RACISM: CALLING A SPADE A SPADE

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Research has documented the deleterious effects of racism on the mental health of people of color. However, the practice of psychotherapy sorely underutilizes these important findings, thereby providing less-than-optimum care. Through the presentation of research and personal stories, the author discusses the necessity of naming racism and of identifying its effects. Guidelines are suggested for transforming difficult racial dialogues into healing experiences for clients, and the necessity of taking stands against racism inside and outside of the therapy office is discussed.

I call a fig a fig, a spade a spade.
—English proverb attributed to Menander, 342-292 B.C. (Titelman, 1996, p. 38)

Call a spade a spade, to. To speak frankly and bluntly, to be quite explicit. (Ammer, 1992, p. 48)

spade, n. [derog.] A Negro, esp. a very dark-skinned Negro. (Wentworth & Blexner, 1975, p. 505)

My breath quickens and my heart adds a few extra beats to its rhythm as I begin to write here about racism. I worry. Will readers think, “Oh, (sigh) yet another racism article,” or “That word—racism—is a bit strong now, isn’t it?” It’s the same feeling I get in a staff meeting, when my Latino colleague reminds our clinical and administrative staff (again) to address issues of language by hiring more bilingual, bicultural staff. I notice other colleagues discretely shifting their gaze or giving him only curt acknowledgment. I feel the discomfort of those moments. I feel the same discomfort as I initiate this topic of racism—Will it too be dismissed?

I have begun with the phrase “calling a spade a spade” with purpose (and some hesitation). Commonly and innocently used by some, its utterance sends a shock through me and momentarily distracts me when I hear it. The meaning is understandable, but does the speaker recognize the very derogatory connotation of “spade”? I have chosen to use it here for several reasons—to garner attention to the topic I discuss, to gain some degree of command over words and phrases that control me through their ever-present ability to injure me, and to inspire emotions (as well as thoughts) in my readers. As clinicians, we must name racism and directly address it.

The subject of racism has been described in scholarly writings and has been the focus of psychological research. I believe that we can best learn about its impact in the context of psychotherapy by combining such scholarly approaches with personal stories. In this article, I weave together multiple lines of thinking and personal experiences to suggest approaches we can take to address racism in psychotherapy.

Racism Lives

As previously noted (Tinsley-Jones, 2001), “Racism is defined as a system of cultural, institutional, and personal values, beliefs, and actions in which individuals or groups are put at a disadvantage based on ethnic or racial characteristics” (p. 573).

Studies suggest that over any 1-year period, a large percentage (as high as 98% in one study) of Black Americans experience some type of racial discrimination, such as being called a racist name (Klonoff, Landrine, & Ullman, 1999). Although
I am concerned that a White person will not, in a pinch, act in my best interests, based solely on my racial minority status. In one study, when White bystanders were the only witnesses to an emergency, they assisted Black and White victims with similar frequency (95% vs. 83%) (Dovidio, Gaertner, Kawakami, & Hodson, 2002). However, when they believed other bystanders were present, the rate of assistance to Blacks dropped to 38% versus 75% to White victims. “If the situation were real, the White victim would have died 25% of the time; the Black victim would have died 62% of the time” (Dovidio et al., 2001, p. 422). The authors hypothesized that aversive racist behavior emerges in situations in which negative “behavior can be justified on the basis of some factor other than race” (Dovidio et al., 2002, p. 90). In another experiment, when presented with job candidates holding the same ambiguous qualifications, White raters tended to recommend White job candidates significantly more strongly than Black applicants (Bobo et al., 1996). Although a nationwide survey reported that in 1999, 67% of Whites approved of interracial marriage (Williams & Williams-Morris, 2000)—a significant rise from the 39% reported in the early 1980s—I was not euphoric. The results essentially meant that 33% of Whites—3 out of every 10 White persons—were most likely non-supportive of who I am (being of mixed race ancestry), of how I have configured my primary relationship (interracial), and of who my children are.

Racism Damages

Outside of the researcher’s laboratory and in the real world, therapists now know more convincingly than ever that racism injures us all, and at its worst, kills bodies, minds, and spirits. Ethnic minority populations are at greater risk for premature death related to heart disease, cancer, and diabetes; more prone to occupational injuries and toxic exposure (Kaiser Permanente National Diversity Council, 1999); less likely to be placed on a kidney transplant waiting list; and less likely to be screened for cholesterol levels or to receive a hypercholesterolemia diagnosis even when cholesterol levels registered higher than 240 mg/dL (Van Ryn, 2002). Latino and African American patients obtain less pain treatment than White patients when presenting in an emergency waiting room with fractures (Hood, 2000), and African American patients are less likely than their White counterparts to be screened for cholesterol levels or to receive a hypercholesterolemia diagnosis and “higher risk for psychological distress, racial/ethnic discrimination, and toxic exposure (Kaiser Permanente).”

