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Addressing Racial Trauma in Counseling: Perspectives and Lessons from the Field

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A Dissertation Submitted to The Graduate School at the University of Missouri-St. Louis
in partial fulfillment of the requirements for the degree
Doctor of Philosophy in Education with an emphasis in Counseling

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Abstract

Racism has permeated all aspects of American life (Bell, 1992) and many Black communities suffer racial trauma as a result. Mental health professionals have an ethical responsibility to develop strategies to serve the needs of diverse communities. The purpose of this qualitative study was to explore the experiences of Black mental health professionals who serve individuals experiencing racial trauma. Using Critical Race Theory as a theoretical framework and qualitative Thematic Analysis as a methodology, twenty-three (23) Black mental health professionals were asked the following questions: (1) What are the experiences of Black mental health professionals working with clients who have experienced racial trauma; (2) How do Black mental health professionals meet the personal and professional challenges of serving clients who experience racial trauma; and (3) What competency training do mental health professionals need to promote and enhance their effectiveness when working with individuals who experience racial trauma? Results of the study highlighted four themes: (1) Rewards and Challenges; (2) The Importance of Self-Care; (3) The Importance of Implementing Culturally-Informed Clinical Strategies; and (4) The Importance of Engaging in Professional Growth and Development. Discussion of the findings in addition to implications and recommendations for clinical practice, training, curriculum development, and research are included.

Keywords: racial trauma; race-based trauma; trauma; racism; trauma training; multicultural competency; trauma-informed practices

Dedication

In loving memory of my mother, Germaine Dessalines (aka Mrs. Franck Louissaint), my father, Franck Louissaint, and my brother, Frantz Louissaint. All of you were taken too prematurely from me; I will be forever thankful for how you have impacted me. I am particularly grateful for my mother for imparting me with her strong moral and ethical principles of life: a thirst for education, love and commitment to family, a passion for justice and fairness, and a strong sense of work ethics. I do everything with you in mind, Manman. May your legacy continue to shine through me while I am on this earth!

To Todd Martin who has been and continues to be my ROCK all throughout this journey. Your fun, loving, and quirky ways of loving me and showing me support is what kept me going. Thank you for being my biggest cheerleader.

To my sister, Marjorie Louissaint (Jo), and my brothers, Guyto Chery (Jean Jean), and Jacques Louissaint (Toutou) for always supporting me, loving me unconditionally, and for all the sacrifices that you made for me to be where I am today. Your endless prayers were not in vain. To my nieces and nephews, Reginald, Ralph, Jayden, Jaylene, Justin, Julian, and Isabelle; thank you for bringing joy to my life.

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And lastly, to my clients for inspiring through your stories with dealing with racial trauma.

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“It takes a village to raise a child.”—African Proverb

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“We must learn that passively to accept an unjust system is to cooperate with that system, and thereby to become a participant in its evil.”

~ Martin Luther King Jr.¹

Chapter 1 - Introduction

Racism is ubiquitous and systemic throughout the U.S., and constitutes a source of psychological and physical distress for many minoritized groups (Moreland-Capuia, 2021; Walker, 2020; Winters, 2020). In recent years, we have witnessed a national outcry against racism and discrimination, and against law enforcement practices targeting communities of color. Highly publicized incidents such as the killing of George Floyd, Michael Brown, Ahmaud Arbery, Philando Castile and Breonna Taylor have shed an international and global spotlight on the problem of police brutality and racism in America (Ater, 2020). Ruthless killings and the responses of the criminal justice system confirmed the continued prevalence of institutional racism, a system that accounts for the plight of many Black communities that continue to keep disenfranchised individuals at the bottom of the economic and social well (Winters, 2020). Accumulated tragic killings in conjunction with historical deaths of Black people in America are constant reminders and proof that lynching is not something of the past, but remains a modern-day occurrence (Winters, 2020). The failure of the U.S. justice system to acknowledge racial injustice is also a persistent reminder of the unequal treatment and oppressive environment impinged upon Black people. The logistics and costs of these systems of injustice and oppression are salient and very well-known to dominant oppressive societies who know how to use institutions to their advantage when necessary. For example, Amy Cooper, a White woman who called the police on a Black man under the pretense that she felt threatened, behaved in a very

¹Dr. Martin Luther King Jr. in *Strength to Love*, a collection of sermons (1963)

racially-scripted and calculating way. She relied on historical White female privilege to demonize Blackness and side in her favor. Such incidents serve to continue a persistent stereotype that Black people are second-class citizens and unworthy of equal treatment. Orelus (2012) noted how Blacks in the time of slavery would rather take their own lives instead of living in such oppressive conditions. These incidents, including killings of Black people, constant harassment of Black people by the police, exoneration of those involved in the killings of Black people, and persistent macro and microaggressions in public spaces often lead to similar symptoms as those encountered in post-traumatic stress disorders (PTSD). Symptoms include increased and persistent anxiety, depression, erosion of one's self-esteem, isolation, triggers, flashbacks, fatigue, and persistent fear among Black individuals and the Black community (Winters, 2020).

Similarly, the advent of the COVID-19 pandemic in 2020 highlighted racial disparities with respect to access to health care, jobs, economic stability, and affordable housing. Black communities were two to four times more disproportionately impacted than White communities (Moreland-Capuia, 2021; Winters, 2020). The impact of the pandemic exacerbated already strained and destitute living conditions in many Black communities (Moreland-Capuia, 2021; Winters, 2020). They were more likely to be impacted by being laid off or by being required to report to their jobs which increased their chances for exposure to the virus. Lastly, in the midst of the pandemic the U.S. recently experienced a very polarizing and contentious presidential election, one that laid fertile ground to racist thinking reminiscent of Civil War times.

RESEARCH PROBLEM

Although racism is not new and has always been part of the fabric of America, what is recent are the ways in which Black communities have begun to seek formal counseling services

to deal with racial trauma and its impact. To this end, many mental health professionals have been tasked with increasing their knowledge of communities that experience racial trauma, in addition to developing cultural competencies that enhance their overall counseling effectiveness.

Researchers have taken a closer look at race-based traumatic stress associated with acts of racism, discrimination, and bigotry, as described in the study by Carter (2005), but closer examinations are needed to explore if mental health professionals are well-equipped and trained to effectively identify and serve Black and African-American clients who present with symptoms of racial trauma.

RACIAL TRAUMA

Gaining an in-depth understanding of trauma has been a central focus for many clinicians and researchers who represent different fields in health, education, and social sciences, including the mental health fields. As the focus on trauma in research and practice has grown, it has become crucial for mental health professionals to be supported in their work with clients who have experienced trauma. While much attention has been placed on the psychological and physiological impacts associated with traumatic experiences, the adverse impact of racism-based experiences has not garnered much mainstream attention among traditional trauma scholars and mental health professionals (Carter, 2007b; Helms et al., 2012). While there are still debates on whether racism and discriminatory practices can be classified as trauma, researchers have established a strong association between race-based traumatic incidents and the development of adverse symptoms such as depression, anxiety, hypervigilance, flashbacks, feelings of worthlessness, helplessness, shame, and hopelessness (Carter & Forsyth, 2009; Hemmings & Evans, 2018). As mental health professionals, one of our primary roles is to help clients identify, heal, and gain freedom from harmful circumstances that may present a threat to their well-being.

Further, all mental health training programs have an ethical responsibility to support mental health professionals in their work with diverse clients.

PURPOSE STATEMENT

The purpose of this dissertation is twofold. The first aim is to explore how racism and other oppressive practices constitute racial trauma and how racial trauma can be toxic to the wellbeing of the individual through the eyes of Black mental health professionals who serve Black clients. To this end, various mental health professionals who are deemed experts in the area of racial trauma and have worked with racially traumatized individuals will be interviewed to gather critical information on best practices. By sharing their experiences and expertise, I hope to introduce or bring to light a readily accessible conceptual and cosmopolitan approach to effectively work with clients who have experienced racial trauma. The second goal is to explore the training needs of mental health professionals who serve communities where racial trauma may be prominent.

IMPORTANCE OF ADDRESSING RACIAL TRAUMA IN COUNSELING

Research on the psychological and physiological effects of racial trauma has steadily gained traction in recent years (Carter & Forsyth, 2009; Johnson & Melton, 2021). Despite some of the controversies surrounding whether the impacts of racism and other discriminatory practices can be considered as trauma, the negative sequelae that could result from race-based trauma has been well documented in multiple ethnographic studies (Bryant-Davis & Ocamo, 2005; Carter, 2007; Carter & Forsyth, 2009; Helms, et al., 2010). The literature on the pervasive effects of racism and discrimination is rich (Carter & Forsyth, 2009; Johnson & Melton, 2021). Racism and discrimination has been linked to a myriad of health issues, including obesity, drinking problem, and high blood pressure in Black individuals. Furthermore, the effects of

racial trauma have been equated to that of post-traumatic stress disorder (Comas-Díaz et al., 2019). These effects include, but not limited to, a state of hypervigilance, flashbacks, nightmares, feeling isolated, avoidance, paranoia, and somatic symptoms that mimic PTSD symptoms (Comas-Díaz et al., 2019). Other injuries associated with racial trauma is the erosion of cultural identity, anxiety, depression, suicidal thoughts, substance use disorders, eating disorders resulting from a lack of agency, and other mental illnesses (Comas-Díaz et al., 2019). The high comorbidity of racial trauma with other mental illnesses make it highly susceptible to be overlooked or misdiagnosed; hence, it is imperative that mental health professionals be well equipped to recognize racial trauma symptoms.

STATEMENT OF THE PROBLEM

The unswerving scarcity in trauma research that fails to include the experiences of Black people with discrimination and racism increases the likelihood that Black people may be misdiagnosed or dismissed when they report on symptoms related to racial battle fatigue (Smith et al., 2006). When we invalidate the race-based traumatic experiences of Black people, we are further perpetuating a discourse of oppression and racial microaggressions; in doing so we are also participating in the preservation of a cycle of racial trauma. As the mental health field continues to expand its knowledge base on trauma and its impact on individuals and communities, more research, training, and resources are needed to help mental health professionals address the needs of Black clients who demonstrate signs of racial trauma, racial microaggressions, and racial battle fatigue (Smith et al., 2006). Because of the novelty in recognizing the harmful impact of racism on Black people in the U.S., the literature on how mental health professionals address racial trauma in counseling is limited. To respond to the mental health needs of their Black clients, Black mental health providers have had to adapt their

cultural knowledge of the Black experience to the Eurocentric training resources and knowledge taken from the field. The frequent exposure and experience working with racial trauma have given Black mental health providers the expertise needed in the area of racial trauma.

Optimistically, I hope to fill this gap with this study that will contribute to the competency training of mental health providers.

Black mental health professionals are not exempt from experiencing racial trauma themselves. Acuff (2018) noted the accumulation of emotional and psychological baggage that Black people carry as a result of having to perform, function, and thrive in spaces percolated by unrelenting oppression and discrimination. Studies have shown that Black mental health professionals often experience negative symptoms related to direct experience with racism and discrimination, vicarious trauma, counselor burn-out, and racial battle fatigue which is characterized by exhaustion, helplessness, anger, resentment, burnout, and anxiety (Acuff, 2018). Social justice advocate and expert, Mary-Frances Winters (2020), used the term Black Fatigue to describe the emotional toll that Black people experience as a result of racism and which can be manifested as physiological and psychological health issues. This is an important element of investigation considering that the emotional state of Black professionals have a significant impact on the outcomes of their consumers (Acuff, 2018). This study will highlight significant aspects of the racialized experiences of mental health professionals working with populations who have experienced racial trauma by explicating these systemic structures that contribute to Black mental health experts' emotional and psychological baggage. This study may also shed light on the effective ways in which mental health experts have managed their own exposure to the racial trauma that they have experienced vicariously through their work with clients. It will

also explore cultural competency training and other professional development activities that may increase counselor effectiveness.

While gaining expert advice on how to most effectively work with clients who have been racially traumatized, this study can potentially contribute to the broader mental health field by creating an awareness of race-consciousness, race-muting practices in the mental health field, and social injustices in our communities. It may also help practitioners gain an understanding of how these practices impact clients and mental health professionals working with racially traumatized clients. Subsequently, this study may help non-Black mental health professionals engage in self-reflection with the goal of unmasking their implicit biases toward minoritized clients.

GAP IN THE LITERATURE

Though the literature on racism and discrimination and its deleterious impact on the psychological and physical wellbeing on Black people is emerging, significant gaps remain (Hemmings & Evans, 2018). There is a paucity of research in the literature of traumatology that has investigated how racial trauma is assessed and treated by mental health professionals. Additionally, no other studies have investigated the impact of providing racial trauma therapy on the well-being of mental health professionals. Most recently, clinical psychologists Johnson and Melton (2021) published a book, *Addressing Race-Based Stress in Therapy with Black Clients*, in which they offered guidelines to mental health providers working with Black clients who show signs of race-based stress. The authors specifically emphasize the integration of a multicultural framework, including advocacy and dialectical behavioral therapy techniques to help clients heal from race-based stress. While this book is practical in that it provided a practical framework that includes worksheets, vignettes, and case studies to assist practitioners, it does not

encapsulate the experiences of Black mental health professionals working with clients with racial trauma. Similarly, researchers Hemmings and Evans (2018) conducted a quantitative study investigating the experiences of 106 counselors with identifying and treating race-based trauma in counseling. While this study provided insightful feedback, specific narratives and the voices of these counselors is still an enigma. The present study aims to address these specific gaps by capturing the voices of Black mental health professionals on the subject.

SIGNIFICANCE OF THE STUDY

According to the U.S. Census Bureau (2020), it is estimated that non-White racial and ethnic groups will represent more than 57.8 percent of the population by 2050. The Black communities across the United States make up 13.3 percent of the country's population which includes immigrants from African nations, the Caribbean, Central America, and other countries; this percentage does not include Blacks of multiple races (American Psychiatric Association [APA], 2017; Ellis et al., 2019; U.S. Census Bureau, 2020). The following is a breakdown of the various ethnic groups that make up the Black American population: 1.6 million (4%) identify as being African (e.g., Ghanaian or Kenyan) and 1.7 million (4.4%) report as being of Caribbean Black decent (e.g., Haitian or Jamaican) (Ellis et al., 2019). People who identify as being two or more races constitute 24.9 percent of the U.S. population (APA, 2017). Despite the increasing amount of research including people of color, Blacks in the U.S. continue to be an underserved and marginalized population in the mental health field.

Racism and discrimination have a far-reaching detrimental effect on the lives of Black people in the U.S. (Walker, 2020). Winters (2020), a passionate advocate for justice and equity, author, and a well-renowned expert in diversity, equity, and inclusion issues, noted that "racism exhausts Black people" (p. 69). In her book titled *Black Fatigue: How Racism Erodes the Mind*,

Body, and Spirit, Winters (2020) eloquently and poignantly writes about the emotional impact that racism, and its many shapes whether in the form of implicit bias, microaggressions, or overt racism, has on the wellbeing of Black people. Her data represents the voices of thousands of Black and Brown employees who have shared their taxing and sometimes traumatic experiences in having to function and perform in toxic Predominantly White Institutions (PWI) and corporate spaces. Data results from focus groups and cultural audits indicated unfair treatment of Black and Brown people in hiring, promotions, involuntary terminations, and performance reviews. This study also revealed that racism led to health disparities, chronic illnesses, chronic stress, race-based intergenerational trauma, and lower-quality healthcare (Winters, 2020).

In a cross-validation study of the Schedule of Racist Events (SRE), a brief inventory that assessed the frequency of various types of racist discrimination in the life of Black people, the results indicate that 96% of the 520 African Americans surveyed experienced racial discrimination during the past year and 98% reported that they had experienced racial discrimination at some point during their lifetime. Almost all (95%) of the sample indicated that these race-based stressors were hazardous to their well-being (Landrine et al., 1996).

The recent pandemic of 2020 put the spotlight on the abominable major health disparities between Black and White people living in the U.S. resulting in lower life expectancies for Blacks (Moreland-Capuia, 2021; Winters, 2020). Research on mental health of minorities has shown that Black adults are 20 percent more likely to report serious psychological distress than their White counterparts (APA, 2017; Winters, 2020). A recent census on the mental health prevalence among people who identify as multiracial indicated that Blacks were more likely to report a mental illness within the past year than any other race or ethnic group (APA, 2017). Furthermore, when White people and Black people present the same symptoms, Black people

were more often diagnosed with schizophrenia disorders while their White counterparts were more likely to be diagnosed with mood disorders (APA, 2017). Because of the high prevalence of mental illness among minority and disenfranchised groups combined with the existing likelihood of being misdiagnosed by mental health professionals, it is imperative to create a sense of urgency to provide relevant training and support to practitioners in the mental health field working with diverse populations.

Historically, through oppressive practices, the Black American voices and narratives have been dominated and omitted from the historical development of medicine. The Black bodies have traditionally been subjected to atrocious medical research accounting for the deeply rooted sense of distrust and reticence in medicine (Washington, 2006). Consequently, fear and distrust of Westernized medicine, including mental health practices, is one of the major elements explaining some Black individual's reluctance to seek mental health services or premature termination in treatment (Chang & Yoon, 2011). In fact, greater interpersonal trust has been found to be a significant predictor of clients' treatment outcomes and overall satisfaction in mental health services (Chang & Yoon, 2011). Considering that trust is foundational to the therapeutic relationship between mental health clinicians, it is not surprising to see Black clients fearful of disclosing or broaching their racialized experiences with their White counselors. Other factors contributing to Black clients' fear of disclosing is the fact that the mental health field has historically been a Westernized practice dominated by White providers (Sue et al., 2019). Additionally, studies have shown that counselors' attitudes and biases toward Black clients tend to permeate their therapeutic relationships with minority clients (Johnson & Melton, 2021). Hence, it is imperative that counselors are aware and knowledgeable of the detrimental impact of

racism and other racialized experiences on clients. Furthermore, counselors ought to develop the aptitude necessary to help clients build trust in the therapeutic relationship.

The increased awareness of the prevalence of racism in the U.S. coupled with the increased awareness of the psychological impact of racism on the mental health of minority communities has placed a greater emphasis in the mental health field on providing trauma-informed care and culturally sensitive services to diverse clients. As social justice advocates, mental health professionals have the ethical responsibility to do all diligent efforts to obtain the necessary skills to provide relevant services to diverse clients.

RESEARCH QUESTIONS

Approaches toward racial trauma in counseling are examined through the following research questions:

1. What are the experiences of Black mental health professionals working with clients who have experienced racial trauma?
2. How do Black mental health professionals meet the personal and professional challenges of serving clients who experience racial trauma?
3. What competency training do mental health professionals need to promote and enhance their effectiveness when working with individuals who experience racial trauma?

RELEVANCE TO COUNSELING

Competency in trauma, crisis, and disaster is integral to the 2016 Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards (CACREP, 2016). In the last decade the awareness of the high prevalence of trauma in diverse communities has raised a call to provide Trauma Informed Care throughout all establishments directly servicing all individuals (Betancourt et al., 2017; Zigelbaum & Carlson, 2011). For mental health providers,

this entails recruiting, developing, and maintaining staff who can meet the unique needs of clients without further retraumatizing them. Examination of the literature on trauma competencies of mental health professionals have shown that there is a dearth of trauma training in mental health programs' curriculum (Asselt et al., 2016; Ober et al., 2012). Mental health trainees are graduating without adequate training in trauma care (Jais et al., 2017). Such practices could present a threat to clients' engagement, trust, and treatment outcomes. Without the skills to adequately assess and respond to trauma, mental health professionals are placing vulnerable populations at risk. Shifting an organization's climate to be more trauma-informed comes with many challenges, including staff readiness and commitment to adopt newer approaches. Such a shift in culture requires staff buy-ins through hands-on training, reliable data, substantive tools and resources. The need for trauma-informed care, added to the fact that the fifth edition of the *Diagnostic Statistical Manual* (DSM-V) has failed to include race-based trauma in their definition of trauma, has made the need to provide mental health professionals tools and resources to work with racial trauma quintessential (APA, 2013). This study will help concretize the experiences and expertise of mental health professionals working with clients who have experienced racial trauma.

DEFINITION OF KEY TERMS

Racism

Race expert, David Wellman, defines racism as a “system of advantage based on race” (Tatum, 2017, p.87). This definition recognizes the oppressive systemic structure embedded in cultural messages, institutional policies and practices, and individual actions that constitute the foundation of racism (Degruy, 2005; Tatum, 2017; Winters, 2020). Racism is rooted in our social structures with the goal of keeping people of color in subordinate positions (Hartlep & Ball,

2019). Racism chips away at an individual's sense of self-esteem, self-confidence, self-compassion, self-efficacy, identity, sense of belonging, quality of life, view of life, physical health, mental health, spirituality, and sense of agency (Degruy, 2005; Winters, 2020;).

Structural Racism

Structural racism refers to the synchronous ways in which all systems of racism across multiple institutions and multiple arenas join forces to create a structure that is pervasive, cumulative, lasting, and indiscernible. Structural racism is characterized by inequalities of power, economic inequalities, unequal access to resources, and unfair and unjust policy outcomes based on race (Garran et al., 2022; Lawrence & Keleher, 2004). According to Lawrence and Keleher (2004), structural racism is:

the normalization and legitimization of an array of dynamics – historical, cultural, institutional and interpersonal – that routinely advantage Whites while producing cumulative and chronic adverse outcomes for people of color. It is a system of hierarchy and inequity, primarily characterized by White supremacy – the preferential treatment, privilege and power for White people at the expense of Black, Latino, Asian, Pacific Islander, Native American, Arab and other racially oppressed people. (p. 1)

Because structural racism is interwoven in the fabric of institutions and cultural norms, it is the most debilitating and pervasive form of racism. It is difficult to detect and eradicate. Structural racism births all other forms of racism such as institutional, interpersonal, and internalized (Lawrence & Keleher, 2004). It is a system that kneels down on the necks of Black people and leaving them gasping for the basic needs for survival.

Interpersonal Racism

This is the racism that occurs when an individual holds negative attitudes towards another individual of a different race or culture (Garran et al., 2022; Lawrence & Keleher, 2004).

Individual or Internalized Racism

Individual or internalized racism are racist beliefs and attitudes manifested at the individual level and that are influenced by the dominant culture; examples include prejudice, xenophobia, and more (Garran et al., 2022; Lawrence & Keleher, 2004).

Institutional Racism

Institutional racism is discriminatory treatment that lies within and between institutions. They are manifested through unjust and biased institutional policies and practices based on race with the aim of maintaining minoritized groups at the bottom of the social, political, and economic hierarchy (Garran et al., 2022; Lawrence & Keleher, 2004). Examples of institutional racism are Jim Crow laws and redlining practices (Alexander, 2012).

Aversive Racism

Aversive racism is a covert form of racism characterized by individuals who believe that they are non-prejudiced and egalitarian but harbor unconscious negative beliefs, attitudes, and emotions toward Black people and other minoritized groups (Constantine, 2007; Dovidio & Gaertner, 2000).

Racial Microaggressions

The literature on racial microaggressions has defined racial microaggressions as the complex, intentional or unintentional, verbal or nonverbal disparaging insults directed at people of color (Hernández & Villodas, 2020; Ogunyem et al., 2020; Sue et al., 2019). These microaggressions can be conveyed in hidden messages or in commonplace behaviors or verbal communications (Sue et al., 2007). They tend to obfuscate the reality or experiences of already

marginalized groups, leaving them questioning the reality of their experiences. Microaggressions tend to conceal the hostility toward the target. Examples of racial microaggressions include being treated with less respect or comments that leave a person feeling isolated and unwelcomed.

Microassaults. Microassaults are conscious, purposeful, and deliberate transgressions that are directed toward people who appear to be members of culturally minoritized or disenfranchised populations (Boske et al., 2016; Sue et al., 2007). An example of a microassault is people assuming that a Black person's achievement is solely due to Affirmative Action and not their qualifications. Another example is openly displaying the confederate flag in a public space.

Microinsults. These are rude or insensitive verbal and nonverbal communications that are hurtful or demeaning to someone's race, ethnicity, gender, or sexual orientation (Boske et al., 2016; Sue et al., 2007). An example of a microinsult would be insinuating a Black woman who is speaking passionately as being aggressive or assuming that a Black man is threatening because of their stature but think differently of a White man with similar built.

Microinvalidations. Microinvalidations include the exclusion, negation, or devaluing of a person's lived experiences or reality (Boske et al., 2016; Sue et al., 2007). An example of a microinvalidation would be attributing Black people's economic disparity to their own lack of efficacy and laziness; in doing so, the perpetrator is denying that the structural racism, glass ceilings, and "crooked rooms" that constitute as barriers to Black individuals' efforts to success.

Racial Macroaggressions

Racial macroaggressions are systemic racially discriminatory beliefs, behaviors, attitudes that are pervasive and anchored in institutional policies and practices (Smith et al., 2007). They exist within the larger structures of society and serve as the pillar to hegemonic culture. Boske, Osanloo, and Newcomb (2016) contend that macroaggressions are persistent and malicious transgressions that are intended to create longitudinally enervating and depressive results in the offended. Microaggressions and macroaggressions act in tandem to sustain oppressive and subjugating policies and practices (Boske et al., 2016).

Stress

Stress is a negative or unwanted event or circumstance that requires a person to change psychologically, physiologically, and in their social interactions in order to adapt or cope (Carter et al., 2017).

Trauma

Trauma is defined as an extreme form of stress that severely impedes on an individual's capacity to cope with the stressor (Carter et al., 2017). According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2019), a branch of the U.S. Department of Health and Human Services, trauma is defined as an individual's response to any event or experience that is perceived to be physically or emotionally harmful or life-threatening and can have lasting adverse effects on the functioning and well-being of an individual. Trauma is often conceptualized as posttraumatic stress disorder (PTSD) in mental health professions (APA, 2013). PTSD criteria as indicated in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.) is necessitated for the diagnosis of trauma in the mental health fields (Carter et al., 2017). The American Psychiatric Association (2013) defines trauma as the "exposure to actual or

threatened death, serious injury, or sexual violence . . . by directly experiencing, or witnessing, (the) traumatic event” (p. 271).

Traumatic Stress

Traumatic stress is a form of stress in which the core stressor stems from emotional pain instead of a life threatening event or series of events (Carter et al., 2017).

Racial Trauma

Racial trauma, a form of stress, based on race is the overall psychological, emotional, physical responses expressed by people of color as a result of psychological, emotional, and sometimes physical threats and injuries endured by the hand of oppressive systems (Comas-Díaz et al., 2019). Hemmings and Evans (2018) described race-based trauma or race-based traumatic stress as the emotional, psychological, and physical pain brought by the feeling of being discriminated against. Race-based traumatic stress is characterized by emotional injury, an inability to cope, severe stressors that threaten safety and wellbeing, or extreme racism experienced at the interpersonal or institutional level causing fear and feelings of helplessness (Hemmings & Evans, 2018).

Cultural Competency

Cultural competency has been defined as the ability to provide culturally effective and relevant services to individuals of diverse backgrounds (Alizadeh & Chavan, 2016). It is the ability to approach the counseling process from the cultural lens of the client (Ahmed et al., 2011).

Racial Battle Fatigue/Black Fatigue

Racial Battle Fatigue (RBF) refers to the social determinants, meaning nonmedical factors or social disadvantages that directly influence the wellbeing of individuals. These include

health, life satisfaction, lifespan, quality of life, values, beliefs, intellect, knowledge, attitudes, and behaviors (Hartlep & Ball, 2019; Notterman & Mitchell, 2015). Black Fatigue is a term coined by diversity and inclusion pioneer, Mary-Frances Winters (2020) that refers to repeated stressors that lead to extreme exhaustion and mental, physical, and spiritual maladies. RBF can have a long-lasting physiological, emotional, and psychological impact on the individual, community, and future generations (Hartlep & Ball, 2019; Smith et al., 2006). Smith et al. (2006) noted that the psychophysiological symptoms of racial battle fatigue may be directly linked to low self-esteem, social withdrawal, and many negative health concerns. RBF is toxic and can impact individuals and communities alike (Hartlep & Ball, 2019). RBF can bring out feelings of depression, anxiety, rage, frustration, exhaustion, shock, anger, disappointment, resentment, helplessness, hopelessness, fear, withdrawal behaviors, physical health issues, and serious emotional and physical stress (Hartlep et al., 2019; Smith et al., 2007; Smith, et al., 2006).

Blacks

To be inclusive of Black Americans of the broad African diaspora, in this study, I referred to Black mental health professionals as anyone who identifies as a person of African descent. These include African Americans, immigrants from African nations, the Caribbean, Central America, and other countries (Ellis et al., 2019; APA, 2017).

Mental Health Professionals

In this study, the term mental health professionals was used to refer to individuals who are licensed and working in fields where they provide mental health services. These are psychologists, psychiatrists, counselors, or clinical social workers.

THEORETICAL FRAMEWORK

Critical Race Theory (CRT) is the theoretical framework in which this study is anchored. The seminal ideas of CRT posit that racism is woven into the fabric of this country (Bell, 1992; Hartlep & Ball, 2019; Ladson-Billings et al., 1995; Ogunyemi, et al, 2020; Solórzano et al., 2001). It is infiltrated in our social, political, and economic realms and privileges Whites while subjugating and minoritizing all non-Whites (Bell, 1992; Hartlep & Ball, 2019). Early scholarship on CRT first emerged through the writings of Du Bois (1903) when he declared that “the problem of the 20th century was the problem of the color line.” Du Bois, a sociologist by training, sought to explore race relations at a time that predated boycotts and the civil rights era. Bell (1992) was another early significant contributor to CRT discourse. Bell argued that racism was a permanent fixture in American life because it was embedded in all economic, educational, and institutional structures. Bell further argued that only temporary racial gains could be gained only if it benefited Whites. Another essential tenets of Critical Race Theory is its ability to expose systemic structures that serve to maintain the hegemony of racism and also empower marginalized groups (Bell, 1992; Hartlep & Ball, 2019). Using CRT for this dissertation research has allowed me to anthropomorphize and challenge critical macro and micro constructs such as racism, sexism, xenophobia, homophobia, classism, and its derivatives. Scholars influenced by CRT posit that CRT has the epistemological qualities of giving voice to the experiences of marginalized and oppressed groups through the embodiment of their counternarratives (Smith et al., 2006). Furthermore, the counterstories in CRT have the potential to foster a sense of community through shared experiences with various forms of subordination (Smith et al., 2006).

