entrenched within American society that they are essentially invisible to many White Americans. They are obscured by White privilege.

Clark et al. (1999) have demonstrated that the perception of racism is the most important aspect of its impact. They have defined perceived racism as the "subjective experience of prejudice or discrimination" (p. 809). The recognition that racism need not be proven "objectively" in order to produce stress was a very important step forward in research on this topic. Harrell (2000) has clarified the linkage between this subjectivity, perceived racism, and race-related stress:

> The subjective judgment of the individual is the critical point of analysis in understanding the impact of racism on well-being. However it is not uncommon for experiences of racism to be questioned or challenged by others. Such requests for "proof" can create a my-perception-against-yours dilemma that may include accusations of paranoia, hostility, oversensitivity, manipulation, self-serving motives, or having a chip on one's shoulder (Essed, 1991). Thus, the stress–and potential damage–of racism lies not

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> only in the specific incident, but also in the resistance of others to believing and validating the reality or significance of one's personal experience. (pp. 44-45)

RACE-RELATED STRESS

Harrell's (2000) research has identified six types of stress related to individual, institutional, and cultural racism. These stressors can lead to intense emotional and psychological reactions in people of color that might include anxiety, anger, a sense of vulnerability and sadness. *Racism-related life events* are significant life experiences with racism that often involve overt discrimination. *Vicarious racism experiences* may not occur directly to the individual but to friends or family members. They can also involve strangers, such as the 1998 dragging death of James Byrd, Jr., a Black man in Jasper, Texas. *Daily racism microstressors* are frequent reminders that one's race matters through little acts of slights or exclusion. Pierce (1995) and Franklin (1999, 2004), as previously noted, refer to this as microaggressions. *Chronic-contextual stress* is related to societal structural inequities and diminished opportunities for people of color. In addition, Harrell (2000) points out that the experience of being the "token" or "the only one" in predominantly White settings can lead to increased stress for people of color. *Collective experiences* involve perceptions of discrimination towards one's racial group as represented by ongoing disparities in the distribution of political power, wealth, and socioeconomic status. *Transgenerational transmission* is stress associated with the legacy of racism for many people of color. Harrell (2000) argues that one must understand the experience of each racial/ethnic group within the context of their history of treatment in America. Many researchers and scholars have documented that transgenerational traumas such as slavery, oppression, segregation, and discrimination can be transmitted through stories and "collective memory" (Crawford, Nobles, & Leary, 2003; Klonoff & Landrine, 1999; Marsella, Friedman, Gerrity, & Scurfield, 1996; Root, 1992).

Post-Traumatic Slave Syndrome

Some scholars believe the legacy of trauma from slavery transcends generations, creating residual effects that are manifested in present behavior. *Post-Traumatic Slave Syndrome* is a conceptual framework provided by Leary and colleagues (Crawford et al.,

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2003; Leary, 2002) to describe the multigenerational trauma experienced by African Americans as a result of slavery and their past and present experiences of racism and discrimination. These injustices have created distinct psychosocial outcomes. Leary (2002) argues that these emotional and psychological traumas transmitted intergenerationally have never healed, and continue to have psychological consequences for African Americans. Some examples are a lack of self-esteem, or the anger and violence currently seen in some young African American males.

RACISM-RELATED EMOTIONAL ABUSE, PSYCHOLOGICAL TRAUMA, AND PTSD

Sanchez-Hucles (1998) clarifies that racism can be a form of emotional abuse and trauma for ethnic minorities because it involves negative, rejecting, and/or demeaning societal messages that undermine self-esteem. Building on the work of Hart, Germain, and Brassard (1983), Sanches-Hucles describes emotional abuse as "consisting of both acts of commission and omission that are psychologically damaging and can be perpetuated by groups or by individuals" (p. 73). Emotional abuses can adversely impact one's affective, behavioral, and cognitive functioning.

