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Leaving part of myself outside the door: An exploration of pitfalls and promising practices for Black millennial survivors of racism

Sheriece L. Hooks

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Pepperdine University
Graduate School of Education and Psychology

LEAVING PART OF MYSELF OUTSIDE THE DOOR:
AN EXPLORATION OF PITFALLS AND PROMISING PRACTICES FOR BLACK
MILLENNIAL SURVIVORS OF RACISM

A clinical dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by

Sheriece L. Hooks

December, 2022

Thema Bryant Davis, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

Sheriece L. Hooks

under the guidance of a Faculty Committee and approved by its members, has been submitted and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

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DEDICATION

This dissertation is dedicated to all the Black clients who inspired me to find additional resources for healing in the face of oppression. With this work, I hope to help my fellow clinicians better understand the needs and lived experiences of the Black American community.

I also dedicate this project to future students who face the challenge of standing against racial injustice throughout their education and career. It is your courage and strength that will continue to uplift communities of color and lessen the load that minoritized students and professionals must carry.

ACKNOWLEDGMENTS

I would like to offer a special thanks to my dissertation committee for their unlimited patience and support as I navigated my dissertation process over the last several years. Dr. Thema, you challenged, motivated, and empowered me in so many ways beyond your role as my chairperson. You took the time to pray with and support me through every challenge that life threw at me since beginning my educational journey. Dr. Castañeda-Sound, for the past several years you have mentored and helped me to become the advocate for social justice that I am today. Dr. Moore-Lobban, your knowledge and feedback has been essential to my learning process and helped me to grow as a researcher in the field of race-based stress and trauma. I would also like to thank the many Black supervisors and mentors who helped me to merge my clinical identity with my identity as a Black, Christian woman. Dr. Rhonda Brinkley-Kennedy, Dr. Shelly Harrell, Dr. Daryl Rowe, Dr. Jacquelyn Johnson, and Dr. Kandace Timmons, collectively, you uplifted and empowered me to make change throughout my journey and molded me into my authentic self in all aspects of my professional and educational journey.

To my family and friends, none of this would have been possible without you! You have sacrificed so much for me to be here, and I am forever grateful. I would like to give a special thank you to Nana, who called to check on me every day and supported me in every decision. To Dad, Papa, and my siblings, you pushed me on my most difficult days to keep going when I felt like I could not. To my aunts (Puja, Cheryl, Genetha, Monique, and Christy), my many friends, and my cousins, you have been present, sheltered me, read my papers, and stayed up with me during late nights. You are all my village, and it is with you that I have made it to this point. Lastly, to Mom, who passed away along this journey, you taught me passion and nurture and inspired me to enter this field. Your spirit carries me forward, and I hope that I made you proud!

VITA

EDUCATION:

Pepperdine University

Expected Completion: 08/2022

Doctor of Psychology in Clinical Psychology

- **Dissertation Chair:** *Thema Bryant-Davis, Ph.D.*
 - “Counseling Black and African American Survivors of Racism”
- **Specialty Tracks:** Multicultural and Community Interventions & Cognitive Behavior Therapy

Pepperdine University

09/2015 – 06/2017

- Clinical Psychology with an Emphasis in Marriage and Family Therapy

Chapman University:

08/2011 – 05/2015

- Bachelor of Arts in Psychology
- Minor in Women’s Studies

HONORS & AWARDS:

Pepperdine University Graduate School of Education and Psychology

- Glen & Gloria Holden Scholarship (2018-2020)
- Colleagues Grant (2015-2019)
- Conrad N. Hilton Foundation Fellowship (2017-2018)
- Creative Care Fellowship (2016-2017)
- Urban Fellows Grant (2016-2017)
- Harry & Izelle Shafer Scholarship (2016-2017)
- John & Rebecca Barton Scholarship (2015-2016)

CLINICAL & PSYCHOLOGICAL ASSESSMENT EXPERIENCE:

Staff Psychology Provider/Lieutenant: Naval Medical Readiness Training Command,

Okinawa, Japan (40 hrs/week)

11/2021 – Present

Outpatient Mental Health/Substance Abuse Rehabilitation Program:

- **Training Supervisor:** Christopher Udell, Ph.D., Tuong Setala, Psy.D., & Mathew Rariden, Psy.D.
 - Assess, diagnose, and create treatment plans for active duty service members with substance use concerns.
 - Complete evaluations and written reports to determine fitness for duty for active duty service members with mental health concerns.
 - Provide evidence-based, recovery-oriented mental health services in an outpatient setting to active duty service members with a variety of diagnostic presentations.
 - Interpreted and wrote neuropsychological assessment reports to form diagnostic conceptualizations and assess for fitness for duty concerns.

Psychology Intern/Lieutenant: Naval Medical Center San Diego, Balboa (40 hours/week)
09/2020 – 11/2021

1st Rotation: Adult Outpatient Psychotherapy (09/2020 – 11/2020)

- **Training Supervisor:** Denise Boychuk, Psy.D. & LCDR Anne Murray, Ph.D.
 - Provide evidence-based, recovery-oriented mental health services in an outpatient setting to AD service members with a variety of diagnostic presentations.
 - Conducted comprehensive neuropsychological assessments for AD service members for diagnostic clarity.
 - Interpreted and wrote comprehensive neuropsychological assessment reports to form diagnostic conceptualizations and assess for fitness for duty concerns.

2nd Rotation: Health Psychology (11/2020 – 02/2021)

- **Training Supervisor:** Genelle Weits, Ph.D.
 - Provide evidence-based, recovery-oriented mental health services in an outpatient setting to service members with somatic disorders, sleep-wake disorders, and difficulties managing chronic pain.
 - Conduct individualized treatment planning and utilize empirically supported treatments to counsel Veterans with a broad range of diagnoses.
 - Engage in weekly multidisciplinary meetings to strengthen patient care and provide a collaborative approach to treatment.

3rd Rotation: Inpatient Psychology/Emergency Psychiatric Services (02/2021 – 04/2021)

- **Training Supervisor:** Pia Khandekar, Ph.D.
 - Provide psychoeducational and process group therapy to individuals in an inpatient setting to improve coping skills and strengthen ward milieu.
 - Conduct individualized consultative sessions to strengthen patients' use of coping skills as well as improve treatment team diagnosis and conceptualization for patients in crisis.
 - Collaborate with treatment teams including psychologists, psychiatrists, social workers, and substance abuse response and prevention workers to develop treatment plans for patients and strengthen quality of care.
 - Evaluate patients presenting to the emergency department for dangerousness to self, others, or grave disability to determine need for acute hospitalization.

