CHAPTER 3

Institutional Racism against African Americans

Physical and Mental Health Implications

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ALTHOUGH THE RACIAL and ethnic composition of our nation has been changing rapidly over the past 40 years, and although legislation such as the Fair Housing Act of 1968 and the Civil Rights Act of 1964 have been passed to try to ensure fair treatment across races (Williams & Jackson, 2000), the historical legacy and ramifications of racism and discrimination still persist, particularly for African Americans. Profound racial disparities continue to exist across work settings, housing, income levels, and health statuses. For example, White applicants tend to be favored five times more than Black job applicants with equal qualifications, and the rate of unemployment among African Americans is often twice than that of White Americans (U.S. Government, 1998). Residential racial segregation in the 1990 census was almost equal to that of the 1968 census (Massey, 1996). In addition, the U.S. government (1998) reported that the household income of African Americans in 1996 was nearly 60% of that of White American households. Moreover, the difference between Black and White mortality rates due to heart disease, diabetes, cancer, and cirrhosis was larger in 1995 than it was in 1950 (Williams & Jackson, 2000). As a result of living for generations in a society sickened with the viruses of racism and discrimination, the physical and mental health of many African Americans has been compromised.

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Racism and discrimination have roots that undergird the history of Africans in the United States, starting with the kidnapping and torture of Africans on slave ships, generations of slavery, and the centuries of social, political, and economic subjugation that followed (Cohen & Northridge, 2000; Hollar, 2001). The heading of racism includes three specific forms that describe the sources of bias and experiences of dehumanization against African Americans and other People of Color in the United States: (1) individual racism, (2) cultural racism, and (3) institutional racism.

Individual racism refers to both the intentional and unintentional acts of discrimination that White individuals exert on others who are not members of their racial group because of their belief in their own cultural, emotional, intellectual, social, and moral superiority (C. P. Jones, 2000). Dovidio and Gaertner (2000) discussed the notion of "aversive racism," a corollary of individual racism in which people who see themselves as nonprejudiced and who outwardly support racial equality actually discriminate against others in subtle ways, thereby revealing their hidden racial prejudices. Unlike more overt racists, aversive racists rationalize or attribute their biases to nonracial factors because social pressures stigmatize overt race-related discrimination (Dovidio & Gaertner, 2000; Lowery, Hardin, & Sinclair, 2001). Thus, aversive racists express racism in ways that reveal their subconscious negative attitudes toward People of Color.

A second form of racism in the United States, cultural racism (J. M. Jones & Carter, 1996), occurs when White cultural phenomena and values as reflected in art, music, religion, standards of beauty, and so forth are preferred to and held up as cultural norms relative to the cultural phenomena and values of People of Color. In cultural racism, cultural practices and norms that differ from those of Whites are minimized, erased, distorted, dismissed as fads, or pathologized (Thompson & Neville, 1999). For example, when the term *classical* modifies the word *music*, it denotes refinement and antiquity, although it is used largely in reference to historical White European music. Unlike individual racism, in which some people manifest prejudicial behavior based on the assumed inferiority of others (J. M. Jones & Carter, 1996), the sources of cultural racism can feel more amorphous to People of Color (Collier, 1999).

Acts of individual racism, such as everyday racial slurs in the workplace or being followed in a retail store, can be protected behind the veil of institutions. Institutional racism is characterized by an organized network, such as an educational system, business, or health care system, that enacts normative practices that disadvantage others based on their racial or ethnic group membership (Thompson & Neville, 1999). It includes the reflection and perpetuation of racial inequality in which the racial group assumed to be superior monopolizes access to information,

goods and services, opportunities, and power (C. P. Jones, 2000), thereby imposing restrictions on others. A workplace that passively tolerates racist slurs and jokes may function on the norm that such banter is harmless and it unwittingly may perpetuate institutional racism. In the next section, I provide specific examples of institutional racism in action, particularly with regard to the experiences of African Americans.

INSTITUTIONAL RACISM IN ACTION

General examples of present-day institutional racism against African Americans include housing discrimination, such as obstacles in home loan approvals and housing tracts (Sanders Thompson, 2002); salary and promotion denial because of biased workplace performance evaluations (Dovidio & Gaertner, 2000); health care treatment inequities (Hollar, 2001: Morgan, 2002); and police practices such as racial profiling (Collier, 1999). A specific example of institutional racism can be found in the Supreme Court case related to the Affirmative Action policy at the University of Michigan (Kantrowitz & Wingert, 2003) in which White applicants contested their rejection from law school because they held that university Affirmative Action policies unfairly advantaged applicants of color, specifically African Americans, Latinos, and Native Americans.[1] In this case, the White applicants/plaintiffs asserted that U.S. society was no longer racist and that Black Americans, Latinos, and Native Americans held the same opportunities as White Americans to enter prestigious institutions of higher learning. They asserted that enforcing Affirmative Action policies was equivalent to having a race-based admissions policy and was therefore unconstitutional. In effect, this case represented aversive racism at an institutional level. The plaintiffs' argument denied the facts that racist barriers to equal education historically have denied educational and employment opportunities to People of Color and that standardized admissions tests may not truly represent fair criteria on which to predict the future academic success in a field of study for many People of Color. Even in some higher education settings that do not adhere to Affirmative Action admission policies, African American students may be accused of gaining academic admission through such policies. These kinds of accusations tend to minimize or ignore (a) African American students' personal achievements and intellectual parity with their White peers and (b) the role of White privilege and, therefore, the impact of preferential treatment practices that Whites have benefited from over the course of their lives (Franklin & Boyd-Franklin, 2000).