DELIMITATIONS

The slow movement from the mental health field in recognizing the deleterious impact of racism on the mental health outcomes of people of color has added to the scarcity in finding

well-trained experts in racial trauma. The literature has shown that Black people have been the most impacted by racism and oppression. For these reasons, I limited my selection of participants to Black mental health professionals who are knowledgeable about the relevance of the problem and have first-hand experience and expertise serving Black clients who experience racial trauma. Excluding White voices from this study constitute a delimitation but one that is necessary to gain meaningful insights.

ORGANIZATION OF THE STUDY

This dissertation on *Addressing Racial Trauma in Counseling: Perspectives and Lessons from the Field* is presented in five chapters. Chapter 1 was designed to introduce the ideology of racism and the hegemony of discriminatory beliefs and practices as traumatic experiences that aim to subordinate and dehumanize Black people. I then situated racial trauma and its relevance in today's cultural and political climate. Chapter 1 also provided the lens in which racism was examined, meaning from a mental health perspective and from a critical race theory framework. Key concepts surrounding racial trauma were defined. Chapter 2 gave the reader an in-depth overview of the literature on racial trauma, an accurate picture of its deleterious effect on Black communities, the ways in which mental health professionals address it in therapeutic settings, and lastly the bearing on mental health professionals. Chapter 3 highlighted the methodology and theoretical framework that was used to gather the data and interpret the results. It also presented the most pertinent aspects of the results. Chapter 4 provided a description of the sample of Black mental health professionals who were selected to participate in the study. This section also highlighted some relevant demographic information along with trends observed in their level of training. Lastly, this chapter also introduced the themes that were developed from the data analysis. Chapter 5 concluded the dissertation by providing insights on the meaning surrounding

the themes; limitations of the study; implications for the counseling field, including policies and practices; and recommendations for future research.

SUMMARY

This chapter provided an introductory overview of the context and purpose of the study. It also provided the research questions that guide the focus of research study, including a definition of term. The next chapter provided an in-depth literature view of key constructs that guide the focus of this study.

Chapter 2 - Literature Review

"For those of you who wish to leave politics out of dealing with trauma, I wish to remind you that trauma is all about people living under social conditions where terrible things are allowed to happen, and where the truth cannot be told."

~ Bessel van der Kolk²

A substantial amount of scholarship on racism and mental health outcomes has brought to light the pernicious effect of oppressive and discriminatory practices and policies. To understand the link between racism and trauma, this study will examine the history of racism in the United States (U.S.), the epistemology of trauma, including what constitutes racial trauma, and lastly, the history of race studies in mental health, including how race is addressed in mental health training programs.

HISTORY OF RACISM IN AMERICA

Race

Race is a socially constructed concept that society rely heavily on to categorize people; race has significant impact on our lives (DiAngelo, 2016). At the inception of the U.S., freedom and equality were radical ideologies that seemed to contradict atrocious practices such as the enslavement of African peoples, the displacement and the genocide of Indigenous North American peoples, and the colonization of Mexican lands (DiAngelo, 2016). Race was constructed to justify the aforementioned atrocities which served the foundation of the U.S. economy (DiAngelo, 2016). Race created a system of hierarchy that promulgated the notion of one race being superior to another and thus, justifying the use of the inferior race to benefit the one that is believed to be superior, the White race.

² The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma by Bessel van der Kolk (2015)

Despite the abolition of slavery in the U.S. in 1865, racist ideologies and policies persisted (DiAngelo, 2016). The notion of being White was equated to being American (Kendi, 2019). People fought legally to be considered White (DiAngelo, 2016). To put an end to the many ambiguity around who warranted admission to the White rank of the racial hierarchy, the court empowered the White man to decide who could be categorized as White based on their common understanding and perception of Whiteness (DiAngelo, 2016). With the wave of immigrants coming to the U.S. during the early 1900's, European immigrants were granted citizenship to the hierarchical of Whiteness with the idea that they would assimilate to the dominant culture (DiAngelo, 2016). DiAngelo (2016) argued that assimilation perpetuated the belief that America is White; conversely, anything other than White is considered non-American. This notion of White being equated to being American dictates the lived experiences of individuals depending on their phenotypes; someone who appears to be White will be perceived as White and thus treated as White (DiAngelo, 2016).

Prejudice

Understanding prejudice is foundational to understanding racism (DiAngelo, 2018). Prejudice is the pre-judgment that is made of a person based on social group membership (DiAngelo, 2018). It is rooted in preconceived assumptions, omissions and distortion of information about this group (Tatum, 2017). Prejudice is unavoidable and affects us all (DiAngelo, 2018). When prejudice is infiltrated and endorsed in institutional policies and legal authority, it births a system of oppression, hegemony, and racism (DiAngelo, 2018).

Racism

According to American antiracist activist and historian of race and discriminatory policy, Ibram X. Kendi, racism is a collection of policies that are reinforced by racist ideas and that

result in racial inequity (Kendi, 2019). Kendi (2017) postulates that racist ideas and its derivatives (e.g., racial discrimination) spiraled out of economic, political, and cultural self-interest. Structural discriminatory practices and policies are usually created to maintain and increase profit margins (Kendi, 2017).

Racist ideas are concepts that view one racial group as superior than another racial group in any way (Kendi, 2017, 2019). Kendi (2017) further defines anti-black racist idea as any thought or notion that postulates that any group of Black people are inferior to another racial group. Racist ideas in America serves to hinder any attempts to rebel against or dismantle racial discrimination and racial disparity (Kendi, 2017). Kendi (2019) further asserted that racist ideas explicate racial inequities as a function of inferiority or superiority of racial groups. Contrary to popular belief, Kendi (2017) contends that racist and discriminatory policies and practices lead to racist ideas that eventually lead to racialized ignorance and hate.

Tatum (2017) maintained that racism is an integral part of our society and we are all impacted by it. Similarly, Kendi (2017) noted that anyone can hold racist ideas, including Black people themselves. Racist ideas can be produced or consumed (Kendi, 2017). Consumers of racist ideas are individuals who buy-in into the notion that there is something viscerally wrong with Black people. Producers of racist ideas are powerful White American people who have created racialized discourses to support and justify existing sociopolitical and cultural racist policies to explicate racial disparities of their regime and subsequently shifting all responsibilities to the inferiority of Black people (Kendi, 2017).

Kendi (2017) chronicled two types of racists; the assimilationist and the segregationist. Assimilationists, which Kendi (2019) categorized as individuals who hold racist ideas, hold Whiteness to be the standard to which all other racial groups must be measured up to and strive

toward. They believe that Black people have the capacity to achieve this standard if given the proper scaffolding. Segregationists on the other hand believe that Black people are viscerally defective and are incapable of achieving or measuring up to Whites. According to Kendi (2017, 2019), antiracists acknowledge that discrimination and racist policies are the explainable causes of racial disparity among racial groups and that all racial groups are inherently equal with their differences. American sociologist, socialist, historian, and civil rights activist W.E.B. Du Bois coined the term “double consciousness” to refer to the cognitive dissonance that Black people experience when evaluating themselves from a Black lens and from that of the assimilationist (Kendi, 2019). These concepts are crucial for counselors to understand in order to develop deeper awareness of where one stands with regards to segregationism, assimilationism, and antiracism to avoid imposing Eurocentric expectations on Black clients.

Many scholars believe that racism can be expressed overtly or covertly. We see racism manifested overtly in individual shootings of Black people, mass shootings of Black people as in the Charleston church massacre, the Ferguson killing of Michael Brown, and the racial reckoning following the George Floyd killing, the unjust treatment of Black people in the legal justice system such as in the Breonna Taylor and Walter Scott trials, the injustice in the criminal justice system, and the U.S. Capitol attack of 2021. Racism also exists in covert forms such as in housing discrimination, racial bias in mortgage and lending practices, racial tracking in schools, the myriads of hate crimes running rampant throughout the nation such as the lynching of Ahmaud Arbery, bureaucratic mandates that contribute to the dehumanization and unequal treatment of immigrants, acrimonious debates about affirmative action, racial profiling of Black men by cops, the misuse of Black bodies as subjects in research studies, the unfair treatments of Black people in medicine, and the inequalities in education (Tatum, 2017). Unlike Tatum (2017),

Kendi (2017) does not ascribe to the notion that racism can be covert. He sees racism or racist ideas as always overtly expressed.

White Silence

Winters (2020) asserted that White people have been socialized to not “see” race and refer to it as “*sublime ignorance*”. Only 15% of Whites recognize their Whiteness as part of their identity while 75% of Blacks and 50% of Asians and Latinx reported on how salient their race was in how they identify (Winters, 2020). The “*raceless and cultureless*” (Winters, 2020, p. 25) attitude of White people often results in the unwillingness to recognize racial differences, engage in meaningful cross-racial conversations, and recognize the impact of their Whiteness on non-Whites in a culture in which they are the dominant (DiAngelo, 2016; Winters, 2020). It can also lead to an inability to empathize with members of the non-dominant group. Kendi (2017) referred to this lack of racial responsiveness of Whites as “*White silence*”, the tendency of White people to remain silent in racial discussions. Kendi (2017) posited that White Silence restricts our capacity to engage in continuous self-enlightenment on issues related to racism and the need to build cross-racial relationships. When Black people and other people of color overtly discuss the impact of racism and discrimination on their personal wellbeing and on that of their communities, especially in White spaces, they are demonstrating vulnerability (DiAngelo, 2016). If this vulnerable act is met with “*White silence*” or “*sublime ignorance*”, it leaves the Black person or people of color feeling invalidated and dismissed (DiAngelo, 2016). Moreover, the freedom to remain unaware, subliminally ignorant, or silent to the experience of Black people and other minoritized groups is a form of White privilege (DiAngelo, 2016). For Whites to be antiracist, one needs to challenge these norms expecting Whites to remain unscathed by issues of race (DiAngelo, 2016).

The aforementioned preambles are not uncommon to the mental health profession. The therapeutic environment constitutes a microcosm of society which calls for similar coping strategies in cross-racial and cross-cultural interactions (Chang & Yoon, 2011). Research has shown significant discomfort in cross-racial therapeutic relationships (Chang & Yoon, 2011).

Chang and Yoon (2011) conducted a consensual qualitative study to examine perceptions of race in cross-racial therapeutic dyads and its impact on the therapy relationship. They interviewed 23 ethnic minority participants who recently had a therapeutic relationship with a White therapist. Participants reported complex and contradictory appraisals of racial mismatch and racial match of their therapeutic relationship with their White therapist. The authors found that most of the participants were resistant to discuss issues of race and other sociocultural issues with their White therapist in fear that their White therapist would not validate their experiences. Overall, participants in this study reported that their therapist showed lack of engagement and culturally incompatible communication style. Participants further expressed that their therapist operated from a “textbook” and “superficial” approach (Chang & Yoon, 2011, p. 574), which did not resonate with them and constituted a barrier to healing and growth in treatment. One Black male participant felt that his therapist only had “second-hand knowledge” of his community (Chang & Yoon, 2011, p. 573); another mixed-race participant felt that her therapist was unable to grasp the historical trauma that her ancestors had endured and its inherent impact on her lived experiences.

This is particularly important considering that the clinical arena is disproportionately represented by White therapists who have been socialized in a racialized culture that openly demonstrated discomfort in broaching racial issues. Johnson & Melton (2021) noted that therapists’ ethical professional practice were anchored in their personal values and morals which

are anchored in the larger societal culture in which these professionals live in and identify with. Along the same line, Sue & Sue (1999) noted that people in general unconsciously operate from a worldview, which they referred to as *invisible veil* that is conditioned by the dominant culture in which people live. They further note that collective biases, beliefs, cultural values, assumptions, and social norms are systematically structured to favor the dominant culture (Sue & Sue, 1999). Such ethnocentric monocultural approaches can be oppressive in heterogeneous societies (Sue & Sue, 1999). Recognizing the influence of the clinician's personal values and morals on adherence to professional ethical standards is imperative to contesting or rejecting dominant societal norms that could be detrimental to the therapeutic relationship (Johnson & Melton, 2021).

To help mitigate the possibility of influencing, overpowering, or even patronizing clients, Johnson & Melton (2021) recommend that mental health professionals adhere to a multicultural framework in their practice therefore, fostering open-mindedness, pluralism, cross-cultural empathy, a dialectic attitude toward differing moral and cultural views, and an inclusive culture. Johnson & Melton (2021) further urged therapists to be aware of their position of power as therapists and how their personal values may impact clients' values and experiences in therapy. Overall, White therapists' silence or avoidance in discussing sociopolitical concerns that directly impact clients can have harmful consequences on clients' satisfaction with treatment and in the creation of a strong therapeutic alliance with clients of differing cultural backgrounds.

INSTITUTIONAL RACISM, MICROAGGRESSION, AND MACROAGGRESSION

Structural racism, institutional racism, or systemic racism have been used interchangeably by various scholars to refer to racialized policies, laws, and procedures that are entrenched in social, cultural, and political entities and that serve to sustain racial inequity

between racial groups (Kendi, 2019). Kendi (2019) used the term racist policies to refer to these terminologies that seem nebulous in nature. Racial discrimination refers to how racist policies are manifested.

First coined by Harvard psychiatrist Chester Pierce in the 1970s, racial microaggressions referred to the verbal and nonverbal slights and attacks that Black people experienced on a daily basis (Tatum, 2017):

The chief vehicle for proracist behaviors are microaggressions. These are subtle, stunning, often automatic, and nonverbal exchanges which are ‘putdowns’ of blacks by offenders. The offensive mechanisms used against blacks often are innocuous. The cumulative weight of their never-ending burden is the major ingredient in black and White interactions. (Pierce et al., 1978, p.66)

Since its inception, the term microaggression has been expanded to include similar racialized lived experiences of other marginalized groups (Tatum, 2017). Psychologist Derald Wing Sue describes microaggressions as denigrating messages that people experience as a result of their group membership (Boske et al., 2016; Kendi, 2019; Sue et al., 2007). Kendi (2019) uses the term “abuse” in lieu of microaggressions because he believes that the term “micro” does not encapsulate the unrelenting, pervasive, and harmful impact of these transgressions on individual’s mental health and overall wellbeing. He noted “abuse accurately describes the action and its effect on people: distress, anger, worry, depression, anxiety, pain, fatigue, and suicide” (Kendi, 2019, p. 47).

Pierce (1974) recognized that these racialized, incessant, cumulative, and never-ending assaults of Blacks by Whites to be the cause for the “pervasive effect to the stability and peace of this world” (p. 515). In a study examining the effects of racial microaggressions on depression,

anxiety, and trauma on 179 Black women with different occupational prestige, it was found that microaggression frequency positively predicted depression and anxiety symptoms (Reid, 2017). Black women in this study reported being treated as incompetent or as if they did not earn their space in the workplace and professional settings. They were subject to inquisition for which they felt the need to continuously prove their intellectual abilities. Of utmost importance, the impact of such treatment was psychologically damaging. They reported feeling devalued, disrespected, invalidated, delegitimized, disempowered, ostracized, and marginalized (Reid, 2017).

Macroaggression is used to describe participation in big systems of oppression (Boske et al., 2016). At the structural level, macroaggression included practices and policies that aim to exclude or marginalize (Boske et al., 2016). Boske et al. (2016) further purported that macroaggressions are transgressions committed in public arenas and that are maliciously taxing and disastrous to the victims. They can be verbal or non-verbal; they are persistent in nature (Boske et al., 2016).

In an effort to examine the ways in which macroaggression, microaggression, and structural racism are exemplified in intercultural relationships in K-16 educational institutions, Boske et al. (2016) found that school community members often employ apparent and sometimes insidious deficit-laden behaviors and practices when interacting with people across cultural groups. They define deficit-laden attitudes, beliefs, and practices as approaches that center on a child's weakness or internal deficits versus their strengths. Examples of internal deficits include limited intellectual abilities, lack of motivation, language issues, family structure, or lack of resources (Boske et al., 2016). Furthermore, they contend that these arcane, hegemonic, and deficit-laden perspectives, behaviors, and practices are birthed in historical racist discourses and include acts of microaggression and macroaggression that act collectively to perpetuate

oppressive racist systems (Boske et al., 2016). Hegemonic refers to a theory of hegemony suggesting that we live in a society that embraces an overarching set of attitudes, beliefs, and practices aligned with the dominant culture's beliefs to perpetuate oppressive racist systems (Boske et al., 2016). Hegemonic claims that people impacted by oppressive systems, both positively and negatively, actively participate in the creating and recreating of oppressive and dominating conditions (Boske et al., 2016).

Boske et al. (2016) postulate that these racist perspectives often lower educators' hopes, beliefs, and expectations for children who are deemed different than what is considered the norm and furthermore, weaken educators' capacity to recognize gifts, talents, and extraordinary abilities in those children. Similar to educators, mental health professionals who harbor such bigoted perspectives through microaggressive and macroaggressive practices are highly inclined to foster lower expectations of clients who hold ethnic minority statuses. Additionally, such practitioners may be incapable of validating and recognizing these clients' experiences, resilience, support network, strengths, progress, and extraordinary abilities.

PREVALENCE OF RACIST INCIDENTS

The eerie manifestation of racism in the United States and the nebulous ways in which racism is conceptualized makes it difficult to detect. While some people hold the belief that racism is something of the past, many ethnic minorities have reported racial discrimination at a fairly high rate (Bryant-Davis & Ocampo, 2005). It has been reported that nearly 90% of African Americans and 77% of other ethnic minorities reported experiencing racial discrimination routinely and daily compared with 21% of Whites (Ogunyemi et al., 2020).

Hemmings and Evans (2018) maintained that racially motivated crimes have gained much attention in recent decades due to advancements in technology in the form of easy

accessible recording devices and multiple ways of transmitting information. We see this in the numerous unjust killings of Black people by law enforcement such as in the cases of Henry Dumas, Rayshard Brooks, Daniel Prude, Breonna Taylor, Atatiana Jefferson, Aura Rosser, Stephon Clark, Botham Jean, Philando Castille, Alton Sterling, Michelle Cusseaux, Freddie Gray, Janisha Fonville, Eric Garner, Akai Gurley, Gabriella Nevarez, Tamir Rice, Michael Brown, Tanisha Anderson, Trayvon Martin, Amadou Diallo, George Floyd, and many more (Ater, 2020). In the absence of readily available recording devices, many of these killings could have remained furtive.

Numerous researchers found that Blacks, particularly African Americans, experienced higher incidences of discrimination than European Americans (Bryant-Davis & Ocamo, 2005). Bryant-Davis & Ocamo (2005) noted that over the past 10 years there has been consistency in the number of reported claims of racial discrimination in the workplace; and according to the U.S. Equal Employment Opportunity Commission statistics (n.d.), more than one third of the total to be precise. According to the hate crime statistics reported by the Federal Bureau of Investigation (n.d.), 57% of the hate crimes reported in 2019 were based on race and ethnicity.

In a mixed-method study, Goode and Landefeld (2018) sought to examine the prevalence and impact of stereotype threat among students in academic health professions settings. Stereotype threat is a negative psychological phenomenon that individuals of color experience when they fear self-fulfilling or confirming negative stereotypes attributed to their social identity and group (Aronson et al., 2013; Burgess et al., 2010; Goode & Landefeld, 2018). Stereotype threat is pervasive and is often experienced by underrepresented people of color at predominantly White institutions. Stereotype threat negative consequences include hypervigilance, anxiety, impaired working memory, emotional dysregulation, impaired self-

efficacy, isolation and avoidance, imposter syndrome which is a feeling of not deserving one's accomplishments, and dis-identification characterized by a sense of not adding value to the arena in which they belong (Goode et al., 2018; Aronson et al., 2013). Results of Goode and Landefeld (2018) study indicated that students of minority status in the health professions were at higher risk for stereotype threat based on their minority status. More specifically, students of color had to navigate fear of not being perceived as smart as White students and of not belonging in the health professions.

Shavers and Moore (2014) conducted semi-interviews with 15 Black female students in doctoral programs at PWI. Echoing the previous study and many others, this study highlights the hostile, oppressive, and unfriendly racial climates at PWI that Black students often have to navigate compared to their White counterparts. Despite the pluralistic strategies that participants reported using to resist systemic racism and oppression in doctoral programs at PWI, they reported deleterious psychological consequences that include feeling incomplete, disengaged, disconnected, and fatigued.

A systematic review of forty articles underpinning the prevalence of microaggressions at higher education institutions from 1998 to 2018 shed light on the frequency and trends surrounding racist incidents (Ogunyemi, et al., 2020). Most studies used for this review were conducted at PWI with 38% from the Midwest region of the United States. The review identified 33 (82.5%) studies that reported on microinsults, 18 (45%) reported on microinvalidations, eight (20%) reported on microassaults, five (12.5%) reported on racism, eight (20%) White privilege, 11 (27.5%) reported on institutional microaggressions, and one (2.5%) reported on environmental microaggressions (Ogunyemi, et al., 2020). The overall themes of these studies revealed that the majority of students experienced microassaults, such as racial jokes, racial slurs,

being treated like second-class citizens, and ignored (Ogunyemi, et al., 2020). Given the widespread and pernicious effect of racist incidents in the form of microaggressions and other discriminatory practices, therapists must develop awareness of the trends surrounding these occurrences in their clients' lives and be comfortable to effectively address them in the therapy room.

Mass incarceration has become yet another form of enslavement rooted in systems of racism. The racial gap in the criminal justice system is alarming and points out to the unequivocal unjust treatment of Black people. Though Black people represent only 13% of the U.S. population and Whites 64%, they are overrepresented in the prison system; in 2017 the Black population represented 33% of the prison population while Whites accounted for only 30% (Winters, 2020). Winters (2020) noted the injustice in the legal system by pointing out that Black people are often put in jail innocently or for minor offenses for which Whites would not have gone to jail for and later acquitted (Winters, 2020).

HISTORY OF RACISM IN MENTAL HEALTH

Unfortunately, the therapeutic environment is typically not any different. Some studies that have examined racial and ethnic microaggressions in therapeutic settings have found that racial microaggressions in cross-racial therapeutic dyads can be manifested unconsciously in the counseling alliance even in White therapists who have received multicultural training or White therapists who see themselves as nonracist, egalitarian and socially just (Constantine, 2007). Racism has taken so many forms that are ambiguous, thus making it rampant and unable to discern (Constantine, 2007). This is quintessential considering that racial and ethnic microaggressions in therapy have been found to negatively impact the working alliance as well as treatment outcomes (Constantine, 2007; Owen et al., 2014).

Constantine (2007) conducted a study that examined the relationship between African American clients' perceptions of (a) racial microaggressions in cross-dyad counseling relationships with White therapists, (b) the impact on the therapeutic alliance, (c) the White therapist's competency in multicultural and general counseling and (d) African American clients' satisfaction with counseling. Participants consisted of 40 African American clients and 19 self-identified White therapists. The results found a negative association between perceived racial microaggressions and African American clients' perceptions of the therapeutic relationship, indicating that aversive racism, whether conscious or unconscious, was damaging to the therapeutic alliance. The results also found a negative association between perceived microaggressions and African American client's perception of White therapists' general and multicultural counseling competence. Furthermore, this study also revealed that African American clients who perceived a weaker therapeutic alliance with their White therapists were more likely to perceive their therapists as lacking general and multicultural counseling competency to effectively work with them.

Morton (2011) conducted a similar study of 19 cross-racial dyads of African American clients and White therapists. The results suggest that espousal of colorblind ideology was highly predictable of racial microaggressions in cross-racial dyad therapeutic relationships. Colorblind is a racially-based ideology that allows individuals to repudiate the existence of oppression.

Owen et al. (2014) conducted a survey of 120 racial ethnic minority clients at a university counseling center to examine trends of racial and ethnic microaggressions in their therapy experience. Similar to previous studies, 53% of the participants reported experiencing a microaggression from their therapist and that the incident caused duress and strain in the therapeutic alliance regardless of the current psychological well-being of clients, frequency of

sessions, and therapist race and ethnicity. Only 24% of those reported experiencing microaggression in therapy indicated that the incident was addressed but to no avail, causing ruptures in the therapeutic relationship.

IMPACT OF RACISM

Racism has been associated with numerous racial disparities that negatively impact various aspects of the well-being of Black communities (Hemmings & Evans, 2018). From a health standpoint, racial minority groups have been found to have higher health issues such as obesity, infant mortality and/or maternal mortality during childbirth, postpartum deaths, hypertension, cancer, diabetes, heart diseases, stroke, liver cirrhosis, autoimmune diseases, and homicide (Hemmings & Evans, 2018). Racism has also been shown to affect the quality of life of ethnic minority communities through limited income, poor access to education (e.g. the recent closing of several historical Black schools), barriers to economic and social upward mobility (e.g. barriers to high-paid employment or barriers to move to different neighborhoods), inadequate housing, increase exposure to community violence resulting from lack of opportunity and depleted communities, and engagement in risky behaviors and drugs as means to escape or cope with the negative consequences brought up by discrimination.

Racism leads to psychological distress. In the systematic review on microaggression noted in the previous section, Ongunyemi et al. (2020) found that the abusive treatments had devastating psychological impact on students' wellbeing leading to feeling excluded, invisible, and being treated to a lower standard by faculty. The adverse campus racial climate experienced by minority students was associated with the development of posttraumatic stress disorders (Ogunyemi et al., 2020). Research has shown that chronic childhood abuse and neglect interrupts the proper wiring of the sensory system of the brain which can impact one's ability to regulate

emotions, interpret information, processing day-to-day information, and making decision which can often resemble learning disabilities (van der Kolk, 2014). Additionally, research on the epigenetic effects of trauma and social adversities such as racism and discrimination has identified the existence of a causal link between health disparity and social adversity (Notterman & Mitchell, 2015).

SCIENTIFIC RACISM

American politician, scientist, and slave owner, Thomas Jefferson (1743–1826), turned to science to justify the inferiority of Black people and thus justifying their enslavement (DiAngelo, 2016). In *Diseases and Peculiarities of the Negro Race* (1851), a highly respected and widely published physician from the University of Louisiana, Dr. Samuel A. Cartwright (1793-1863) used the term “drapetomania” to explain the behavior and attitude of enslaved individuals who wanted to escape captivity as a form of disease (DiAngelo, 2016, 2018). Cartwright went on to identify many diseases that were specific to Blacks and for which the cure was physical beatings and whippings (Washington, 2006). He identified "Dysaesthesia Aethiopica" as a disease causing "rascality" or mischievous, dishonest behavior in free or enslaved Black people; “Hebetu” or shiftlessness as a form of laziness that allowed Blacks to misuse their masters’ properties; “Cachexia Africana”, Blacks’ preference for nonedible substances such as dirt; and “Struma Africana”, a Black-only tuberculosis (Washington, 2006). Physicians claimed that Blacks’ anatomy and physiological differences were proof that they were a different race and inferior to Whites. To justify their abominable use of Black bodies to practice medical experimentation, they postulated that Blacks did not feel pain to the same degree as Whites nor anxiety and thus did not necessitate anesthesia or consent (Washington, 2006). Anthropologists also joined the scientific racism wagon to claim that Blacks were inferior and that intermarriage or

miscegenation would produce inferior and genetically weak children (DiAngelo, 2016). From early to mid-1800s, famous American scientist, Samuel Morton, conducted a series of biased research to induct that the brains of Whites were larger and therefore deemed superior.

Cartwright made claims that Black craniums were 10% smaller than that of Whites and that this deficit prevented them from being fully developed and incapable of surviving with no supervision of Whites (Washington, 2006). Additionally, Black cadavers were stolen from cemeteries to be used as materials for internist to practice medicine (Washington, 2006).

In *Medical Apartheid* (2006), medical ethicist, Harriet Washington chronicled and exposed the long history of exploitation of Blacks in American medicine. During the Antebellum era, the healthcare of enslaved Blacks rested on slave owners who must decide what types of medical care, if any, that they would recommend for their slaves. It was the norm for enslaved Blacks to be accused of malingering if they reported being sick for which they would be brutally abused (Washington, 2006). James Marion Sims and many other southern surgeons were largely responsible for performing inhuman and unethical experimentations on Blacks, including gynecological experimentations, eugenics practices aiming at reducing the reproduction of African American communities, prison experimentations, radiation experimentations, experiments involving Black children, and the infamous Tuskegee Syphilis Study (Washington, 2006). The latter study entails the treachery of a group of Black men diagnosed with syphilis and whom were left untreated even after an effective treatment was discovered through their participation in the study (Washington, 2006).

Scientific racism has caused tremendous harm to Blacks, especially African Americans (Washington, 2006). It helped propagate the perception that Blacks inherent biological flaws which made them ideal fodder for research (Washington, 2006). Despite the fact that Black

bodies have been used to develop cutting-edge medical practices, they are less likely to benefit from these advancements due to lack of access (e.g., the immortal cell line of Henrietta Lacks used in scientific research to treat cancer) (Washington, 2006). We see a prime example of this in the most recent Covid-19 vaccination trend in which Blacks have been the most impacted population and used for research to develop a much needed vaccine, yet are the less likely to have received the vaccine due to lack of access and mistrust. In sum, scientific racism has significantly and, rightfully so, contributed to Blacks' aversion to medicine (Washington, 2006).

ATTITUDES OF BLACKS TOWARD MENTAL HEALTH

The long history of injustice that Black people experienced in medicine coupled with oppressive racial systems leading to limited social, educational, and material resources make Black communities vulnerable to experiencing health care disparities (Hemmings & Evans, 2018). Scholars interested in examining trends around Blacks' attitudes toward mental health seeking behavior indicate that, unlike other groups, people of color, especially Blacks, are the least likely to seek mental health services from a mental health professional (Ellis et al., 2019). Research indicates that nearly 10 million Black Americans currently experience clinical symptoms of anxiety or depression (Ellis et al., 2019). Twelve-month prevalence rates show that Black Americans meet criteria for anxiety (13.5%) and depression (7%) at a much higher rate than the general U.S. population (18% and 7%, respectively) (Ellis et al., 2019; SAMHSA, 2018). Considering that Black makes up over 13% of the U.S. population and considering that it is estimated that, by 2050, 55.7% of the U.S. population will identify as non-White; it is imperative that experts in mental health fields seek ways to lessen the disparity in mental health seeking behavior of people of color and barriers to seeking treatment (Ellis et al., 2019).