4th Rotation: Mental Health Operational Outreach Division Clinic (04/2021 – 06/2021)

- **Training Supervisor:** LT Sarah Mebane, Ph.D.
 - Conduct intakes to create thorough client profiles in an effort to determine fitness for duty and connect patients with appropriate resources.
 - Provide triage mental health services and referrals to necessary resources for AD service members.
 - Collaborate with patient commands in order to communicate limitations and changes in fitness for duty.
 - Provide recommendations for patient separations based on mental health conditions for AD service members.

5th Rotation: Miramar (06/2021 – Present)

- **Training Supervisor:** Scott Green, Ph.D.
 - Provide evidence-based, recovery-oriented mental health services in an outpatient setting to AD Marines with a wide range of mental health conditions.
 - Conduct intakes to create thorough client profiles in an effort to determine fitness for duty and connect patients with appropriate resources.

Psychology Pre-Intern: VA Long Beach Healthcare Systems (16 – 20 hours/week)

08/2019 – 07/2020

1st Rotation: Neuropsychology Rotation (08/2019 – 02/2020)

- **Training Supervisor:** Christine Kim, Ph.D.
 - Conducted comprehensive neuropsychological assessments for veterans with neurocognitive and mood disorders.
 - Administered, scored, interpreted, and wrote comprehensive neuropsychological assessment reports to form diagnostic conceptualizations and assess for possible cognitive deficits.
 - Provided feedback and recommendations to veterans based on test data and presenting problems.
 - Attended didactic seminars and received individual supervision to improve clinical skills, increase knowledge of neuroanatomy, and ensure implementation of effective, competent treatments.
 - Engage in weekly individual supervision in order to develop and strengthen knowledge and skills related to neuropsychology.

2nd Rotation: Santa Fe Springs Community Based Outpatient Clinic (02/2020 – 07/2020)

- **Training Supervisor:** Amy Potts, Ph.D.
 - Provide evidence-based, recovery-oriented mental health services in an outpatient setting to Veterans with PTSD, substance-related diagnoses, and various comorbidities.
 - Conduct individualized treatment planning and utilize empirically supported treatments to treat Veterans with a broad range of diagnoses.
 - Conduct intakes to create thorough client profiles to deepen understanding of clinical presentation and needs, formulate case conceptualizations, devise treatment plans, and maintain quality of care.
 - Engage in weekly supervision in order to develop and strengthen clinical skills and ensure that effective evidence-based treatments are used with Veteran patients.

Doctoral Trainee: Los Angeles Job Corps (8 hours/week)

09/2018 – 12/2020

- **Training Supervisor:** Jacquelyn Johnson, Psy.D.
 - Provide evidence-based treatments for individuals struggling with adjustment, depression, anxiety, substance use, and various trauma-related disorders.
 - Conduct culturally congruent group therapy services utilizing pop media for transitional-aged youth struggling with anger management, depression, anxiety and a broad range of related disorders.

- Create safety plans and conduct crisis management in order to ensure the safety and wellbeing of the client, their peers, the staff members, and the agency.
- Provide weekly group interventions for suicide and bullying prevention of students.
- Conduct comprehensive personality and neuropsychological assessments for students with ADHD, learning disabilities, or mood disorders.
- Engage in weekly individual and group supervision in order to develop and strengthen clinical skills and ensure that effective, evidence-based treatments are used.

Doctoral Trainee: Union Rescue Mission (8 hours/week) *09/2017 – 12/2019*

- **Training Supervisors:** Shelly Harrell, Ph.D., Aaron Aviera, Ph.D., & Dity Brunn, Ph.D.
 - Conduct weekly individual psychotherapy with culturally diverse clients struggling with substance use co-occurring disorders and homelessness.
 - Provide group therapies, such as mindfulness, art therapy, and a gender-based women’s group therapy, to improve healthy coping strategies, address mental health challenges related to homelessness and a wide range of disorders, and build a group support system amongst clients.
 - Develop treatment plans for individuals of all genders to guide and inform the course of therapy.
 - Create safety plans and engage in crisis management interventions to ensure the safety of the clients and larger agency.
 - Work collaboratively within a multidisciplinary team composed of psychologists, chaplains, medical professionals, and legal services to ensure compliance and provide more comprehensive and holistic healthcare for clients.
 - Engage in weekly individual and group supervision to develop and strengthen clinical skills and ensure that effective, evidence-based treatments are used.

Lead Mental Health Counselor: Hope Gardens Family Center (4 hours/week)

08/2016 – 06/2017

- **Training Supervisor:** Rhonda Brinkley-Kennedy, Psy.D.
 - Train and provide support to trainees by reviewing agency rules.
 - Assign and update client caseloads to marriage and family therapist trainees to ensure organization.
 - Interview prospective trainees and collaborate with the program’s clinical supervisor to determine the best fit.
 - Facilitate interdisciplinary communication between agency staff and the mental health department to increase productivity and better meet client needs.

Marriage and Family Trainee: Hope Gardens Family Center (24 hours/week)

01/2016 – 06/2017

- **Training Supervisor:** Rhonda Brinkley-Kennedy, Psy.D.
 - Provide therapy services to homeless women and children living at Hope Gardens Family Center.
 - Communicate with colleagues, case managers, and the supervisor to assure the client’s needs are met.

- Create treatment plans for clients to direct the course of care throughout the time that therapy is offered.
- Run community outreach groups for senior citizens living at the center to increase socialization.
- Engage in weekly group supervision to develop and strengthen clinical skills and ensure that effective evidence-based treatments are used.

TEACHING & CONSULTATION EXPERIENCE:

Peer Consultant: Pepperdine University (2-6 hours/week) *09/2019 – 07/2020*

Training Supervisor: Aaron Aviera, Ph.D.

- Provide peer supervision to supervisees to build support and strengthen clinical skills.
- Review supervisees' written documentation to provide constructive feedback on writing skills, case conceptualization, and diagnoses.
- Conduct regular chart audits of peer supervisees' client records to ensure proper maintenance of session documentation and treatment progress.
- Attend weekly group supervision to develop skills in supervision, address challenges, and identify further areas for personal growth related to supervision.

Teaching Assistant: Pepperdine University: (6 hours/week) *08/2019 – 12/2019*

Training Supervisor: Shelly Harrell, Ph.D.