According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000), some instances of emotional abuse or psychological trauma can be justifiably diagnosed as Post Traumatic Stress Disorder (PTSD). The DSM-IV-TR discusses cultural aspects of PTSD in terms of immigrants' experiences of psychological trauma from abuse (e.g., torture) in their countries of origin. However, it does not discuss racism as a trauma despite the fact that racism can be extreme and catastrophic (Butts, 2002). Some argue that racism-related aspects of trauma may operate in ways that are different from classic PTSD (Marsella, Friedman, & Spain, 1996; Sanchez-Hucles, 1998). In particular, the DSM-IV-TR specifies that traumatic events must involve actual or witnessed "death, serious injury or threat to one's physical integrity" (American Psychiatric Association, 2000, p. 463). Yet Sanchez-Hucles (1998) notes that "the trauma and emotional abusiveness of racism is as likely to be due to chronic, systemic, and invisible assaults on the personhoods of ethnic minorities as a single catastrophic event" (p. 72).

A number of scholars, clinicians, and researchers have argued for expanding the definition of PTSD to include responses to racism by peo-

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ple of color (Allen, 1996; Butts, 2002; Marsella, Friedman, Gerrity et al., 1996; Root, 1992; Sanchez-Hucles, 1998). Root (1992) describes the trauma of racism as "insidious trauma." Sanchez-Hucles (1998) and Root (1992) both argue that current trauma theory and definitions of PTSD "fail to address the accumulated effects of devalued status for ethnic minorities that begins upon birth, persists through a lifetime, and carries threats to individuals' well-being even when actual violence is not acted out" (Sanchez-Hucles, 1998, pp. 78-79). Butts (2002) notes that the origins of trauma related to PTSD in the DSM-IV-TR are not inclusive enough. In his opinion, racial/ethnic discrimination experiences can result in symptoms associated with a diagnosis of PTSD.

Carter, Forsyth, Mazzula, and Williams (2004) have presented an important caution, however, against a blaming-the-victim approach to racism and PTSD. They clarify that the use of the term "disorder" locates the problem in the individual person of color. These researchers argue that "it is more accurate to assess the effects of racism (e.g., harassment and discrimination) as psychological and emotional injury than as mental disorder since the effects of racism come from the sociocultural environment, not from an abnormality that resides within the individual" (p. 12). They caution clinicians that diagnosing persons of color who have encountered race-related trauma with PTSD may lead to individual treatment strategies that may ignore the systemic, environmental, and institutional factors of racism.

Allen (1996) has established the link between racism, the trauma of urban community violence and PTSD. Hacker (1992) has argued that the persistent racism in America and its sociopolitical consequences have created a reality of trauma and deprivation in the lives of many persons of color, particularly those living in poverty. In fact, Hacker has referred to Black-on-Black violence as "self-inflicted genocide." Allen (1996) describes these experiences as "traumatogenic" (p. 216) and as major contributing factors in PTSD in inner-city, poor communities of color. He notes that the number of African American youth who have witnessed or experienced violence has added to the increase in violence in inner-city communities and to the increase in PTSD.

In this ongoing debate about racism and PTSD, it is important to note that the responses of people of color to racism-related trauma vary from person to person. Clearly, it would be unlikely that every person of color who experiences racism would also have PTSD. Other responses may include depression, anxiety, violence, problematic family and couple relationships, and medical symptoms. Many intervening variables may impact the extent of the psychological effects of racism, including

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the severity of the stressor. For example, the most at risk may be persons of color who have experienced or witnessed racial attacks or racial violence such as homicide, police brutality, or other events resulting in death or serious injury. It may also be helpful to explore the development of a new category such as "Reactions to Racism-Related Trauma" that would more broadly recognize the impact of racism without stigmatizing the victim. Risk factors such as poverty, mental illness, substance abuse, disabilities, and prolonged exposure to intense negative experiences with racism may all impact the response of a person of color. It is also important to recognize the impact of protective factors such as family and extended kinship networks, religion and spirituality, strong cultural values and racial identity, and personal strength and resiliency that may allow many people of color to rise above the debilitating, ongoing trauma of racism.

CONSEQUENCES OF RACISM

Effects on Mental and Physical Health

Clark et al. (1999) developed a biopsychosocial model demonstrating that when a person of color perceives an environmental stimulus as racist, it results in a sequelae of psychological and physiological stress responses that can seriously compromise both mental and physical health and well-being. A number of researchers have documented that racism is a unique source of stress impacting African Americans' mental health (Klonoff & Landrine, 1999; Utsey et al., 2002; Williams & Williams-Morris, 2000). Utsey et al. have shown that the stress of racism is associated with anxiety and major depression. African Americans report significantly more unfair treatment and chronic stress than Whites (Troxel, Matthews, Bromberger, & Sutton-Tyrell, 2003). The Surgeon General's Report entitled, *Mental Health: Culture, Race and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General,* has documented ethnic and racial disparities in mental health services (U.S. Department of Health and Human Services, 2001).