BARRIERS TO MENTAL HEALTH SERVICES

Researchers have identified a wide array of barriers contributing to Black people's lack of participation in mental health services (Ellis et al., 2019). Among the many obstacles to seeking mental health treatment, cultural mistrust, structural barriers such as poverty, racism, discrimination, reliance on other coping mechanisms, stigmatization of mental health, negative perception of the mental health system, unemployment, housing issues, low education, fear, and underrepresentation of minority therapists in the mental health field have been the most cited in research, with cultural mistrust being the greatest of the barriers (Ellis et al., 2019; Gaston et al., 2016; Walker, 2020).

Throughout the U.S., a long history of systemic inequities and policies have contributed to Black communities' economic disadvantage which consequently, has disproportionately and adversely affected Black people's access to health insurance (Ellis et al., 2019). Cultural mistrust has been associated with resistance to seeking treatment from mental health reasons and with negative views and expectations of White mental health providers (Cuevas et al., 2016; Walker, 2020) and a lower likelihood of seeking treatment. Black people in the U.S. are more likely to refrain from seeking mental health services due to history of mistreatment and racist attitudes and practices from mental health providers (Ellis et al., 2019; Hemmings & Evans, 2018).

In an effort to ensure equitable access of Black people to mental health treatment and minimize barriers to mental health help-seeking behaviors, many researchers have examined factors explaining disparities in mental health service use (Ellis et al., 2019; Gaston et al., 2016; Mutiso et al., 2018). Using an experimental design, Ellis et al. (2019) conducted a study to investigate the impact of several salient biography characteristics (i.e., years of experience, professional membership, tone of voice, race of therapist, and expressed acceptance of religion/spirituality) in a therapist's online profile on Black and White clients' interest in

pursuing counseling services. Consistent with previous research findings, the results indicate that racial characteristics were a more important factor for Black participants than White participants when making a decision to pursue treatment (Cabral & Smith, 2011; Ellis et al., 2019).

Nonetheless, both Black and White participants placed more value on reported years of experience and professional membership in their decision making process for seeking mental health treatment than on racial concordance (Ellis et al., 2019). Black participants also felt impartial about endorsement of cultural inclusivity statements, expressed religious inclusivity, and commitment to minority groups on therapists' online profiles (Ellis et al., 2019).

The importance of culturally responsive services is also salient among other minority groups' help-seeking behavior. Concurring with other studies, Mutiso et al. (2018) found that the main barriers to accessing mental health among urban Somali refugees residing in Eastleigh, Kenya to be linked to differences in cultural and religious beliefs, inadequate health services, culture-insensitive mental health services, poverty, language barriers, stigma, and discrimination. To mitigate barriers to mental health help-seeking behavior among minority groups, social researchers have proposed that matching therapists with clients of the same ethnicity as a viable remedy (Cabral & Smith, 2011). According to theory of social comparison, people are more likely to show preferences and trust for others whom they perceive to be similar to themselves (Cabral & Smith, 2011). A meta-analysis of a substantial number of studies (53) that have examined the effects of racial/ethnic matching with other racial/ethnic minority groups suggests that therapists' race/ethnicity is irrelevant in how clients evaluate their therapist and how much benefit they received from treatment (Cabral & Smith, 2011). Nevertheless, this same review found notable exceptions to (a) preferences for therapists of individuals' own race/ethnicity, (b) perceptions of therapists across racial/ethnic matching, and (c) outcomes in therapy as a function

of racial/ethnic matching when the population of interest was African Americans. The findings suggest that African Americans significantly preferred to be matched with African American therapists whom they rate more positively than non-African American therapists (Cabral & Smith, 2011). Additionally, when African American clients were racially and ethnically matched with their therapists, they showed greater treatment outcome. Cabral and Smith (2011) attributed these positive outcomes to clients' strong racial/ethnic identification with their African American therapists and the perceived unbiased relationship with their African American mental health providers. Results of this meta-analysis suggest therapists' multicultural competencies were crucial to foster positive outcomes, especially when working with African American clients (Cabral & Smith, 2011; Sue et al., 1992).

Moreover, studies on ethnic minority clients' perceptions on the significance of race in cross-racial therapy relationships suggest that clients from ethnic minority groups were more likely to be suspicious of the counselor-client therapeutic relationship when their counselors were White than when they were of other racial groups (Chang & Yoon, 2011). These clients believed that White therapists misunderstood their experiences and, thus, intentionally avoided broaching racial and cultural issues in therapy. However, racial differences were minimized if the therapist demonstrated multicultural competency through compassion, acceptance, and comfort in discussing racial, ethnic and/or cultural issues.

BRIEF HISTORY OF TRAUMA

The construct of psychological trauma has been of interest to social scientists since the nineteenth century. Trauma was first acknowledged in the field of psychiatric and other mental health diagnostic arenas (Carter, 2007b). Pierre Janet and Sigmund Freud were the pioneers to provide the first writings on what characterizes as trauma and its clinical implications (Herman,

1992). Throughout the history of psychological trauma, there has always been a push to discredit the experience of the survivor by questioning the trustworthiness of their narratives or lived experiences, the validity of whether or not their experiences are deemed trauma-worthy, and the intentions of the investigator (Herman, 1992). The social context in which psychological trauma is anchored require that voice be given to the disempowered (Herman, 1992).

Psychological trauma is the condition and the suffering of those whose power have been stripped from by means of force (Herman, 1992). Subsequently, the study of psychological trauma has developed over the past century as a result of strong political movement for human rights (Herman, 1992). Three particular waves of psychological trauma studies have emerged over the past decades. The first wave grew out of the republican, anticlerical movement in late nineteenth century in France, a movement that aimed to challenge oppressive systems rooted in the Church and other religious institutions (Herman, 1992). These first waves of psychological studies centered on the diagnosis of hysteria or the psychological disorder of women; it was concluded that hysteria was a condition caused by psychological trauma (Herman, 1992). Leading scientist on hysteria, Pierre Janet (1859-1947), a protégé of Jean-Martin Charcot who birthed the diagnosis of hysteria, was the first to establish a direct link between dissociation, a psychological defense against overwhelming traumatic experiences, and hysteria (Onno van der Hart & Rutger Horst, 1989). Janet defined trauma as any life event that elicited an emotional shock (*émotion-choc*); he distinguished this emotional shock from the automatic physiological response that we exert in the face of atrocious events to regulate behavior (Heim & Bühler, 2006). In the mid-1890s, Janet and Freud developed theories on the etiology of hysteria (Herman, 1992). Particularly, they attributed the source of hysteria to sexual trauma (Herman, 1992). The second wave of psychological trauma developed in the aftermath of the First World

War and flourished with the Vietnam War (Herman, 1992) in a sociopolitical context of an antiwar movement. Following World War I, the interest developed as a need to understand and treat the complex and unusual behaviors seen in returning combat veterans as a result of experiencing traumatic events. Scientists were interested in investigating “the shock shell” condition that combat veterans were exhibiting, a term coined in World War I by British psychologist Charles Samuel Myers. Stress-related trauma were viewed to be either resulting from combat wars (shell shock) or railway accidents in civilians (Carter, 2007b). The third wave of psychological trauma awareness to the public emerged with the feminist movement with a focus on sexual and domestic violence (Herman, 1992). In the context of the Black Lives Matter movement, a call to unmask and end oppressive systems that are psychologically damaging and physically harmful to Black communities, we are now experiencing the emergence of a fourth wave of psychological trauma, racial trauma.

DEFINITION OF TRAUMA

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (American Psychiatric Association, 2013) defines trauma as any phenomenon that accompanies “actual or threatened death, serious injury or sexual violence” (p. 271). Because of the continued limitation of the *Diagnostic and Statistical Manual of Mental Disorders* to include wide range of experiences other than PTSD, acute stress reactions, and other diagnoses, which excludes other experiences such as racism that could result in trauma, Carlson and other researchers offered different ways to assess and classify trauma reactions (Carter, 2007b). Some of the main goals of Carlson’s model were to expand trauma classification to include a diverse array of traumatic incidents, including psychologically and emotionally laden incidents and experiences that can be damaging but not necessarily physically threatening (Carter, 2007b). A more inclusive

understanding of trauma would allow us to view trauma beyond single incidents and beyond short-term trauma reactions (Carter, 2007b, 2020). Additionally, this confined definition of what constitutes trauma according to the DSM-5's definition presents barriers to receiving proper diagnosis, treatment, and insurance reimbursement (Carter, 2020; Kirkinis et al., 2018). Several researchers have called for a modification to the DSM-5 criteria of PTSD to include other experiences that could result in trauma (Carter, 2020). A modification to the definition and classification of trauma will allow for mental health clinicians to develop a more in-depth awareness and understanding of how race-based stress or racial trauma is manifested (Carter, 2020).

According to Carlson and Dalenberg's conceptual framework of traumatic experiences (2000), three elements must be present for an event to be deemed traumatic—the event must be sudden, uncontrollable, and hold a negative valence (Carter, 2007b). Though racist encounters are widespread, individuals who encounter racism still found it difficult to predict and control which makes racism a sudden and uncontrollable negative encounter (Carter, 2007b).

Trauma exposure may be experienced first-hand (e.g., experiencing Hurricane Katrina) or vicariously by directly viewing the event (e.g. witnessing the murder of George Floyd in 2020); learning about shootings of Black people by the police and other White civilians (e.g., the Charleston Church shooting in 2015); or repeatedly having to deal with incidences that remind us of the possibility of these events reoccurring (e.g., being Black and being pulled over by the police for no apparent reason or being scrutinized at a department store just for being Black) (APA, 2013). Trauma scholars using this definition have estimated about 70% of adults worldwide to report exposure to a traumatic event with only 6% developing a mental health diagnoses following trauma exposure (Benjet et al., 2016; Raghavan & Sandanapitchai, 2020).

MANIFESTATIONS AND IMPACT OF TRAUMA

Despite the nuances in what constitute trauma, it has been well-documented that trauma impacts the cognition, behavioral, physical, and emotional. Stress and trauma have been used interchangeably across disciplines to describe the physiological, psychological, and behavioral impact of external events deemed as stressors (Carter et al., 2017). Not everyone experiences potentially harmful incidents in the same way; the extent to which an event is experienced as stressful or traumatic is contingent on the individual's prior experiences, resilience, contextual framework, awareness of their identities, and more (Carter, et al., 2017; Sherin & Nemeroff, 2011).

According to trauma experts, “trauma affects the entire human organism—body, mind, and brain” (van der Kolk, 2014). Trauma has been associated with several adverse physical and mental health outcomes. When a person has experienced a traumatic phenomenon, they remain in a state of hyperarousal anticipating the threat to return at any time; their system of self-preservation goes into a permanent state of alert (Herman, 1992; Snyder, 2020; van der Kolk, 2014). They behave as if their nervous system is still in the time of when they have experienced the trauma; they are disconnected from the present. Long after the trauma has occurred, the individual experiences flashbacks which are spontaneous and vivid memories of the traumatic experience that come during waking hours or during sleep (Herman, 1992; van der Kolk, 2014).

With the advancement of cutting edge science, we have gained a better understanding of trauma. We now know that trauma constitutes a threat to humanity and to the national public health (van der Kolk, 2014). Trauma disrupts our ability to function to our fullest potential in society (van der Kolk, 2014). Additionally, we now understand the connection between politics

and trauma (van der Kolk, 2014). Trauma cannot be understood without looking at the social conditions that serve as incubators for trauma. Van der Kolk noted:

In today's world your ZIP code, even more than your genetic code, determines whether you will live a safe and healthy life. People's income, family structure, housing, employment, and educational opportunities affect not only their risk of developing traumatic stress but also their access to effective help to address it. Poverty, unemployment, inferior schools, social isolation, widespread availability of guns, and substandard housing all are breeding grounds for trauma. (van der Kolk, 2014, p. 350).

In this, van der Kolk was referring to trauma that is rooted in oppressive systems, discriminatory practices, racism and prejudices; he was referring by what other experts refer as racial trauma or race-based trauma.

The pattern of psychological reactions to trauma include nightmares, fear, startled responses, numbing symptoms, lower self-esteem, increasing self-doubt, decreased sense of self-efficacy, decreased sense of agency, helplessness, hopelessness, anger, frustration, internalized hate, depression, anxiety, intrusive recollections, paranoia, dissociation, and depersonalization (Benjet et al., 2016; Carter, 2007b; Herman, 1992; Snyder, 2020). The physiological effects of trauma include obesity, heart diseases, high blood pressure, and weakened immune system, a constant state of hypervigilance which activates the stress response system and which is toxic for the body.

The literature underpinning the impact of trauma on mental health problems across the lifespan is substantial (Cross et al., 2018). Trauma shatters our ability to nurture and socially engage with others. "*Trauma breeds further trauma; hurt people hurt other people*" (van der Kolk, 2014). There has been ample evidence linking trauma and PTSD to child rearing practices,

including parenting dissatisfaction, parental emotional absenteeism, issues with parental bonding, and risk for child abuse and neglect (Cross et al., 2018). Cross et al. (2018) conducted a study with a sample of 112 mother– child dyads of primarily African American mothers and children from low-income communities to examine the role of maternal trauma and PTSD symptoms on parenting practices, and child trauma exposure to child PTSD symptoms. Multiple hierarchical regressions analysis indicate that both maternal trauma exposure and PTSD symptoms significantly predicted increased risks for potential child abuse and PTSD in their offspring. Both maternal trauma and PTSD were significantly associated with higher parental distress, thus inferring that PTSD may be a hindrance to a parent’s positive emotional engagement with their children and sense of efficacy as a parent. This study echoes findings corroborating that trauma-related mental health risk can be intergenerational.

Studies on the epigenetics of trauma have heightened our awareness on the long-term impact of trauma across generations. Studies of Holocaust survivors provide evidence that early childhood trauma can have long-lasting and detrimental impact on aging adults (Fridman et al, 2011). These studies also show that early childhood trauma can lead to dissociative symptomatology, diminished satisfaction with life, increased cognitive impairment, and greater perception of stress later in life (Fridman et al, 2011). A preliminary review of the emerging literature on the effect of trauma on exposed individuals suggests that psychological trauma can affect the biology and behavior of exposed individuals and their offspring suggesting that risks of PTSD can be transmitted from generation to generation (Youssef et al., 2018).

PREVALENCE OF TRAUMA

Studies on the effect of childhood abuse and adults’ health risk behaviors and diseases continue to remain rudimentary (Archer, 2021; Felitti et al., 1998). Health behaviors and lifestyle

factors, many of which stem from traumatic childhood experiences, are considered to be the leading causes of morbidity and mortality in the United States (Felitti et al., 1998). Higher levels of ACEs (Adverse Childhood Experiences) strongly correlates with higher psychological distress in adulthood, including but not limited to, substance use, suicide attempts, self-medication, premature death, and generally poor psychological mental health outcomes.

In a systematic review of empirical research on PTSD, it was made evident that people of color are more at risk of developing PTSD symptoms after exposure to a stressful event than the general population. While 5%-10 % of the general population who have had an exposure to a stressful life event will potentially go on to develop PTSD symptoms, the risk for people of color increases to 20%-40%. Non-combat veterans of color are two to three times (20%-60%) more likely to develop PTSD than their White counterparts (Carter, 2007b).

In Cross et al.'s study (2018) described above in which there were 112 African-American mother-child dyads, 97.32% of the mothers reported at least one type of traumatic exposure, including individual trauma, community trauma, and family violence. All 112 children (50 girls and 62 boys; ages 8–12 years old) in the study self-reported exposure to at least one trauma type. A study conducted data from structured diagnostic interviews from a nationally representative sample of adult respondents (n=34 653) showed that lifetime prevalence of trauma exposure ranged from 66.38% to 83.66% with 76.37% of African Americans reporting at least one trauma exposure (Roberts et al., 2011). When analyzed for race and ethnicity differences, the data indicate that Blacks had the highest lifetime prevalence of PTSD (8.7 %), followed by Hispanics and Whites (7.0% and 7.4%, respectively); Asians had the lowest lifetime prevalence for PTSD (4.0 %). Whites had the highest rates of exposure to any traumatic event while Blacks had the lowest rates of exposure to any traumatic event. Nonetheless, among those exposed to trauma,

Blacks were at higher risk for PTSD than all other groups. The authors warn of the possible limitations in the study which could help explain these counterintuitive results. They noted that the study did not account for racial and ethnic group differences in reporting behaviors of incidences of trauma that may be seen as stigmatizing. Other factors not mentioned by the authors might be that Whites are more knowledgeable about what constitutes trauma and PTSD compared to other groups. It is also important to note that this study did not consider racism as potential sources of traumas. When compared for types of trauma exposure, Whites reported significantly higher exposure to trauma related to injuries, shocking events, vicarious trauma through close friends or relatives, and learning unexpected death, compared with Blacks, Asians, or Hispanics. Hispanics and Blacks reported significantly higher exposure to child abuse and neglect compared with Whites. The authors argued that this may be mainly due to higher rates of witnessing domestic violence (Roberts et al., 2011). As seen in Cross et al.'s study (2018), parental history of trauma has been associated with risk for child maltreatment. The data also shows that Blacks had higher exposure to violence related to assaults than Whites. Asians were most likely to report trauma exposure related to war-related events or refugee experiences. Overall, all minority groups were less likely to seek treatment for PTSD than Whites with less than 50% of those minorities seeking treatment for PTSD (32.7%–42.0 %).

There is ample evidence in the literature suggesting that trauma can be passed from one generation to another (Nir, 2018; Youssef, 2018). Dashorst et al. (2019) conducted a systematic literature review of 23 studies with the goal of broadening our understanding of the psychological impact of trauma exposure on offspring of Holocaust survivor parents. The data showed evidence that mental wellbeing of these offspring were negatively impacted by parents' mental health issues, perceived parenting, parental attachment style, and parental gender. The

data revealed greater impact in offspring with two parents impacted by the Holocaust. Lastly, evidence suggests that these offspring were more susceptible to stress in the face of actual danger and were more likely to have higher levels of cortisol (Dashorst et al., 2019).

RACIAL TRAUMA OR RACE-BASED TRAUMA

Though the literature on trauma is scant in addressing the relationship between racism and trauma (Quiros et al., 2020), racial trauma or race-based trauma has undergone a lot of research under alternative names including, but not exhaustively, insidious trauma, intergenerational trauma, societal trauma, racist incident-based trauma, psychological trauma, emotional abusiveness, and more (Bryant-Davis, 2007). While there is unanimity that racist experiences are considered to be stressful and leading to psychophysiological symptoms that may resemble PTSD, very few researchers, including the American Psychiatric Association, have yet to categorize racist incidents as trauma (Bryant-Davis et al., 2005; Carter et al., 2020; Carter, 2007b). The ambiguity in adequately classifying racism as trauma is detrimental to the wellbeing of people of color, the mental health field, and the nation at large. Without proper qualifications, impacted individuals would have limited access to treatment due to insurance companies requiring a diagnosis for services. This can also negatively impact the quality of mental health clinical programs. Without proper nomenclature, counseling programs may not deem it necessary to offer courses related to trauma and racism beyond the required one diversity course offered at most institutions.

The terms *racial trauma* or *race-based traumatic stress* have been used to indicate ‘severe cases of racism-related stress’ (Hemmings & Evans, 2018; Truong & Museus, 2012). Truong et al. (2012) noted that racism-related stress and racial trauma stem from racialized interactions between people and their environment. Hemmings and Evans (2018) noted that race-

based trauma has the potential to negatively impact “one’s self-concept, identity development, and ability to cope” (p.27). Other researchers have defined racism-related stress as “the emotional, physical, and psychological discomfort and pain resulting from experiences with racism” (Truong & Museus, 2012, p. 228). Yet others have defined race-based trauma as the emotional, psychological, and behavioral responses to personal experiences with harassment and discrimination that cause hurt (Carter, 2007b; Evans et al., 2016). Bryant-Davis (2007) offers a more comprehensive definition of race-based traumatic stress that includes “(a) an emotional injury that is motivated by hate or fear of a person or group of people as a result of their race; (b) a racially motivated stressor that overwhelms a person’s capacity to cope; (c) a racially motivated, interpersonal severe stressor that causes bodily harm or threatens one’s life integrity; or (d) a severe interpersonal or institutional stressor motivated by racism that causes fear, helplessness, or horror (Bryant-Davis , 2007, p.135-136).

Racial trauma is embedded in discrimination and racism (Comas-Díaz et al., 2019). Racial trauma is exacerbated by the intersectionality of multiple marginalized identities that one holds (Comas-Díaz et al, 2019; Hill Collins & Bilge, 2016). Intersectional oppression such as racial, gender, sexual orientation, and xenophobic microaggressions contribute to the cumulative effects of racial trauma. Racism and ethnoviolence can be life-threatening to people of color and indigenous (POCI) due to their exposure to racial microaggressions, vicarious traumatization, and the invisibility of racial trauma’s historical roots (Helms et al., 2012). While many non-White groups may experience racial trauma rooted in discrimination and racism, Blacks are more likely to experience race-based trauma because of historical and sociocultural factors that continue to place them at higher risk for intersectional oppressive epithets and treatments such as

gender, sexual orientation, socioeconomic status, ableism, family constellation, education level, phenotypes, judicial status, and immigration status (Comas-Díaz et al, 2019).

Harrell (2000) identified six types of occurrences leading to racism-related stress and racial trauma: (1) racism-related life events, (2) vicarious racism experiences, (3) daily racism microstressors, (4) chronic-contextual stress, (5) collective experiences of racism, and (6) the transgenerational transmission of group traumas (p. 45).

Exposure to racist encounters have been linked to the development of post-trauma symptoms in some victims (Bryant-Davis & Ocampo, 2005). In a study with 106 counselors assessing their level of preparation to work with race-based trauma showed that the chief factors leading to race-based trauma included, but not limited to, covert and overt acts of racism (e.g., social avoidance, exclusion, harassment, verbal and physical attacks, verbal and physical threats), hate crimes, institutional racism, microaggressions, racial profiling, outside-group and within-group racialized affronts (Hemmings & Evans, 2018). Other studies have found other sources of racial trauma to include racial vilification; racists ideas, beliefs, attitudes, and behaviors; denial of racism (Sue et al., 2007).

Post-trauma symptoms have been associated with depression, headaches, anxiety, low self-esteem, low self-worth, humiliation, upset stomach, chest pains, tunnel vision, ulcers, back pains, nightmares, loss of appetite or overeating, nausea, shortness of breath, crying, vomiting, fatigue, increased heart rate and hypertension, anger, frustration, difficulty concentrating, lack of productivity, lower sense of self-efficacy, lack of motivation, difficulty sleeping, sexual dysfunction, derealization, depersonalization, self-hatred or internalized racism, and constant rehashing of racist encounters days, weeks, months, and years after they occur as if they happened more recently (Bryant-Davis, 2007; Bryant-Davis & Ocampo, 2005; Carter, 2007b;

Carter & Forsyth, 2009; Harrell, 2000; Smith et al., 2007; Smith, et al., 2006; and Sue et al., 2007). According to SAMHSA (2014b), trauma-related symptoms and behaviors are an individual's way of coping and adapting to traumatic events and therefore must be seen from a strength-based lens.

A meta-review of 28 studies on racial discrimination and trauma was conducted with the aim of offering clarity and understanding into the relationship between racial oppression and psychological functioning (Kirkinis et al., 2018). Similar to other studies (e.g., Carter, 2007b), the findings of this study suggest that exposure to race-based traumatic stress can lead to trauma symptomology. More specifically the results indicate that 70% of the trauma symptoms were statistically significantly associated with discrimination. Furthermore, results of the study also show that conventional measures of PTSD symptoms may not be adequate to fully assess race-based trauma (Kirkinis et al., 2018).

RACIAL TRAUMA THEORY

Several researchers have laid the foundation to help mental health professionals understand racism and its derivatives as forms of traumas. Wyatt (1990) was the pioneer to establish a parallel between racist incidents and childhood sexual abuse. Wyatt argued that both childhood sexual abuse and racist incidents can potentially lead to feelings of shock, betrayal, and powerlessness and the sense of being stigmatized as “not good enough” (Wyatt, 1990). Similarly, Villena-Mata (2002) equated child abuse and racist incidents by highlighting the similarities in symptoms associated with these transgressive acts, including loss of trust in self and others, dissociation, and muteness about the abuse or about the racist incident. Carter and Helms (2002) also established parallels of racist incidents with sexual harassment. Expanding on these earlier models, Bryant-Davis et al. (2005) proposed a framework for conceptualizing racist

incidents as trauma by drawing parallels between racist experiences, rape, and intimate partner violence.

Social researchers have examined the relationships between trauma reactions and race-based traumatic stress and found significant strong relationships between race-based traumatic stress and trauma symptoms (Carter et al., 2020). Carter et al. (2020) conducted such a study including 421 community-based participants of a wide racial background: 48.8% Black ($n=206$), 30.8% White ($n=130$), 9.9% Hispanic ($n=42$), 4.5% Asian ($n=19$), and 2.9% biracial ($n=12$), 1.4% ($n=6$) identified as “other” and three people did not identify their race. The results of this study indicate that negative, racial affronts or race-based events are likely to result in trauma symptomatology such as dissociation, anxiety, depression, difficulty sleeping, and sexual problems. The results are pointing out to the fact that, contrary to the criterion set forth by APA (2013), experiences that can result in trauma symptomology are not limited to exposure or being a witness to violent or accidental death/threatened death, actual/threatened serious injury, or actual/threatened sexual violence (Carter et al., 2020).

ADDRESSING RACIAL TRAUMA IN THERAPY

It is without a doubt that racist beliefs, attitudes, and practices run rampant in all aspects of life in the U.S. Considering the staggering number of self-reported encounters with discrimination and the outrageous number of racially-motivated hate crimes, it is unquestionable that mental health professionals will at some point in their careers work with ethnic minority clients whose lives have been impacted by these trauma-laden incidences either directly or indirectly. Consequently, it is imperative that mental health professionals be knowledgeable of the sociopolitical climate that impact client’s lives and their lived experiences, be knowledgeable

of trauma responses and treatment in order to provide ethically-sound services (Bryant-Davis, 2007).

Competency in multicultural and trauma, crisis, and disaster is integral to the 2016 Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards (CACREP, 2016). Wylie et al. (2018) found that there is a need to improve understanding and assessment strategies of the mental health of disenfranchised clients. While the DSM-V is useful for diagnosing, it may not always be the most effective tool to capture the mental health needs of Black clients who experience race-based stress, racial microaggressions, and racial trauma. This may be a disservice to providing quality care to Black clients. Proficiency in racial trauma and its impact on Black clients could affect counselors' approaches to assessment, treatment, services rendered, and ultimately treatment outcomes.

As the faces of our clients are changing, mental health providers need to be skilled at assessing and responding to the needs of diverse clients (Ahmed et al., 2011). Additionally, with increased awareness on how social conditions can preserve trauma-laden conditions, it is imperative that mental health providers become aware of the social conditions that impact clients and how they are further recreating these conditions in counseling settings, whether consciously or unconsciously (Bryant-Davis, 2007). Counselors need to become aware of their own prejudices and biases which may negatively impact the therapeutic alliance and further perpetuating trauma. Culturally sensitive, racially responsive, and trauma-informed practices require awareness of the ways in which clients are impacted by their multiple marginalized identities and by systems of oppression (e.g., racism, ethnocentrism, sexism, heterosexism, and nativism) (Adames et al., 2018).

Bryant-Davis (2007) notes that it is crucial for counselors to first understand constructs of race, racism, power, privilege, and racial oppression in order to effectively recognize, acknowledge, assess, and develop intervention strategies to address race-based traumatic stress. Other researchers have proposed that all counselors, including counselors in training and veteran counselors who had graduated prior to the inception of a cultural competency requirement course, must receive a comprehensive education on race-based traumatic stress that include knowledge of self, knowledge of other cultures, culturally relevant intervention skills, and understanding of systems of oppression in the U.S. and its impact on communities (Bryant-Davis, 2007; Carter, 2007b; Hemmings et al., 2018; Sue & Sue, 2003).

BARRIERS TO IDENTIFYING AND ASSESSING RACIAL TRAUMA

Using a trauma framework to examine racist incidents can be beneficial to the mental health field in helping to understand, identify, assess, and treat the psychophysiological symptoms associated with exposure to racist incidents (Bryant-Davis et al., 2005). Unfortunately, the lack of a solid trauma framework has remained a challenge in the mental health field. Bryant-Davis et al. (2005) advise researchers and mental health clinicians to take into account the severity of racist experiences when assessing the possible trauma associated with the incidents.

Bryant-Davis et al. (2005) identify five barriers to the acknowledgment of racialized trauma responses in victims of racism. The first is the exclusion of racism and its sequelae in the DSM-V as forms of traumas. By defining PTSD primarily on the basis of exposure to actual or threatened death, serious injury, or sexual violence, the DSM-V excludes the many ways in which overt and covert discrimination can be manifested such as denial of one's experience, psychological abuse, withholding of resources, marginalization, and stereotyping which can

potentially lead to PTSD symptoms. The second barrier is the exoneration from taking responsibility for dehumanizing behaviors and for responding to trauma incidents. By denying that racism is traumatizing, mental health professionals can continue to engage in discriminatory beliefs and practices without feeling ethically immoral. The third barrier is the notion that broadening the category of trauma will diminish the severity of other types of traumas. These sorts of beliefs establish a hierarchy of trauma. Historically, trauma definitions have expanded to include survivors of domestic violence and sexual assault through advocacy. Similarly, with ample information on the deleterious impact of racism on the psychological and physical wellbeing of victims of racism, social justice allies and advocates are ethically obligated to advocate for the inclusion of racist incidents as trauma-laden. The fourth barrier is the fear of assuming financial and legal accountability of perpetrators if the scope of trauma is broadened. The fifth barrier is the fear of receiving a diagnostic label for normal responses to traumatic racist incidents. In an effort to address these barriers, Bryant-Davis et al. (2005) recommend that mental health professionals acknowledge the various ways (e.g., emotional, cognitive, relational, behavioral, and spiritual indicators) in which trauma symptoms can be manifested beyond the PTSD symptoms listed in the DSM-V. Other researchers suggest using a race-based traumatic stress category to help address trauma symptoms associated with racism (Carter et al., 2005).