- Facilitate small group discussions to strengthen ability to engage in dialogue about multicultural topics.
- Provide support to students by answering questions related to multiculturalism.
- Support Dr. Harrell in planning and grading class assignments to assist in learning class material.
- Provide feedback on student diversity interviews in order to strengthen interviewing skills and attention to culture.

Teaching Assistant: Pepperdine University: Elizabeth Irias, MFT (6 hours/week)

09/2017 – 12/2017

- Provide support to students by answering questions about Couple and Family Therapy.
- Support Professor Irias in planning and grading class assignments to assist in learning class material.
- Create and grade quizzes in order to assess student learning.

COMMUNITY OUTREACH & SUPPORT EXPERIENCE:

Intern: The Ayaan Hirsi Ali Foundation (4 – 15 hours/week) *04/2018 – 07/2020*

- Provide supportive and compassionate communication for women and girls facing crisis situations in the US and internationally.
- Locate mental health, medical, and legal resources for women and girls that are at-risk or struggling with the effects of honor violence, female genital mutilation, forced marriage, and child marriage.

- Track help requests to identify patterns and assess for common challenges and needs related to the population.
- Research topics surrounding honor violence, female genital mutilation, and forced marriages to support newsletters and better connect women and girls to resources.
- Lead trainings in the greater Los Angeles area for legal, mental health, educational, and medical professionals on topics of honor violence, female genital mutilation, child marriage and forced marriage.

“Blank Canvas: An Art Workshop” Higher Ground Youth & Family Services, Anaheim, CA
04/2019

- Collaborated with organization leaders to better understand the agency population and needs.
- Engaged in interdisciplinary communication and planning to organize an event to benefit students within the program.
- Provided developmentally-appropriate education about emotions and methods of coping with stressors to 4th – 8th grade students in at-risk environments.
- Explored the use of creativity and art therapy techniques as a method of expression for students in a community-based after school program.

“Race & Racism” New Wine Community Church, Long Beach, CA
09/2018

- Discussed issues of race related stress in order to increase awareness and understanding
- Provided descriptions of coping techniques in order to handle racial stressors
- Described when individuals should seek mental health services in order to increase mental health and necessary service utilization within the community

“Creative Expression Group” Sycamore Junior High School, Anaheim, CA
03/2018

- Created a one-time art therapy group to address symptoms of trauma for students.
- Utilized art therapy techniques to increase emotional vocabulary and increase coping skills.
- Utilized music therapy as a method to express and cope with emotions for students.

“Trauma-Informed Verbal De-Escalation”
03/2017

Workshop Developer & Facilitator, Hope Gardens Family Center, Sylmar, CA

- Co-developed an interactive workshop for paraprofessional staff and masters’ level practicum students regarding evidence-based, trauma-informed verbal de-escalation strategies adapted to the women’s shelter setting.

LEADERSHIP & MENTORING EXPERIENCE:

Lieutenant/Swim Officer: Officer Development School, Newport, RI (5 weeks)
07/2020 – 08/2020

- Participated in daily Officership experiential programming to strengthen leadership and teamwork skills.
- Engaged in online and in-person courses centering military bearing and culture to better understand the focus population.

- Taught swim lessons for fellow officers struggling to pass 3rd class swim qualifications to increase shipboard safety.

Diversity Chair: Pepperdine University Student Diversity Committee (8 hours/month)

10/2018 – 07/2020

- Developed a student diversity and inclusion committee on campus to improve recruitment and retention of diverse students.
- Created guidelines to build a structure for future committee members to follow.
- Managed committee members and served as a liaison between students and faculty.
- Collaborated with student committee members to create an LGBTQ+ handout with references and terminology in order to increase knowledge, sensitivity, and support for LGBTQ+ individuals.

Lead/Peer Mentor: Students & Professors Advocating for Collaborative Engagement

08/2016 – 06/2017

- Planned and organized bimonthly meetings for master's level students to promote professional growth.
- Provided mentorship to first-year master's level students to share academic and clinical experiences.
- Meet with students individually to answer questions about Pepperdine's master's program and practicum.

Pepperdine Chapter Leader: Christian Association for Psychological Studies

08/2016 – 06/2017

- Organized monthly meetings for fellowship and to discuss psychological topics.
- Planned and led club events, such as panel discussions and fellowship events.

Malibu Campus Representative: Psi Chi Honors Society in Psychology

06/2016 – 06/2017

- Planned and organized meetings and events for members of the Pepperdine chapter of the Psi Chi Honors Society.
- Promoted and encouraged academic support and self-care for master's level psychology students.

Mentor/Grant Writer: Higher Ground Youth and Family Services

09/2014 – 07/2015

- Tutored children in grades 4 – 8 to improve their knowledge and understanding of academic material.
- Ran programs, such as cheerleading and crafts, for children to provide appropriate outlets for coping.
- Researched and wrote grants to support programs offered.
- Discussed family issues and future goals with children in order to provide guidance.

Treasurer: Chapman Feminists – Chapman University

09/2012 – 01/2013

- Kept records of club finances in order to ensure financial stability.

Co-Manager: Homeless Mission – Unity Church of God in Christ (10 hours/month)
01/2009 – 01/2015

- Bought and prepared food to feed people who were homeless or in need.
- Provided prayer and conversation to those in need to increase hope for a better future.
- Collected and distributed clothing and toiletries to homeless individuals in order to improve health and hygiene challenges associated with homelessness.

RESEARCH EXPERIENCE:

Oasis: Culture and Trauma Research Lab, Pepperdine University 12/2017 – Present

Dissertation Lab Member: Psychology Department, Thema Bryant-Davis, Ph.D.

- Engaged as a researcher to study the counseling experiences of individuals faced with various cultural traumas.
- Conducted a review of clinical literature to examine counseling recommendations and treatment plans for forms of cultural trauma across diverse populations.
- Co-authored regional and international conference presentations and poster sessions and engaged in monthly lab meetings.

Manager of Practice Operations: Michael J. Perrotti, PhD, Inc. (35-45 hours/week)
04/2014 – 06/2015

- Researched psychological disorders and their relationship to crimes for court reports.
- Outline patients' files for expert review in preparation for court.
- Interviewed and trained new employees to strengthen the research team.
- Scheduled and delegated tasks to other staff members to increase productivity and performance.