Compelling research on mental health, that as a consequence of racism, racial/ethnic minority populations are at greater risk for psychological distress and anxiety, as immigrant Mexicans; Chinese-Americans; Black and 9th-grade children and Caribbean immigrants in Toronto; Southern whites; and Miami (Williams & Williams-Morris, 1999). The Surgeon General’s report on Mental Health (2001) concludes, “clearly stressful experiences at risk for depression and anxiety.

Racism Lives in the Body

Racism permeates a psychologist, I use vignettes to assess patient samples that are representative of racial or ethnic populations. One study, whose normative samples included Hispanic patients, whose normative samples excluded White subjects were clustered in African American, Hispanic subjects. I feel in using this paragraph and assigning a dependent variable, given how poorly the norming process that is to be quite stressful and anxiety from children by the test manual does not clearly state that the normative sample is unavailable.
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Racism permeates our field—often subtly. As a psychologist, I use psychological testing instruments to assess patients. Many well-regarded and widely used tests are not normed by using samples that adequately represent the true percentages of racial/ethnic groups in the general population. One such test is a depression scale, whose normative sample is 91% White, 4% African American, 4% Asian American, and 1% Hispanic. Not only are the minority sample percentages lower than actual population statistics, but the absolute numbers of minority persons included in studies are quite low. Although 454 White subjects were included, there were only 21 African American, 18 Asian American, and 7 Hispanic subjects. How secure can a clinician feel in using this particular depression inventory and assigning a depression rating to a Latino client, given how poorly this group was represented in the norming process? Another test I rely on and find to be quite helpful involves elicitling stories from children by showing them picture cards. The test manual does not give the breakdown of the normative sample by race, and this information is unavailable, according to the test manufacturer representative to whom I spoke by telephone. A new, racially representative sample is being recruited, and the results are expected in 2 years. The cards are packaged in two boxes—one is labeled simply as being “Test Cards,” with pictures of White children, and the other is labeled “Test Cards for Black Children.” I will still use this test, which provides rich clinical material, but I am sorely reminded that the field still utilizes the White population as the reference point against which all other populations are compared.

Overall, psychological research has a poor track record for including adequate numbers of people of color as subjects (Tinsley-Jones, 2001), and this is also the case with randomized clinical trials (Bernal & Scharrón-Del-Río, 2001), which help set the gold standard for the treatment of specific disorders. The Surgeon General’s survey (U.S. Department of Health and Human Services, 2001) revealed that only 9 out of 30 attention-deficit/hyperactivity disorder trials, 2 out of 28 depression trials, 10 out of 25 schizophrenia trials, and none of the 15 bipolar disorder trials either included any subjects of color or substantively described the race/ethnic composition of their samples. None provided analyses of their data by race/ethnicity. So although these randomized clinical trials are quite important to us, in that they provide guidelines for our therapeutic interventions, they fail to take race/ethnicity seriously. How can we actually trust that their recommended ADHD treatment strategies for children are the most effective when applied to our work with Black or Native American children? We actually can’t.