Other barriers include the inadequacy of training in mental health programs that specifically address race-based trauma, trauma, multiculturalism in the U.S., a history of the U.S. that include the experiences of Blacks and other people of color and how racism is integral in this culture.

RACIAL TRAUMA TRAINING

Research indicates that there is a paucity of race-based trauma opportunities (Hemmings & Evans, 2018). Within most counselor education training programs at the master's level, only one course in social and cultural diversity is required. This course is usually intended to cover all areas related to diversity and inclusion, but best practices indicate that an infusion of diversity discussion and content should take space in every course, including supervision. However, this model may serve inadequate for the training needs of mental health professionals who want to specialize in serving communities who experience racial trauma. Often, there is a lack of specificity or distinction between racial trauma training and multicultural and diversity training.

Hemmings & Evans (2018) conducted a study with 106 mental health professionals to assess their experiences with identifying and treating race-based trauma using the Race-Based Trauma Survey for Counselors to assess for competency. While seventy-five (70.8%) participants indicated that they have worked with clients of color who had exposure with race-based trauma, only 35 (33.0%) of the clinicians reported to have received training to help identify race-based trauma and 20 (18.9%) reported to have received training to help with treating race-based trauma among individuals of color. When the relationship between training, identification of trauma, and treatment were examined, it was found that training consisted of continuing education and materials integrated into course work and supervision for those who had training to help identify race-based trauma; training to help treat race-based trauma was only provided through continuing education. Moreover, 93 (87.7%) of the participants indicated an absence of race-based trauma-informed policy regarding treatment plan and strategies. This study highlights the need for advanced research to reveal the association between racism and trauma. It also highlights the disparities between counselor training, community needs, and adequacy of mental health services provided to communities. This study further reveals a

negative correlation between reported competencies and all predictors being investigated (e.g., training to help identify trauma, training to help treat trauma, and race-based trauma-informed professional policies for practices).

Other researchers have argued that, when training courses are offered in mental health programs, race-based trauma or multicultural training are too often centered on addressing differences in culture and ethnicity and neglect the importance of race, racism, and Whiteness (Quiros et al., 2020). Often, when race is integrated in training, it espouses a monolithic narrative of racism that is focused primarily on the experience of People of Color and excludes an examination of Whiteness. Addressing diversity without a critical examination of racism, Whiteness, and White supremacy only undermines the experience of People of Color and does not challenge racism and hegemonic ideologies and systems. Such color-blind and nonracist approaches to teaching cultural competency to mental health professionals does not prepare them to recognize and analyze race, racism, and dominant White ideologies (Quiros et al., 2020).

Furthermore, such teaching does not foster understanding of racialized experiences among ethnic minority groups based on intersections of nationality, immigration status, gender, religion, class, ability, and color (Quiros et al., 2020). Mental health professionals socialized within such institutions that do not integrate critical analysis of Whiteness are often ill-prepared to recognize and respond to racial issues when working with clients (Williams et al., 2018). Mental health professionals need to commit to antiracist values and practices; as such, they need to understand the differential social power that is rooted in race and the systematic ways in which oppression is embodied (Varghese, 2016). Thus, curriculum, instruction, and learning must address issues of equity and social justice from the context of Whiteness in America; they also

need to incorporate an educational history of racism in the United States and its impact on communities.

Only a few educational mental health institutions such as Smith College and the Center for Race and Social Problems at the University of Pittsburgh have demonstrated an explicit commitment to addressing race and racism and being antiracism organizations (Quiros et al., 2020). Curriculum (i.e., courses and field placements), faculty pedagogy and training, and research reflect the goals of antiracism at those institutions (Quiros et al., 2020).

MULTICULTURAL COMPETENCY

Mental health professions are bound by their code of ethics to provide culturally responsive counseling and be committed to social justice and diversity (American Counseling Association, 2014; American Psychological Association, 2017; National Association of Social Workers, 2015; Quiros et al., 2020). Several researchers contend that the cultural competency framework in which these constructs are addressed in mental health training programs are insufficient (Hemmings & Evans, 2018; Quiros et al., 2020). Counselors' multicultural competency have been linked to clients' satisfaction with counseling. Clients' perceptions of their therapists' multicultural competency have been found to be positively related to working alliance, a sense of genuine relationship, and psychological outcomes (Owen et al., 2011). A study by Owen et al. (2014) revealed that clients reported greater therapeutic outcomes when they perceived their therapists to have greater cultural humility. Multicultural competency has also been understood in the context of cultural humility which involves respect toward the client, the absence of feelings of superiority vis-à-vis the client, and attunement to the client's cultural heritage (Hook et al., 2013).

In addition, research has shown that counselors' multicultural competency may be linked to biases and prejudices in the therapeutic relationship. Studies have shown that counselors' lack of awareness may account for the implicit biases and assumptions that counselors hold toward clients which has the potential to jeopardize the therapeutic alliance (Duncan, 2005). Boysen and Vogel (2008) conducted a study in which 105 counselors who reported a high level of multicultural competency also reported a high level of implicit bias toward African American, lesbians, and gay men. Uehara (2005) suggests that counselors, as change agents, have the ethical obligation to promote positive attitudes toward diversity and inclusion through awareness, education, skills, and also by creating opportunities that promote appreciation of cultural differences.

Largely, counselor multicultural competency has been an area of investigation by experts in mental health education for a few decades. With the increased diversity of our communities, it has become imperative for counselors to be knowledgeable and skilled at working with individuals who present with various identities. Lack of expertise in working with diverse populations can be detrimental to the well-being of clients, often leading to a higher likelihood of misdiagnosis, premature termination, disengagement in counseling, and counselors' lack of awareness (Duncan, 2005, Zigelbaum, 2011).

COUNSELOR BURNOUT

There has been a great deal of research in the area of safeguarding against counselor burnout (Craig & Sprang, 2010; Dehlin & Lundh, 2018; Lee et al., 2015; O'Connor et al., 2018; Singh et al., 2020; Sprang et al., 2007). Professionals working with traumatized clients may experience high levels of stress that may lead to burnout which is often manifested in a condition called compassion fatigue, a term first coined by Figley (Craig & Sprang, 2010; Figley, 1995).

Counselor burnout can be defined as physical or psychological exhaustion that results from prolonged stress (Bray, 2018). Throughout the literature the terms compassion fatigue, vicarious traumatization, or secondary traumatic stress have been used interchangeably to describe the cognitive, emotional, and behavioral symptoms associated with the burnout experienced by professionals as a result of indirect exposure to trauma survivors. Vicarious traumatization was first introduced by McCann and Pearlman (1990) as an expansion of the concept of countertransference reactions to refer to the negative psychological, cognitive, and schematic effects associated with empathic engagement with survivors of traumatic experiences. Vicarious traumatization is often characterized by disruptions in the professional's sense of self, level of connection with others, and worldview (Craig & Sprang, 2010; Sprang et al., 2007). Other associated symptoms include anxiety, depression, disconnection, isolation, becoming judgmental, and somatization (Sprang et al., 2007). Secondary traumatic stress was later introduced to describe the visceral and inherent behaviors and emotions resulting from learning about the traumatic experience of a significant other or someone that arouse empathy in others (Craig & Sprang, 2010). Compassion satisfaction is defined as the amount of gratification that a professional experiences from helping others (Dehlin & Lundh, 2018). Compassion satisfaction has been found to be positively associated with resilience which is the ability to withstand, cope, learn, and grow from adversities (Dehlin & Lundh, 2018).

Craig and Sprang (2010) conducted a study to examine the degree to which clinical psychologists and clinical social workers with experience in trauma treatment experienced compassion fatigue. A sample of 532 participants were selected from the 2003 National Association of Social Worker's (NASW) registry for social work clinicians. Participants were administered various tests to assess whether utilization of evidence-based practice for trauma has

had a direct impact on burnout, compassion fatigue, and compassion satisfaction. In this study, evidenced-based practice included psychosocial interventions with exposure therapy (e.g., Behavioral Therapy/BT), cognitive-behavioral interventions (e.g., Cognitive Behavioral Therapy/CBT), and eye movement desensitization and reprocessing (EMDR), which are all known for their efficacy in the treatment of trauma in adult clients. Consistent with other investigations, results of this study revealed that increased use of evidence-based practices for the treatment of trauma reduce burnout and compassion fatigue and increase compassion satisfaction. The results also revealed that being younger, having no special training in trauma, having a high caseload with PTSD clients, and being a practitioner at an inpatient facility significantly predicted burnout and high level of compassion fatigue (Craig & Sprang, 2010). Other studies have corroborated Craig and Sprang's findings, indicating education, years of experience, and expertise in trauma work to protect against the emotional toil associated with working with traumatized people (Pearlman et al., 1995; Abu-Bader, 2000; Cunningham, 2003). Other studies have found similar results; for example, Adams et al. (2001); Nelson-Gardell & Harris, (2003); and Vredenburgh et al. (1999) found that being older constituted a mitigating factor for secondary traumatic stress, vicarious trauma, and burnout. Other studies found that females were significantly at higher risk for secondary traumatic stress and vicarious traumatization than males (Brady et al., 1999; Kassam-Adams, 1999; Meyers & Cornille, 2002). Personal trauma history has also been associated with increased risk for secondary traumatic stress or vicarious trauma (Cunningham, 2003; Nelson-Gardell & Harris, 2003). Research findings have also suggested that clinicians working in community mental health teams may be more at risks of burnout than those working in specialized community teams, crisis teams, or specialized outreach teams (O'Connor et al., 2018). These findings may indicate that mental

health professionals in specialized community team may be receiving greater levels of training and supervision specific to trauma.

With a sample of 1,121 mental health providers in a rural southern state, Sprang et al. (2007) proposed to examine individual and contextual factors contributing to the mental health consequences of professionals with exposure to trauma clients. An examination of the relationship between compassion fatigue, compassion satisfaction, and burnout, and provider and setting characteristics revealed similar patterns to previous studies. Results of this study indicate that gender was a significant predictor of levels of compassion fatigue with females being at higher risks. Specialized training in trauma work was also found to significantly predict compassion satisfaction among clinicians. More specifically, clinicians who received trauma training reported greater compassion satisfaction than those who did not receive any trauma training. Results of this study suggest that specialized trauma training could preemptively attenuate the deleterious effects of trauma exposure. The authors argue that the attainment of more effective assessment and treatment tools through specialized training may have heightened clinicians' sense of self-efficacy skills. Additionally, such training may have created the opportunity to develop peer support beyond the educational realm. Often many mental health professionals work in isolation and experience limited opportunities to engage with others if they are in private practice. Contrary to other studies that found no significant difference in reaction to trauma exposure among different professions (e.g., counselors, social workers, and psychologists) (Creamer & Liddle, 2005), Sprang et al.'s study (2007) unexpectedly found psychiatrists to be the most impacted by exposure to trauma. Psychiatrists reported the highest level of compassion fatigue than all other professionals, including counselors and social workers.

Research has also shown that work relationship to be strong indicators of protective factors against burnout or compassion fatigue. A study conducted by O’connor et al. (2018) found that role clarity, perceived professional autonomy, perceived socially just and fair treatment, collegial support, and access to sound and consistent clinical supervision constituted strong protective variables against the development of counselor burnout and compassion fatigue. Similarly, results of a survey of 374 Swedish psychologists (320 women and 63 men) aiming at examining factors that help foster compassion satisfaction and factors that help mitigate burnout, compassion fatigue, or secondary traumatic stress revealed that psychologists who had the greatest access to supervision also reported greater compassion satisfaction (Dehlin & Lundh, 2018). These findings are particularly significant for Black counselors considering that many of them may find themselves in predominantly White spaces with minimal collegial support and possibly in racially hostile environments. When clinical supervision is provided, Black mental health professionals may be reluctant to bring up issues of race in supervision or case staffing meetings in fear of fulfilling negative stereotypes associated with their intersecting identities; thus, experiencing stereotype threats. Additionally, considering the novelty in understanding the impact of racism on the psychological wellbeing of individuals, there may be very limited training opportunities specific to racial trauma being offered to support Black counselors working with clients who have experienced racial trauma. This dissertation study could augment the current literature by shedding light on variables that constitute risk or mitigating factors to Black counselors burnout when working with racial trauma.

THEORETICAL FRAMEWORK

Year 2020 has been marked as a time of racial reckoning in the U.S., which has called international attention to racist practices and policies that present a threat to the well-being of

minoritized groups. Within the mental health field, conversations around anti-racist practices and policies have not gained much popularity. Unfortunately, some mental health professionals believe that politics, including conversations about race, do not have their place in therapy. While some professionals abide by a color-evasive approach; others, remain silent when conversations about race are initiated. DiAngelo (2016) argues that anything that does not challenge the racial status quo is racist. White silence and colorblindness inhibit all efforts to dismantle dominant ideology that supports the current racial equilibrium which is pervasive in our current society (DiAngelo, 2016). When race discussions are deliberately or inadvertently kept taboo in the counseling room through silence or dismissiveness, it causes the traditional racial relations to remain unchallenged, and thus maintaining a sense of comfort or racial stability. Additionally, it serves to perpetuate racial inequality (DiAngelo, 2016), White privilege, White supremacy, marginalization, and racial retraumatization.

The complexity of the marriage of race and mental health can be situated within a Critical Race Theory (CRT) paradigm. CRT provides us with a lens by which systems of subordination and power can be examined (DeCuir et al., 2019). Critical race theory is grounded in five fundamental principles: (1) racial stratification permeates the everyday life of people of color, their daily interactions, and impacts their quality of life; (2) racism and discrimination are nearly impossible to eradicate because they are not acknowledged and because of their elusive attributes. Policies and practices that claim to be colorblind or based on meritocracy often camouflage the ways in which dominant groups benefit from systemic racism; this is sometimes referred to as “interest convergence” or material determinism; (3) race and races are socially constructed and used whenever deemed convenient; (4) the self-expression of the lived experiences of Blacks and other subordinated groups are legitimate and appropriate. Delgado et

al (2017) purports that people of color's voices hold the truth in recounting the lived experiences of people of color with racism and oppression. The voice- of- color can be used to educate and inform White counterparts on matters related to race and oppression. The authors noted "minority status, in other words, brings with it a presumed competence to speak about race and racism" (Delgado et al., 2017, p. 11); and (5) critical race theorists should be anti-racist and advocates of social justice (Brown, 2003; Delgado et al., 2017).

As an academic and activist movement, CRT refutes the notion that racial stratification can be eradicated (Brown, 2003). Brown (2003) posits that racial stratification is a system of structured inequality in which one's ethnic-racial group membership determines accessibility to vital and sought-after resources. In racial stratification, individuals are assigned roles and functions based on their ethnicity and race (Brown, 2003). CRT was first introduced in the 1970's among the lawyers, activists, and law scholars in an attempt to restore the exhilarating progress made during the civil rights era in the 1960's. CRT draws primarily from critical legal studies by highlighting the indeterminacy of the law, meaning that legal cases may have multiple outcomes; and from radical feminism by examining the sociopolitical structures that embolden gender inequality and women sufferings resulting from male dominance (Delgado & Stefancic, 2017). CRT rapidly gained popularity among other disciplines, including Women's Studies, Political Science, American Studies, Ethnic Studies, Sociology, Theology, Philosophy, Health Care, and Education. The usage of CRT in these fields largely focuses on the examination of relationships between race, racism, and power (DeCuir et al., 2019; Delgado & Stefancic, 2017).

Correspondingly, I will attempt to adapt CRT to examine how mental health professionals in various spaces, including predominantly White spaces, respond to racial trauma of Black clients. Applying a CRT lens to the study of racial stratification and mental health can

help challenge the notion that mental health and mental health problems are etiologically determined by the individual's internal factors and which exudes the role of racism in the manifestation of unique mental health problems (Brown, 2003), including racial trauma.

This study will focus on the three approaches of CRT paradigm suggested by Brown (2003) to examine the relationship between race and mental health problems with the primary goal of providing an understanding of the experiences of mental health professionals working with racial trauma. The first approach entails the study of the social conditions (e.g., poverty, scarcity of resources, crime) or risk factors (e.g., perceived experiences of microaggressions, racism) (Brown, 2003). The second approach is an examination of standard indicators of mental health status and the construction of psychiatric disorders; in this study I will focus on the standard indicators of what constitute trauma. The third approach involves the examination of deleterious mental health issues stemming from racial discrimination.

CONCLUSION

In conclusion, to effectively address racial trauma in counseling the body of literature consistently evidenced the need to integrate racism in the Diagnostic Statistical Manual definition of trauma; without proper classification of racial trauma there will continue to be a challenge in providing effective services to people impacted by racism. Additionally, the literature reflects the need for awareness of the prevalence and pervasiveness of racism in the U.S. and its impact on Black people and other people of color. Lastly, there remains the importance of including opportunities for training specific to racial trauma and multicultural counseling competencies that focus on race.

As noted previously, there is a need for a racial trauma framework to help guide mental health professionals working with individuals who have been exposed to racism and have

developed trauma consequently. The current study is an attempt to fill this gap in the literature by gathering strategies and interventions from Black mental health experts who have developed the skills to effectively work with Black clients impacted by racism.

Chapter 3: Methodology

QUALITATIVE METHODOLOGY

This study was conducted in the context of increasing awareness of police brutality against Black people in the U.S. and in the context of increased awareness of how oppression and racism is perpetual, omnipresent, and a threat to the betterment of society. Oppression and racism have harmful emotional, physical, and psychological effects on Black people that can potentially lead to traumatization. Trauma stemming from acts of racism or discrimination is not new in the U.S.; trauma has impacted Black people since the start of slavery but has received little to no attention in the literature of mental health until recently. What is new and yet scant is information on how well-equipped mental health professionals are in working with impacted individuals and its toll on mental health professionals. There is no existing research that has explored the inner experiences of mental health professionals working with Black clients who may have experienced racial trauma. This study is an attempt to fill the existing gap by seeking to understand how mental health professionals have managed to work with individuals who have experienced race-based trauma and the impact on the wellbeing of these professionals. Using qualitative research methods, I hope to gain insightful and meaningful data to help provide a holistic and comprehensive understanding of racial trauma from a mental health perspective. My preference for qualitative research resides in my proclivity for the fluid, evolving, and dynamic nature of qualitative inquiry (Corbin & Strauss, 2015). As a professional counselor who values human connections, relationships, and helping people making meaning of their experiences, I find qualitative inquiry to be an empowering research conduit to this study in that it can help bring to life the experiences of Black mental health professionals working with racial trauma.

Philosophically grounded in social constructionism, phenomenology, and symbolic interactionism, qualitative research has earned its place and popularity in research literature for its ability to help understand the meaning that people make out of their experiences (Merriam & Tisdell, 2016). Both constructionism and interactionism focus on the process by which people create and interpret their realities by use of language and human interactions (Walker, 2015). It is important to note that constructivism does not refute the existence of reality, instead, constructivism affirms that the meaning of people's realities are constructed within a shared social prism in which language is used to create concepts (Walker, 2015). From this standpoint, qualitative inquiry in this study will seek to understand the process by which Black mental health professionals have constructed meaning into their experiences of working with racial trauma from an emic perspective or from an insider's perspective (Merriam & Tisdell, 2016). The language and the social context in which these meanings are created will be of paramount importance in understanding this phenomenon. In qualitative research, the researcher is essential to the study in that they are the outlet to data collection and analysis (Merriam & Tisdell, 2016). As a primary instrument, the researcher must due diligence to account for any shortcomings and biases to becoming an emic researcher or a researcher with an insider's perspective. Another key characteristic of qualitative research is that it is inductive, meaning that it does not seek to confirm or disconfirm a hypothesis but rather it seeks to gather data to generate theories or hypotheses where none existed (Merriam & Tisdell, 2016). Qualitative approaches provide rich descriptives that are diverse, sensitive, insightful, complex, nuanced, and multifaceted (Braun & Clark, 2006; Creswell, 2003; Merriam & Tisdell, 2016). As such, researchers must be transparent in reporting well-structured and detailed descriptions of how analysis and interpretations of data are organized and generated (Braun & Clark, 2006; Merriam & Tisdell, 2016). Researchers are

responsible to assure rigor and trustworthiness of the study through avid documentation, recording, evaluation, systematization, and disclosing of the process (Nowell et al., 2017).

Research Questions:

The formulated questions helped answer the following:

1. What are the experiences of Black mental health professionals working with clients who have experienced racial trauma?
2. How do Black mental health professionals meet the personal and professional challenges of serving clients who experience racial trauma?
3. What competency training do mental health professionals need to promote and enhance their effectiveness when working with individuals who experience racial trauma?

THEMATIC ANALYSIS PHILOSOPHICAL FOUNDATIONS

Thematic analysis (TA) is the process of systematically making meaning of data by looking for patterns and meanings across a dataset. It involves identifying similarities in themes across the data, grouping items based on relationships, and offering interpretations to those themes and categories (Maguire & Delahunt, 2017). TA is considered the stepping stone of many other analytical research methods as it provides foundational skills that all researchers must acquire to be an effective qualitative researcher (Braun & Clarke, 2006; Nowell et al, 2017). As a research methodology, TA was first introduced in the 1970's and recognized in the field of psychology as a research approach to analyzing data (Clarke & Braun, 2013). It was further developed and demarcated by Braun and Clarke (2006). While there are many different ways of conducting TA, for this study I will ascribe to Braun and Clarke's (2006) 6-step framework to TA because of its preciseness and yet simplistic approach to data analysis; additionally, I will ascribe to this approach because it is the most influential approach in the social sciences.

Advantages to Thematic Analysis

There are many advantages to thematic analysis. Compared to other qualitative methodology, TA can be used as a standalone method of analyzing data as opposed to a methodology. It is not associated with any particular theoretical or epistemological perspective which makes it simple to use and appealing to researchers who are at the start of their research career (Braun & Clark, 2006; Clarke & Braun, 2013; Nowell et al., 2017). This characteristic of TA makes it appealing to qualitative researchers as it provides a flexible approach to diverse fields of studies.

Thematic analysis is adaptable to a wide variety of field of studies, including but not limited to the field of education (Xu & Zammit, 2020), counseling and psychology (Clarke & Braun, 2018), health care (Braun & Clarke, 2014), sport and exercise (Braun et al., 2016), and beyond. Thematic analysis is beneficial in that it can be used to analyze a wide range of data sets, including transcripts from individuals or focus group interviews and secondary sources (e.g., archival data, media); it is adaptable to a small or large data set. It is useful in comparing interview data by bringing forth similarities and differences among participants (Nowell et al., 2017). Thematic analysis is suitable for both data-driven studies and theory-driven studies (Merriam & Tisdell, 2006; Nowell et al., 2017). Since there are no clear theoretical approaches to understanding how mental health professionals work with racial trauma, the current study will assume a data-driven approach. Lastly, thematic analysis is useful in helping to answer a wide range of research questions, including questions that seek to understand participants' experiences to questions that help people understand how a phenomenon is conceptualized or constructed in particular contexts (Clarke & Braun, 2013, Nowell et al., 2017).

Disadvantages to Thematic Analysis

One of the most major shortcomings of thematic analysis is the lack of ample and substantive literature on how to conduct analysis in contrast to other forms of qualitative research methods such as grounded theory, ethnography, and phenomenology (Nowell et al., 2017). Additionally, there seems to be ambiguity as to what constitutes thematic analysis and how it is conducted (Braun et al., 2006). This is particularly problematic for novice researchers who do not possess adequate competency in research to ensure rigor in the analytical process. While flexibility is one of the desirable attributes of thematic analysis, it can be considered a potential threat to the trustworthiness of the outcome data in the absence of a consistent and cohesive process. To mitigate this threat, the researcher's epistemological position must be explicitly stated along with clear and concise guidelines on the procedural process (Nowell et al., 2017). Braun and Clarke (2006) contend that an over simplistic thematic analysis can be disadvantageous as it limits interpretation of language from raw data.

RATIONALE FOR THEMATIC ANALYSIS

I was inclined to using thematic analysis in this study primarily because it does not necessitate adherence to a particular theoretical framework to human experiences or theory of language to examine patterns across language (Clarke & Braun, 2013). To that effect, TA was highly suitable to examine the experiences of mental health professionals within a Critical Race Theory framework. Other reasons for my preference for this method of analysis is its ease of accessibility and comprehensible characteristics and its suitability to address multiple research questions. In the context of this study, TA helped with questions that seek to examine the professional experiences of Black mental health professionals working with clients who have experienced racial trauma, questions that help examine training needs to most effectively work with racial trauma, and questions that highlight the impact of such work on mental health

professionals' personal wellbeing. Moreover, TA helped uncover how racial trauma is viewed by mental health professionals in light of the recent sociopolitical climate. Lastly, I have chosen this method of analysis because of its relevance to produce data-driven analyses (Clarke et al., 2013).

RESEARCHER POSITIONALITY

I identify as a first-generation Haitian Black female who have been practicing for over five years as a mental health professional. I am licensed as a professional counselor and own a private practice in the St. Louis region, servicing couples and adult individual clients of all identities. As a Black woman living in the U.S. for nearly 27 years, 11 being in St. Louis, I have experienced racism and oppression in various realms routinely. Additionally, as a scholar in the field of education and counseling, I possess an in-depth astuteness to matters related to race. Lastly, as a mental health provider and a counselor educator, I am committed to educating others about the impact of racism on the emotional, psychological, and physical wellbeing of individuals. I also want mental health programs to develop sound and relevant curriculum to arm professionals with the tools needed to effectively respond to racial trauma and mitigate counselor burnout.

PARTICIPANT SELECTION AND RECRUITMENT

Participant Selection

To maximize efficiency, validity, and credibility of results, participants was selected via purposeful sampling. Purposeful sampling is widely used in qualitative research to accentuate informative and insightful cases to further illuminate an area in which little is known (Patton, 2002; Palinkas et al., 2015). There are many types of purposive sampling, ranging from maximum variation sampling or heterogeneous sampling, homogeneous sampling, typical case sampling, extreme or deviant case sampling, critical case sampling, criterion-i sampling or expert

sampling, and many more (Palinkas et al., 2015). The type of purposeful sampling selected is based on the research questions to which the researcher desires to find answers. I have chosen to use criterion-i or expert purposeful sampling because my aim is not to seek empirical generalizations but rather to help fill the gap in knowledge and expertise on how to address racial trauma from a mental health perspective. My hope was that insightful information shared by these experts will serve as a guide in helping mental health programs and other mental health organizations develop relevant curriculum and training to best equip clinicians in their work with clients who have experienced racial trauma. Criterion-i or expert sampling aims to bring forth detailed (depth) and generalizable (breadth) knowledge from entities that have particular proficiency and expertise in an interested area (Palinkas et al., 2015). In criterion-i purposive sampling, participants are selected from the larger population because they are assumed to be “representative” of a particular group based on similarity in criteria (Palinkas et al., 2015).

Participants were selected based on years of experience, licensure status, and self-reported expertise with the phenomenon under investigation. As such, I recruited research participants who identify as Black and who self-report having experience working with Black clients who have experience and expertise in racial trauma. By selecting professionals with a Black identity, I hoped to get deeper insights and greater sensitivity to the phenomenon being studied. Selecting participants based on similarities in roles is often cautioned because of the potential to limit the depth of understanding by excluding the voices of those who have the greatest knowledge on the topic of interest but do not meet the criterion (Palinkas et al., 2015). This potential threat in participant selection was moderated in this study by selecting participants who report having expertise in racial trauma and thus possess the knowledge to provide rich descriptive data.

Achieving Saturation

First coined in the field of qualitative research by Glaser and Strauss in 1967, the concept of “theoretical saturation” is defined as the point to which a researcher has reached limitation in variation of data in which case no substantial or relevant categories or themes can be interpreted from the data (Guest et al., 2020). Saturation implies that replication is obtained in the data and all characteristics, dimension, or perspective of the phenomenon has been accounted for (Heppner et al., 2016). Saturation occurs when all major concepts have been fully developed and integrated and when there are no new concepts being generated through interviews and data analysis. Using a rigorous and tedious participant selection, I hoped to achieve saturation at about 12-15 participants. From a methodological perspective, it was hard to determine how many participants would be used to achieve saturation; however, it is recommended that researchers overestimate the size of their sample rather than underestimating to get as much usable data as possible as the greater the number of usable data obtained, the smaller number of participants the researcher needs (Heppner et al., 2016; Morse, 2000). I went over my anticipated number of participants in order to include male perspectives; the study had 24 participants with 23 usable data.

Recruitment

Prior to data collection, I secured appropriate clearance from the Institutional Review Board (IRB) committee at my institution (see Appendix A). An electronic *Call for Participant* message was used as the primary recruitment tool (See Appendix B). The electronic invitation contained information about the purpose of the research and a link created through Qualtrics, an online survey software system, to obtain more detailed information about the research and consent for participation. All recruitment materials included selection criteria and the anticipated

incentives for participation that include a \$30 Amazon gift card. All prospective participants were informed about research procedures and what their participation would involve: (1) A demographic questionnaire that would take about 5 minutes to complete which would include participants' contact information (email or phone) to be contacted for the interview; (2) completion of a recorded 60-75 minute semi-structured interview. Due to the Global Pandemic of 2020, all interviews were conducted via video conferencing (e.g., Zoom); participants would have the option to have their camera on or off; and (3) the opportunity to participate in a follow-up interview in order for the researcher to share preliminary data analysis and check for accuracy of research findings. All interviews were recorded.