Research/Administrative Assistant: Michael J. Perrotti, PhD, Inc. (35-45 hours/week)
06/2013 – 04/2014

- Researched psychological disorders and their relationship to crimes for court reports and expert witness testimony.
- Outlined patients' files for expert review in preparation for court.
- Prepared documents explaining office rules and policies for new patients.
- Interfaced with attorneys to assist with practice-based needs.

CONFERENCE PRESENTATIONS & POSTERS:

- **Hooks, S.** (2018, November). *Racism and Race-Based Trauma: Therapy Models for Healing in the Black Community*, Presentation conducted at the National Conference on African Black Psychology, Tallahassee, FL
- **Hooks, S., Saavedra, A., Choi, L., Duncan, M., & Bryant-Davis, T.** (2018, September). *The Impacts of Racism and Race-Based Trauma for African Americans*, Poster presented at the 23rd International Summit on Violence, Abuse, and Trauma, San Diego, CA
- **Duncan, M. Hooks, S., Saavedra, A., Choi, L., & Bryant-Davis, T.** (2018, September). *“Keep the Faith: How Religion is Used as a Coping Mechanism for African American*

Survivors of Partner Abuse, Poster presented at the 23rd International Summit on Violence, Abuse, and Trauma, San Diego, CA

- Choi, L., Duncan, M., **Hooks, S.**, Saavedra, A., & Bryant-Davis, T. (2018, September). *Cultural Considerations: Asian Immigrant Families and Intergenerational Conflict*, Poster presented at the 23rd International Summit on Violence, Abuse, and Trauma, San Diego, CA
- Saavedra, A., Choi, L., Duncan, M., **Hooks, S.**, & Bryant-Davis, T. (2018, September). *Counseling Considerations: Immigration Related Stress and Trauma Among Undocumented Latina/o Families*, Poster presented at the 23rd International Summit on Violence, Abuse, and Trauma, San Diego, CA
- **Hooks, S.**, & Morcos, M. (2017, March). *The Stigma of Mental Illness in Faith-Based Communities*, Poster presented at the Christian Association for Psychological Studies 2017 International Conference, Chicago, IL
- Perrotti, M. & **Hooks, S.** (2015, March). *Assessments of Trauma Induced Dissociation and Disorders of Extreme Stress in Children and Adolescents*, Presentation conducted at the American College of Forensic Psychology, San Diego, CA

ABSTRACT

Experiences of racism and discrimination are a prominent concern within the Black community and often cause symptoms of stress or trauma for those who endure it. However, there are limited research studies which examine best practices and pitfalls for treating individuals of this population who struggle with race-based stress or trauma. This study uses a phenomenological approach to examine the therapy experiences of six clients, identifying as Black or African American, when discussing stress or trauma related to racism. Results identified several pitfalls, such as experiences of racism, color blindness, inattention, and countertransference, as well as promising practices, such as active listening, validation/affirming racial experiences, and authenticity. This study produced themes related to racial identity and experiences of racism. Lastly, participants provided recommendations for treating therapists who wish to be helpful, including efforts to learn about Black history and current events, use of consultation and continued review of the literature, and intake questions centered on racism and discrimination. A primary aim of this study is to decrease the gap in the literature for interventions to treat race-based stress and trauma in order to increase cultural competence among clinicians. Ideas for future research studies to build on these results are discussed.

Chapter I: Introduction

Contrary to popular belief, the concept of race is not representative of actual differences between groups but rather social constructions that developed over time. According to Smedley (1999), the term, “race,” was originally used to describe a breeding line or stock of animals, and later, European settlers in the Americas adopted it to describe populations of people from different origins. A Swiss scientist, named Linnaeus, first used this construct as he divided humans into four geographic categories and assigned hierarchical, individual characteristics to each group based off their common “fluid,” such as blood, phlegm, cholera, and melancholy (Hays & Grimmett, 2010). These categorizations idealized European ancestry and assigned pejorative qualities to people from all other regions. Others expanded on Linnaeus’ ideas, continued to build on a foundation that was Eurocentric in nature and suggested a hierarchy in which Europeans were at the top, Asians and Americans in the middle, and Africans at the bottom (Hays & Grimmett, 2010). By creating this hierarchy, Europeans became the ideal version of human beings, and people from other backgrounds were viewed negatively and as less desirable.

Through the construction of race and a corresponding hierarchy of certain races as superior to others, the concept of racism developed. According to Jones (2000) and Hays and Grimmett (2010), racism is defined as an ongoing, multidimensional, and dynamic process associated with the development and maintenance of a racial classification system, which is both institutionalized and hierarchical. Moreover, racism can be described at three different levels: individual, institutional, and cultural. While each level differs in its method or delivery, they are all intersecting and significantly impactful in society. Individual racism is both a belief that one race is superior to another and subsequent behavioral actions through which this hierarchy of

racism manifests (Franklin, 2014; Jones, 1997). The concept of individual racism serves as a foundation on which institutional and cultural racism are built. Jones (1997) and Franklin (2014) further describe institutional racism as (a) the maintenance of racist advantages for one group over another primarily through the use and manipulation of institutions or (b) limitations or the denial of choices, rights, mobility, and access for groups of individuals as the result of institutional practices. Cultural racism, like individual racism, may be understood as the belief of the superiority of one race's cultural heritage over another's at both the individual and the institutional levels (Franklin, 2014; Jones, 1997).

Chapter II: Literature Review

Racism

Due to differences in the perception of what is considered to be an act of racism, its prevalence in the United States of America today remains unclear. Carter and Murphy (2015) suggest that there are differences between the perceptions of what is considered to be an act of racism; specifically, between the perceptions of Whites, and those of Blacks. Recent surveys examining perceptions of the prevalence of racism between White and Black individuals found grave differences between the two groups. While 53% of Black individuals reported that discrimination against ethnic minority groups is a critical issue in American society today, only 17% of White individuals endorsed these same perceptions (Cox et al., 2012). Differences in perceptions of racism are also highlighted in many previous studies that suggest African American individuals report higher levels of perceived racism than other ethnic groups (Kessler et al., 1999; Pieterse et al., 2010; Pieterse et al., 2012). Specifically, Kessler et al. (1999) reported that 8.8 % of non-Hispanic Blacks report that they never experience day-to-day discrimination, compared to 44.4 % of non-Hispanic Whites and 19.5 % of others. Additionally, 24.8 % of non-Hispanic blacks endorsed experiencing day-to-day discrimination, whereas only 3.4 % of whites and 17.4 % of others endorsed these same experiences (Kessler et al., 1999).