Experiences of racism and discrimination are also negatively associated with psychological and physical health (e.g., Bowen-Reid & Harrell, 2002; Carter et al., 2004; Jackson, Brown, Williams, Torres, Sellers, & Brown, 1996; Kwate, Valdimarsdottir, Guevarra, & Bovbjerg, 2003; Thompson, 2002; Troxel et al., 2003). There is a link between African Americans' racism-related stress and hypertension, heart disease, and

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poor functioning of the immune system (Brondolo, Rieppi, Kelly, & Guerin, 2003; Clark et al., 1999; Din-Dzietham, Nembhard, Collins, & Davis, 2004).

As a result of societal and institutional racism that has consistently led to inferior treatment for people of color by the medical field, disparities in health care have become a major health issue for the country (Allen, 1996). Johnson, Lee, Cook, Rowan, and Goldman (1993) compared African Americans and European Americans who presented with acute chest pain. Blacks in this study received a much lower rate of coronary bypass procedures than their White counterparts, irrespective of their socioeconomic level (Allen, 1996). Consistent with this finding, Kasiske et al. (1991), in their study of kidney, pancreas, and liver transplants, noted that fewer Black than White patients actually received these procedures (Allen, 1996). The AIDS epidemic is yet another example of these health care disparities (Allen, 1996; Boyd-Franklin, 2003; Hutchinson, 1992; Rockeymore, 2002; Smith, 1992). Allen (1996) and Smith (1992) describe AIDS as a devastating illness that is now the leading cause of death for Black men between the ages of 35 and 44. Boyd-Franklin (2003) and Rockeymore (2002) report that African Americans represent almost half (47%) of all U.S. AIDS cases while they comprise only 12% of the population. Hutchinson (1992) has indicated that the government's slow response to AIDS in minority communities is partly determined by racism (Allen, 1996).

The Effects of Racism and Poverty

The impact of racism contributes to conditions of poverty. Unemployment, underemployment, social and medical problems, and inequities in schools and financial lending institutions are as much consequences of racism as they are of poverty (Allen, 1996; Hacker, 1992). The unemployment rate in inner-city African American communities has had a devastating impact on the well-being of these individuals and their families (Allen, 1996; Wilson, 1996). Many of these chronically unemployed workers are no longer counted in national statistics and have become so discouraged that they have lost hope (Hacker, 1992). Such conditions have led some to become part of an underground illicit economy, such as selling drugs, in a desperate attempt to survive.

The statistics related to the disproportionate numbers of African American men in prison are staggering, and further represent the poverty dilemma. Allen (1996) considered this disproportional represen-

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tation as a result of endemic societal racism and a source of ongoing psychological trauma for many African Americans. He discusses Hacker's (1992) research that demonstrated that the percentage of Black men in prison had doubled from 22% to 45%. Research also reveals that one-fourth of African American men aged 20 to 29 are either in prison, on probation, or on parole, and that more African American men are in prison than in college (Prothrow-Stith, 1991, as cited in Allen, 1996). Franklin (2004) notes that Black men continue to comprise 45% of male inmates in federal, state, or local prisons. Moreover, now close to a third of Black males have had some official contact with the justice system. They are also "overrepresented in all phases of the juvenile justice process. Blacks are more than six times as likely as Whites to be sentenced to prison by juvenile courts" (Franklin, 2004, pp. 155-156). The disproportional representation of adolescents of color in the juvenile justice system is in sharp contrast to their White counterparts, who are far more likely to be referred for mental health services (Boyd-Franklin, 2003).