1Although the focus of this article is on racism, we—as psychotherapists—must acknowledge the deleterious effects of all forms of discrimination. For example, studies (Kessler, Mickelson, & Williams, 1999) with New York City gay men and Toronto lesbians and gay men reported lower life satisfaction and higher psychological distress as a function of discrimination. When Kessler et al. randomly surveyed over 3,000 persons in the contiguous United States, they found that perceived discrimination was associated with an increased risk of generalized anxiety disorder and major depression for all respondents, and most interesting, the magnitude of this increased risk was comparable to that associated with traumatic life occurrences such as sexual assault and combat exposure. Clearly, the many forms of oppression that reside among us—including discrimination based on race/ethnicity, gender, class, sexual orientation, disability, and age—adversely affect us all.
As a psychotherapist, I encounter racism on a regular basis—I receive it from clients, feel it toward them, and belong to organizations that inadvertently perpetuate it. Nevertheless, each such instance often surprises me, creating dilemmas about how to respond or how to remain therapeutically engaged. For example, a White woman whom I have seen for several months revealed near the end of a session that, as part of the job she just lost, her employer had asked her not to take applications from job seekers who sounded Black over the telephone. Why had she not told me this at the time it had occurred? What was I to do with my outrage? Arriving in the waiting room to pick up a new family who is White, I quickly scan their faces and demeanors for all kinds of therapeutic clues, especially clues as to their reactions to my being of color. In what is but a fraction of a second, I feel an almost imperceptible twinge in my stomach—will my color make a negative difference to them, will I have to alter what I do (e.g., push myself to look smart) to be accepted by, to work effectively with them? My Black client tells me that for 2 years of the time we have worked together, she has been suspicious of me because of my lighter skin color. She suspects I am married to a White man and feels angry about this possibility. While I actually understand her feelings, as well as her reluctance to tell me and her bravery at telling me now, I feel distress. Not only do I have to prove myself to Whites, I also have to do so with other people of color. At a clinic at which I work, a White mother requests that her daughter’s therapy be transferred from me to a White therapist, because the mother believes her daughter will have difficulty relating to a Black therapist. The transfer is done without questions. What responsibility does my clinic have to not support the potential racism embedded in such a request? As a person of color, I am having racist ideas toward a Southeast Asian client I just met. I am surprised at how quickly my inner voice quips, “They’re always so worried about saving face, and pushing their kids way too hard. I’m actually jealous! They don’t even have to deal with all the prejudice we Blacks do.” Although I have learned to counter these voices, I am ashamed to have them, ashamed I have bought into the racist ideology into which we have all been inducted, and from which I wish to be free.

Windows Into Treatment: Lessons From a Personal Story

My goal here is to move clinicians from facts and observations to what we need to do. Before proposing antiracism strategies for psychotherapists, I would like to add a personal story.

It is important to note that I am a woman of Black-White mixed race descent, a woman of color who is most often identified as Black by others. As a member of the human race, I most certainly possess my own share of common neuroses. For example, I am not the speak-before-a-crowd type. Some might say I am slightly on the anxious side. It is quite true that I briefly passed through a mildly exhibitionist phase in fourth grade, when I rallied a bunch of equally shy friends to join me in putting on “one-act plays” for our fellow classmates (I even supplied the cast with costumes, thanks to my mother’s donation of discarded, slightly torn and smudged curtains). Since then (and with only a few exceptions), I have been reasonably successful at shielding myself from the terror of talking for more than 15 minutes in front of more than six people at a time. As a person of color, however, I live a set of realities that are very different from those attached to being in the general category of human being. What I bear, along with those of color, is the everyday awareness, weight, responsibility, and pain of racism.

Several months ago, in a state of overconfidence or a stronger-than-usual desire to engage others in discussions of diversity, I agreed to present a workshop on racism in the provision of mental health services at a national conference convened by a major healthcare provider. In trying to come up with a pithy opening to my presentation, I curiously stumbled upon an old and powerful memory. While attending high school in rural Massachusetts (read as: all White), I lived what I now know to be a very detached experience. I developed this (now strange to me) ability to act as if nothing were wrong, or as if I didn’t really stand out. My stance was a true triumph in denial in the service of survival. I made good female friends and excelled academically. I did not do anything to garner negative attention, and the teachers and students acted accordingly. Until the end of my senior year, no one ever even openly acknowledged that I was different because I was of color (except my guidance counselor who managed scholarship reserved). In the spring of my best friend and I bunch, were chosen. Now, why would I take a stand for energy in anonymity, again, only in retrospect. Here I was—a shy, repressed almost every year; who had not been represented in other traditional materials; whose opening to be heard and whose parents conspired of silence and of that speech and its in necessary pain. In 1963, I rehearsed my speech had been taught by had to be perfect, succeed in a White hush. The sound of the microphone opening to be heard, and I dimmed, a sea of lies, behind the hush. The sound of my intensity. An “Nigger . . . “ and a call.) Then, there is packed auditorium lies, behind the dimmed, a sea of hush. The sound of the microphone opened, and I finish subjectivity of my Genuine applause, though, I felt alone rience went unproached; I cried, and to him the first sentence.
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years; who had not seen her image substantively