Similarly, when viewing statistics of hate crimes, it is undeniable that African Americans are significantly more often reported as the targets of racially motivated crimes. According to the U.S. Department of Justice (2016), 58.9% of hate crimes (3,489 incidents and 4,426 victims) were motivated by bias against race/ethnicity/ancestry, making it the largest percentage of reported hate crimes. Of these reports, 50.2% were motivated by their offenders' anti-Black or African American bias (1,739 incidents and 2,220 victims), which is significantly higher than the

next largest group at 20.5% (720 incidents and 909 victims) motivated by anti-White bias (U.S. Department of Justice: Federal Bureau of Investigations, 2016). Through these statistics, it is evident that both dominant and non-dominant group members may experience race-based discrimination and violence. Although racism and discrimination impacts all racial and ethnic backgrounds, this study will focus on the experiences of Black/African American individuals due to its prominence within this cultural group.

Impacts

When considering the impact of racism on Black individuals direct and intergenerational effects can be seen in mental and physical health, as well as in environmental influences. Although much of the racism seen today is subtle, unconscious, and passive, the effects remain damaging to those within the community (Bounds et al., 2010). Racist treatment and systemic differences between African Americans and their White counterparts have influenced the overall quality of life for many Black individuals in the United States.

Depression

Russell et al. (2018) suggests that one reaction to racial discrimination may be depression. More specifically, they followed 695 African American women over 11–12 years and found that racial discrimination was a predictor for major depression (Russell et al., 2018). Previous studies presented similar findings across diverse populations of African American individuals, while controlling for a variety of different factors (English et al., 2014; Nadimpalli et al., 2015).

Anxiety and Trauma

As with depressive symptoms, research also supported anxiety and trauma as effects of experiencing racism (Graham et al., 2016; Pieterse et al., 2012). Graham et al. (2015), reported

that in a sample of participants who racially identify as Black, there was a significant positive association between the frequency of racist experiences and symptoms of anxiety. Previous studies also identified internalized racism as a mediator between racist experiences and symptoms of anxiety (Graham et al., 2016). Specifically, researchers note a relationship between negative thoughts and anxiety, as well as between self-criticism, self-degradation, self-alienation, and internalized racism. These suggest that internalized racism may be a mechanism through which racism connects to symptoms of anxiety for Black individuals (Graham et al., 2016). In a meta-analytic study by Pieterse et al. (2012), results demonstrated that common responses to trauma, such as somatization, interpersonal sensitivity, and anxiety, which are strongly correlated with PTSD, appear to be positively associated with negative racial experiences. The implications of these studies suggest a variety of negative mental health effects after experiences of racism and discrimination.

Societal

Other impacts of societal discrimination on families and individuals have persisted within the community as well. For example, McRoy (2008) describes the significant incarceration rate of Black individuals, which results in a lowered family income and an increased likelihood of children placed in foster care (thereby creating a cycle of poverty and/or incarceration). Additionally, African Americans appear to struggle financially as a community, making up a significant proportion of the homeless population (41.4%) despite only representing 13% of the overall population (Weisz & Quinn, 2017). Statistics on employment for Black American individuals suggest additional struggles. According to the U.S. Equal Employment Opportunity Commission (2015), there has been a significant increase in African American private sector employment (from 8.2% to 14%), however, the average median income for African Americans

was only \$33,321 in 2013, the last data collection available, which was significantly lower than the national median of \$51,017. Further research demonstrates significantly higher and more cyclical unemployment rates for Black individuals than their White counterparts, even when accounting for differences in age, education level, job type, and location (Cajner et al., 2017). These differences appear to account for employment decisions as well as the ability for African Americans to secure resources when they begin to experience struggles. Zambrana (2017) reported consistent research findings that when Black families experience major life events, such as job loss or illness, they often experience difficulty accessing economic or social resources and institutional policy support systems.

Historical Trauma

Although often overlooked or ignored, the effects of historical trauma on African American culture and the community at large have persisted over generations. Intergenerational trauma, which relates to the historical experiences of African Americans (i.e., slavery, segregation, discriminatory laws, and racist treatment), has given rise to a phenomenon known as posttraumatic slave syndrome, which has contributed to a culture of aggression, resentment, and sadness (Hanna et al., 2017; Leary, 2005). In recent years, several researchers started to examine the lasting effects of slavery as well as past and present-day discrimination within the African American community. Leary (2005) describes several lasting mental health effects of posttraumatic slave syndrome, including low self-esteem, racist socialization, and anger. Moreover, more recent research has reframed anger as a sensitivity to disrespect, resulting from centuries of intolerable shaming (Gump, 2010).

Many recent incidents of police brutality and racially motivated crimes have been brought to the forefront of the public's attention (i.e., Trayvon Martin, Eric Garner, Michael

Brown, Philando Castile, the murder of 9 African American Christians at a church in South Carolina, etc.). Hanna et al. (2017) suggest that incidents such as these may serve as modern day triggers for the African American community. Additionally, those who are direct targets of individual acts of racism and hate crimes are at risk for negative mental health effects. According to Pieterse et al. (2012), a meta-analytic review of the literature on the mental health of African American individuals in the United States suggests positive associations between negative racial experiences and anxiety, depression, and trauma-related symptoms. Within the study, psychiatric symptoms and general distress effects were reported as stronger than the effects of overall life satisfaction and self-esteem. Additionally, the greater the reported exposure to and appraised stressfulness of racist events, the more likely the individuals were to report mental distress. When considering the applicability of these results today, concerns of vicarious trauma may begin to arise. With frequent media coverage and incidents of harmful and fatal racist experiences towards Black individuals going viral, the Black community may be placed at greater risk for mental distress surrounding racism.

Physical Health

As with mental health, the effects of racism, historical trauma, and discrimination are visible in physical health and healthcare utilization within the African American community. Brondolo et al. (2012) describe barriers to practicing physical health behaviors, such as exercise, healthy eating, and mediating, and the relationship between obesity and aspects of institutional racism, such as residential segregation and neighborhood disadvantage. Similarly, literature suggests that negative mood states are mechanisms for strong associations between race-based stress and adverse health risks, such as smoking (Brondolo et al., 2012). Not only does racism

increase the chances of developing obesity or engaging in smoking, but it also impacts help seeking-behaviors.