The trauma of racism begins early in life for people of color as is evident in inner-city school systems. Racism, particularly for African American males, has contributed to low teacher expectations, heavy reliance on biased standardized tests, the overrepresentation of African American males in special education, and the disproportionally large numbers of children of color who are diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and placed on Ritalin (Boyd-Franklin, 2003; Boyd-Franklin, Franklin, & Toussaint, 2001). Allen (1996), Hacker (1992), and Kozol (1991) have documented hyper-segregation in the majority of American public schools. Kozol (1991) found chronic underfunding of inner city schools serving African American children. These are examples of patterns of societal and institutional racism.

As discussed by McGlade and Ackerman (this volume), the child welfare system is another arena in which the traumatic effects of institutional racism have been documented. Roberts (2002) in her book, *Shattered Bonds: The Color of Child Welfare*, has thoroughly researched the disproportionate representation of Black children in the foster care system. Roberts clearly describes the processes of racism and racial injustice that result in the removal of children from struggling, poor Black families, while keeping White families with similar presenting problems intact.

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Consequences of Race-Related Stress and Trauma for Family and Couple Relationships

Racism clearly has an impact on family and couple relationships for people of color (Boyd-Franklin, 2003; Boyd-Franklin et al., 2001; Franklin, 2004; Kelly, 2003). Parents of color often report fear for their children, particularly their male children, when faced with such realities as racial profiling, police brutality, violence, and high homicide rates (Boyd-Franklin et al., 2001). African Americans and other parents of color have the challenge of developing positive racial identity in their children, while preparing them for the realities of racism in today's world (Stevenson & Davis, 2004). The additional challenge of this task is also cultivating in them a sense of efficacy and hopefulness in the midst of the continuing significance of racism across class levels.

Couple relationships are also profoundly affected by experiences of racism (Boyd-Franklin, 2003; Kelly, 2003). Racism and the invisibility syndrome of African American men affect the nature and quality of the couple's dynamics on all levels (Franklin, 1999, 2004). A number of researchers have discussed the relationship between experiences of racism, unemployment rates of Black men, the shortage of African American men, and the decline in marriage rates among African American couples (Taylor, Jackson, & Chatters, 1997; Tucker & Mitchell-Kernan, 1995). Racism has also influenced the racial identity dynamics in Black couples (Kelly & Floyd, 2001), the socialization of African American males and females, the complex and often contradictory gender messages that they receive, gender roles, and the dynamics of power in Black couples (Boyd-Franklin, 2003). All of these dynamics have major clinical implications for individual, family, couple and group treatment of African Americans and other people of color (Boyd-Franklin, 2003; Franklin, 1997, 1999, 2004; Kelly, 2003).

Racism and Middle Class People of Color

In the last 30 years, there has been a dramatic increase in the number of people of color who are middle class (Boyd-Franklin, 2003). Despite external manifestations of an improved lifestyle, however, many of these individuals and families still expressed that they felt a more subtle and covert form of individual and institutional racism that can be equally emotionally abusive and traumatic (Boyd-Franklin, 2003; Cose, 1993; Feagin & McKinney, 2003; Hill, 1999). Many of these individuals, although earning good incomes, feel a constant sense of vul-

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nerability related to their own invisibility in the workplace (Franklin, 2004), the ongoing experience of the glass ceiling in terms of promotions and upper-level opportunities, and the continued experience of being the "last hired and first fired," particularly during times of economic hardship and downsizing (Boyd-Franklin, 2003; Cose, 1993; Feagin & McKinney, 2003; Hill, 1999).

Cose (1993), in his research on successful African Americans, discovered a tremendous amount of anger and rage about their daily encounters with multiple levels of racism. He reports the following types of experiences: the inability to fit in, low expectations by coworkers and supervisors, shattered hopes, faint praise, presumption of failure, coping fatigue, self-censorship and silence, and the fear of being forced to shed one's racial identity in order to succeed. Some of his respondents also reported feeling the pressure to keep quiet regarding the racist practices of their organizations.

Racism in the Mental Health Field

Although Cose (1993) addressed racism experienced by African Americans primarily in corporate America, many examples exist in other work environments, such as mental health and social service agencies (Markowitz, 1993; Rastogi & Wieling, 2004). The following example illustrates the experiences of a young African American social worker subjected to the subtleties of institutional and individual racism at work. (See Samuel-Young, this volume, for additional discussion of the impact of racism on helping professionals.)