Eligible participants were professionals who identify as Black mental health professionals, counselors, clinicians, or therapists who have experience and expertise working with Black clients who may have endured racial trauma. They must have been licensed and could be from fields related to psychology, psychiatry, counseling, or social work. Recruitment of participants was done via an email sent to various Listservs, including but not limited to COUNSGRADS, CESNET-L, DIVERSEGRAD-L, and other similar listservs that have a highly diverse readership and from various Facebook groups for Black clinicians and clinicians specialized in trauma work (e.g., Clinicians of Color in Private Practice; St. Louis Black Therapists; St. Louis Black Therapists United; Black Mental Health Professional Network; Black Therapists ROCK; Black Online Therapists; Black EMDR Clinicians; Therapy in Color Clinicians; Black Mental Health Professionals; Melanin & Mental Health Professionals; The EMDR Therapist Collective; EMDR Therapists; Professional Mental Health Counselors, Social Workers, & Psychologists; The Black Girl Clinician Collective; St. Louis Area Counselors; Mental Health Professionals Group; Therapists and Mental Health Professionals; STL Metro

Black Therapist to Therapist). I also sent out the survey to clinical mental health practitioners who identify on the national professional website *Psychology Today* as providing racial trauma therapy. Participant selection were made after the review of the initial respondents' demographic data to see if they met the criteria. The researcher contacted respondents for a recorded video conferencing interview at an agreed-upon time.

Informed Consent

The consent form included questions to help identify mental health professionals with the required criteria. Our construct of Blacks included all individuals who are of African descent. The researcher collected data on participants' identifiable characteristics, including age, identified gender, ethnicity, and geographic region. Information was obtained on participants' credentials, licensure status, years in practice, academic and professional training in multicultural and trauma-informed counseling.

Anonymity, Safety, Privacy, and Confidentiality

It is the researcher's responsibility to maintain confidentiality and anonymity of participants. Some ways to ensure these are: assigning pseudonyms to participants, grouping participants' identifiers together and reporting on ranges of characteristics, avoiding assigning specific quotations to participants unless there are compelling reasons to do so (Morse, 1998).

The primary method of data collection was interviews via protected and secured video conferencing platforms (e.g., Zoom). To ensure anonymity of participants, I was the only person conducting all interviews. Prior to data collection, I submitted a research protocol to the IRB detailing how participants would be recruited, types of data that would be collected and how, data storage, and any pertinent information that might impact the research or the participants. IRB approval would be obtained prior to any data collection.

DATA SOURCES AND DATA COLLECTION

Sources of Data

The most frequently used type of data in qualitative research are interviews and observations. Other means of data are also acceptable such as journals, memoirs, pictures, videos, and other artifacts (Corbin & Strauss, 2015). For this study, I utilized interview data and archival data from the media that can provide contextual and rich information to best situate this research. Additional data consisted of shadowed data. Morse (2000) defines shadowed data as information from participants about other's experiences. Morse (2000) argues that shadowed data gives the researcher an idea of how widespread a phenomenon is; shadowed data also helps bring light to the differences in participants' experiences, and helps the researcher in deciding on a theoretical approach. Another possible source of data is secondary selection which would be data that are less rich or descriptive but that can be used at a later point when deemed necessary (Morse, 2000).

Data Collection

Interviews were recorded via teleconferencing services (e.g., Zoom) upon receiving consent from participants. In conjunction with the recordings of the interviews, the interviewer also took notes during the interview and after the interview, documenting non-verbal cues and other noteworthy descriptors they have observed in the participants, the setting, themselves, or anything else unexpected that arose.

Data Storage

Data were stored in a password protected document on my personal home desktop computer that is also password-protected. The data would be kept for seven years and destroyed thereafter.

INTERVIEWS

This study involved the use of in-depth interviews of Black mental health professionals (See Appendix C for Interview Protocol). Interview questions derived from information found in the literature and in practice. The main objective of in-depth interviews is not to test out assumptions or hypothesis but to help fill in the gaps while providing insights into the experiences of mental health professionals working with Blacks who have experienced racial trauma (Seidman, 2019). Agee (2009) discussed the importance of writing research questions as a guide to further expand our inquiries about a particular phenomenon to be studied. Interview questions included demographics about participants, no specifics about clients that could jeopardize their anonymity would be asked of participants. Other questions would be tailored to capture the experiences of mental health professionals working with Blacks who have experienced racial trauma.

Semi-structured interviews were the interview of choice to allow for additional contribution from participants to further elaborate on a topic. Semi-structured interviews is also beneficial because it allows the researcher to make adjustments as necessary based on previous interviews while maintaining some consistency (Corbin & Strauss, 2015). All questions were open-ended and aimed at shedding light on the lived experiences of mental health professionals working with Blacks who have experienced racial trauma and the impact such experience may have on mental health professionals' personal and professional life.

Rabionet (2011) discussed the many stages involved in conducting semi-structured interviews. The stages include interview selection, ethical decisions, crafting the interview, conducting the actual interview, data analysis, and reporting findings. Rabionet warns us about being intentional about the process of conducting semi-structured interviews and the importance

in having a good grasp of the knowledge on the topic being researched. Knowledge, skills, vision, and integrity of the researcher are essential to good qualitative interviews—Rabionet’s account of semi-structured interviews should be a reminder for researchers to reflect on their acknowledge they have on the topic of mental health professionals’ experiences working with Blacks who have experienced racial trauma.

TRANSCRIPTS

After downloading and storing interview recordings, I transcribed the verbiage from the audio, using Otter.ai, a protected software system for transcribing. I then checked for accuracy and made changes as needed.

PROCEDURES

I created a survey in Qualtrics, an online survey software system that includes informed consent and a demographic questionnaire to determine eligibility for the study (See Appendix C). At the end of the demographic questionnaire, prospective participants were given the opportunity to insert their email addresses to be contacted for the interview. I reached out to interested participants to schedule one individual 60-75 minute semi-structured interview (See Appendix D) via a videoconferencing platform such as Zoom. Participants had the option to keep their cameras on or off; however, all interviews will be recorded. Participants were told that participation is anonymous and voluntary and that the purpose of the study is to understand the experiences of mental health experts in working with racial trauma. Participants were given a \$30 gift card upon completion of the interview which will be mailed or emailed. The demographic questionnaire included questions about the respondent’s age, gender, race/ethnicity, level of education, discipline, whether they had received courses in trauma-informed care during their program of study or during their professional career, and years in practice as a mental

health professional. At the end of the interview, the interviews were systematically analyzed using a thematic analysis approach. I emailed the themes and categories created from the interviews to the participants along with relevant sections of the interview transcripts to check for accuracy of information. It was optional for participants to follow through.

DATA ANALYSIS

Interpretation of Data

During the process of analysis, the researcher must make several decisions; one of which is determining at which level themes will be identified (Braun & Clark, 2006). Braun & Clarke (2006) differentiate two levels of themes, semantic or explicit level and latent or interpretive level. Themes created at the semantic level are superficial or surface level (Braun & Clark, 2006; Maguire & Delahunt, 2017). Narratives are taken at face value with no insightful interpretation, analysis, or search for meaning. Themes created at the latent level offer insights and meaning. The researcher conceptualizes the narratives in contextual and meaningful ways, looking for underlying ideas and assumptions (Braun & Clark, 2006; Maguire & Delahunt, 2017).

Braun and Clarke (2006) developed a six-step approach to conducting thematic analysis which include: (1) becoming familiar with the data; (2) generating initial codes; (3) searching for themes; (4) reviewing themes; (5) defining themes; and (6) writing-up the report (Maguire & Delahunt, 2017; Xu & Zammit, 2020). Thematic analysis is not a linear process; it is a process that is iterative and reflective, requiring that the researcher engages in multiple aspects of the analysis concurrently and moving back and forth over time across data (Fereday & Muir-Cochrane, 2006). Lincoln and Guba (1985) have offered criteria to ensure trustworthiness during each phase of thematic analysis. Nowell et al. (2017) have compiled these recommendations into

a table (Table 1) which is represented below. I followed these guidelines in my implementation of the six-phases.

Table 1

Establishing Trustworthiness During Each Phase of Thematic Analysis.

Means of Establishing Trustworthiness	Means of Establishing Trustworthiness
Phase 1: Familiarizing yourself with your data	<ul style="list-style-type: none"> Prolong engagement with data Triangulate different data collection modes Document theoretical and reflective thoughts Document thoughts about potential codes/themes Store raw data in well-organized archives Keep records of all data field notes, transcripts, and reflexive journals
Phase 2: Generating initial codes	<ul style="list-style-type: none"> Peer debriefing Researcher triangulation Reflexive journaling Use of a coding framework Audit trail of code generation Documentation of all team meeting and peer debriefings
Phase 3: Searching for themes	<ul style="list-style-type: none"> Researcher triangulation Diagramming to make sense of theme connections Keep detailed notes about development and hierarchies of concepts and themes
Phase 4: Reviewing themes	<ul style="list-style-type: none"> Researcher triangulation Themes and subthemes vetted by team members Test for referential adequacy by returning to raw data
Phase 5: Defining and naming themes	<ul style="list-style-type: none"> Researcher triangulation Peer debriefing Team consensus on themes Documentation of team meetings regarding themes Documentation of theme naming
Phase 6: Producing the report	<ul style="list-style-type: none"> Member checking Peer debriefing Describing process of coding and analysis in sufficient details Thick descriptions of context Description of the audit trail Report on reasons for theoretical, methodological, and analytical choices throughout the entire study

Coding

The coding were done manually. The coding process involved finding narratives that are deemed of importance to encode (Boyatzis, 1998; Fereday & Muir-Cochrane, 2006). There are six stages to coding which includes: (1) developing a coding manual; (2) testing the reliability of the code; (3) summarizing data and identifying initial themes; (4) applying codes from the codebook to the text while searching for meaningful data; (5) identifying themes and patterns in the data; and (6) checking for accuracy of findings by validating and legitimizing coded themes (Fereday & Muir-Cochrane, 2006).

Establishing Trustworthiness

To ensure credibility and trustworthiness of the data, qualitative inquiry emphasizes the importance for researchers to maintain ongoing analytical records of their personal biases and assumptions, reactions to interviews, and all influential factors that may emerge throughout the process of data collection (Heppner et al., 2016). To this effect, I employed multiple strategies, including triangulation, respondent validation, prolonged engagement with the data, discrepant case analysis, reflexivity or positionality, and peer consultation.

Credibility

Credibility is concerned with the ability for readers and researchers to identify the phenomenon in real life. This is also known as internal validity. Internal validity questions whether a research is capturing the real essence of a phenomenon. It urges one to question whether mental health professionals' account of their experiences working with Blacks who have experienced racial trauma can truly be attributed to the nature of their work such as training, skills, or responses to their work (Merriam & Tisdell, 2016). Construct validity speaks to whether the research is measuring what they claim to measure. Descriptive validity refers to

accuracy of accounts. Interpretive validity refers to accuracy of interpretation assigned to the data. There are many techniques that are recommended to ensure credibility. Accordingly, to ensure credibility in the study findings, I had peer debriefing, triangulation, prolonged exposure with the data, member checking, and other techniques to help achieve triangulation (Lincoln & Guba, 1985).

Transferability

Transferability, also referred to as external validity, is concerned with the extent to which a research can be generalized and applied to other contexts and settings (Nowell et al., 2017). As such, researchers are encouraged to provide thick, rich, and detailed descriptions of the research and methods to enable research readers to apply the research outcome to their personal setting and context (Lincoln & Guba, 1985; Nowell, et al., 2017). My goal in conducting this research was that the information obtained from professionals would be transferred on a macro level to help practitioners and training institutes develop effective strategies and curriculum to best serve Black clients impacted by racial trauma. To achieve this, I maintained and provided detailed and specific descriptions of the research methods to allow other non-Black clinicians and mental health programs and organizations the opportunity to apply this knowledge to better their practice. Additionally, to ensure external validity of this study, I included the voices of mental health professional with experience on racial trauma from various states and from a wide range of work settings. By expanding my invitations to social media groups that are located throughout the U.S., I increased the likelihood of getting participants from a wide range of regions throughout the U.S.

Dependability

Dependability has to do with ensuring that there is evidence of clear documentation to enable all steps to be traced (Nowell et al., 2017). Also known as reliability, it is the extent to which a study can be replicated and yield similar results. Reliability speaks to the effect of dependability and consistency. According to Merriam and Tisdell (2016) it is not so much about whether one can achieve the same result if one was to replicate a study, it is rather about whether the results are consistent with the data. For instance, if I interview a second group of mental health professionals who work with Blacks who have experienced racial trauma, will my interpretation of their interviews lead to similar results with the original group and do the results seem plausible?

Issues with reliability include (1) Participant Error, factors that alter the performance of participants; (2) Participants Bias, factors leading to false responses from the participant. Similar to desirability; (3) Researcher Error, factors that can affect the researcher's interpretation; and (4) Researcher Bias, factors contributing to biases in the researcher. This can be achieved by maintaining and reporting well-structured and organized processes to enable replicability.

Confirmability

Confirmability is concerned with ensuring that the data outcome is grounded in the participants' narratives rather than the researcher's personal views, assumptions, and biases. Confirmability is achieved when credibility, transferability, and dependability have been maintained (Nowell et al., 2017). It is recommended that researchers established various set points throughout the study to explicate the readers of all rationales for decisions (Nowell et al., 2017). To this end, upon completion of the data collection, I maintained rigorous records of all that have transpired and influenced my decisions throughout the study.

Reflexivity

As humans, we all have our own biases that may influence decisions and perspectives of the world and lived experiences. Researchers as instruments in the study process bring with them their personal values, beliefs, and biases. Agee (2009) urged researchers to be mindful of how they position themselves vis-à-vis the research, the participants, the setting, etc. Rabionet (2000) calls into question how the issue of positionality might influence outcomes of interviews. As such it is recommended that researchers keep a self-critical account of their internal and external dialogue by maintaining a reflexible journal (Nowell et al., 2017). The purpose of the journal is to help minimize those biases and assumptions to ensure objectivity to the best we can. A research journal can help the researcher become aware of how much influence they have on the outcomes of the study and how much impact the study has on everyone involved in the study (Corbin & Strauss, 2015). By keeping a journal, the researcher is able to gain greater insight on the impact that their positionality has on the research. Memoing or journal writing is a process by which the researcher engages in writing notes or memos explaining how themes and categories are used or modified. This process also serve to explain the processes taken by the researcher(s) throughout the study; to document researcher(s)' hunches, theoretical reflections, and links to the literature; and to note personal characteristics of the researcher that may impact data collection, analysis, interpretation, or results (Heppner et al., 2016). That that end, I maintained a journal to keep records of all steps affecting the study. This included every action taken related to the study; all decisions made and rationales for those decisions; problems that arise and how they are handled; appointments, meetings, and summary of meetings; reactions of researchers and participants throughout the duration of the study; and prior knowledge, assumptions, and biases of researchers.

Audit Trail

Keeping a journal entry can also serve as an audit trail to help maintain transparency with all decision processes with data collection and analysis; hence, establishing consistency and credibility in the research (Nowell et al., 2017). I demonstrated with confidence how I have arrived at the conclusion or findings by keeping a sound-proof audit trail of every step taken and rationales for making decisions throughout the study. I maintained rich and thick descriptions of the participants, the settings, and the results to allow the reader or consumer to locate themselves in the study (Merriam & Tisdell, 2016).

Member Checks or Respondent Validation

This is yet another common strategy to help establish credibility or internal validity in your study. This process requires that the researcher present the preliminary findings to the participants to check for accuracy of the researcher's interpretation of their experiences (Merriam & Tisdell, 2016). To achieve this, I emailed participants sections of their transcripts along with themes to inquiry for accuracy of my interpretation (See Appendix E).

Triangulation

Triangulation are strategies used to reinforce the internal validity or credibility of a study. According to Merriam and Tisdell (2016), Denzin (1978) proposed 4 types of triangulations to help confirm emerging findings: (1) use of multiple methods of data collection—this method involves comparing similar information from different sources such as interviews, artifacts, and observations; (2) multiple sources of data—this technique suggests that the researcher compares and cross-checks data collected either from observations at different times or different settings, interview data collected from different participants with different perspectives, or from follow-through interviews with the same participants; (3) multiple investigators—this method is based on the use of multiple researchers to analyze the same data independently and come together to

compare findings; and (4) multiple theories—this method implies that the researcher approaches data analysis with several hypotheses in mind and assessing how well each represents the data.

For this study I used the multiple sources of data collection approach in that I cross checked my interview data with observable data readily accessible through several Black clinicians groups and accounts from Black practitioners. I also consulted with peers on what the findings meant and on the categorization of codes.

Ethical Issues

According to Corbin and Strauss (2015), there are three areas for ethical considerations: participants, research, and researchers. First, participants must be treated with respect regardless of their values and beliefs which may differ from that of the researcher. The researcher must exercise due diligence in creating an environment free of judgment and one in which the participant feels valued for their input and safe to express their views and experiences. Researchers must ensure to get participants' consent and due all necessary measures to ensure and maintain confidentiality. Second, Corbin and Strauss (2015) stress the importance for researchers to ensure fidelity in the implementation of a methodology; meaning a researcher cannot choose to be selective as to which aspects of a methodology to adopt and which to discard. Methodologies must be treated as a whole to ensure integrity of research findings. Researchers must be committed to ensure proper follow through on a study to its publication (Corbin & Strauss, 2015). And lastly, researchers must be cognizant of how the data affect them and thus have the obligation to take the necessary measures to avoid researcher bias or burnout (Corbin & Strauss, 2015). As a researcher who identifies as Black, I must be self-aware of how participants' views affect me emotionally and continuously gauge their influence on my interpretation of the data. I must also be cognizant of what influences my beliefs and

assumptions on the topic. To this end, it is advisable that I, as the researcher, maintain a research journal to annotate my assumptions, values, beliefs, experiences, insight into my behaviors as I go through this journey from data collection to reporting results (Corbin & Strauss, 2015). The researcher or interviewer should also maintain notes on the reactions of participants and challenges encountered throughout the study. Additionally, Corbin and Strauss (2015) argue on the importance of documenting how one is changed and shaped by the research.

Cultural Concerns

The cultural concerns around using thematic analysis as a method of inquiry is the possibility for misinterpretation of the data or researcher bias due to the researchers' background being possibly too similar to that of the participants. I identify as a Black female therapist with extensive knowledge and experience working with racial trauma. Another cultural concern is how the researcher's worldview and personal characteristics may influence the interpretation of the data and how comfortable participants are in sharing their experiences with a researcher who identifies as an immigrant.

HYPOTHESES

As stated earlier, the philosophical assumptions underpinning this research stem from the principles of CRT, as well as historical and contemporary knowledge of race relations in America. There has been an increased public awareness of racism and its impact on the wellbeing of people, especially those directly impacted. As a mental health practitioner, I have seen transparency in Black and Brown clients expressing the exhausting and toxic impact of racism on their physical, emotional, and psychological wellbeing. Additionally, as a counselor educator, I am aware of the dearth in training provided to counselors-in-training that could help recent graduates be effective in identifying, assessing, and treating race-based trauma. One of the

assumptions guiding this research is that counselors, especially White counselors, are not well-equipped to work with Black clients who are the most impacted by racism. Another assumption that is rooted in critical race theory is that Black counselors may have the most experience in working with racial trauma because they are more likely to have experienced racism and as such, they may have become sensitized to its impact on the wellbeing on individuals.

Hypothesis 1: Black mental health professionals will report to have experience working with racial trauma.

Hypothesis 2: Black mental health professionals will engage in multiple modalities of self-care strategies to maximize their effectiveness in working with individuals impacted by racial trauma.

Hypothesis 3: Black mental health professionals will report need for specific training that are culturally relevant and trauma-sensitive.

In closing, this chapter provided an overview of the research methodology of study, in addition to procedures that were undertaken to maximize ethical research protocol. The subsequent two chapters address data analysis and discussion of the research findings.

Chapter 4

Results

This study sought to examine the experiences of mental health professionals with expertise in working with racial trauma. More specifically, this study aimed at collecting and sharing lessons learned from these mental health experts. Through semi-structured interviews, participants shared valuable strategies to effectively address race-based trauma in Black clients. Using a thematic analytical approach to conducting semi-structured interviews, participants' experiences were captured with three main research questions:

1. What are the experiences of Black mental health professionals working with clients who have experienced racial trauma?
2. How do Black mental health professionals meet the personal and professional challenges of serving clients who experience racial trauma?
3. What competency training do mental health professionals need to promote and enhance their effectiveness when working with individuals who experience racial trauma?

This chapter provides a detail account of the participants responses, including direct quotes, themes that emerged from the interviews; and trends observed in the data. Tables and figures are provided to facilitate understating of the data. Participants' identifiable information has been removed for anonymity and confidentiality; participants were assigned numbers. Quotes were directly taken from the transcripts of participants' interviews; nonetheless, unnecessary parts were omitted to provide a more concise illustration of participants' experiences. Omitted sections did not take away nor did they alter the meaning of the participants' statements.

Participants Descriptives

A total of 24 participants were selected from a pool of 344 responses to the survey sent out. Of the 344 responses, 257 were deleted for the following reasons: no contact information provided, dummy email accounts, duplicate surveys, incomplete surveys, and those who did not meet the criteria for participation. Twenty-four participants were strategically selected from the remaining pool of 87 to ensure that all demographic variables were represented by years of experience, educational background, and region. All selected participants were licensed. Participants with a counseling background were prioritized over participants from other disciplines. Of the non-counseling participants, priority was given to male participants due to the scarcity in finding male participants, longevity in work experience, and regions due to overrepresentation of participants from the Midwest. To rectify the dearth of male participants represented in the initial pool, snowball sampling method was used to recruit male participants from which six male participants responded and were interviewed. However, one of those interviews was omitted due to participant's licensure status. By the end of the selection process, there remained 18 self-identified female participants and 5 self-identified male participants.

Table 2 provides a graphic of all twenty-three (23) participants' demographic. All 23 participants identified as African American or Black. Participants ranged from 31 to 60 years of age. The average mean age was 39.5. All participants were fully licensed in their field of studies which included counseling (82.6%; n=19) and clinical social worker (17.4%; n=4). Those who identified from the counseling field were either clinical mental health counselors, school counselors, or marriage and family therapists. Participants were recruited nationwide: participants were primarily from the Midwest (73.9%; n=17); two (8.7%; n=2) participants were from the Southeast region; two (8.7%; n=2) were from the Southwest region; one (4.3%; n=1) was from the West region; and one (4.3%; n=1) was from the Northeast region.

Table 2

Participants Demographic Summary

Participant Number	Gender	Ethnicity	Age	Discipline	Region
P1	F	African American/Black	31	CNS	MW
P2	F	African American/Black	35	CNS	SE
P3	F	African American/Black	42	CNS	SW
P4	F	African American/Black	33	CNS	MW
P5	F	African American/Black	47	CNS	SW
P6	F	African American/Black	48	CNS	West
P7	F	African American/Black	32	CSW	MW
P8	F	African American/Black	39	CNS	MW
P9	F	African American/Black	60	CNS	MW
P10	F	African American/Black	37	CNS	NE
P11	F	African American/Black	32	CNS	SE
P12	F	African American/Black	49	CNS	MW
P13	F	African American/Black	38	CNS	MW
P14	F	African American/Black	33	CSW	MW
P15	F	African American/Black	42	CNS	MW
P16	F	African American/Black	45	CNS	MW
P17	F	African American/Black	42	CNS	MW
P18	F	African American/Black	43	CSW	MW
P19	M	African American/Black	60	CNS	MW
P20	M	African American/Black	44	CNS	MW
P21	M	African American/Black	35	CSW	MW
P22	M	African American/Black	41	CNS	MW
P23	M	African American/Black	40	CNS	MW

Note: P (Participant); CNS (Licensed Clinical Mental Health Counseling, Licensed School Counseling, Licensed Marriage and Family Therapy); M (Male); F (Female); MW (Midwest); SW (Southwest); SE (Southeast); NE (Northeast)

Table 3 provides a summary of participants' level of education, years of experience, and work setting. The majority of the participants (82.6%; n=19) held a terminal master's degree in their respective field (i.e. counseling or social work). Four participants (17.4%; n=4) held doctorate degrees; two participants held Doctor of Philosophy degree (PhD) and two participants held Doctor of Education degrees (EdD).

Eighty-seven percent (87.0%; n=20) of the participants worked in Outpatient Private Practice settings (Table 3). Three participants (13.0%; n=3) worked both in Outpatient Private Practice and In-Patient facilities such as shelters, prison settings, and psychiatric facilities (Table 3). Participants reported conducting therapy sessions face-to-face; some participants use telehealth as an alternative mode of conducting therapy in response to the pandemic.

Table 3

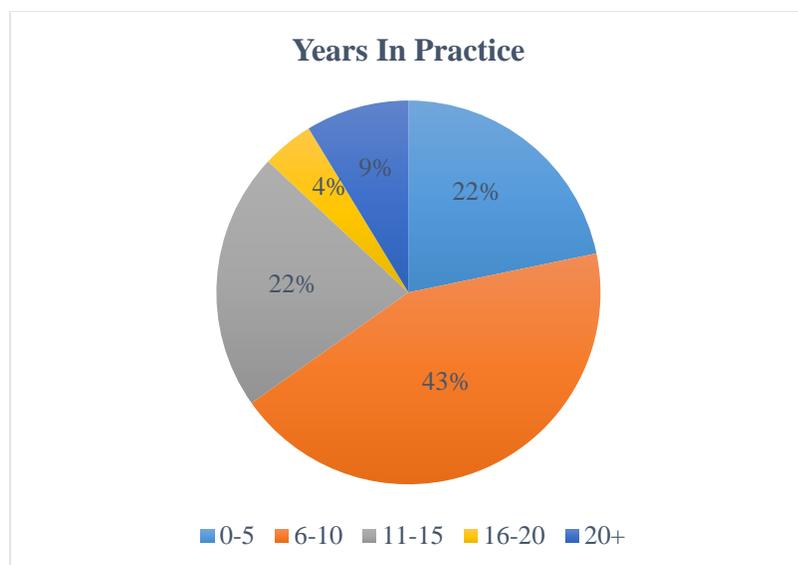
Participants' Summary of Educational Background, Work Experience, and Work Setting

Participant Number	Degree	Years in Practice	Work Setting
P1	Master	8	PP
P2	Master	8	PP
P3	Master	8	PP & IP
P4	PhD	5	PP
P5	Master	9	PP
P6	Master	25	PP
P7	Master	5	PP & IP
P8	Master	6	PP
P9	Master	15	PP
P10	Master	7	PP
P11	Master	8	PP
P12	Master	3	PP
P13	EdD	15	PP
P14	Master	8	PP
P15	Master	3	PP
P16	Master	7	PP
P17	PhD	15	PP
P18	Master	10	PP
P19	Master	27	PP
P20	Master	14	PP
P21	Master	3	PP
P22	Master	18	PP
P23	EdD	15	PP & IP

Note: P (Participant); PhD (Doctorate in Philosophy); EdD (Doctorate in Education); PP (Private Practice, Outpatient Services, and/or Telemental health); IP (Inpatient Services, including shelters, hospitals, and prisons)

Figure 1 provides a graphic of participants' years of experience. In total, participants had 242 years of experience in their respective discipline. The mean average of years of experience was 10.5 and the range was 3 to 27. Nearly half of the participants (43.5%; n=10) had between 6 and 10 years of experience. Nearly a quarter of the participants (21.7%; n=5) had less than 5 years of experience and the same percentage had between 11 and 15 years of experience. One participant (4.3%; n=1) had between 16 and 20 years of experience (18 to be exact). Two participants (8.7%; n=2) had over 20 years of experience; 25 and 27, respectively.

*Figure 1**Years In Practice*



Note: Range= 3-27; Average=10.5; Total Years in Practice=242

Table 4 and Figures (2, 3, and 4) highlight frequencies of participants' training in multiculturalism and trauma-informed practices (TIP). Eighty-seven percent (87.0%; n=20) of the participants reported to have received a multicultural graduate course during their academic training but only thirty percent of the participants (30.4%; n=7) reported to have had a course on trauma-informed practices during their academic graduate training (Table 4 and Figure 2). Regarding professional development training received in multiculturalism and trauma-informed practices, nearly ninety-six percent (95.7%; n=22) reported to have received training in those areas as professional development (Table 4 and Figure 3). Professional development included, but not limited to, training received from their workplace, continuing education training, self-selected workshops and webinars being offered by experts in the field.