In a meta-analytic review of the literature on racism and health service utilization, Ben et al. (2017) conclude that those experiencing racism are 2 to 3 times more likely to report reduced trust in healthcare systems and professionals, compromised communication and relationships with healthcare providers, and a general lower satisfaction with health services and perceived quality of care. For Black individuals, a history of exploitation, medical experimentation, policies targeting African American women, and federally funded reproductive health procedures (i.e., coerced sterilization) have contributed to present day mistrust of the healthcare system (Prather et al., 2016). Furthermore, these differences extend beyond African Americans' perceptions. Prather et al. (2016) reported that in a study of the quality of health care received by individuals from different ethnic groups, African Americans received lower quality of health care than White Americans, even when socioeconomic status, insurance coverage, and healthcare access were the same. Moreover, racism towards African Americans and its resulting mistrust of the community towards health care providers, has led to a series of health disparities within the community. For example, African American women living with HIV have expressed mistrust towards health care professionals, possibly stemming from historical experiences of African Americans with the health care system and current discriminatory practices from providers (Prather et al., 2016). Discrimination for these women was associated with delayed reproductive health screenings, such as HIV treatment adherence, pap smears, and mammograms, which further reflects increased health risks for African American women (Prather et al., 2016).

In addition to the stress and trauma produced by racism towards African Americans in the United States, it is also important to note the strengths of the community. Although identification

of the negative effects of racism is a necessary step, neglecting to include the strengths of a community may reinforce pre-existing, deficit-oriented perspectives, such as a tendency towards rage, low self-esteem, deviance, and psychopathology, most notably towards African Americans (Harrell & Sloan-Pena, 2006).

As seen throughout the literature, individual, institutional, and historical racism continues to impact the mental health, physical, and financial stability of the African American community. Its effects endure through the intergenerational transmission of trauma as well as racist attitudes within society. As suggested by Gump (2010), the past and present influences of racism support the notion that, without intervention, the past experiences of racial trauma in the African American community will continue to manifest in the future.

Therapy

While the presence of individual and community racism and its effects have been documented in several research studies within the past few decades, little information has been presented about treating clients with racist-based incidents as trauma. This may be related to the manifestation of racism and discrimination within clinical contexts. Harrell & Sloan-Pena (2006) describe racism as manifesting clinically through contexts of unequal access to services, a lack of clinical integration of racism experiences, the dynamics of racism within the therapeutic relationship, inadequate assessment and treatment planning, and an underutilization of strengths-based interventions to promote protection and coping resources. These pitfalls are well documented in the literature and remain prominent issues when providing therapy to the African American community.

Access

According to the U.S. Department of Health and Human Services (USDHHS, 2001), individuals from ethnic minority groups are less likely to have access to mental health care than non-Hispanic Whites, less likely to receive treatment for mental illnesses, and when treatment is accessed, the care is more likely to be of poor quality. Studies such as this reflect an overwhelming need to further examine barriers to mental health treatment in these communities. The study went on to mention that disparities also stem from current and historical racism and discrimination, which has impacted mental health and further contributed to lower social, political, and economic status (USDHHS, 2001). Additional studies examining attitudes, disparities, and help seeking patterns for mental health services further highlight this need in the African American community. For example, African Americans report more positive attitudes towards mental health services than other racial groups (Shim et al., 2009). This study demonstrates a need to move beyond ideas that attitudes towards mental health are mediating the relationship between race-based disparities and treatment seeking, and instead begin to explore more client, provider, and systemic mediators.

While the effects of racism appear to be robust, impacting social, mental and physical health as well as help-seeking patterns, clinicians may lack adequate understanding about its effects. Carter (2007) suggests that one major aspect that contributes to the problem of racism and discrimination and its impact on mental health is the failure to understand its effects. As clinicians make decisions within the therapeutic process, it is important for them to understand conceptualization methods and possess an awareness of personal biases. Mental health professionals often apply universal, color-blind standards, which ignores the impact of race and culture (Carter, 2007; Hansen et al., 2006). By ignoring race in the therapeutic environment,

ethnic minority clients may be less understood and feel less safe to discuss distressing and traumatizing experiences such as racism.

Color Blindness

Concerns about color blind attitudes and methods in therapy have been recognized within the Black community. In a focus group of African Americans in one community, Thompson et al., (2004) found that most participants viewed psychologists as older, White males who could not be understanding of the economic and race-based realities they face. The study also noted that individuals with therapy experience reported a fear of communicating issues such as racism, discrimination, exposure to community trauma, and economic difficulties due to beliefs that the therapist would not understand. Additionally, clients indicated that they would attend counseling if they felt clinicians made sincere efforts to understand their communities. Participants cited community outreach and education in the Black community and African American reading materials in the waiting room as beginning steps to building trust between African Americans and mental health professionals. These initial stages of building trust can be extremely important to engage the community and begin addressing difficult topics such as racism and discrimination.

According to Polanco-Roman et al. (2016), individuals who cope with race-based trauma through passive methods, such as keeping it to themselves, are more likely to develop dissociative symptoms compared with those who employed active coping methods, such as talking about the experiences. This suggests that if individuals are able to have a positive experience in therapy, where they can openly discuss their traumatic racial experiences, they are less likely to develop trauma responses, such as dissociation.

Clinical Understanding

In addition to bridging the gap between clinicians and the African American community, research has also demonstrated the need for clinicians to change their understanding of racism. Several authors have discussed the lack of inclusion of racism as a stressor in the criteria for trauma diagnoses, such as PTSD (Bryant-Davis, 2007; Carter, 2007). Regardless of the client's racial or ethnic community, Bryant-Davis (2007) notes that, when appropriate, it is important to consider experiences of racism as potential sources of traumatic stress in order to better capture the significance of the individual's experiences. Effects of racism, such as hypervigilance, avoidance, dissociation, numbing, or emotional distress, are consistent with traumatic responses and may further highlight the importance of the traumatic stress label (Carter, 2007; Polanco-Roman et al., 2016). Additionally, clinicians must also change the ways in which they discuss and respond to topics of race. They must give sufficient attention to racism, race-related traumas, and race-related positive experiences and respond with validation, competence, and compassion, as they would with other traumas and experiences (Bryant-Davis, 2007).

