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The Need for Shared Nomenclature on Racism and Related Terminology in Psychology

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Abstract

With the increased desire to engage in anti-racist clinical research, there is a need for shared nomenclature on racism and related constructs to help move the science forward. This paper breaks down the factors that contributed to the development and maintenance of racism (including racial microaggressions), provides examples of the many forms of racism, and describes the impact of racism for all. Specifically, in the United States of America, racism is based on the social construct: race, which has been used to categorize people based on shared physical and social features with the assumption of a racial hierarchy presumed to delineate inherent differences between groups. Racism is a system of beliefs, practices, and policies that operate to advantage those at the top of the racial hierarchy. Individual factors that contribute to racism include racial prejudices and racial discrimination. Racism manifests in multiple forms (e.g., cultural, scientific, microaggressions) and is both explicit and implicit. Given the negative impact of racism on health, understanding racism informs effective approaches for eliminating racial health disparities including a focus on social determinants of health. Providing shared nomenclature on racism and related terminology will strengthen clinical research and practice and contribute to building a cumulative science.

Keywords

racism; microaggressions; terminology

The ongoing killings of Black people at the hands of police and White vigilantes, and video documentation of these atrocities, have resulted in increased awareness and discussion of racism. There is now a greater focus on racism as a social determinant of health and incorporating an *anti-racism* (actively deconstructing manifestations of a presumed racial hierarchy) framework in research. However, engaging in anti-racist work requires a shared nomenclature on the definitions of racism and related terminology (Table 1) to meet these objectives. Providing clarification on racism and related terminology can help us move

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beyond efforts, whether intentional or unintentional, to resist change often through over-intellectualizing so we can move toward doing the hard work of achieving health equity. Further, having a shared nomenclature is imperative for informing research practices and identifying the drawbacks of using terms interchangeably. The use of clearly defined terminology will allow for improved comparisons across studies and enhanced specificity of which components of racism contribute to health disparities, which will further the science aimed at improving health equity.

The Roots of Racism

Racism is a system of beliefs (racial prejudices), practices (racial discrimination), and policies based on race that operates to advantage those with historical power, White people in the United States of America (USA) and most other Western nations. In the USA, race is a social caste system used to group people based on shared physical and social features and is ever evolving. Race is a social construct with no biological basis and stems from White supremacy, an ideology that presumes the superiority of White people and inferiority of People of Color (POC) (Bamshad et al., 2004; Frank, 2007; Jones, 2000; Maglo et al., 2016; Williams et al., 2019). Although the roots of racism in the USA can be traced back to colonization and the Atlantic slave trade, the concept of racism is rather contemporary.

Racial prejudices and discrimination are individual-level factors that contribute to the development and maintenance of racism (Jones, 2000) (Figure 1). Notably, power is key to the development of racism. Each individual-level factor contributed to the development of the system of racism only when the perpetrator was in a position of power (i.e., serve as a gatekeeper for opportunities, goods, or services). That is, racism manifests when racial prejudices and discrimination are implemented by people who develop or enact policies, procedures, laws, or standards of practice. However, racism is also maintained by these individual-level factors. That is, racial prejudices and racial discrimination perpetrated by anyone regardless of power help to support and maintain the system of racism. By being socialized into a society in which racism is pervasive, almost everyone has developed *racial prejudices* (beliefs about a person based on stereotypes of their presumed racial group), and these racial prejudices can contribute to *racial discrimination* (mistreatment of a person based on their presumed racial group). Racial discrimination may present covertly or overtly across a spectrum from *racial microaggressions* (everyday slights based on racial prejudices) to select apportionment of societal goods or direct threats or acts of violence. Racial discrimination can be perpetrated by anyone regardless of their race or intentionality. To better inform points of intervention, rather than using the term “racist” to describe these individual-level behaviors, we suggest using the more specific terms of racial prejudice and racial discrimination.