Table 4

Participants Multicultural and Trauma Informed Practices Training Trends

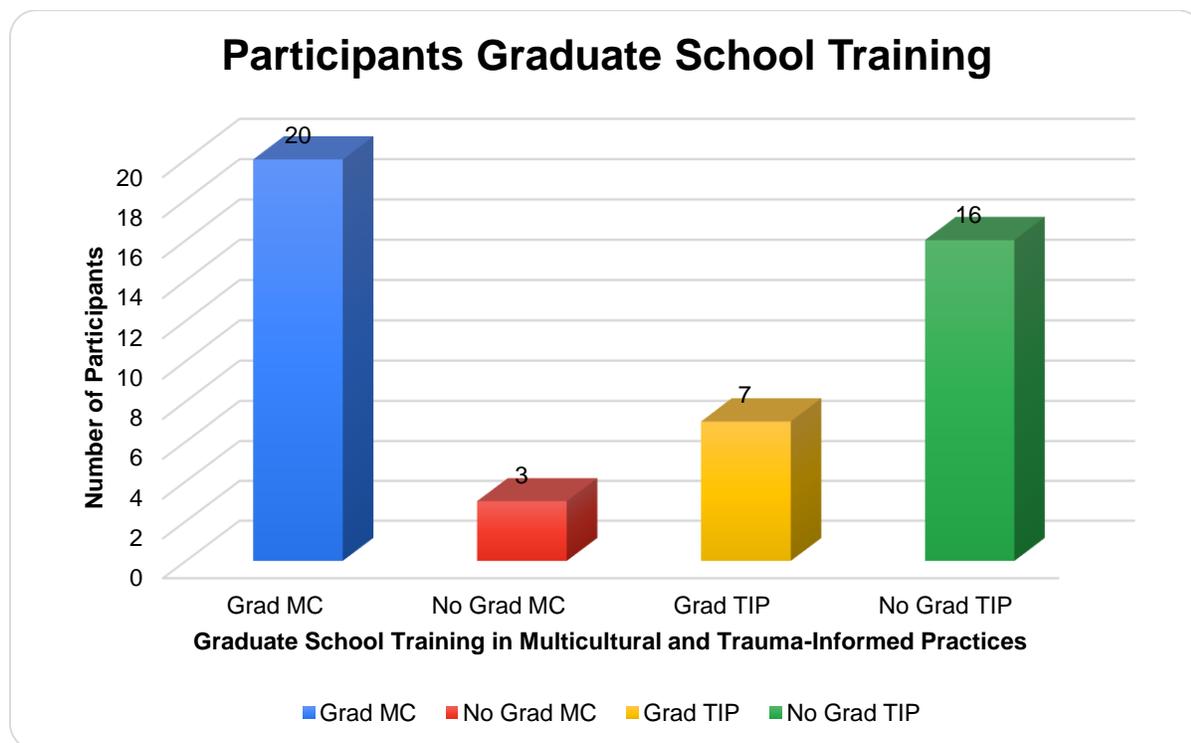
Participant Number	Have taken a Graduate Course in Multiculturalism	Have taken a Graduate Course in Trauma Informed Practices	Have taken a PD Training in Multiculturalism	Frequency of PD Training in Multiculturalism	Have taken a PD Training in Trauma Informed Practices	Frequency of PD Training in Trauma Informed Practices
P1	Yes	Yes	Yes	2-3/year	Yes	2-3/year

P2	Yes	No	Yes	2-3/year	Yes	1/year
P3	Yes	No	Yes	2-3/year	No	-----
P4	Yes	No	Yes	2-3/year	Yes	4+/year
P5	Yes	No	Yes	2-3/year	Yes	2-3/year
P6	Yes	No	Yes	4+/year	Yes	4+/year
P7	No	No	Yes	4+/year	Yes	4+/year
P8	Yes	No	Yes	1/year	Yes	2-3/year
P9	Yes	Yes	Yes	4+/year	Yes	4+/year
P10	Yes	No	Yes	2-3/year	Yes	4+/year
P11	Yes	No	Yes	2-3/year	Yes	4+/year
P12	Yes	Yes	Yes	2-3/year	Yes	2-3/year
P13	Yes	No	Yes	1/year	Yes	2-3/year
P14	No	Yes	Yes	2-3/year	Yes	4+/year
P15	Yes	Yes	Yes	4+/year	Yes	2-3/year
P16	Yes	No	No	-----	Yes	1/year
P17	Yes	No	Yes	2-3/year	Yes	1/year
P18	Yes	Yes	Yes	4+/year	Yes	4+/year
P19	Yes	No	Yes	1/year	Yes	1/year
P20	Yes	No	Yes	4+/year	Yes	4+/year
P21	No	No	Yes	4+/year	Yes	4+/year
P22	Yes	No	Yes	2-3/year	Yes	2-3/year
P23	Yes	Yes	Yes	2-3/year	Yes	4+/year

Note: P (Participant); PD (Professional Development)

Figure 2

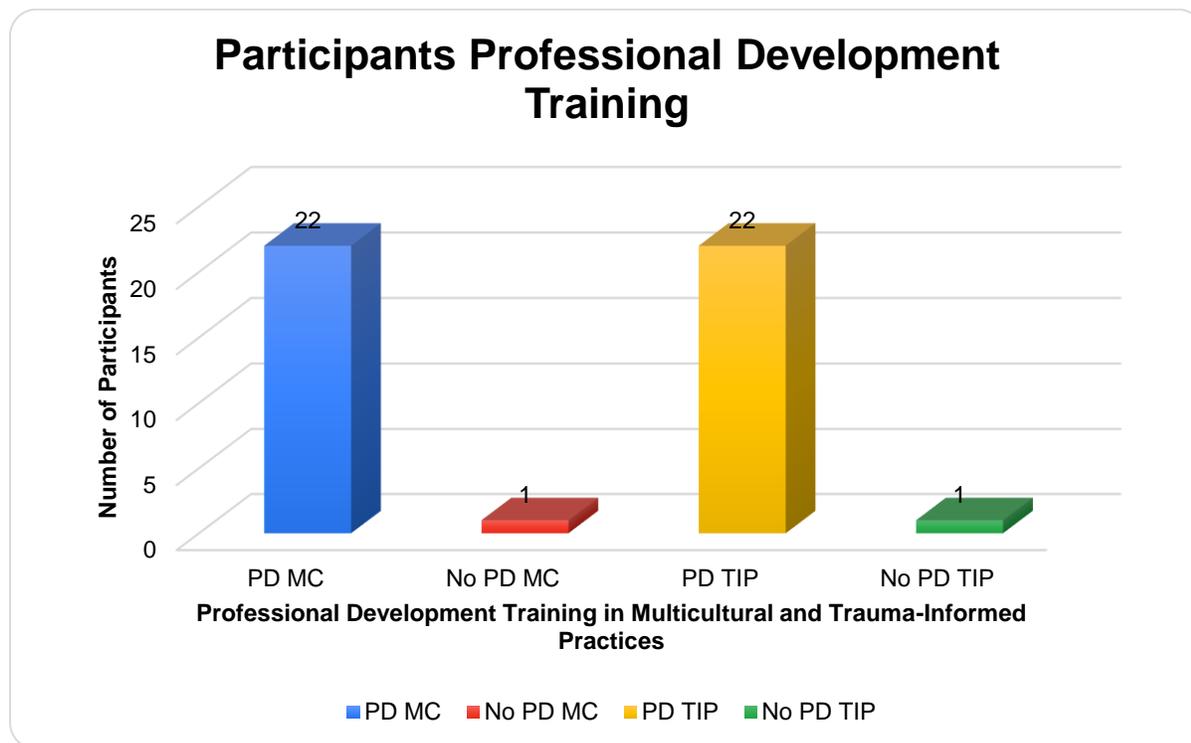
Participants Graduate School Training



Note: Grad MC (Graduate Course in Multiculturalism); No Grad MC ((Graduate Course in Multiculturalism); Grad TIP (Graduate Course in Trauma Informed Practices); No Grad TC (No Graduate Course in Trauma Informed Practices)

Figure 3

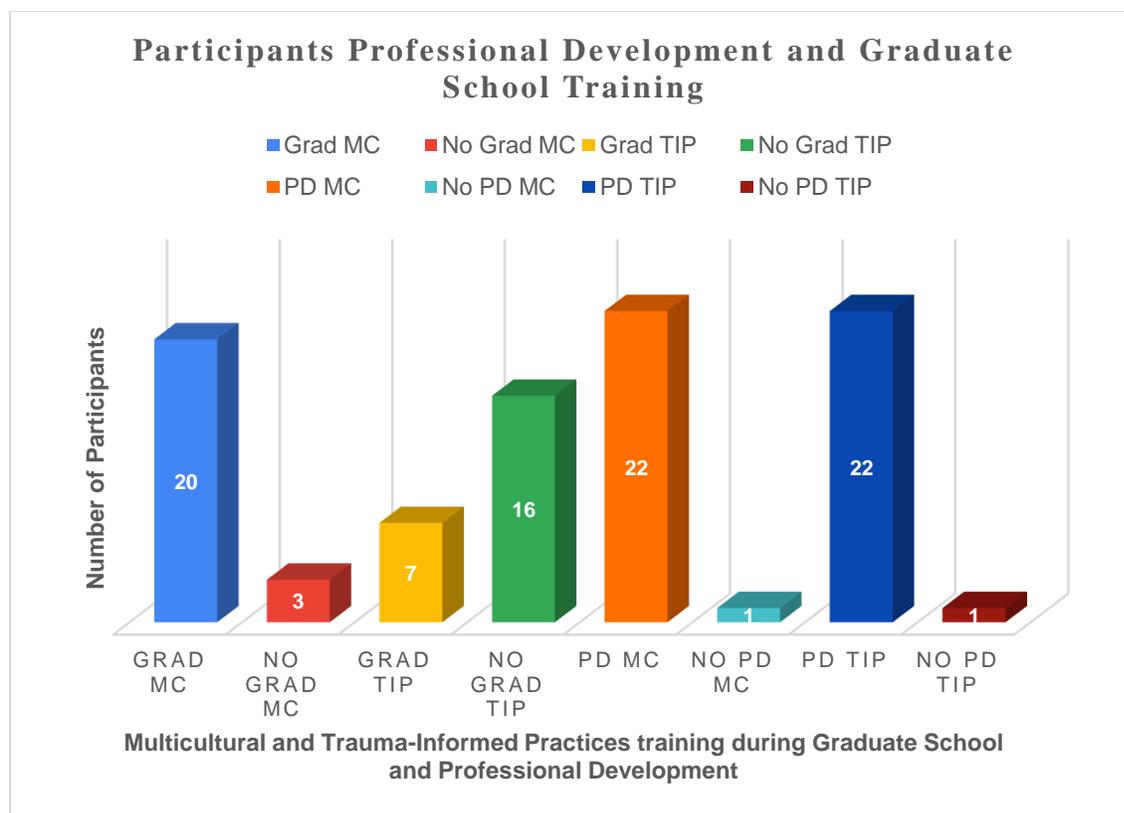
Participants Professional Development Training



Note: PD MC (Professional Development Training in Multiculturalism); No PC MC (No Professional Development Training in Multiculturalism); PD TIP (Professional Development Training in Trauma Informed Practices); No PD TIP (No Professional Development Training in Trauma Informed Practices)

Figure 4

Participants Graduate School and Professional Development Training



Note: Grad MC (Graduate Course in Multiculturalism); PD MC (Professional Development Training in Multiculturalism); No Grad MC (Graduate Course in Multiculturalism); No PC MC (No Professional Development Training in Multiculturalism); Grad TIP (Graduate Course in Trauma Informed Practices); PD TIP (Professional Development Training in Trauma Informed Practices); No Grad TIP (No Graduate Course in Trauma Informed Practices); No PD TIP (No Professional Development Training in Trauma Informed Practices)

Data Analysis

Using purposeful sampling and snowballing methods, data collection was conducted over a period of a month from June 4th, 2021 to July 19th, 2021. Invitations to participate in the study were sent electronically via various web-based networks. Eligibility for participation was determined based on responses to a screening survey questionnaire. Eligible participants were contacted for a 60-75 minutes interview and offered a \$30 Amazon gift card for compensation. All interviews were conducted via Zoom, a secured web-based platform. All interviews were recorded and subsequently transcribed by use of a secured transcription web-based service, Otter.ai.

Participants were asked about the types of trauma that they encountered when working with Black individuals. The most prevalent types of traumas reported were chronic and complex traumatic stress, sexual violence, child abuse and neglect, intimate partner violence (IPV), human trafficking, financial trauma, race-based workplace harassment, hate crimes, sexual orientation trauma, and institutional racism including in the workplace, schools, and neighborhoods.

Themes

An aggregation of the data shows four distinct themes in the data: (1) Challenges and rewards, (2) Self-Care, (3) Culturally-Informed Clinical Strategies, and (4) Professional Growth and Development. Across each of the four themes, there was a widespread refrains of cultural awareness, cultural appreciation, cultural respect, and cultural affinity, indicating that an overall sense of humility and transparency were essential to working with Black clients.

Table 5
Codes and Major Themes

Theme	Subthemes	Definition	Code	Definition of Code
Challenges and Rewards	<p>Rewards 1. Intrinsic Reward</p> <p>Challenges 2. Managing cultural mistrust 3. Feeling helpless 4. Providing mental health literacy</p>	<p>Descriptions of participants' challenges and rewards faced when working with Black clients who have experienced racial trauma</p>	<p>1. Sense of gratification and fulfillment. 2. Persistent Systemic Disenfranchisement 3. Persistent Traumatic Environment 4. Time Constraints and Obligations 5. Inadequate Resources 6. Understanding of Trauma 7. Coping Skills 8. De-stigmatizing mental health</p>	<p>1. Gratification from knowing that they are empowering their communities and resisting the status quo. 2. Difficulty in helping clients establish trust and build rapport and establishing sense of safety 3. Clients living in trauma-laden environments in which they are being hurt and triggered 4. Clients managing multiple roles , causing schedule conflicts or time constraints in finding adequate time for treatment 5. Excessive drop-out rates due to personal obligations, financial burdens, and lack of insurance or other source of affordability for therapy 6. Overcoming stigma in seeking help 7. Providing literary and skills to help clients cope and navigate systemic issues. 8. Reframing of mental health and help seeking behaviors and helping clients understand the link between experiences and the complexity of trauma</p>
The Importance of Self-Care	<p>1. Physical self-care 2. Social Self-care 3. Intellectual self-care 4. Mental and Emotional Self-care 5. Spiritual self-care</p>	<p>Descriptions of participants' approaches to self-care</p>	<p>1. Engagement in physical activities that promote wellbeing 2. Use of social support systems to promote healthy practices 3. Engagement in activities that promote mental acuity and growth 4. Engagement in activities to help manage emotional stress and promote emotional wellbeing 5. Engagement in activities that foster spiritual growth and connection</p>	<p>1. Commitment to an exercise routine (i.e., running, yoga, eating healthy, sleep) 2. Setting healthy social boundaries, spending time with loved ones, seeking peer consultation and support. 3. Engaging in Professional Development training, asking for help, reading relevant materials, engage in activism work, conducting research 4. Engaging in self-awareness activities (i.e., journaling, therapy, support groups); setting healthy professional boundaries (i.e., accepting one's limits and scope of expertise) 5. Engaging in activities that promote grounding and connection with one's meta belief system (i.e., prayers, meditation)</p>

The Importance of Culturally-Informed Clinical Strategies	<ol style="list-style-type: none"> 1. Multicultural Competency 2. Psychoeducational Approaches 3. Open Attitude 4. Bicultural infusion of clinical theoretical approaches 	Descriptions of participants' clinical strategies for working with Black clients who have experienced racial trauma	<ol style="list-style-type: none"> 1. Developing empathy and compassion 2. Teaching of skills 3. Reflective practice 4. Adapting Western theories and approaches to fit the need of Black clients 	<ol style="list-style-type: none"> 1. Prescribing to approaches and techniques that take into account the client's worldview and holistic experiences. 2. Learning of a wide variety of approaches to address trauma. 3. Examination of fitness of Eurocentric modalities to Black clients' needs. 4. Adjusting Eurocentric clinical strategies to fit clients' needs.
Professional Growth and Development	<ol style="list-style-type: none"> 1. Trauma-Informed Training 2. Peer Consultation, Supervision, and Mentoring 3. Reflexivity 4. Reading for Professional Development 	Descriptions of participants' commitment to professional growth and development	<ol style="list-style-type: none"> 1. Trauma-Informed Training 2. Mentoring 3. Reflexivity 4. Literacy 	<ol style="list-style-type: none"> 1. Need to remain engaged in professional development by seeking advanced training that address the impact of systems of oppression on the mental well-being of Black people. 2. Seeking Peer Consultation, Supervision. 3. Engaging in reflective practices that promote self-awareness. 4. Engaging in reading for personal and professional growth

Theme 1: Rewards and Challenges

Participants found the work to be intrinsically gratifying in that it allows them to strengthen and empower their community and resist systems of injustices. Almost unanimously, participants reported experiencing major challenges when working with Black clients who have experienced racial trauma. The rewards resided in the ability to empower their own community with the tools needed to combat injustices and help Black communities heal from racial trauma. Of the many challenges that participants described, the most significant centered on: (a) managing cultural mistrust, (b) feeling helpless, and (c) providing mental health literacy.

Rewards

Internal Rewards: Despite the challenges in working with racial trauma, when asked about their experiences working with Black clients who have experienced racial trauma,

participants expressed that this type of work was “fulfilling”, “enriching and exhilarating”, “rewarding”.

Participant 19 explained:

...my experience personally... as a professional therapist has been very enriching and exhilarating because it gives me the opportunity as a Black male to not only mentor, but also to provide clinical support and help to these young men. The population that I serve is predominately African American males, and the typical ages between ages of nine and probably 25 to 35 years of age.

Participant 20 also explained the mixed of emotions that they experience when working with racial trauma:

My experience working with Black clients has been ... very fulfilling, it's been very rewarding, and also very challenging.

Challenges

Managing Cultural Mistrust: Eight (35%; n=8) of the participants reported cultural mistrust as a major barrier to working with Black clients who have experienced racial trauma. Cultural mistrust is described as the apprehensiveness of clients in well-established systems that have historically caused generational harm to Black people. This cultural mistrust can take the form of cross-racial mistrust, meaning the lack of trust in others that are of different races.

Persistent Systemic Disenfranchisement: An important aspect that makes it more difficult to working through the cultural mistrust is the ongoing inequitable policies and oppressive practices that exist in spaces that do not welcome diversity and inclusion. Participant 2 explained the challenges that they face in helping Black clients establish trust in societies and institutions that have historically hurt them to this day through discriminatory practices:

...trying to coach them [clients] through this cross-racial mistrust that could be hindering them from progressing... in society when we still have things that are going on, when we still have ...police that are still killing people because they're black and we still have ... businesses and careers that are discriminating against... people because they are black.

Black providers are not exempt from this cultural mistrust; often Black clients are reluctant to trust Black providers who work in spaces or field that have harbored harmful discriminatory ideologies and practices. The following comments from Participant 17 give light to the experiences of Black counselors in dealing with the lack of trust or stigma associated with White institutions:

I would say the greatest challenge for some might be just getting over some of the stigma that comes with talking to a mental health professional, and ensuring that they feel safe enough to share their story at their pace. Sometimes that can be the challenge to let them know they don't necessarily have to disclose everything in all things, and that it's really about them feeling comfortable enough to share their story. And really sort of trying to talk through some of the fears that they have and what they think about those stigmas and what it will mean, to share this story, how I will, you know, support them versus label them.

Participant 23 discussed how their success is perceived with skepticism by Black clients because of his profession as a correctional officer and because of their prestigious higher degree credentials.

For one, personally, it comes off that, when I'm dealing with African American males or Blacks regarding the trauma is the fact that the way I present myself, the fact that I'm a successful individual, that there's no way I could have been here and experienced trauma.

Actually, I tell them, I am a success through trauma...And then when I talk with them, they're like "oh, wow, you really have one thing on what we go through." And I have to let them know too that just because I'm a doctor doesn't mean that my trauma stops.

People talk about different lives ...matter. Okay, and me working in corrections ... So like, I support the blue, but at the same time blue shirt, blue is a uniform, you can take the shirt off. And that's why I try to let them know, "no, that's ongoing trauma" I can deal with when I go to different places.

Feeling Helpless.

Persistent Traumatic Environment: Eight (35%; n=8) participants expressed a feeling of helplessness and hopelessness regarding helping Black clients heal from race-based trauma. Notably, participants reported feeling "not knowing what to say" at times due to the incessant occurrences of race-based and permissible crimes against Black people. Participants noted the difficulty in finding tangible ways to help clients cope with continued trauma. Some participants described one of their major challenges is helping clients fully heal when their environment continues to present a threat and a trigger to their healing.

Several participants commented on barriers to treating clients and keeping them consistent in their healing journey. Some participants felt that one major challenge was dealing with apathy; the feeling that one develops as a result of an awareness of living in lasting, unchangeable, and unpleasant circumstances. Similarly, another participant, Participant 4, noted "normalization" as one of the main challenges to supporting clients in their healing. Traumatic experiences are so prevalent in the Black community that individuals have become desensitized to race-based killings, injustices, oppressive practices, and community violence:

I think it's hard to heal from something that you're still experiencing. I think that there's ... a power in ... normalizing that ... a lot of Black people experience these things. ... I also think that there's like a fatigue and exhaustion, an almost pessimistic nature to that.

The following is an excerpt from Participant 3 describing feeling helpless in the face of recurrent and random acts of crimes on Black bodies.

I had a client who ... the presenting problems was "I'm having a hard time and tired of seeing Black people be killed", and so, I guess the issue for me with that was ... I know that this is going to happen again. So I don't, I don't always even know what to say to myself to process it... how can I help her through this when, you know, all of us are trying to make sense of it, and it's gonna happen again.

Other participants offered yet another perspective on what they think is contributing to clients' progress towards healing. Participant 11 shared how clients' healing journey can be compromised by their own family and support system who are traumatized, but have yet to engage in healing work.

...the major challenge that I have is ... getting them [Black clients] to a point to where they heal, but still within the environments that they live in. ... the work and the healing that my clients have done is almost belittled by their support system...

Lastly, participants spoke of the challenges in helping clients navigate hopeless circumstances that are trauma-laden. Participant 19 discuss the sense of hopelessness and dread that he observed with his clients as a result of ruptured families. He explains:

The major challenge is a sense of hopelessness, a sense of dread... as a result, once again, of those two foundational pieces not being in place. What foundational pieces am I talking about? I'm talking about the biological mother, for whatever reason who may not

be there, maybe because of drug abuse, maybe because she had her own emotional psychological issues. And same thing with the Father; oftentimes, in the father's case, there may be a case of incarceration, it may be a case where the father is deceased. So again, that opens the door for trauma within these young black men that I serve. So that creates that sense of dread and sense of hopelessness.

Time Constraints and Obligations: Similarly, participant 14 echoed challenges with clients experiencing high dropout rates and recidivism as result of lack of consistency related to multiple roadblocks, including scheduling conflicts, dealing with multiple stressors, and managing multiple family obligations.

Some of the challenges has been consistency with their scheduling. So a lot of them a large portion of women come wanting to do the work, but because they wear so many hats, their issues, confounded by their roles that they play, we sometimes are never able to stay on one specific trauma, because they're in environments where multiple stressors are happening. So it's hard to really fixate, because they're coming in every week with something different.

Inadequate Resources: Racial trauma was characterized as rooted in systems of oppression and inequality. Participants explained the need to view racial trauma from a systemic lens. Participants viewed racial trauma as multilayered and as an accumulation of microaggressions combined with lack of access to resources. Participant 23 specifically spoke about the interconnectivity between financial disparity and trauma. He noted the traumatizing nature of poverty, which could have a generational ripple effects that impact quality of education, access to resources, and availability of resources.

Financial hardship creates this cycle of poverty and poverty is a traumatic thing You're depriving a family of this that causes generational ripple effects. Such as pedagogy of children...you know.... being limited by financial hardships, they're not gonna have the best education, they're going to be limited education, limited resources, they're going to be limited to the social networks they develop, and these things affect that individual's path. So, that's why I feel like at the end, if people at least had financial resources that can at least minimize the trauma.

Participant 18 echoed similar sentiments with clients lacking health insurance or the resources to afford continuity of care. They stated:

I have a portion of my clients have issues with access. So, you know, not having not been covered, insurance wise and not being able to afford care. A portion of them have work schedules that are not consistent. So staying in therapy becomes difficult because their work schedule is all over the place. I think those are the biggest the two biggest economic and figuring out as consistent time to meet.

Mental Health Literacy. Introduced by Jorm et al. (1997), mental health literacy refers to awareness, knowledge, and education of mental health issues and how to seek help. Eleven (48%; n=11) participants indicate that limited or lack of mental health literacy was yet another major challenge in working with racial trauma is the lack of understanding of how trauma is manifested and interwoven with various social strata.

Understanding Trauma: Lack of awareness, resources, and education about what constitutes trauma and how trauma is manifested have been a major contributor to the perpetuation of trauma among generations in the Black community. Unaddressed generational trauma and historical trauma is often coupled with normalcy and acceptance.

According to participants, clients are often ambiguous on how to label their experiences or understand how their trauma is rooted in their lived racialized experiences. The lack of acknowledgement for the impact of contextual factors on one's emotions and behaviors can be internalized and cause further mental health issues, including complex trauma. Participant 6 shared:

I think the biggest ones [challenges] are how complex racial trauma is because of the gaslighting around it... and receiving persistent and consistent messages that it's actually your individual problem that you just need to bootstrap yourself and work harder.

Participant 12 offered:

I think one of the biggest challenges that I've seen so far, is that many of my clients don't necessarily know how to describe their experience of racialized trauma.

Participant 9 spoke of the challenge in working with individuals who have normalized their traumatic experiences.

Many times Black people think that this is just how it's supposed to be. ...People think about trauma as being something happening to them, and many times..., especially in the Black culture, it is also not just something that's happening to them, but it's something that's not happening to them, or not happening for them.

In the previous excerpt, Participant 9 is referring to trauma associated with lack of resources, including but not limited to electricity, food, shelter, transportation, health insurance, education, and other basic needs. Overall, it is the trauma associated with not being provided with equitable opportunities or resources.

Participant 16 noted the detachment that arise for prolonged exposure to traumatic experiences, causing a state of apathy and numbness toward their experienced.

...they [Black clients] usually are of the mindset that this is just kind of life and this is what happens. You know, it is what it is sometimes it's normalized, because there's been generations of abuse going on and it's what they've seen is what the mom the parents saying is what the grandparents saying. So getting them to not be so numb to it.

After prolonged exposure of one's traumatic conditions, Black clients become insensible to the impact of trauma in their lives. Respondent 16 explicates some behaviors related to the impact of the trauma that Black clients have been exposed to, including erratic and intermittent behaviors such as frequent changes in jobs or relationships.

... they have suppressed for so long... because they've suppressed for so long and some of them have gone on, and are successful in life. ...So they feel as if they're doing okay, not realizing that it's mentally affecting them.

Participants also described the need to educate clients on the complexity of trauma.

Coping Skills: Yet, another challenge to working with Black clients who have experienced racial trauma is finding a balance between helping clients develop boundaries and helping them gain a sense of autonomy. Participant 10 explained: The challenges is helping them [Black clients] feel safe and allow them to ... helping ... set some boundaries... because they've experienced so much trauma, they don't have boundaries.Another challenge is also making sure ... I'm telling them what to do, and I'm not “mothering” them; but I'm allowing them to make their own choices ... helping them to build autonomy.

Participant 20 described one of the major hurdles when working with Black clients is helping them understand how their traumas in interwoven in long-standing discriminatory narratives that had them believe that they are inherently “less than” or “no good” simply

“because you were born Black”. In their commentary, Participant 20, explained how these racist ideologies have created a trauma that is inherent of Black people’s identity. These narratives propagate the notion that being Black is inherently “bad” and shameful.

I think it really ties in into our blackness because this society feeds us this narrative and all that because it's simply because you were born black.

Participant 20 used the metaphor of a “shark” to describe racist societies that have created racist ideologies that serve to bring about shame and traumas to Black people. Black people are faced with a shark that continuously sees them as prey. Hence, this participant sees a need to teach Black clients how to confront the shark “head on” to mitigate its impact and disempower its weapon, meaning those racist narratives.

So [the] major challenges or hurdles I would say it's getting them to be comfortable with facing the shark. Somebody once said...”what do you do if you down face a shark? Would you swim away? What do you do with it?” And that sounds counterintuitive, but the shark then does not see you as prey and so the idea is that when we are experiencing and trying to heal from our traumas, trying to heal from this, this shame, we have to begin to face it head on. Otherwise, we will continue to feed, if you will, that which is pursuing us and continually driving us in places that we don't necessarily want to go that are unproductive and unhealthy. You're making us feel continually driving the narrative that “we're less than”, driving the narrative that “we are no good” essentially, and that's one of the results of trauma.

Participant 23 spoke of the importance of being mentored by those who have had similar trajectories and have showed him the way. As a result, he learned to develop acumen as he successfully navigates trauma-laden spaces. He noted:

I'm a success because I do not allow trauma to dictate my life. I'm a success because I have people like myself, before who weren't family or different friends who all integrated and built success into me. .. They even had financial resources; they say, "hey, go here, this could help you out". ...they won't just tell me, they walk me through the door, or they did introduction. And so when I worked with those individuals, I say, "hey, what don't you guys have anyone who work with you", like..."well, we had mentors, but they weren't listening", like okay, it's two way street. And I let them know that "hey, guys, I am here because a) I listened, and other times because I didn't listen". I learned a lot from the times I didn't listen. But I learned more because I listened because I didn't want to repeat their mistakes.

De-Stigmatization of Counseling: Another obstacle that participants describe when working with Black clients is getting clients to de-stigmatize a process that has been seen as a "White people thing". Participants encountered challenge in helping clients overcome their fear of being vulnerable and of breaking generational rituals of whom to confide in. To this effect, Participant 20 stated:

And so helping people come to overcome that hurdle, I think is one of the tougher parts. Because you know, people give you pieces of this story, people have these parts of story that they don't want to share, not because...of anything other than it's hard for them to talk about... it's been a defense mechanism for them to not talk about it, to not identify that part of the life that is so troubling... because it means that it also reveals that they're in so much pain.

Regarding breaching cultural beliefs or rituals, Participant 21 noted:

Therapy is still largely seen as a White people thing. There's a part of that that has to do with... mental health and medical history, and other parts of that ... culturally ... not telling my business to other people, not sharing what's happening with me and my family with other people.

Theme 2: The Importance of Self-Care

Several participants emphasized how the work can be emotionally and physically taxing. Some reported experiencing physical symptoms resulting from working with Black clients who have experienced sexual trauma. They described experiencing physical symptoms indicating signs of vicarious trauma; these included being easily startled, being hypervigilant, and fatigued. As such, participants spoke of the importance of being intentional about engaging in self-care activities that promote physical, social, mental, emotional, intellectual, and spiritual wellbeing. Participants engaged in self-care to prevent counselor burnout, compassion fatigue, vicarious trauma, retraumatization, and countertransference. They approached self-care from a holistic perspective and saw the need to attend to all aspects of themselves. Participants saw self-care practices to be an essential to the work that they do.

Physical Self-care: To attend to their physical wellbeing, participants reported engaging in physical activities, including incorporating a workout regimen in their routine (e.g., yoga, running, cycling), getting adequate sleep, and keeping a healthy diet. Participant 1 shared:

One of the first things I try to do to stay pretty consistent with ...physical coping strategy.... I'm a runner, so I tend to run as often as I can or do different types of other kind of physical workouts just to get a bit of a physical release. I try to do yoga every now and again, as well too, I guess like connected with like that.

Other activities that participants participate in include, mentally and emotionally enriching engagements. Others noted physically engaging in mindless activities to help unwind after work.