Avoidance and discomfort with the exploration of race-related topics such as racism, discrimination, and positive race-related experiences can sometimes reflect a lack of awareness or clinician bias. Bryant-Davis and Ocampo (2006) report that counselors should explore their own racial identity; study the history, power, and privilege associated with differing ethnic groups; understand the traumatic dynamics of racist events; and learn the recovery process. Focusing on these aspects before meeting with ethnic minority clients, and during the initial phases of treatment, may be helpful in strengthening client trust in the clinician. This work will aid the clinician in identifying their own biases and exploring common racial experiences and responses within different communities before addressing them with the client. These

suggestions, however, are only initial steps in the therapeutic process. According to Bryant-Davis and Ocampo (2006), the following additional actions should also be employed: (a) highlighting the idea that the clinician and client can have similarities as well as differences, which are welcomed for discussion in therapy, (b) explaining one's process and approach to therapy, and (c) conducting a full assessment of trauma, which should include race-based incidents of trauma. It is important convey a sense of openness and understanding of racial differences and experiences in order to make the client feel safe to address topics such as race in therapy (Williams et al., 2014). Without this sense of safety, clients may continue therapy without bringing up these distressing or traumatic stressors or decide not to return to therapy.

Race-Based Trauma

When considering treatment, several researchers have suggested strategies for clinical work with survivors of race-based trauma. Mainstream therapies and interventions such as Cognitive-Behavioral Therapy (CBT), Eye Movement Desensitization and Reprocessing (EMDR), and Prolonged Exposure Therapy, as well as unique and multicultural-informed therapies and techniques including feminist psychodynamic therapy, storytelling, racial identity development, and spiritual development, amongst many others, have been suggested for working with survivors of trauma (Bryant-Davis & Ocampo, 2006; Daniel, 2000; Villena-Mata, 2002; Wyatt, 1990). When addressing experiences with racism, however, it may be necessary to make cultural adaptations to the pre-existing modalities in order to treat the individual. Williams et al. (2014) outlines this process for providing Prolonged Exposure Therapy, with cultural adaptations to African American survivors of trauma and race-based traumatic experiences, for treatment and prevention of PTSD. Specifically, the cultural additions introduced were as follows: (a) inquiring about race-based trauma, even after administration of trauma assessments, (b) addressing how

racism can be a factor in the development of PTSD during the psychoeducation phase of treatment, (c) spending extra sessions on building rapport and developing trust, (d) assigning activities that incorporate situations related to race-based trauma and racism, ensuring that the clinician has an appropriate level of comfort surrounding race before conducting imaginal exposure, (e) acknowledging that racism may still take place but likely not to the extent of their trauma, and (f) focusing on concepts that relate to Black American culture (Williams et. al, 2014). Clinicians should continue to research treatments such as these before providing treatment, in order to further their knowledge about how to provide culturally informed care in ethnic minority populations, which are likely to be impacted by racism and its effects.

Emerging Frameworks

Within educational and clinical contexts, multicultural curricula have been developed to create and promote less Eurocentric methods of working with diverse populations (Harrell & Sloan-Pena, 2006). Modalities, such as Womanist therapy, focus on the specific needs of the Black community. This treatment modality acknowledges the failure of multiple styles of therapy to include the intersection of race and the female gender and, instead, uses community strengths and traditions, such as narrative models, bibliotherapy, biblical stories, group counseling, and community resources, to treat African American women (Williams & Frame, 1999). New strategies have also been developed at the community level in recent years. Community Healing Network and the Association for Black Psychologists conjunctively developed the concept of Emotional Emancipation (EE) circles. These grassroots mobilization efforts form safe spaces where Black people can work together to overturn the lie that they are inferior (Grills et al., 2016). EE circles may serve as helpful adjunctive services for clients struggling with issues of race-related stress or race-based trauma. While the aforementioned

interventions and styles of therapy are few of many options, they all highlight the needs of the individual in therapy and the larger community. Through intention, therapists may select an appropriate style of therapy and interventions that are most compatible for African American survivors of racism.

Chapter III: Methodology

While the literature surrounding the impacts of trauma are plentiful, research examining the impacts of race-based trauma and stressors is minimal. Notably, very few studies give space for Black and African American individuals to discuss racism and their experiences in counseling. To better inform the literature, this study seeks to understand the experiences of Black and African American survivors of racism in counseling. Specifically, the study aims to answer the following two questions:

- 1) What was helpful when race-based trauma and/or stress was discussed in therapy?
- 2) What was not helpful or appeared to be more damaging?

Participants

After approval to begin data collection from the Institutional Review Board (see Appendix A), seven participants were recruited for this study with convenience sampling, via placement of flyers (see Appendix B) within community clinics and private practice offices (see Appendix C), as well as places of worship, barber shops, hair salons, and other businesses with a large Black consumer base in the Greater Los Angeles and Orange County areas of California. Sampling also occurred through online and social media postings on pages related to Black health and wellbeing, as well as via snowball, or “word of mouth,” method. The initial interview process took place over the phone, during which the interview process was described and the individual was assessed for inclusion and exclusion criteria. Seven individuals were interviewed for the current study; however, one of the interviews needed to be excluded as she disclosed that she never discussed her experiences of racism with her treating provider. This resulted in a total number of six interviews being included in the current study. Once participants were selected, a formal, semi-structured interview took place via secure video conference calls on

securevideo.com. In person interviews were unable to be conducted due to the impact of COVID-19 health risks and related restrictions.

As criteria for inclusion, individuals had to be 18 years or older and identify as Black or African American. The individual must have experienced a form of racism (i.e., microaggressions, discrimination on the basis of race, hate crime, etc.) and discussed an experience of racism during a current or past course of personal counseling treatment. Participants consented to an audio recorded interview for the purpose of the study. Those who did not meet the aforementioned criteria were excluded during the initial phone screening interview. Those who met criteria for the study and agreed to participate received \$25 gift cards as incentives for their participation in the study. A total of six participants were recruited for the purpose of this study.

Procedure

Upon being contacted by interested participants, a digital copy of informed consent (see Appendix D) and demographic questionnaire (Appendix E) were emailed to review, complete, sign, and return digitally. The informed consent discussed the individual's rights as a participant in the study. It was noted that as a participant, one can choose not to answer any questions (see Appendix F) they feel uncomfortable with or end the interview at any time they feel they do not wish to continue. Additionally, the informed consent noted that the interviewer could use their clinical judgment to stop the interview at any time if they feel the participant is distressed and needs to discontinue or take a break. Participants were informed that their identities would be kept confidential and that the information from the interview would be combined with other narratives to support the research. Once participants agreed to the informed consent terms, the interviews were scheduled for the process of data collection to begin. Interviews later took place

via secure video conference platform due to the limitations and risks associated with the COVID-19 pandemic.