[1] People of Asian descent often are omitted in the discussion of affirmative action due to the presumed overrepresentation of this population in academic institutions, which is ideologically founded on the model minority myth (see Wu, 2002).

Conditions such as unfair distribution of responsibilities, biased performance evaluations, differential treatment based on race, unfair salary disparities, lack of institutional support, and obstacles to promotion may lead some African Americans in the workforce to describe their environments as institutionally racist (Jeanquart-Barone & Sekaran, 1996). In employment selection decisions, race may affect how employers weigh African American applicants' qualifications when hiring decisions are ambiguous. For example, if a White American person and an African American individual have similar job qualifications, some White employers may extend latitude and preference toward the White American person and not to the African American candidate (Dovidio & Gaertner, 2000). African Americans who challenge institutional racism in the workplace may risk hostility, ostracism, and being labeled as aggressive, loud, or even lazy (Collier, 1999). Additionally, some African American employees may experience institutional racism by feeling pressured to indoctrinate themselves into the norms and values of an organization that are demoralizing to their own cultural norms, values, or behaviors (Jeanquart-Barone & Sekaran, 1996).

Another form of institutional racism against African Americans in the United States is housing discrimination. Housing discrimination is rooted in the (a) historical physical separation of the races and was driven by the fear of miscegenation, particularly the fear of Black men impregnating White women; (b) Whites' avoidance of social contact with Blacks; (c) maintenance of socioeconomic disparities between Whites and Blacks; and (d) overarching belief in the inferiority of Blacks relative to Whites (Williams & Collins, 2001). United efforts of real estate institutions, banks, and federal housing policies have sustained housing discrimination practices for centuries in attempts to confine working-class African Americans to destitute and chemically contaminated living conditions (Thompson & Neville, 1999). Housing discrimination also has been manifested in middle-class neighborhoods by the relocation of White families (i.e., "White flight"; Crowder, 2000). This latter behavior has reduced the tax base in many urban cities, which deprives impoverished neighborhoods of much-needed funding for social and community services to improve the quality of life for their constituents (Williams & Williams-Morris, 2000).

Housing discrimination also can truncate education and employment opportunities for some African Americans, thereby restricting their socioeconomic mobility. Schools in financially struggling African American neighborhoods tend to have lower test scores, fewer qualified teachers, less focus on academic counseling and college-bound programming, and higher drop-out rates (Williams & Williams-Morris, 2000). In such segregated communities, opportunities for African American children to interact with and learn from same-ethnic role models with stable employment or high academic achievement also are restricted (Williams & Williams-Morris, 2000).

INSTITUTIONAL RACISM'S EFFECTS ON THE HEALTH OF BLACK AMERICANS: IMPLICATIONS FOR MENTAL HEALTH PROFESSIONALS

Racial disparities in health care treatment may stem from numerous institutional factors, including scientific philosophies that deny cultural and environmental factors in considering the etiologies of presenting illnesses in African Americans (Braun, 2002), geographic and socioeconomic obstacles to adequate health care (Williams & Neighbors, 2001), and health care professionals' and patients' attitudes toward treatment (LaVeist, Nickerson, & Bowie, 2000). In particular, racial disparities in the use of medical services are associated with some African Americans' general mistrust of the medical profession, much of which has been founded in the personal and historical mistreatment of African Americans by this profession. There is evidence to suggest that patients who perceive greater levels of racism and have greater distrust of the medical system tend to report less satisfaction with medical treatment (LaVeist et al., 2000). Further, racial disparities in the morbidity rates of certain conditions such as hypertension (Williams & Neighbors, 2001), diabetes, and breast cancer (Shinagawa, 2000) may be associated indirectly with African Americans' lack of trust in medical services and lack of access to adequate medical care.

Stress-induced changes in the neuroendocrine and immune systems have been considered in the explanation of links between perceived racism and the health of African Americans (McKenzie, 2003). Although racism-related life events and daily microstressors have acute effects on the health of many African Americans, transgenerationally transmitted racism-related stress also may play an important role in their overall physical health. For example, Williams and Neighbors (2001) reported that many African Americans are at increased risk for hypertension, in part due to (a) the history of racism against Black Americans; (b) emotional responses, such as anger or guilt, which may stem from anticipated racial discrimination by and feelings of suspicion toward Whites; (c) increased cardiac activity in anxious situations, such as feeling discomfort in encounters where an individual is the only person of color among White people; and (d) a sense of performance anxiety in work or school settings where African Americans are pressured to prove their competence in the face of negative expectations.