Pamela: A Case of Race-Related Stress and Trauma

Pamela, a 27-year-old African American social worker and recent MSW graduate, began her first job in the field at a mental health agency in New Jersey. A well-trained clinician, she had received excellent evaluations in her graduate program and from her supervisors at her field placements. She had been pleased when she was offered this position because she knew that the clinic was in a poor, inner-city area. Her dream throughout her schooling had been to work with people of color in treatment. On her first day at the clinic, however, she was very surprised to learn that she was the only person of color on the social work and supervisory staff.

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During her years with the agency, most of her White colleagues went out to lunch and socialized together but did not include her. Despite the fact that she was naturally friendly and often reached out to the other social work staff, they seemed polite but distant. As a consequence of these experiences, Pamela felt very isolated. These experiences are not unusual for persons of color in predominantly White institutions.

When Pamela changed her hair to "locks," an Afrocentric hairstyle, her supervisor commented that some of the staff had suggested that it was "inappropriate" and raised concerns about her ability to "fit in" at the agency. This was an example of cultural racism because the norms of the agency only accepted a more Eurocentric style and required her to behave in ways that were in conflict with her own cultural practice.

In supervision, Pamela often attempted to discuss the cultural issues related to the treatment of her clients of color, but her supervisor was dismissive. Staff meetings and case conferences were particularly difficult for her. The majority of the staff viewed cases and clients through a very White, Eurocentric lens and was not open to her attempts to discuss cultural dynamics and related issues of diagnosis and treatment. At one meeting, a staff member referred to their clients of color as "those people" and added that they are "all abusive of their children." When Pamela raised a concern about this use of racial stereotypes, she was told that she was "too sensitive." She would make comments in meetings that were ignored. Often, later in the meeting another staff member would raise exactly the same point and it would be welcomed and discussed favorably. Some of the other clinical staff would come to her privately and acknowledge her concerns about the treatment of clients, but they would remain silent during the meetings. Her supervisor began giving her feedback that she was "too assertive and outspoken" at meetings, and "too obsessed with cultural and racial issues." Over time, she felt silenced, invisible, and marginalized.

At the end of her second year, in response to a mandate from a funding source, the agency began instituting cultural competency training. Despite this training, her colleagues seemed oblivious to issues of White privilege and subtle forms of racism at their agency. For example, several of the young White social workers were being mentored by the director and were being given opportunities for training that were important to their career development and their ability to apply for supervisory positions in the future. They were given the opportunity to present at conferences with senior staff and supervisors and were en-

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couraged to start a private practice. None of these opportunities for mentoring were ever offered to Pamela. She later learned that her salary was far less than many of the other social workers. The ability to find mentors and professional role models within our agencies is often a privilege that is unavailable to therapists of color.

As a benefit of the diversity training, the agency began a process of attempting to recruit other therapists of color. Pamela was often asked to be a part of the interviewing and recruitment of these candidates. A year later, when she raised the concern that very few persons of color were actually hired, she was told that they could not find "qualified" candidates, even though many were very qualified and had years of clinical experience. As a consequence of this institutional racism, she often felt like a "token," included only when the agency wanted to demonstrate its cultural sensitivity.

The cumulative effects of these microaggressions, everyday racism, experiences of invisibility, discrimination, institutional racism, and White privilege, were very traumatic for Pamela. Many of these experiences may have been unintentional on the part of her agency and her colleagues but the experience of racism led to increased stress and conflict for her. By the end of her third year, she began to feel depressed, overwhelmed, and burnt out. She was often angry. Although she loved her work with clients, she began to dread going into work. At night, she would often have nightmares about stressful work situations and would often relive the trauma during the day. Initially, she shared her experiences with her family and friends, who were sympathetic but had their own experiences of racism to share. She was so upset that she sought treatment to address this race-related stress and trauma. Despite her positive feelings for her clients and her sense that she was a good clinician, she began to look for another job and ultimately left the agency.

Pamela's experiences are very common among therapists of color in the mental health field and social service agencies. While the field has begun to address the issues of race-related stress, emotional abuse, and the trauma of racism related to the treatment of clients of color, the concerns of social workers, psychologists, child and family workers, and support staff of color have been largely ignored and "invisible" in the literature (Markowitz, 1993; Rastogi & Wieling, 2004). It is extremely important that their concerns be included in the dialogue if we are to create truly antiracist organizations.