represented in other students, teachers, or educa-
tional materials; who had not been given any
opening to be herself without fear of reprisals;
and whose parents were complicit in this
conspiracy of silence and denial of self. The creation
of that speech and its presentation were exercises
in necessary pain. In the solitude of my bedroom,
I rehearsed my speech until I knew it flawlessly (I
had been taught by my father's example that you
had to be perfect, or at least overrehearsed, to
succeed in a White world). I lay in my bed, eyes
staring at the ceiling, stomach tense and filled
with butterflies, sleepless, for the handful of days
before the event. (The vitriolic telephone call I
received right before the event heightened
my intensity. An unidentifiable voice cackled,
"Nigger . . .," and what else, I frankly can't re-
call.) Then, there I was, standing in front of a
packed auditorium of students, faculty, and fami-
lies, behind the podium. The house lights
dimmed, a sea of faces before and below me. A
hush. The sound of my voice amplified through
the microphone in the large cavernous space.
I began, and I finished my speech. Even in the
subjectivity of my terror, I knew it had gone well.
Genuine applause followed. And, curiously
though, I felt alone. And, predictably, the expe-
rience went unprocessed, unmetabolized, and
was neatly folded and tucked away into the far
reaches of my memory.

Until 27 years later. Seeking an unsuspecting
volunteer on whom to practice my workshop pre-
sentation, I corralled my generous husband. I had
particularly wanted to talk through the graduation
speech idea because I intended to start my pre-
sentation with this. A handful of words came,
then hesitation; my voice choked, my heart
ached; I cried, and then, sobbed. I had only told
him the first sentence of the story. For many min-
utes, my patient husband held me, listened, and
waited until I was ready to say it all. I then tele-
phoned my daughter and repeated my effort—the
tears also fell, but this time I could tell her what
I was feeling as I cried, and then I finished my
story. I had to make several practice runs (alone)
before I could tell the story, feel the emotions, but
not be overwhelmed by them. By the time I stood
in front of my workshop audience, a transforma-
tion had truly occurred. Pain from the past had
been reclaimed; something inside me had gotten
repaired.

Countering Racism: Building Antiracist
Therapeutic Strategies

I have shared my story for a very specific pur-
pose. Combining the lessons of this story with my
previously presented observations and research
results, we have arrived at an important juncture:
As psychotherapists, how can we counter rac-
ism's negative effects on our patients? Although
it is impossible to offer an exhaustive list of strat-
egies—I do not have one, and as a community of
psychotherapists, we have not yet developed
one—I will offer the following as essential con-
siderations:

First, we must call a spade a spade. We must
name what we know to be true: 

Racism is a sig-
nificant mental health risk factor. Additional re-
search is required to better understand how rac-
ism is promulgated and mitigated, how it con-
tributes to psychiatric problems, and how as clinici-
ans, we can help our clients heal. As clini-
cians, we do listen to and incorporate culture into
treatment. The depression of a person who has
recently immigrated to this country will be
viewed within the context of that immigration
and the cultural clash, which may impinge upon
him or her. Understanding a racial/ethnic minor-
ty client's spiritual beliefs can help clarify his or
her psychotic-like reaction to a family member's
death as culturally congruent and transitory,
rather than as thought-disordered. But this is not
what I am talking about. What I am talking about
here is that for most people of color (and many
White people), racism is a disease-inducing
agent, as psychologically destructive as other
known agents, such as physical and sexual abuse.
Our research and clinical attention to racism are
essential, not optional, for our patients' health.

Second, sometimes, however, a spade is more
than just a spade. Racism, as it presents itself in

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a client's distress, often is intertwined with other issues. My story to you makes this point. My lifelong struggle with anxiety may not only be the result of my temperament, childhood exposure to criticism, or other family-of-origin matters, but it also has significant roots in the racism of my past. Being trained to monitor myself and my surroundings for potential signs of danger because of my race exacted a very large toll on me. Self-and other-vigilance fueled a tenacious anxiety. Because my healing depends on accounting for this, my therapist must help me address my anxiety on the racial front as well. As clinicians, we are all well trained to toggle between the various levels of our patients' experiences to help them understand a particular problem. We must listen for and include racism as one of those levels. Simple questions are all that are sometimes necessary. My therapist's inquiry as to how racial issues might have affected me in a particular situation made an opening for us to explore racism's effects on me.

Third, we have to go beyond asking questions, however, or thinking that healing is accomplished on the levels of individual, family, or group psychotherapy only. Taking a stand against racism for and with our clients in and outside the therapy office is required.