Participant 6 shared:

I love things that allow me to also know that there's joy in the world. So music is a huge part of my life. My partner is a musician. We sing, dance, make music, play drums, you know, really have a lot of that in our lives. I also do art, not as art therapist, but art workshops with clients, with groups, and I teach other practitioners about... expression through art... And I love to bake.

In addition to attending to their physical wellbeing, participants spoke of the need to make concrete changes to their lifestyle, including adhering to a healthier diet, drinking in moderation, connecting with nature. Participant 4 noted the need to assume control of when to schedule clients based on their emotional capacity and the client's unique issues. Participant 4 noted the following:

...I think exercise has been important, I schedule that in, I schedule in a 30 minute rest before my session, start for the day. I don't schedule more than three clients back to back. I have gotten a lot more restrictive about my ... scheduling calendar.

I used to kind of let my clients' schedule drive that [i.e., their scheduling calendar]. I think that's helpful for me to kind of know and prep myself for when I'm going to go into that space with clients. And so when clients just kind of like pop up on my calendar that just doesn't... I'm just not able to show up for them. It just takes it takes a lot of emotional energy for me to hold that space for them.

Social Self-care: They also find support from connecting with friends and family and maintaining healthy boundaries with their social network. Participant 20 described how spending time with their family has helped them in staying engaged in doing this kind of work.

Connecting with my kids, being more intentional about that is also very, very helpful.

One of the things I've been doing this summer, so my youngest is seven and he has a cousin, my nephew, who was six and a half; so they're like brothers. And so over zoom, we have been reading a book. So I read, you know, big chapter books. And so we do that in the evenings. And so that really kind of helps reset me. It's pretty fun. They call them the cool kids club.

Managing their professional lives also constituted a form of self-care. Ways that they manage their professional lives included, finding a peer support system to discuss difficult cases, maintaining healthy boundaries with clients, setting clear expectations for clients, understanding their own limitations regarding the amount and the types of trauma cases they can handle, keeping a manageable caseload, and being systematic with their schedules. For example, participants noted keeping a healthy caseload and schedule by not scheduling or taking on too many clients with similar traumas.

Several participants discussed staying engaged with colleagues and engaging in activities to empower the Black community has brought them a sense of satisfaction and resilience in knowing that they are investing in their community. Participant 2 shared:

I have a group of colleagues that we meet weekly, and we do things like a podcast with a group of my colleagues. We have been ... coming together to find ways to help our community more... I feel like it gives us a coping skill, because we are providing more resources for our people... I have an online group that I belong too as well as like a

mental health group that teaches mental health and coping strategies and things like anxiety and depression, which is growing quite a bit... I think giving back to the mental health field is professionally rewarding to me, in a sense that is allowing me to be able to cope with the things that are going on, on different levels.

Similarly, in addition to engaging in speaking engagement to further educate their communities, others have found liberation and resistance to injustices by conducting research on trauma in the Black community. Yet, others found stamina and determination in engaging in activism work, including anti-oppression and anti-racist work.

I'll do a ton of reading. And then I'll typically make some kind of... YouTube video or some kind of presentation and then present... I professionally do a lot of writing, I've actually changed my research agenda. And it was a little bit more broad, just looking at crisis and trauma. Now it is looking much more specifically at communities of color... for me, that feels like the space that I can give back on a large scale level, professionally. And there's enough people talking about crisis and trauma broadly. I don't think that there's enough people talking about specifically communities of color. And so that's what my research agenda has shifted to. And I think that has been really helpful too, to make me feel like I'm doing something on a on a larger scale.

Others emphasized the importance of creating strong communities of family and friends that share similar ideologies and identities. Participant 6 expressed the sense of safety and support that they get from relationships with trusted circles who share similar goals.

... the self-care that I employ is having a small, very close circle of partner, friends, family in my life, that also, very much, are dedicated to and working on issues of anti-racism... connected and grounded in their own, identity as people of color and who are,

are willing and able to give me really solid support. So, I am very particular, I have pretty strong boundaries, about the relationships that I have.

In addition to creating professional and personal boundaries and commitment to various self-care practices, participants noted the importance of having a trusted supportive system to lean on for when times are difficult. More specifically, participants discussed the need to have someone who can be a sounding board for when you are at your most vulnerable moment and to help you refocus. Participant 4 shared:

I think my partner is a really good and he works in diversity and inclusion. And so, he has been very helpful in either bouncing stuff off of or helping me with resources or just kind of like theoretically thinking through things. And I think he's also pretty intuitive. When I'm overextended and has gotten to a place where he can kind of gently ask me "what can you take off your plate right now? We want you to be well enough for your clients and for your students." And "if there's something that doesn't fall in those two parts that we can take off your calendar, like what can we do?" And so I think that has been really helpful. I practice from EFT (emotionally focused therapy). So I've very much grounded in the thought that, as humans, we co-regulate each other. And so I think having a partner that can help me co-regulate has been really, really helpful. I don't think I was as well seeing clients when I was a single woman, honestly. I think I needed somebody else there to help me keep balance.

Intellectual Self-care: To nourish their intellectual wellbeing, participants are intentional about staying current with the literature on trauma and the Black experiences, getting training to sharpen their skills, and also by reading relevant materials that helps validate their own experiences as Black mental health professional doing this type of work. Participants stressed the

importance for counselors to be aware of their limitations and refer out when necessary. They spoke about the need to “refer out” both in the context of self-care to prevent burnout and also to ensure that clients are receiving the best care possible. Practicing within one’s limits of expertise is paramount to mental health professions.

Mental and Emotional Self-care: To manage their own mental health, participants noted the need to see their own therapist and practiced journaling to help process emotions that arise from doing this type of work. Additionally, through journaling, participants are able to self-reflect on emotions that they carry about their work. They use their own therapeutic modalities (i.e., individual counseling, journaling, meditation ...) to process emotions that have arisen from their work. They also rely on trusted group of clinicians to discuss transference and countertransference that may have arisen in their interactions with clients. Participant 22 described the boundaries that they must put in place to help manage the emotional peel that this work can have on one’s wellbeing:

Self-care is very important. Boundaries, you have to establish if you're going to do this type of work, you have to establish healthy boundaries. So that you don't have the transference and kind of taking those problems or those challenges into your own personal life.

While many participants spoke of practicing journaling and seeing a therapist as effective means to manage their mental health needs and self-reflect, others have found refuge in living a congruent lifestyle in which they practice being transparent and vulnerable with clients.

Participant 3 noted:

I try to be grounded and be present during the sessions [with clients]. I tend to be pretty transparent with my clients. I find that that helps too to say out loud if I'm worried about them for something. I will say, you know, I'm worried about this. So that helps.

Through journaling and other self-reflective activities, participant 21 expressed how they've come to realize that they were taking overextending themselves to exhaustion. This following is an excerpt of their self-reflection.

I did find myself feeling really just like burnt out from the amount of work that I was doing, from the amount of commitments that I was taking on. And so, I had to learn that, one, I had to learn what my capacity is? How much can I do? And not only how much can I do, but especially ... what is my place in this work? Mental health is a big field; and even being a therapist is a big sort of thing. And I've really come to an understanding of "I don't, I don't want to be everything to every black person"; I really want to perform in a certain nice kind of way that gives me life and doing the work.

Spiritual Self-care: Another subtheme that emerged as a coping strategy that participants adhere to is the use of spirituality as a means to ground themselves and connect with their spiritual values. Participants noted carving out time in their daily routine for prayers or meditation practices. They reported finding comfort and strength in engaging with their spiritual side. Participant 7 shared the following:

I am heavy into spirituality and so, I use Spiritual cleansing baths, I use sage, I use candles, I use divination tools. I use journaling. I view getting out into nature. And so those are the ways that I cope.

Theme 3: The Importance of Implementing Culturally-Informed Clinical Strategies

Another salient theme that participants echoed throughout their interviews was the importance of implementing culturally-informed clinical strategies when working with Black individuals who have experienced racial trauma.

Multicultural Competency. Participants described prescribing to culturally-informed clinical strategies as an overall multicultural competency that includes therapeutic approaches and techniques that take into account the client's worldview and holistic experiences. This includes approaching this work with a deep level of empathy, transparency, and a willingness to learn about race. When participants were asked about which skills they felt were essential to possess to effectively work with this population, they stressed the importance of building rapport and trust with clients by demonstrating cultural awareness, respect, cultural humility, congruency, transparency, and a non-judgmental attitude.

Participant 5 stated the following on the need to foster empathy and multicultural competence.

So empathy and some multicultural competence... An understanding of the interventions or treatment modalities that work for trauma clients... [It's] really having a heart for understanding where they're coming from and being able to connect with them wherever they are. I think helping them feel seen, valued, and heard is the empathetic part of it.

Participant 1 expressed the following with regards to cultivating humility:

So humility... maybe I could speak a little bit more about what I mean by humility. I think... knowing how to self-reflect is important. I think knowing how to recognize how my actions could be impacting the client is really significant because, even in the counseling relationship, even though I try to really work as collaborative... I try to partner with clients as much as I can, I'm also mindful that, just inherently in that role,

there's some power present and so I try to empower other people as much as possible while also being intentional with the power that I hold. So that way I'm making sure that I'm using my power in ways that feel supportive and helpful to clients. And so I think self-reflection is really important.

Participant 1 explained further how humility can serve as a tool to keep counselors accountable in ensuring that they are being intentional in the ways they work with Black clients, in understanding the various forms and layers of racism and oppression and how they manifest in covert ways.

Participant 4 further elaborates on the notion of humility:

I think especially my Black clients feel the ability to really be like, “are you okay? Tired today?” I’ve never actually had a White client that has called me out in the way that my Black clients have, and I have to not be offended by that and that's okay. I think that there's a huge... element of humility that has to happen. There has to be a curiousness that has to happen, especially with my Black clients.

Participant 10 discussed the need for transparency and forthrightness when working with Black clients because of their continuing mistrust in authority.

The first thing I work on is creating safety and build rapport because ... I'm aware that there's a mistrust in authority, and I'm aware that if I'm sitting down with clients and I'm writing, they want to know what's going on. And so upfront, I let them know “hey, this is the assessment. This is the most questions I'm going to ask you. This is the most I'm going to be writing.

Participants also spoke of the need to adopt a client centered approach to working with racial trauma which includes, taking a collaborative approach to counseling, and resisting acting

as the "expert". In doing so, the counselor will not only validate the client's experience, but they will also help dismantle systemic oppression that may be rooted within the profession.

Participant 6 stated the following in regards to what contributes for their competency in working with racial trauma.

I think what adds to my competency is not just theoretical, neurobiological book knowledge, or clinical expertise, because then I could use that power and expertise to take away power and control or to create a dynamic of disparity in therapy all over again. And I do think that's out there where folks very much use a sort of a clinical hammer to still do a lot of "I'm the expert and I know better than the other the person that's maybe seeking that support." I think it's the philosophy from which I practice, which is one of, it is survivor centered, it's trauma informed, it is feminist, which means dismantling different systems and thinking about those systems that impact us and harm us, most specifically, systems that reinforce racism.

Effective communication was assessed to be an essential skill to possess to successfully advocate for clients. Several participants put great emphasis on the role of the counselor as advocates for clients. Participant 2 emphasized the diversity in communication and language skills between populations and how counselors need to adapt their communication to clients' interpersonal language to fully understand a population's needs and fully advocate for them.

Participant 2 shared:

.... knowing how to be supportive and knowing how to advocate for the population as a skill. Advocacy is such a gray area; so, being able to communicate is huge... because everybody communicates in a different way, and everybody is receptive to communication in a different way. So being able to communicate in different ways and in

multiple and various ways to different people in populations, in order to understand how to support them, and how to advocate for them is a skill set that's super essential. So, aside from being patient and being open minded, and being able to educate yourself, and being knowledgeable of who you're working with, the population and environment, and all those factors are things that fall into those categories. Knowing how to be able to advocate and support them, or be able to ask them how you can advocate and support them is a skill set. A lot of people want to advocate for people and want to support people, but the reality is you have to really ask, be able to communicate, and ask that person how you can advocate and how to support them to be effective.

Still on communication, Participant 4 stressed the importance for clinicians to not make assumptions about clients' vernacular and seeking understanding of the nuances within each client's regional verbiage.

... The vernacular that they use is very regionally specific. I can't make assumptions. I have one client, that's always, "yeah, I can't wait to go home, I'm gonna be so "ratchet" the whole time." I'm insinuating from their words that for them that means a very good thing. I have another client that when she uses the word "ratchet", that is not good.

There's a curiousness of the verbiage, of the context of how they're using it, of what's the meaning that they're making of that. ... For some counselors that may make them feel lost or out of their depth, but for me, that's kind of fun. And, I think there's a humility, there's a curiousness, there's my own self-regulation skill that happens.

Psychoeducational Approaches. Participants emphasized the need to use psychoeducation as a means to help clients de-normalize trauma. They spend time educating clients on trauma, the various types of trauma, its characteristics, and its impact on the individual

and the community. They also spoke of other approaches such as giving clients the language to express their experiences and creating the space for clients to know that it is acceptable to discuss these issues. Participant 4 discussed how they used somatic approaches to help their clients identify their emotions. They stated:

I use my own bodily reactions a lot with my clients. And so if they tell me something, but don't ever give me a feeling word, a lot of times, I'll be like, "man, I feel that in the pit of my stomach, like someone just punched me, do you feel that? I heard that when you said that to me."... That is a skill that I've cultivated and gotten really, really comfortable using, like my body based reactions to, to try to put words to my clients experience. And I found that they can often pinpoint that somatic experience much easier than try to put a feeling word to it or cognition to it. That has been a skill that has been really helpful for me. That's what's super exhausting, you're using yourself as an emotional witness in session. It's very tiring.

Participants also provided other ways of supporting clients that include helping them develop counternarratives and relevant strategies to navigate spaces that have traditionally excluded them. To this effect, Participant 10 spoke of the need to understand clients' background and, therefore, helping them in areas where they lack support. For instance, helping clients develop a sense of autonomy by teaching them to examine the consequences in events, actions, and behaviors. Participant 10 noted:

... Clients having that demographic lack mothering. They often ask me, "What should I do? Yeah, no, ma'am." So, helping them to build autonomy is a challenge and to freely think and to help them kind of look at pros and cons and consequences. Just for that younger, that younger demographics.

Open Attitude. Participants emphasized the need for counselors to stay open in their approach with clients. An open attitude to working with Black clients include exercising patience, not generalizing Black clients in assuming that they all want to talk about race and racism, inviting clients to speak about their experiences and not taking offense in what their clients have to say about their experiences. An open attitude to working with racial trauma also requires that the counselor take initiative in educating themselves about the lived experiences of their Black clients. In referring specifically to counselors who are racially and ethnically different than their Black clients, Participant 3 stated the following:

I would give them [non-Black clinicians] the advice.... being patient, and also inviting the topic to the floor, not waiting on them to bring it up. Also, I would invite them to make sure that they're doing their own self work. So it's not to say that they need to make sure they're grounded and everything, it's not to take any of what's being said or expressed personally, like to not personally internalize what's being said.

Participants noted the importance for counselors to be knowledgeable about the history of systemic political and social structures that impact Black clients. They also noted the need to stay current on issues impacting clients. Regarding the need for counselors to seek their own education and awareness of the Black experience, Participant 3 added:

I would tell them, don't make the client do all of the work of educating you on whatever the topic or the trauma is, that you get out and do your own work. That, their Black clients are already doing so much labor in their lives, that it's not fair for them to pay you to come to therapy, and have more labor of trying to educate you... that's your responsibility to do the work, do the research and come to the table with some level of understanding and awareness.

Participants did not see the need for racial congruency between therapist and client to be effective in counseling Blacks with racial trauma. Their sentiments on this subject can be summarized by the following statement made by Participant 3:

I do not think that only a Black clinician can help Black people with racial trauma. But I think that in order for clinicians who are not Black to be most successful they have to be willing to do the work. They have to be willing to see their Black clients as, not just a client like every other client who happens to have Black skin, but understand that the lived experiences of those Black clients is going to probably be in many ways vastly different than their non-Black clients. And in order to help them deal with racial trauma, they're going to have some understanding and awareness of that. And the history of trauma that Black people in this country have experienced and continue to experience, all of the oppressions, and ... some awareness of Critical Race Theory.

Along the same line, Participant 4 noted of the potential danger of harming or re-traumatizing clients when counselors fail to assume responsibility of doing the work needed for effective racial trauma counseling.

I think especially with racial trauma, if clinicians are not comfortable talking about race, if they're not comfortable talking about power and oppression, if they're not comfortable talking about systematic oppression, systematic racism, then I think in this space, they really do have the potential to do more harm than good. I do not think this is a space where we rely on our clients to educate us. And I think that emotional burden adds to the racial trauma.

Lastly, another element that is essential to maintaining an open attitude when working with racial trauma is having a genuine desire and passion to work with this population.

Participant 3 discussed some of the elements that contribute to their competency in working with this population.

I have a curiousness and the desire to stay aware of and abreast of current events on things, both positive and negative, that impact Black people. And also my passion and commitment to working within this community adds to my competence; although, having a passion to do something doesn't make you competent. But the passion is what drives me to do that first part, which is staying aware of things that are going on, and actively trying to do work in the community. And having a level of understanding and awareness of what's happening in the community, so that way, when it shows up in my office, I may already have some awareness and understanding of what's being presented.

Bicultural Infusion of Clinical Theoretical Approaches. Participants spoke of the need to infuse Western approaches with their own cultural awareness to effectively work with Black clients. Participant 6 discussed how they utilize a Feminist approach combined with Black Psychology to understand and acknowledge the intersectionality of trauma and various marginalized identities that they encounter in their work with racial trauma. They explained:

And so looking at trauma as not just a single incident, but a consistent impact, by the way that oppression and especially the racial trauma was affecting folks, Black folks, anti-Blackness ... really looking at racism as trauma ... multilayered traumas. So how someone who's already experiencing racism and anti-Blackness, then encounters or is subject to domestic violence in their relationship or child abuse in their family, and how that intertwines and becomes another level of trauma.

Participants also saw the need to acknowledge the intersectionality of trauma and various marginalized identities. Participant 6 noted:

And I would have to try to push them [i.e., multiple marginalized identities] together in some way to kind of understand that both were in play, especially, for Black women and for Black gender nonconforming and trans folks, that marginalized genders were also connected. Having both of those things at play in the traumas that were experienced.

Theme 4: The Importance of Engaging in Professional Growth and Development

Trauma-Informed Training. Professional development opportunities through continued education and relevant professional organizations were seen as essential to increasing cultural competencies. Participants spoke of the need to be proactive and intentional in gaining knowledge of advanced trauma-informed theories and techniques (e.g., Eye Movement Desensitization and Reprocessing (EMDR), Trauma-Focused Cognitive Behavior Therapy (TF-CBT) modalities, etc...) to best assist clients with their traumas.

Peer Consultation, Supervision, and Mentoring. Participants stressed the need to seek support and guidance from peer consultation groups. Participant 4 specifically recommends that clinicians of color partake in consultation with BIPOC groups for clinicians.

Going to my consultation group with other BIPOC clinicians has been really helpful.

They also will call me on my shit all the time. And that's been having colleagues that will point things out.

Other recommendations include engaging in cultural immersion activities and experiences to help deepen one's understanding on the Black experiences; listening to the narratives of Black clients; engaging in research that centers the Black experiences; and not being afraid to make mistakes. Along those lines, Participant 8 made the following recommendations:

Finding and connecting with mental health professionals who have worked with racial trauma specifically; the reason being, racial trauma just comes along with being Black whether it's recognized or not. I think that's just something that comes along with the territory. So, I would say hooking up with professionals who do have experience in racial trauma, specifically for Black therapists. I think even White therapists, White appearing therapists, Asian therapists, indulging oneself in the culture, so submerging in the culture is going to be a way to understand and work. Talking with clients and then understanding the challenges that they experience from their perspective... Another thing, well, networking; being a part of the culture. Research, for sure, looking at research articles, reading journals, asking questions. And being okay to make mistakes, and not necessarily taking those as shortcomings, but just as learning experiences.

Participant 6 shared similar thoughts in highlighting the need to go beyond the conservative conversations and training:

... connect with folks not only who are doing it in a therapeutic modality, but other folks who are teaching critical race theory, folks that are working at those cross sections of Black, indigenous and people of color and LGBTQ orgs, Black folks liberation around immigration, ableism, disability justice. There are a lot of spaces where we can deepen our understanding of oppression and about the suffering that goes with it, but also about the resilience and the revolution.

Reflexivity. Participants highlighted the importance in engaging in reflective practice that would involve continuous assessment on one's desire to work with this specific population and continuous assessment of one's clinical approaches. Participant 5 noted the following:

I think the recommendation would be, really determine if this is the population for you. Like, know yourself, so some self-awareness, really know yourself, so that you know if this is the kind of client that you can work with professionally.

Participant 10 emphasized the need to have a strong sense of self to minimize transference and countertransference.

I think the first, I don't think this was talked about often, dealt with enough in training, but know your own stuff. Know your baggage, know what you bring to the table. You the therapist as an instrument, you need to know what's in your soul and what triggers you. Don't ask the client to go somewhere that you're unwilling to go or you haven't been because you can't sit with a person in their pain.

Reading for Professional Development. While several participants saw the benefit in engaging in literacy activities to promote awareness and empathy, Participant 4, on the other hand, was reticent in recommending readings that address the Black experiences to other Black people. They expressed that engaging in such activities might be emotionally taxing for Black clinicians who might already be desensitized to the experiences of Black people. Nonetheless, they thought that such practice could be enriching for their non-Black counterparts who may lack the knowledge, awareness, and exposure to the experiences of Black people. The following is a quoted from Participant 4:

In general, I hesitate to recommend books because I think that we've desensitized ourselves in anti-racism literature over the past year that I'm really just not even sure that reading about the Black experience is helpful for most people anymore... If a clinician is has never had a Black friend, does not have any experience with the Black community,

then potentially reading about the Black experience from a Black author would be helpful.

Overall, participants felt the need for more targeted professional development training that are trauma-informed to support Black clinicians who might be experiencing similar things as their clients. Participant 13 spoke specifically of training that include the teaching of self-care strategies for Black clinicians.

Conclusion

The three research questions that guided this study were:

1. What are the experiences of Black mental health professionals working with clients who have experienced racial trauma?
2. How do Black mental health professionals meet the personal and professional challenges of serving clients who experience racial trauma?
3. What competency training do mental health professionals need to promote and enhance their effectiveness when working with individuals who experience racial trauma?

This chapter highlighted the voices of twenty three (23) participants who shared their experiences on their work with racial trauma; their voices represent their lived experiences, the impact of this work on their well-being, and their recommendations to help improve services for Black communities. Four major themes emerged from their narratives that include: (1) Challenges and Rewards; (2) The Importance of Self-Care; (3) The Importance of Implementing Culturally-Informed Clinical Strategies, and (4) The Importance of Engaging in Professional Growth and Development. While participants found the work to be intrinsically rewarding, they, nonetheless, encountered significant challenges, which included: (a) Managing cultural mistrust,

(b) Feeling helpless, and (c) Providing mental health literacy. To counteract these challenges, participants felt a great deal of responsibility to be intentional about their self-care strategies to prevent counselor burnout and compassion fatigue. The need for culturally-informed clinical strategies that included trauma-informed care was deemed essential to providing effective services to Black clients with racial trauma. Lastly, participants made strong recommendations for continued culturally-informed and trauma-informed professional development training, a shift in commitment toward working with the Black community that include intentionality, passion, curiosity, and self-awareness.

Chapter 5

Discussion

Summary of the Study

This study explored the lived experiences of Black mental health professionals working with racial trauma. While the aim of this study was beyond confirming the proposed hypotheses, the findings supported what I anticipated finding: (1) Black mental health professionals reported having experience working with racial trauma; (2) Black mental health professionals reported engaging in multiple modalities of self-care strategies to maximize their effectiveness in working with individuals impacted by racial trauma; and (3) Black mental health professionals reported needing specific training that are culturally relevant and trauma-sensitive.

This study sought to bring greater awareness of racial trauma from Black mental health professionals who have experience working with Blacks with racial trauma. Racial trauma is defined as the psychological, emotional, and physical adversities and atrocities that Blacks and other BIPOC (Black Indigenous People of Color) communities endure due to their racial and ethnic background (Carter & Pieterse, 2020; Carter & Scheuermann, 2020). Factors leading to racial trauma include discrimination, racism, sexism, xenophobia, Semitism, genderism, and all other -ism forms rooted in unequal systems of oppression. Race-based trauma is debilitating and destructive to the well-being of those impacted; nonetheless, because it is rooted in systems of oppression that constitute the fabric of this nation, it is often unacknowledged, dismissed, and unaddressed by leading institutions in the mental health field. This insidious form of invalidation or invisibility is damaging to communities of color and helps sustain the status quo of systems of oppression.

To achieve the aim of the study, twenty-three (23) Black mental health professionals were interviewed on their overall experiences as professionals who have first-hand practice and skills necessary to help individuals heal from racial trauma. All interviews were transcribed and examined for themes. Four themes became salient from the interviews: 1) participants expressed feelings of satisfaction and challenges from doing this sort of work; 2) participants were aware of the psychological, emotional, and physical toll that this work has on their well-being and as a result, found it essential to commit to a self-care routine; 3) participants discussed the need to adhere to culturally-informed practices that include, trauma-informed care when working with racial trauma; and 4) lastly, participants see the need to remain engaged in activities that promote professional growth and development.

Discussion of the Findings

Using a Critical Race Theory and a psychological trauma theory framework, this study examined how Black mental health professionals have managed to help individuals heal from racial trauma, the implications for these mental health professionals, and recommendations for best practices.

Key findings of this study highlighted four distinct themes: (1) Rewards and Challenges; (2) Importance of Self-Care; (3) Culturally-Informed Clinical Strategies; and (4) Professional Growth and Development. Participants of this current study shared their experiences working with clients who have experienced racial trauma. Results of this study indicated a variety of strategies used to meet clinicians' identified personal and professional challenges, as well as competency training modalities to promote and enhance the effectiveness of Black mental health professionals.

Results of this study are consistent with scholarship and findings of (Carter, 2007b; Johnson & Melton, 2021; Sue & Sue, 2003) who advocated for the inclusion of culturally-informed therapeutic practices, as well as Hemming and Evans (2018) who surveyed 106 mental health professionals and found that many did not have prior training in identifying race-based trauma. The findings from this research: a) add to the body of literature on racial trauma by centering the voices of Black counselors as experts on issues related to racial trauma; b) provide deeper insight on ways to best serve marginalized populations impacted by racial trauma; and c) help inform and guide counseling programs in being more intentional on the training provided to counselors-in-training to most effectively work with individuals impacted by racial trauma. The significance and implications of the findings from this research are explored in the context of the three research questions that guided this study which were:

1. What are the experiences of Black mental health professionals working with clients who have experienced racial trauma?
2. How do Black mental health professionals meet the personal and professional challenges of serving clients who experience racial trauma?
3. What competency training do mental health professionals need to promote and enhance their effectiveness when working with individuals who experience racial trauma?

RQ1. What are the experiences of Black mental health professionals working with clients who have experienced racial trauma?

As anticipated, Black clinicians in this study reported finding working with racial trauma to be challenging and rewarding. They explained that the challenges stemmed from helping clients establish trust, especially when clinicians work in institutions that mimic or represent systems that have traditionally deceived or harmed minoritized populations.

A second challenge resides in the difficulty in helping client develop a sense of hope when the clinicians themselves are aware of the high probability of being retraumatized from recurring racist incidences. Further, participants found it challenging to help clients heal due to lack of access to resources presenting a barrier to achieving goals. This sentiment was summarized as an overall feeling of being helpless.

Thirdly, participants experienced challenges in helping clients de-normalize racial trauma and understanding its impact on their wellbeing, developing coping skills to deal with racial trauma, and being receptive to seeking help for their mental health.

RQ2. How do Black mental health professionals meet the personal and professional challenges of serving clients who experience racial trauma?

Black mental health professionals stressed the importance for continuous self-care regiment. Providing relevant and ethically sound mental health services is paramount an essential task of mental health professionals. Self-care strategies aid in ensuring that mental health professionals are in the right mental state to serve vulnerable populations. Self-care strategies ensure that the needs of the mental health professional are being met to avoid harm through transference or countertransference, burnout, secondary trauma, compassion fatigue, and discriminatory practices in therapeutic settings. Participants discussed the need to engage in both professional and personal self-care strategies and were committed to developing holistic self-care strategies that included, social, emotional, physical, mental, intellectual, and spiritual aspects. Examples of strategies were: creating healthy professional and social boundaries with clients and friends, respectively; having their personal outlet to mend to their mental health needs such as therapy services or journaling; engaging in physical activities for grounding (e.g., yoga, exercise routine); creating ways to stay mentally attuned (e.g., listening to music, meditation); engaging

in mentally enriching and intellectually stimulating activities (e.g., partaking in meaningful circles that promote enriching conversations, reading); and finally, doing some soul searching and connecting with their higher being through prayers and other meditative practices.

RQ3. What competency training do mental health professionals need to promote and enhance their effectiveness when working with individuals who experience racial trauma?

Almost unanimously (22 participants or 96%), participants reported not having receiving courses on trauma-informed practices. Black mental health professionals reported seeking out these skills beyond graduate school through professional development training and training targeted to address racial trauma in the mental health field. Participants specifically noted the benefit in specialized training to help treat trauma such as EMDR, TF-CBT, Somatic Experiencing, DBT (Dialectic Behavior Therapy).

Additionally, participants expressed the importance of receiving ongoing multicultural training that are holistic, meaning multicultural competency training that address current issues faced by marginalized populations. Participants also spoke of the need to secure mentorship, coaching, clinical and peer supervision, and internship opportunities from Black and other BIPOC mental health experts and communities. They also emphasized the need to adapt Westerners approaches to treatment to fit the need of Black clients. Lastly, participants recommended for clinicians to foster an open and flexible attitude to learning, one in which they are willing to learn of different intersecting identities and one in which they are willing to do the work that they are asking of their clients. Overall, participants felt the need to commit to their own learning to enhance their multicultural competency.