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STRATEGIES IN COMBATING RACISM

Resilience and Survival Skills in the Face of Racism

In combating the stress, emotional abuse, and psychological trauma caused by racism, invisibility, and discrimination, it is important to remember the inner strength, resilience, personal and collective determination, and spiritual faith that have allowed generations of people of color to develop effective coping mechanisms and to survive these traumas (Boyd-Franklin, 2003). Resilience as defined by Masten, Best, and Garmezy (1990) is the capacity for successful adaptation despite challenging or threatening risks. These "culturally constructed modes of adaptation, first learned in the family and at school, become the foundation for resilience across the years of childhood and adulthood" (Cohler, Scott, & Musick, 1995, p. 785). In his seminal research on Black families, Hill (1999) documents the legacy of strengths that have contributed to this survival: strong kinship bonds, spirituality and religious orientation, flexible roles, strong educational and work orientation. Mullings and Wali (2000) show how vital these practices and social networks are to African American women who remain resilient in spite of obstacles from racism in getting reproductive health care and the demands of raising young children in Harlem. Boyd-Franklin (2003) describes the ways in which African Americans utilize their blood and non-blood extended family and friendship networks as a buffer against these traumas. Similarly, spirituality and religious orientation have often provided an opportunity for healing the pain of emotional abuse and psychological trauma. Clinicians can learn to utilize strong kinship bonds and spiritual beliefs to help clients and families deal with the trauma of racism. Other aspects of resiliency and strengths- based interventions are discussed further in Edwards (this volume).

Antiracism: Developing an Antiracist Ideology

Scholars and community activists have identified a number of steps in the development of an antiracist ideology (Chisom & Washington, 1997; Jones, 1997; Sue, 2003). Many of these authors agree that the first step, particularly for concerned Whites, is to educate oneself through reading and discussions with persons of color about the nature of racism in its individual, institutional, and cultural forms. Knowledge of White privilege is equally important because it is so intrinsic to American life

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that deleterious outcomes are often unrecognized and unacknowledged by many White individuals (McIntosh, 1998). Sue (2003) addresses the role of White people and persons of color in the process of moving toward antiracism. He encourages White individuals to take responsibility for learning about racism directly from people of color. He points out that America is still very segregated along racial and ethnic lines, in terms of real, intimate contact between groups, and argues that this contact is necessary outside of the workplace if change is to occur. This involves sharing mutual goals and working with others toward antiracist social change. Sue clarifies that this involves learning from constant vigilance of one's own stereotypes, prejudices, biases, and fears. It also involves the willingness on the part of Whites to speak out about these injustices, particularly in terms of institutional racism, and to take the risks to work with people of color for social change. Blitz (this volume) and Kohl (this volume) offer suggestions for White workers for exploring these issues. One powerful aspect of White privilege is the ability to choose not to get involved. In the case of Pamela, described previously, she often sensed that her White colleagues agreed with her concerns about their clients of color. They would even verbalize their agreement privately. A major antiracist act for these clinicians would be to speak out against policies based on institutional racism as they impact their work with clients and compromise colleagues and staff of color.

Clinicians who are committed to this work may find it helpful to seek out trainings that offer them the opportunity to expand their understanding of racism and to explore their own cultural experiences and values, as well as their own prejudices, within a safe environment. It is also important to participate in trainings and conferences that provide clinicians with the opportunity to explore the ways in which racism, race-related stress, and trauma may impact the lives of clients of color and strategies for addressing these issues in treatment. Those interested in pursuing these opportunities are encouraged to contact their national and local professional organizations in the fields of social work, psychology, psychiatry, and family therapy for information on continuing education programs in areas such as multiculturalism, cultural diversity, and antiracism.

Chisom and Washington (1997) in their book, *Undoing Racism,* and their training by the same name, encourage concerned individuals who share these values to become a part of the antiracist movement toward social change and social justice. This requires that we move beyond the important discussion of individual racism and begin to confront institutional racism on the level of organizational change and social policy.

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Sue (2003) and Chisom and Washington (1997) offer many concrete examples of ways in which White and ethnic minority practitioners can become actively involved in this work.

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