Williams and Williams-Morris (2000) reported that White people were 3 times more likely to perceive African Americans as prone to aggression,

5 times more likely to view African Americans as unintelligent, 9 times more likely to view African Americans as lazy, and 15 times more likely to perceive African Americans as being on welfare in comparison to how they saw other White individuals. Unfortunately, mental health practitioners may not be immune from carrying these biases with them into psychological settings, which may result in diagnoses that are influenced by these stereotypes. Thus, biases in the conceptualizations and definitions of mental health disorders in relation to People of Color have been factors that can contribute to racism in psychological diagnoses. For example, symptoms of paranoid thinking, such as pervasive suspicions of being harmed by strangers, colleagues, or institutions (American Psychiatric Association, 2000), which may be symptomatic of paranoid personality disorder or even schizophrenia, could actually represent legitimate and rational thoughts of African Americans who encounter racism daily in its many forms (Ridley, 2005; Solomon, 1992).

Mental health service institutions also have presented racist barriers to African Americans through the limited availability of therapists and mental health providers of color, the limited multicultural competence of available service providers, the Eurocentric values inherent in many traditional theoretical orientations and approaches to counseling, and some counselors' tendency to emphasize culturally deficit models over models of cultural strength and resilience in conceptualizing the development, experiences, and health of People of Color (Rollock & Gordon, 2000; Solomon, 1992; Whaley, 1998). For example, highly communal and collectivistic worldview value orientations, which tend to be dominant among many African Americans, may serve to underscore the roles of social support networks as coping mechanisms; however, more individualistic therapeutic philosophies may pathologize this behavior as dependent or indicative of an enmeshed, unhealthy family structure (Constantine, Myers, Kindaichi, & Moore, 2004). Furthermore, the reliance on White norms in mental health tests and assessments has assumed generalizability of White norms and standards, clouded the field's understanding of the cultural experiences of African American children, and potentially led to the misdiagnoses of mental health conditions in African American children (Dana, 2000).

Perceived racism also has been positively associated with negative emotional reactions and psychological distress. Utsey, Payne, Jackson, and Jones (2002) found that exposure to institutional and collective racism was associated with higher levels of race-related stress in African American elderly males in comparison to their female counterparts. Conditions in highly racially segregated neighborhoods and urban living conditions, such as high population turnover, exposure to crime and violence, and overcrowding, also may have negative effects on the psychological functioning of African American children and adults (Williams & Williams-Morris, 2000). Furthermore, for some African Americans, the internalization of racism may be manifested in (a) fratricide, (b) emotional responses such as feelings of helplessness and resignation, and (c) behavioral outcomes such as substance abuse (C. P. Jones, 2000).

If institutional racism is a salient component of the etiology and exacerbation of both physical health conditions (e.g., hypertension, asthma, heart disease, and diabetes) and mental health conditions (e.g., depression, anxiety, and substance abuse), mental health treatment necessitates addressing pathological institutions as well as validating and empowering clients (Akinbami et al., 2002; Thompson & Neville, 1999). Following are five suggested strategies to help mental health practitioners address the effects of institutional racism in the lives of African American clients:

1. Mental health professionals interacting with African American clients may need to assess the degree of cultural mistrust of these clients with regard to receiving mental health treatment, along with potential institutional barriers of given treatment facilities themselves. This includes consideration of treatment costs, insurance limitations on treatment, geographic location, racial and ethnic composition of the staff, and whether agency mental health treatment models are founded on racist assumptions.
2. As a corollary to the first strategy, mental health professionals need to be cognizant of social norms that reflect aversive racism through color-blind attitudes that may obfuscate institutional biases (Williams & Williams-Morris, 2000). This may encourage their commitment to challenging institutional policies that perpetuate racial biases in treatment.
3. Mental health professionals should validate African American clients' experiences of institutional racism when clients present for treatment with such concerns. Passive dismissal or overquestioning the validity of clients' experiences with regard to this phenomenon (e.g., doubting the veracity of clients' perspectives about a racial incident) might extend the experience of institutional racism to the psychological setting.
4. The effects of repeated exposure to institutional racism and racism-related stress are not uniform across all African Americans. The assumption of monolithic victimization by institutional racism denies the strengths, resilience, and diversity of experiences in the African American community and may perpetuate deficit approaches to understanding and working with African American clients. Thus, when considering the effects of racism-related stressors for these clients, it is

imperative that mental health professionals identify the types of coping strategies their African American clients might be using or could use with regard to addressing institutional racism in their lives, and that they encourage these clients to explore the advantages and ramifications of using these coping mechanisms in their lives.

5. Outside of their offices, mental health professionals could address racist and oppressive societal systems through their involvement in community-based social justice initiatives. This may include public advocacy for racial parity in education systems, consultation with businesses that are struggling to hire and promote African Americans into positions of power, and involvement with organizations that lobby against housing discrimination.

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