Results of this current study also highlighted key tenets of Critical Race Theory:

Tenet 1: Pervasiveness of Racism—Racism is woven into the fabric of this country (Bell, 1992; Ladson-Billings & Tate, 1995).

Tenet 2: Permanency of Racism—Racism and discrimination are nearly impossible to eradicate (Bell, 1992; Ladson-Billings & Tate, 1995).

Tenet 3: Race and races are socially constructed and used whenever deemed convenient.

Tenet 4: Giving voice to the experiences of marginalized and oppressed groups through the embodiment of their counternarratives (Smith et al., 2006).

Tenet 5: Critical race theorists should be anti-racist and advocates of social justice (Delgado et al., 2017).

Tenet 1 and 2 of CRT were salient in participants' reports of the challenges they face when working with Black clients. More specifically, participants spoke about the barriers that clients experienced when attempting to address their traumas which highlight systems of inequality. These barriers include lack of resources impeding on their treatment, lack of insurance, lack of access to services, inability to find time to attend to their mental health needs. Additionally, the stigma and cultural mistrust that clients have toward mental health institutions highlight the distrust that Black people have toward White institutions resulting from historical injustices they have injured in White spaces. Lastly, the normalization and numbness toward trauma highlight the permanency and pervasiveness of trauma exposure in the Black community. This finding aligns with literature on the occurrences of racism and other discriminatory treatments in the daily lives of Black people (Carter & Scheuermann, 2020; Akbar, 2017; Springer-Daniels, 2021). Akbar (2017) refers to these persistent social and economic discriminatory occurrences that marginalized communities face as urban trauma.

While tenet 3 was not corroborated in this study, tenet 4 was supported through participants' efforts to dismantle systemic oppression that may be rooted within the profession. Specifically, participants spoke of the need to adhere to a client-centered approach that centers Black clients' experiences and voices; create a safe space for clients to know that talking about their racial experiences is welcome; help clients develop a shared language to better understand their experiences in context and develop counternarratives; and help clients develop relevant strategies to cope with injustices in White spaces. Additionally, participants discussed the need to give voices to Black and BIPOC mental health professionals by recognizing that they are essential in providing in culturally competent mentorship, coaching, clinical and peer supervision in matters concerning Black and BIPOC communities. By prescribing to approaches and techniques that take into account the client's worldview and holistic experiences, and by modifying Eurocentric treatment approaches to fit the need of Black clients, participants are decentering White lenses. The conceptualization of being intentional about representing the voices and practices of Black people in clinical settings and research is consistent with literature that discusses strategies for healing from racial trauma (Archer, 2021; Johnson & Melton, 2021)

Tenet 5 which emphasizes the importance of being anti-racist and pro-social justice was apparent in the ways that participants stressed the need to create environments of cultural safety by developing in-depth awareness of one's position of power and privileges and staying informed on current sociopolitical issues impacting Black communities. Participants expanded on the notion of being anti-racist to include a responsibility of educating oneself about the lived experiences of Black people and the history of systemic political and social structures that impact Black people's lives and; and develop some awareness of Critical Race Theory. Moreover, participants shared their sense of responsibility to engage in anti-racist activism by developing

research agendas aiming at challenging racial status quo, White silence, and colorblindness. They also discussed being intentional about taking courses to stay grounded and current in the clinical and intellectual discourse. Lastly, participants stressed the idea of approaching this work with a sense of humility to help understand the various forms and layers of racism and oppression and how they manifest in covert ways.

Implications

This study is significant for counselor educators, clinicians, counselors-in-training, and the counseling field in that it helps in the identification of much needed changes that are necessary to improve policies and practices.

Implications for Counselor Educators. As mental health professionals, we have a duty to improve professional training provided to counselors-in-training; improve services provided to clients; and advocating for the bettering of a just and equitable society. To help mitigate the challenges associated with assisting Black clients and other minoritized clients in healing from racial trauma, as noted by the participants in this study, counselor educators should emphasize the role of counselors as social advocates in all training programs. Counselors need to be trained and encouraged to engage in anti-racist activism that could include, but not limited to, protesting against law enforcement brutality against Black communities and vigorously advocating for real equity and social justice policies and practices. Counselor education programs should collaborate with other social justice advocate entities to provide culturally-informed and trauma-informed training, aimed at dismantling racial injustices and inequalities, to law enforcements and other institutions that have historically contributed to killing or disenfranchisement of Black people. Furthermore, counselor education programs need to have a stronger presence in communities of

people of color to provide education and foster awareness of mental health needs and services to help destigmatize mental health and help establish trust among BIPOC communities.

Counselor education programs should emphasize the infusion of trauma-informed teaching strategies in all courses, including a commitment to self-care. Essential self-care routine must incorporate ways to help counselors identify their own biases and prejudice, develop and maintain healthy professional and personal boundaries, develop self-awareness of one's racial identity, power and privileges, and commitment to a self-care routine.

While many counseling education programs have begun to incorporate a trauma-informed course in their curriculum, there remains a lack of focus on trauma-informed counseling in most training programs. The national accrediting body for professional counseling, CACREP (Council for Accreditation of Counseling and Related Educational Programs), has not made it mandatory for counseling programs to instruct counselors-in-training about trauma. Counseling institutions should be more flexible and proactive in developing therapeutic models specific to racial trauma. For instance, counseling programs could mandate a module on racial trauma to be included in all multicultural courses. Additionally, all courses should be infused with social justice issues that address the ways in which injustices impact mental wellness.

Implications for Clinicians. In response to the challenges noted above, practicing clinicians' input need to be included in the creation of counseling instructions and curriculums. Their challenges also highlight the need for greater supportive spaces in which, clinicians can find support, resources, and mentorship.

Practicing clinicians should adhere to culturally-informed and trauma-informed practices that include a commitment to self-care regiment. Some essential component of self-care strategies should include continuous self-assessment of counselor biases toward Blacks and

diverse populations; and self-assessment of one's capacity and commitment to provide anti-racist services.

Clinicians need to be more intentional about their commitment to gain competency in multimodal approaches to treating racial trauma. Black clinicians who are experts in the areas of racial trauma should continue to find ways to increase their visibility in all aspect of the field and in the community. As experts, they should also be more proactive in raising awareness and education about the impact of racism on the mental wellness of individuals. Lastly, Black clinicians engaging in racial trauma work need to continuously engage in self-examination of the impact of the work on their wellbeing.

Recommendations

Anti-racist counseling: This study sought out to center the experiences of Black counselors working with racial trauma. The discourses of participants highlighted a need for specialized courses in social justice that explicate the history of racism in America and current race relations, and its impact on mental health. The study also points to the need for continued meaningful dialogues, in and out of the classrooms, on anti-racist counseling. Using Kendi's (2019) framework of anti-racism, anti-racist counseling is to refute the notion that there is something inferior about Black people; it is seeing all racial groups as equal given their differences (Kendi, 2016, 2019). Being an anti-racist counselor is seeing that inequities among racial groups are largely rooted in racist policies. It is the ability to see the full potential in clients and recognizing systems that present as barriers to their advancement (Archer, 2021). It is equipping Black clients with the tools needed to feel empowered to overcome race-related adversities (Archer, 2021). Conversely, to be a racist counselor is to actively or passively support racist policies through one's action or other ways of self-expression (Kendi, 2019). To sum up,

shifting to an anti-racist culture in counseling requires a shift in understanding dynamics of power and privileges, engagement in continuous reflexivity in relation to these ideologies, and intentionality in creating culturally affirming spaces.

Increased Diversity among Counseling Faculty and Clinicians of Color: This study also highlights the need for increased representation of Black faculty in counseling programs and increased representation of Black clinicians in the field. Black faculty are needed, not only to serve Black populations, but also to help train and mentor non-Black clinicians on how to best work with racial trauma. Counseling programs need to be more intentional about recruiting, retaining, and developing Black faculty and Black counseling candidates to racially level the playing field of counseling.

Culturally-Informed Training and Practices: Working effectively with racial trauma requires a commitment to providing ongoing culturally-informed training and practices, infused with trauma-informed approaches. Because of the pervasive and the toxic nature of racism, the American Counseling Association should develop a journal to address all issues related to racial trauma to increase awareness and provide education. Counselor education programs should incorporate a trauma-informed course with a racial trauma component in their curriculum, infuse courses with current social justice issues and address the ways in which they impact mental wellness, incorporate a course or class on the history of racism in the U.S. in their curriculum, create opportunities for supervisory and mentorship experiences led by Black and BIPOC clinicians. Lastly, counseling education programs should take a culturally affirming and trauma-informed approaches to teaching that includes teaching practices that recognize the pluralistic identities and experiences of counselors-in-training.

Advocacy: Counselor education programs should have a stronger presence in communities of people of color to provide education and foster awareness of mental health needs and services. An increase in visibility would help in the destigmatization of help-seeking behavior and minimize stigma around mental health. Professional national and local mental health organizations should expand on their efforts to educate all communities about racial trauma and steps for healing. Culturally informed self-care strategies should be at the epicenter of healing discussions.

To sum up, the noted challenges point to the need for the development of research programs specifically dedicated to raise funds to support the mental health of Black communities. Counselor education programs need to add a social justice research course or certificate program with the goal of providing grant writing training and mentorship to counselors-in-training and clinicians. The field of counseling need to shift its focus on the overall wellbeing of those entering the field to ensure adequate, just, and equitable services are being provided to Black clients and other marginalized communities. The American Counseling Association could develop a journal specifically for counseling related issues to racial trauma. Institutions need to make greater effort to promote research addressing racial trauma; for example, institutions can host symposiums or unconference for research that strictly address race issues and other intersecting identities.

Limitations

There are several limitations to this study. First, while the number of participants (23) was fairly reasonable, there was a lack of male voices. Only 5 (22%) of the participants self-identified as males and their stratified sampling was necessary to recruit these male participants.

Greater male voices could offer greater insight on the gender differences in the challenges that Black professionals face in their work with racial trauma.

A second limitation is the lack of exploration of how other marginalized identities of clients contributed to the challenges of working with racial trauma. Very few participants elaborated on the intersection of race, other marginalized identities of clients, and racial trauma. The few clinicians that spoke about other intersecting identities of clients were from the West Coast; it would have been insightful to hear the perspectives of other clinicians residing in more conservative areas like the Midwest.

A third limitation to the study is the absence of the voices of non-licensed Black mental health professionals who work with Black clients. Getting their input would have been instrumental in understanding how this work impact their wellbeing and the support they need from their direct supervisors to effectively serve Black clients impacted by racial trauma.

A fourth limitation is the sample of this study largely representing individuals from the South. Southerners' views on racial trauma and discrimination may be more reflective of this idea of a "double consciousness", which Du Bois refers to as a sense of always assessing oneself through the lens of the dominant group, the Whites (Du Bois, 2020; Kendi, 2019). Hence, participants' account may be influenced, not only by the sociopolitical discourse that they live in, but also by their interpretation of race relations as per this double consciousness.

Suggestions for Future Research

The present study aimed to understand the experiences of Black mental health clinicians working with racial trauma. Their experiences offered meaningful insight into best practices for working with racial trauma. Nonetheless, more in-depth research is needed to explore the impact of racial trauma on clinicians and clients. More specifically, research is needed to understand the cross-racial therapeutic match between counselor and client in addressing racial trauma in

counseling. A quantitative component to the present research could offer valuable information on the prevalence of racial trauma as a presenting issue in various therapeutic settings. Future research could focus on developing evidence-based quantitative assessment instruments to measure the impact of racial trauma counseling on Black counselors.

More research is needed to highlight the experiences and needs of Black counselors. Exploration of how racial identity may influence the experiences, clinical interventions, and coping strategies of Black mental health professionals is needed. Additionally, future research should explore the extent to which multiple intersecting marginalized identities (i.e., sexual orientation, gender, religious affiliations, citizenship status, ableism, etc.) impact race-based support and strategies used by clinicians.

The challenges faced by the participants underline the need for a heightened awareness of the need of Black communities and the need for more funding to help individuals with limited access or resources to mental health services. Additionally, too often clients' voices are left out; as such, future research is needed on the experiences of clients who have experienced racial trauma and their perspectives on the treatment received. Future research is needed to explore factors associated with the prognosis of racial trauma (e.g., racial identity, support system, etc.). Future research is needed to explore the intergenerational elements of racial trauma.

More in-depth research is needed on the benefits of self-care routine among counselors and the provision of culturally-informed and trauma-informed services. Additionally, increased research on the effectiveness of self-care strategies will provide evidence for support or sponsorship of self-care resources for mental health clinicians. We have seen an example of this during the Pandemic of 2020, where several organizations (e.g., headspace) provided free or discounted resources to mental health providers. More research is needed on the impact of

racism and trauma. Researchers need to give voices to Black counselors who are experts in racial trauma to share insights and offer recommendations for best practices.

Conclusion

This study has elucidated the need to view racism as trauma. One cannot talk about being trauma-informed without recognizing factors contributing to trauma. This study showed that trauma is interlocked with systems that promote inequality and injustices. With the push to ban Critical Race Theory and other race and equity discussions in youth education, this study is paramount in highlighting the harmful impact that such a ban could have on the emotional, physical, and psychological well-being of Black people and other people of color. The current gap in discussing race in the curriculum of clinicians has already proven disadvantageous to the care provided to impacted individuals; banning race and equity discussion in existing teaching would further contribute to the invalidation of the experiences of Black people. This study has offered significant insight into the need for targeted training on racial trauma and more relevant race studies for counselors-in-training. This study calls for more commitment from the American Counseling Association and the Council for Accreditation of Counseling and Related Educational Programs to recognize the need for greater inclusivity of cultural competency and trauma competency that address systems of oppression and their impact on the well-being. Lastly, this study has offered insight into the need for intentionality in the commitment to self-care practices to ensure the well-being of mental health professionals working with racial trauma.

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APPENDIX A

Participant Consent Form



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Informed Consent for Participation in Research Activities

Addressing Racial Trauma in Counseling: Perspectives and Lessons from the Field

Participant _____

HSC Approval Number _____

Principal Investigator: Claire Martin, MEd, MA, LPC, NCC

Phone Number 347-860-3351

Summary of the Study

This is a brief description of the project:

1. You are invited to participate in a research study conducted by Claire Martin, MA, MEd, LPC, NCC and Faculty Advisor, Dr. Susan Kashubeck-West, Ph.D. The purpose of this research is to understand the professional experiences of Black mental health professionals working with Black individuals who present with racial trauma symptoms with the aim of developing a practical clinical framework to help guide other clinicians wanting to work with this population. You will be asked about your experiences in assessing and addressing racial trauma. You will also be asked about the specific impact those experiences have had on you and how you've managed them. Finally, you will be asked for feedback on how to better equip clinicians wanting to work with this population.

2. a) Your participation will involve

- Filling out a demographic questionnaire via a link to determine eligibility for the study.
- Answering interview questions in a private, safe and comfortable location selected by you.
- The interview session will be audio and/or video recorded via Zoom. The recording will be destroyed immediately after verifying that the written transcript matches the recorded content.

- All transcriptions (i.e. interview data) will be stored in a password-protected document on my personal home desktop computer that is also password protected. The data will be kept for 7 years and destroyed thereafter.
- The principal investigator will be the only person to have access to the recordings of the interviews.
- The researcher will reach out to you via email to provide you with excerpts of your interview along with the researcher's interpretations of your narrative to check for accuracy. It's optional for you to follow through with this step.

Fifteen (15) participants may be involved in this research at the University of Missouri-St. Louis.

b) The amount of time involved in your participation will be less than 5 minutes to complete the demographic questionnaire and between 60-75 minutes for the interview. You will be compensated with a \$30 Amazon gift card for your participation in the study.

3. There is a loss of confidentiality risk; to minimize this risk, the investigator will be the only individual to establish contact with the participants. All interviews and data transcription will be done by the PI. The PI will assign pseudonyms to all recorded interviews and transcribed data. Additionally, the PI will ensure to group participants' identifiers together, report on ranges of characteristics, avoid assigning specific quotations to participants' characteristics unless there are compelling reasons to do so. The recordings of the interviews will be destroyed immediately after verifying that the written transcripts match the recorded content. Data will be stored on a password-protected desktop computer. The computer is located in the PI's home office.

There is also the risk of participants experiencing discomfort as they recall their experiences working with clients who have experienced trauma. To minimize this risk, prior to the interview, participants will be provided with a list of resources for counseling should they have any emotional concerns.

4. There are no direct benefits for participating in this study; however, your participation will help fill the gap on racial trauma in counseling and psychology research.
5. No clinical assessments of participants will be made during this study.
6. Your participation is voluntary and you may choose not to participate in this research study or withdraw your consent at any time. You will NOT be penalized in any way should you choose not to participate or withdraw.
7. We will do everything we can to protect your privacy. As part of this effort, your identity will not be revealed in any publication that may result from this study. In rare instances, a researcher's study must undergo an audit or program evaluation by an oversight agency (such as the Office for Human Research Protection) that would lead to disclosure of your data as well as any other information collected by the researcher.

8. If you have any questions or concerns regarding this study, or if any problems arise, you may call the Investigator, Claire Martin, MEd, MA, LPC, NCC, 347-860-3351 or the Faculty Advisor, Susan Kashubeck-West, Ph.D., (314) 516- 6091. You may also ask questions or state concerns regarding your rights as a research participant to the Office of Research, at (314) 516-5897.

I have read this consent form and have been given the opportunity to ask questions. I hereby consent to my participation in the research described above. _____

I have read this consent form and have been given the opportunity to ask questions. I hereby DO NOT consent to my participation in the research described above. _____

APPENDIX B

Recruitment Message for Listservs

Dear Prospective Participants,

My name is Claire Martin; I am a Ph.D. candidate conducting dissertation research under the supervision of Dr. Susan Kashubeck-West at the University of Missouri-St. Louis. The purpose of this study is to examine the experiences of mental health professionals working with Black clients who have experienced racial trauma.

To be eligible for participation in this study, you must identify as a Black mental health professional, be 18 years or older, have graduated with at least a Master's degree in a mental health professional field, and currently providing mental health services as a fully licensed clinician. Additionally, eligible participants need to have expertise and experience providing counseling services to Black clients who have implicitly or explicitly reported having experienced racial trauma.

Participation is voluntary and confidential; you may withdraw at any point without consequences. This study has been approved by the University of Missouri-St. Louis Institutional Review Board (IRB#2056444).

There is minimal potential risks associated with the research. To minimize risks associated with loss of confidentiality, the investigator will be the only individual to establish contact with the participants. All interviews and data transcription will be done by the PI. The PI will assign pseudonyms to all recorded interviews and transcribed data. The recordings of the interviews will be destroyed immediately after verifying that the written transcripts match the recorded content. Data will be stored on a password-protected computer. There is also the risk of participants experiencing discomfort as they recall their experiences working with clients who have experienced trauma. To minimize this risk, prior to the interview, participants will be provided with a list of resources for counseling should they have any emotional concerns.

There are no direct benefits for participating in this study; however, your participation will help fill the gap on racial trauma in counseling and psychology research.

Your participation will involve:

(1) Filling out a demographic questionnaire that will take less than 5 minutes to respond in which you will include your contact information (email or phone) to be contacted for the interview;

(2) Participating in a semi-structured interview that will take 60-75 minutes.

The interview will be conducted via a teleconferencing platform (e.g., Zoom). You will be given the option to have your camera on or off. All interviews will be recorded. You will be provided with a list of mental health providers to assist with processing any negative emotions that this interview may bring up. The researcher will reach out to you after the interview has been analyzed to give you the option to check for the accuracy of the researcher's interpretation of your narrative. To compensate you for your time, you will receive a \$30 Amazon gift card.

If you have any questions, please do not hesitate to contact the Principal Investigator/Researcher, Claire Martin, at clairemartin@mail.umsl.edu. To join the study or learn more, click here: https://umsl.az1.qualtrics.com/jfe/form/SV_9Zev2flzlMiYjjw

Thank you.

Respectfully,

Claire Martin, M.A., M.Ed., LPC, NCC | Ph.D. Candidate in Counselor Education & Supervision
Department of Education Sciences & Professional Programs | College of Education
University of Missouri - Saint Louis | 415 Marillac Hall
One University Boulevard | Saint Louis, Missouri 63121-4400
Email: clairemartin@mail.umsl.edu
Pronouns: she, her, hers

APPENDIX B-1

Recruitment Message for Social Media

CALLING ALL BLACK THERAPISTS WITH EXPERIENCE ON RACIAL TRAUMA.

You are invited to participate in a dissertation study examining the experiences of mental health professionals working with Black clients who have experienced racial trauma.

To participate you must identify as a Black mental health professional, be 18 years or older, have graduated with at least a Master's degree in a mental health professional field, and currently providing mental health services as a fully licensed clinician. Additionally, eligible participants need to have expertise and experience providing counseling services to Black clients who have implicitly or explicitly reported having experienced racial trauma.

If you consent to participate in the study, you will fill out a demographic questionnaire to determine your eligibility and participate in an interview that will take approximately 60-75 minutes. Participation is voluntary and confidential. At the end of the interview, you will receive a \$30 Amazon gift card.

This study has been approved by the University of Missouri St. Louis IRB (#2056444). To join the study or learn more, click here: https://umsl.az1.qualtrics.com/jfe/form/SV_9Zev2flzlMiYjjw

Claire Martin, M.A., M.Ed., LPC, NCC
Ph.D. Candidate in Counselor Education & Supervision
University of Missouri - Saint Louis

APPENDIX C

Demographic Form

1. What is your age? _____
2. What is your gender? _____
3. Ethnic Identity
 - a) Black or African American
 - b) Other
1. In which geographic region of the United States do you currently reside?
 - a) Midwest- IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, SD, WI
 - b) Northeast- CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT
 - c) Southeast - AL, AR, FL, GA, KY, LA, MS, NC, SC, TN, VA, WV
 - d) Southwest - AZ, NM, OK, TX
 - e) West - AK, CA, CO, HI, ID, MT, NV, OR, UT, WA, WY
 - f) I live outside of the USA, please specify where _____
1. What is your discipline in mental health?
 - a) Counseling, Including Marriage and Family Therapy
 - b) Clinical Social Work
 - c) Psychology
 - d) Psychiatry
 - e) Other
1. Please indicate your highest level of training received:
 - a) Master's degree
 - b) Doctorate degree
 - c) Post-Doctoral training
 - d) Other
1. How many years have you worked as a mental health professional?
2. In what setting do you work?
 - a) Private Practice/Outpatient in an office setting, including telehealth
 - b) In-patient (please specify--e.g. hospital, group home, substance use disorder, shelters, etc...) _____
9. In your graduate studies, did you have to take a course on multicultural counseling?

10. In your graduate studies, did you have to take a course on trauma, trauma-informed care, or trauma-informed practice (not including crisis intervention)? _____

11. Beyond your graduate studies, have you engaged in professional development activities that address multicultural issues? _____
If yes, how often do you engage in professional development activities that address multicultural issues?
- a) 4 times or more per year
 - b) 2-3 times per year
 - c) 1 time a year
 - d) Less than 1 time a year (i.e. irregularly)
12. Beyond your graduate studies, have you engaged in professional development activities that address trauma, trauma-informed care, or trauma-informed practice (not including crisis intervention)? _____
If yes, how often do you engage in professional development activities that address trauma, trauma-informed care, or trauma-informed practice (not including crisis intervention)?
- e) 4 times or more per year
 - f) 2-3 times per year
 - g) 1 time a year
 - h) Less than 1 time a year (i.e. irregularly)

Please provide your contact information below to be contacted for an interview.

Email: _____

Phone: _____

APPENDIX D

Interview Protocol and Questions

My name is Claire Martin. I am a doctoral candidate at the University of Missouri-St. Louis completing my dissertation. The purpose of this research project is to help identify strategies and recommendations from Black mental health experts on how to best address the needs of clients who have experienced racial trauma.

You were selected for this semi-structured interview because you identified as a Black mental health professional with experience and expertise working with Black clients who have experienced racial trauma.

This interview will be a semi-structured interview, meaning that you will be asked specific questions to which you will provide answers. Feel free to elaborate on your answers as needed. The interview will be recorded and will last approximately 60 to 75 minutes.

Information you provided during the interview will be transcribed and analyzed for recurrent and dominant themes. The findings will be shared with you before final submission of the data to check for accuracy of information. If for any reason I have misinterpreted any of your responses, I will make the necessary changes prior to finalizing the results. This is optional.

If for any reason you feel uncomfortable and do not wish to continue with the interview, please indicate so. The interview will be stopped upon request.

Now is an opportunity for you to ask any questions you may have before we begin recording.

Interview Questions

1. What are the experiences of mental health professionals working with Black clients who have experienced racial trauma?
 - a. What has been your experience working with Black clients?
 - b. What is your experience working with trauma with Black clients?
 - c. What types of trauma do they present with?
 - d. Please describe for me the major challenges you face when working with Black clients who have experienced trauma?
2. What impact, if any, has this work had on your health and wellbeing? (Physical, emotional, etc.)
 - a. What personal coping strategies have you employed to assist in monitoring and addressing your well-being?
 - b. What professional coping strategies have you employed to address your needs?
3. Can you tell me about the training experience you received
 - a. During graduate school; and
 - b. During your Post graduate continuing education?

4. How competent do you currently feel about your work with this population?
 - a. What contributes to your competency or lack of competency working with this population?
5. What do professionals need to feel more competent working with this population?
 - a. What are the essential elements to effectively work with Blacks who have experienced trauma?
 - b. What skills do you feel you need to possess to effectively work with this population?
 - c. What recommendations or training or professional development would you suggest for mental health professionals engaged in this type of work?
 - d. What would you need to feel more competent working with this population?
6. In thinking about your clients, what expert advice would you give to other professionals with regards to working with individuals who have experienced racial trauma?
7. Is there anything else you would like to share with me today about this topic?

APPENDIX E

Follow Up Questionnaire (Optional)

Dear Research Participant,

Thank you for your previous participation in the Research Study on Addressing Racial Trauma in Counseling. Your insight on this subject was essential to understanding how counselors can address racial trauma in counseling. I greatly appreciated your time spent sharing your expert knowledge on this subject. The following summarizes the preliminary findings from the analysis of the 23 interviews conducted for the study. Feel free to review them at your leisure; at the end, I provided a list of questions if you so desire to follow through with further input or clarification on the topic.

An aggregation of the data shows four distinct themes:

1. Rewards and Challenges
2. Self-Care
3. Culturally-Informed Clinical Strategies
4. Professional Growth and Development

Across the four themes, widespread refrains of cultural awareness, appreciation, respect, and affinity indicate that an overall sense of humility and transparency was essential to working with Black clients.

- 1) Rewards and Challenges: Participants found the work to be intrinsically rewarding and empowering while experiencing significant challenges. The rewards are inherent in the ability to help the Black community heal from racial trauma by empowering them with the tools needed to combat injustices and systemic barriers.

Of the many challenges that participants described, the most significant centered on: (a) managing cultural mistrust, (b) feeling helpless, and (c) providing mental health literacy. In particular, participants struggled with helping clients build hope and trust in a mental health system that has historically misrepresented and mistreated them. Participants found it challenging to instill hope in clients when future racialized killings of Black people are imminent. Participants found it challenging to engage clients in continuous healing when clients' resources were limited. Lastly, participants found it challenging to help clients de-normalize trauma and destigmatize help-seeking behaviors.

- 2) Self-Care: Participants stressed the importance of attending to their own mental, physical, and emotional wellbeing to prevent burnout, racial battle fatigue, and vicarious trauma. More specifically, participants were committed to the following:
 - a. Physical wellness regimen
 - b. Connecting with practitioners who share similar values and goals
 - c. Maintaining healthy personal and professional boundaries.
 - d. Engaging in activities that promote spiritual and emotional growth
 - e. Seeking professional support and guidance from mentors and peers.

- 3) Culturally-Informed Clinical Strategies: Participants spoke of the need to maintain an open attitude to adapting Western clinical approaches to culturally appropriate strategies to most effectively work with Black communities. Participants shared the need for practitioners to learn about the Black culture to help develop more profound cultural sensitivity, compassion, and understanding of the Black experience.
- 4) Professional Growth and Development: Participants were committed to their professional growth and development by seeking advanced training that addresses trauma and social justice issues. They were committed to staying engaged in continuous reflective practices that promote self-awareness and growth.

Optional questions for additional feedback or clarification:

1. Do these themes reflect your experiences?
2. Are there any themes that surprised you?
3. What is your reaction to these findings?
4. In your perspective, is there anything missing from the results?
5. After reviewing the results, is there anything additional you would like to add?

Thank you again for your support, expertise, and work you do to promote healing in the Black community.

P.S.: All Amazon gift cards were sent out via Amazon immediately following your interview. If for any reason you did not receive them, please let me know, and I will look into resolving this issue.

Respectfully,

Claire Martin, MA, MEd, LPC, NCC, BC-TMH
 Ph.D. Candidate in Counselor Education and Supervision | University of Missouri - St. Louis
 Instructor | Counseling Faculty | Lindenwood University
 Certified & Registered Trauma-Focused Cognitive Behavior Therapist (TF-CBT)
 Certified Eye Movement Desensitization and Reprocessing Therapist (EMDR)
 Founder & Owner | Spring To Life Counseling, LLC
 Email: clairemartin@mail.umsl.edu
 Pronouns: she/her/hers

"I swore never to be silent whenever and wherever human beings endure suffering and humiliation. We must take sides. Neutrality helps the oppressor, never the victim. Silence encourages the tormentor, never the tormented." - Elie Wiesel-

APPENDIX F

Mental Health Resources

24/7 Crisis Hotline:

- Behavioral Health Response: (314) 469-6644 or (800) 811-4760
- Provident Life Crisis Hotline [\(314\) 647-4357](tel:3146474357)
- National Suicide Prevention Lifeline (800) 273-8255
- KUTO Crisis Helpline: (888) 644-5886
- Mental Health America of Eastern Missouri at (314) 773-1399
- 9-1-1

Low Cost Counseling Services:

- Counseling and Social Advocacy Center @ UMSL [\(314\) 516-4613](tel:3145164613) (low cost counseling)