The Impact of Racism

When a White person engages in racial discrimination (including racial microaggressions) against a POC, this contributes to racism and can have long-term physical and mental health consequences (Carter et al., 2019; Williams, 2020; Williams et al., 2018). When a White person or POC engages in racial discrimination against a White person, this can also result

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in physical and mental health consequences, but it does not constitute “reverse racism” because there is no racial system in place that has historically privileged POC and oppressed White people. When a POC racially discriminates against another POC, this is a manifestation of *internalized racism* (POC assimilating to White supremacy and reinforcing Eurocentric standards) (Jones, 2000; Williams et al., 2019), which contributes to maintaining the system of racism that advantages White people and disadvantages POC. Ethnic identity development can influence internalized racism such that those with stronger ethnic identity may be protected from internalizing negative messages about their racial group. However, the insidiousness of racism can still infiltrate even racially minoritized individuals with a strong ethnic identity.

Although racism benefits White people through *White privilege* (unearned advantages due to perceived White race), racism negatively impacts White people as well. For example, the *myth of meritocracy* (success results from hard work) and *just world beliefs* (good things happen to good people; bad things happen to bad people) contribute to racism and lead White people to falsely believe their success is based solely on their own merit. Holding these beliefs can result in lowered self-esteem when successes are not achieved despite hard work. Racism also blinds White people from addressing social class issues like economic inequality and healthcare access that would benefit them as well. Further, racism results in some White people closing off the possibility of POC as friends, family members, romantic partners, neighbors, and colleagues, and thus, missed opportunities for cherished relationships. Additionally, racism can motivate everyone including White people to give up their ethnic identity and cultural traditions (e.g., language, food, clothing) to fit the expectation of *Whiteness* (White race is the elevated standard by which other racial groups are compared). Because of this, the impact of cultural factors tends to be investigated to improve health outcomes only for POC when White people may also benefit from a greater focus on culture. Therefore, White people should be motivated to engage in antiracism work for the benefit of POC and themselves.

Misconceptions regarding racism and anti-racism are barriers to conducting rigorous anti-racist clinical research. The recent Trump Executive Order (Executive Order 13950, 2020) seriously limited anti-racism training and promoted *color-blind racism* (disregarding unique experiences due to race), which is harmful to POC because it invalidates their experiences of racism and valued aspects of their racial identity and maintains Whiteness as the status quo. The American Psychological Association explicitly emphasizes the necessity of clinicians and researchers challenging their colorblind ideology and reflecting on sources of privilege (American Psychological Association, 2017), both of which are prohibited in the recent executive order.

The Manifestations of Racism

Racism is woven into the fabric of our society and manifests in multiple forms. Examples include *structural racism* (policies, procedures, laws, and customs of practice developed to benefit and maintain White people in power), *institutional racism* (differential access to goods, services, and opportunities based on perceived race), *scientific racism* (the misuse of science to support a racial hierarchy), *medical racism* (differential quality of medical care

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and availability of evidence-based treatments provided to POC relative to White people), *environmental racism* (disproportionate placement of hazardous material near Communities of Color with little regard of the physical or health consequences), and *cultural racism* (preference for Western values and practices resulting in the exclusion or denigration of other histories and traditions). Table 1 provides definitions and examples of additional racism-related terminology. Although the term *systemic racism* is used by many, racism, by definition, is systemic. The impact of various forms of racism manifests as the wealth gap and the disproportionate number of POC unemployed, living in poor neighborhoods and food desserts, attending under-resourced schools, overinvolved in the legal system, and with less access to quality healthcare resulting in disparate morbidity and mortality of health conditions relative to White people. These inequalities are what cause racial disparities in health. Understanding the many ways in which racism manifests can further inform points of intervention to reduce and ultimately eliminate racial disparities in health.