During the course of a research project, an African American psychologist related the following story to me:

A few years ago, on my way to an analysis appointment [with his White psychoanalyst], I was detained by the police, and one of the things I really appreciated was my analyst's ability to empathize with how furious I was, and how difficult it was for me to be, not only furious with them, but furious with him in the transference and envious of the fact that he was never going to have to go through that, and I really am grateful to him for that. [The psychoanalyst's being] able to acknowledge the reality of this experience and then as well to help me appreciate sort of what else, what else it was meaning at the moment . . . was a good example of what I think in fact has to happen in terms of dealing with these issues in treatment . . . in fact [if] the reality is not acknowledged, and one only focuses on what it might mean, I think it's demeaned or trivialized in a way. I don't think it's help. (Tinsley-Jones, 1997, p. 142)

Therapists take antiracism stands for their clients when they join cultural diversity community groups, combat racist jokes in their personal and professional lives, spearhead the tackling of cultural issues in their workplaces, and help clients empower themselves against racism. Steenbarger (1993) describes one such example. An African American medical student, after extensively discussing his fear of failing in medical school, finally revealed that he was reacting to events that had occurred at his school. He had been excluded by peers and had overheard prejudicial comments made by some peers and faculty who questioned his true abilities, given the fact that he was accepted through a minority recruitment program. As part of his therapy, this student formed a support group and helped initiate a schoolwide forum, which successfully elicited a positive dialogue about race within the medical school community. Here is the lesson: Racism is a current inflictor of injury as well as a historical one. It is not enough to only help our clients to process past racist injuries; we must empower them with regard to future assaults.

In addition, significant progress in eradicating racism's adverse effects will only occur with administrators' taking on racism's institutional barriers (Dovidio et al., 2001):

It is the people who occupy the positions of highest status and power within organizations who may be most threatened by further progress of Blacks and other underrepresented groups, yet, ironically who also have the greatest potential to initiate change. (p. 428)

Administrative guidelines for tackling racism include managerial incentives for meeting diversity goals and taking a "long march approach."

Fourth, now here's the tricky part—as clinicians, how do we know when to ask the racism questions, make the comments, and suggest empowerment? And when do we not? Working with racism in therapy is, like everything else we do, engaging in a therapeutic dance with our clients. As healers practicing an art form—and, with respect to racism, one for which we have little established training—we need multiple sources of learning and support. Honing the art is not a task one accomplishes solely on one's own, or only through attending a handful of cultural diversity trainings, or simply by acquiring a pocketful of strategies. (I remember being appalled by a White colleague's approach. She routinely—as in always—asked her non-White patients in the first or second session if her being White was a problem for them. Without having an adequate therapeutic alliance or knowing a client's history and outlook with regard to race and racism, this appeared an insensitive approach, if not one guaranteed to place the alliance in a precarious position.) Developing an antiracist therapeutic approach is a multilevel affair. Yes, it is valuable to attend all-day training such as the ways out:

1. Establish a network of peers and groups in our cases and ongoing basis. Race stays underground often to make a job, we need allies, and in this White communities, allies. It is often racial/ethnic groups. It is intuitive that I do things brought up to accomplish in a group. It is possible to confront a problem based on messages I get, I ask if people of color, attitudes and Whites, and to the tentacles of not just because you do it, you do it differentially than if you do it.

2. Head learning is necessary. It is cultural histories of well as the hard work. However, my own racism—relates the main process and devising an attempt to follow the article—I have researched and surgeries. For example, reliving of my speech led to a new perspective that I had previously had a mill anxiety.

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Fifth, taking on racism with colleagues in our consultation groups or with our clients can seem daunting. As we try to negotiate this challenging crevasse, will a torrent of feelings sweep us away? Let me make a couple of points about managing the powerful emotions that are sometimes released when we foray into this domain. First, it is important to take the point of view that, overall, the anger, fear, and so on, that emerge are not personally directed at us (they come with the territory of racism) and are reflections of our own and our clients’ pain. (Now, if I make a culturally insensitive comment to my client, and she calls me on it or I’m aware enough to catch it on my own, it is personal, and I do need to admit to and deal with it.) If my White client expresses to me, a mixed-race therapist, his outrage at how so-called minority hiring practices have frozen him out, I have to be able to hold that anger (at a distance from me) and help the client examine his experience (and what else it might mean) as fully as possible. My second point, therefore, is that when processing racism, it is helpful to think of ourselves as compassionate witnesses to each other and to our clients. As such, we (and our support groups) provide the emotional table on which clients and colleagues can place this pain. This may appear to be a stretch, but I have come to believe that the following perspective can help us do this work: When feelings emerge—good, bad, angry, and indifferent—think, “Hooray, we have arrived! We are doing the work!”

We have much to learn about unlearning racism and facilitating the healing of our patients. We do not, however, have to know it all at once, nor is it reasonable to expect that we should. Rather, we are part of a movement to do the work. Amazing transformations of self and others can occur in the process, long before the end result is achieved.

References


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