Racism manifests both explicitly and implicitly. Because some explicit forms of racism (e.g., chattel slavery; Jim Crow laws) have been abolished, some people believe racism ended as well. The election of President Barack Obama also led many to believe we live in a post-racial society. However, racism persists in more stark and harmful ways (e.g., continued voter suppression, persistent disparities in wealth and health) and in implicit forms like *aversive racism* (unconscious beliefs in White supremacy resulting in racially discriminatory behavior in ambiguous situations) (Dovidio et al., 2016). Although the surge in explicit racism we witnessed during the Trump era may decrease with the election of Joe Biden as President and Kamala Harris, our nation’s first Black and Indian woman as Vice President, implicit forms of racism will continue, underscoring the need to continue actively engaging in anti-racism work. Regardless of whether racism is manifest implicitly or explicitly, each person is responsible for the consequences. Evidence suggests that when discriminatory behavior is attributed to implicit prejudices, perpetrators are seen as less culpable, less worthy of retribution, and feel less responsible for their actions (Daumeyer et al., 2019). The reality is even when our behavior is informed by prejudices we developed outside of our awareness or we are not aware that our actions support racism, we are still responsible for these actions. Given that we have all been socialized in a racist society, it is each our individual responsibility to develop awareness of racial prejudices that we have internalized and the ways in which we may inadvertently support and maintain racism so we can avoid engaging in discriminatory behavior. Having shared language of racism and related terminology can help develop awareness of the ways in which racism manifests and how we may be contributing.

Next Steps: An Anti-Racist Discipline

It is imperative that we acknowledge our society’s atrocious history of racism and how it continues to manifest today. Rather than ignoring race or taking a “race-neutral” stance, combating racism requires an unequivocal *anti*-racist approach. Anti-racism in clinical research involves actively deconstructing White supremacy by placing the source of racial disparities on racism in society as opposed to on individual POC (Cénat, 2020). This involves focusing on social determinants of health to identify approaches for eliminating racial health disparities (Yearby, 2018). Conducting high quality anti-racist clinical research

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using shared nomenclature will result in more effective and equitable healthcare. Anti-racist clinical research can inform the development of a new system to ensure people experiencing a mental health crisis are funneled into the health care system rather than the legal system. Further, anti-racist clinical research can inform best approaches to reinforce identifying and eliminating discriminatory practices within the healthcare system. Providing clarity on racism and related terminology will further efforts to reduce racism and disparities in health resulting from racism (Williams et al., 2019).

Often researchers do not differentiate between forms of racism (e.g., medical, cultural, environmental) in their studies. In fact, most research has operationalized racism based on racial discrimination (Paradies et al., 2015; Williams et al., 2019). We need to broaden the racism-related constructs investigated to better inform the research. Subsequent studies are needed assessing the impact of multiple levels of racism (e.g., racial prejudices, racial discrimination, racial segregation in neighborhoods) on health outcomes to better inform how specific factors differentially and/or cumulatively contribute to disparities. This will involve having a clear understanding of the history, laws, policies, and common practices related to the outcome of interest that may inadvertently operate differently for racially minoritized groups. Engaging in thoughtful anti-racist clinical research using shared nomenclature will lend itself to identifying areas for improvement to strengthen research and continue to build a cumulative science.

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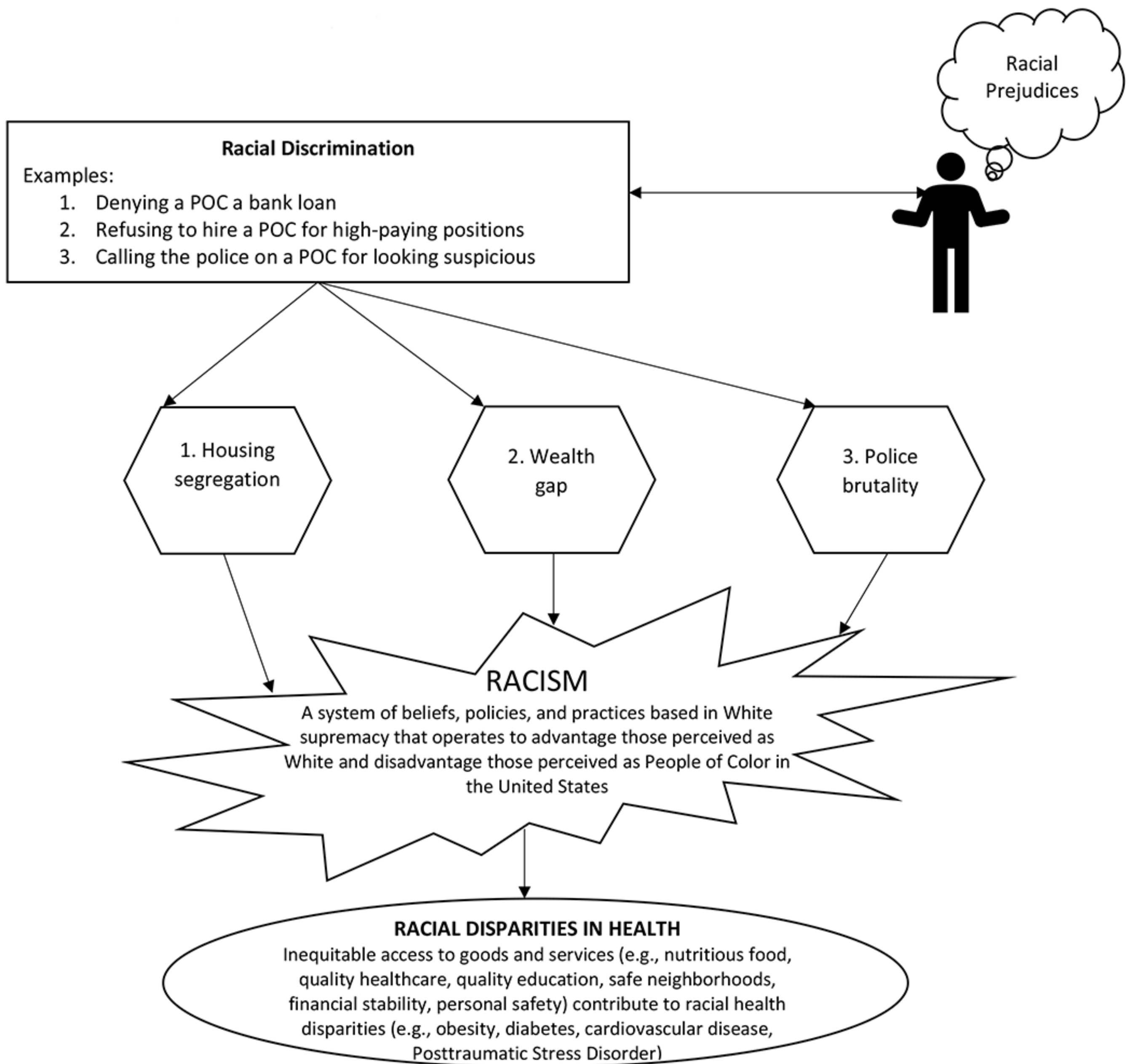

Figure 1.
Depiction of How Individual Level-Factors Contribute to the Development and Maintenance of Racism and Racial Health Disparities.
Note. POC stands for People of Color. Housing segregation and the wealth gap are examples of institutional racism, and police brutality is an example of structural racism.

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Table 1

Definitions and Examples of Terminology Related to Racism

Category	Term	Definition	Example
Beliefs	Racial prejudices	Opinions, beliefs, attitudes, or assumptions about racialized groups based on stereotypes and often without firsthand experience; pathological stereotypes	Believing that Black people are less susceptible to pain (a racial prejudice that can result in substandard medical care)
	Racial biases	Unfairly over- or under-valuing specific racialized groups based on racial prejudices	Preferring to work with White people because you assume you will have more in common with them.
	Stigma	Generalized negative beliefs, attitudes, or assumptions about a group of people	Assuming Indigenous people who live on reservations are suffering and that their suffering is because they have not assimilated to Western culture
	White supremacy	An ideology that presumes the superiority of White people and the inferiority of all other groups	Believing POC are inherently dangerous and are better off dead, as inpatients, or imprisoned
	Myth of meritocracy	A belief that success results primarily from hard work	Interpreting a POC patient’s economic disadvantage to internal factors such laziness or lack of work ethic
	Just world beliefs	Believing that good things happen to good people; bad things happen to bad people	Observing that doctors are disproportionately White and concluding that since they are more likely to be vocationally and economically successful that they must be “good” and thus deserving. Observing that low-income patients who have survived high levels of adversity are disproportionately POC and concluding that they must “bad” and thus less deserving
Behaviors	Racial discrimination	Differential treatment of a person or group of people based on prejudices of their presumed racial group	Promoting a White employee over a POC employee with better qualifications and more seniority
	Racial microaggressions	Everyday slights or harms based on racial prejudices	Expressing surprise and telling a POC colleague they speak eloquently
	Anti-racism	An approach that actively deconstructs White supremacy	Conducting research on social determinants of health disparities, thus challenging the narrative that POC are inferior by placing the source of disparities beyond individual efforts and on racism in society at large
Manifestations of racism	Structural racism	The development of policies, procedures, laws, and customs of practice to benefit and maintain White people in power	Legacy programs that grant preferential college admissions to children of alumni
	Institutional racism	Differential access to goods, services, and opportunities based on perceived racial identity	The overrepresentation of POC youth in underresourced schools
	Environmental racism	The disproportionate placement of hazardous material near POC communities with little regard of the physical or health consequences while intentionally protecting White communities	Rerouting the Dakota Access Pipeline through the Standing Rock Indian Reservation
	Cultural racism	Preference for Western values and practices resulting in the exclusion or denigration of POC history and traditions	Medical textbooks describe the contributions of accomplished White doctors only
	Scientific racism	The use of science to support the belief that White people are superior and POC are inferior; POC disproportionately bearing the harms of science while White people disproportionately reap the benefits	Advancing the idea White people are more intelligent based on higher IQ test scores but only using tests developed by White scholars

Category	Term	Definition	Example
	Medical racism	The differential quality of medical care and availability of evidence-based treatments provided to POC relative to White people	Black patients being denied proper pain medications due to assumptions they might be addicted to drugs or false beliefs that they have a higher pain tolerance
	Internalized racism	POC assimilating to White supremacy; colluding to uphold Eurocentric standards	A Cuban researcher refusing to accept Black trainees in their laboratory because they do not believe they are smart or hardworking enough to do the work
	Color-blind racism	Disregarding unique experiences due to race and maintaining Whiteness as the standard	Professor ignoring the race of medical trainees and only using examples from White culture when teaching
	Explicit Racism	Overt support of White supremacy resulting in racial discrimination	Conducting clinical research with the explicit goal of providing evidence of the inherent inferiority of Black people
	Implicit Racism	Unconscious beliefs in White Supremacy resulting in racial discrimination	Taking no action to increase racial representation when most of the participants in your clinical study are White
	Aversive Racism	The avoidance of racial discrimination in obvious situations but doing so in ambiguous situations	Selecting the White candidate when deciding between two equally competitive applicants that only differ in race
	Colorism	Discriminating against POC based on preference for physical characteristics closest to the Eurocentric standard; the racial hierarchy within POC that places Asian people at the top and Black people at the bottom	An Indian investigator hiring the applicant with lighter skin when deciding between two equally qualified candidates of color
Related Constructs	Intersectionality	The interaction of social identities that contribute to multiple systems of disadvantage; understanding how Christian supremacy, patriarchy, capitalism, and other systems of injustice conspired to create and maintain racism	Forced or coerced sterilization of low-income indigenous women because it is believed they are unable to be good mothers
	Stereotype Threat	Situations in which oppressed identities are made salient and contributes to increased anxiety about perpetuating negative beliefs about their group leading to impaired performance	The only Black resident in the cohort failing a board exam
	Critical consciousness	The process by which socially oppressed people critically examine their social conditions and take steps to advance social liberation	A Black medical resident critically analyzing standards of practice in the clinic and initiating discussions with their attending on how these practices differentially impact patients of color so equitable practices can be instituted
	White privilege	Unearned advantages due to perceived White race	A White doctor verbally abusing nurses because he knows he can get away with it, whereas a doctor of color would be reprimanded
	Whiteness	The accepted and elevated standard to which other racial groups are compared	Expecting research conducted with POC be compared to outcomes of White people but not expecting research conducted on White people to be compared to outcomes of POC
	White Ally	A White person engaging in antiracism work; involves accountability, social risk, and relinquishing White privilege	A White psychologist pointing out racially discriminatory practices in a clinic and taking steps to eliminate them

Note. POC = People of Color. Many of the examples could fall under more than one category.

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