Data Analysis

Phenomenological approaches to research are characterized as deep gathering of information through qualitative studies that aim to examine individual experiences of the individual (Lester, 1999). These approaches place an emphasis on the importance of individual experiences and interpretations, which allows researchers an increased understanding of subjective experiences from an individual's perspective (Lester, 1999). For this reason, phenomenological approaches are frequently used as a way to gain more specific understandings of a group of individuals as opposed to using quantitative studies and generalizing the data to larger groups.

Once the data has been gathered using a phenomenological approach, the researcher summarizes the responses identifying common themes and/or issues discussed by participants, researchers link the findings to previous literature, and then the implications are further discussed (Lester, 1999). These steps are central to the process of the approach as this is where data analysis occurs, in order to draw meaning from the participants' responses.

This study utilized a phenomenological approach to data collection and analysis in order to highlight the experiences of African-Americans who have experienced racism and have attended therapy. The purpose of using this approach was to examine individual experiences of racism and their preferences and struggles of discussing racism during the therapy process. Cultural struggles, such as racism, can often be uncomfortable for therapists and clients to discuss. Utilization of a phenomenological approach can allow clinicians to better understand

experiences of those who attend therapy, and begin to explore best practices as well as pitfalls to addressing and treating racism and race-based trauma.

Additionally, this study applied a “bracketing” method in order to control for the researcher’s personal and emotional connection to the topic at hand. Tufford and Newman (2010) describe bracketing as a method used within qualitative research to decrease the harmful effects of preconceptions or biases related to the research project. More specifically, literature suggests that bracketing be used when there is a close relationship between the researcher and the research topic, in order to protect the researcher from the effects of examining emotionally challenging materials (Tufford & Newman, 2010). For the purpose of this study, bracketing consisted of acknowledging reflexivity, examining preconceived beliefs of the researcher through self-reflection, creating dialogue with other lab members, and utilizing an additional coder and auditor when analyzing the data.

Bracketing

When utilizing a phenomenological approach to qualitative research, it is also important to consider the role that the researcher’s own identity and experiences have on the interpretation of data. Although the intention of phenomenological approaches is to examine the personal experiences of a group of people through their own perspectives (Coolican, 2014), the approach also acknowledges that it is inevitable that researchers will interpret transcripts and data through their own unique lens. To minimize the interference of bias and preconceived assumptions on data interpretation, the researcher and coder for this study engaged in a process of bracketing, due to the researcher’s choice to examine a topic that closely related to their personal experiences.

The researcher, coder, and auditor discussed their intersectional identities and related experiences to better understand their connections to the topic of the study. The researcher and coder both identify as biracial women, with identities including Black/European and Black/Cuban. Within these identities, they reported different experiences of acceptance and rejection by family members based on their skin complexion, family history, and cultural background. Additionally, the researcher and coder both attended Predominantly White Institutions (PWI's) throughout their training in clinical psychology and described numerous experiences with microaggressions, including challenges with Eurocentric beauty standards and colorism amongst peers, professors, and supervisors. The auditor in this study identifies as an African American woman, with personal and professional experiences with racial stress and trauma, including in their clinical practice, academic research, teaching, and advocacy work. It was noted that the researcher selected the topic of this study based on their personal experiences of racism, family history, and the high prevalence of symptoms related to race-based stress and trauma amongst her Black and African American clients. The coder for this study reported that her decision to participate as a coder was based on interest and similar personal connections to the topic.

Chapter IV: Results

The Survivors of Racism

In this section, the six participants whose interviews were included in the study will be described. To establish inclusion criteria, all participants filled out a demographic survey prior to participating in an interview. Demographic surveys obtained by each participant, as well as information obtained within the interview, will be used to describe each participant in the study. All participants were over 18 years of age, identified as either Black or African American and reported either a previous or current engagement in counseling services.

Participants

Participant 1. The first participant in this study was a 27-year-old self-identified Black female. She further described herself as cisgender and bisexual and did not participate in a religious, spiritual, or faith background. The participant reported that she earned an advanced degree at the master's level and employed as an "Actor" with an annual income less than \$35,000. She reported that she first sought mental health treatment from a psychologist for the treatment of trauma, previous suicidal ideation and attempt, and relational problems. She was unsure of the theoretical orientation utilized during this course of treatment.

Participant 2. The second participant was a 30-year-old self-identified Black, Egyptian male. He described his marital status as single and identified as cisgender, heterosexual, and with an Islamic/Muslim faith. He earned an advanced degree at the master's level, was working towards his doctorate, and employed as a "Case Manager," earning between \$60,001 and \$70,000. He began psychotherapy treatment with a Licensed Clinical Social Worker following a romantic break-up and was unsure of the treatment modality used.

Participant 3. This participant was a 32-year-old, self-identified Black, Haitian American, male of the Christian faith. He was married and identified himself as cisgender and heterosexual. He also had an advanced degree at the master's level. He described his job as a "CEO/Founder" and reported that his annual household income (combined with his spouse) was greater than \$100,000. He sought mental health treatment from a Licensed Clinical Social Worker for race-related depression and trauma, and his provider used a Cognitive Behavioral Therapy approach throughout his treatment.

Participant 4. This participant was a 27-year-old self-identified Black female. She described herself as cisgender and heterosexual, and she identified with the Christian-Baptist faith. She earned an advanced degree at the master's level, was employed as an "Early College Coordinator," and chose not to disclose her annual income. She sought mental health services based on a history of depression, adjustment difficulties, and race-based stress caused by workplace racism. She was unsure of the type of mental health professional she saw but knew that she was treated through a psychodynamic lens.

Participant 5. The fifth participant was a 30-year-old, self-identified Black/African American, cisgender, female. She was married, identified as heterosexual, and practiced a Christian faith background. She held a bachelor's degree, was employed as an "Accountant/Administrative Assistant," and earned a combined annual income with her husband between \$35,000 and \$60,000. She sought mental health services due to grief and loss, stress, and family relational concerns. She indicated that she was unsure of the type of clinician she saw and did not know the treatment modality used.

Participant 7. The final participant was a 25-year-old self-identified Black/African American, cisgender, male. He described his marital status as single and further identified as

heterosexual. The participant noted that he was of the Christian faith. He held a bachelor's degree and was working on obtaining a master's degree. He noted that he was employed as an "Adult Outpatient Mental Health Specialist" and earned an annual income between \$35,000 and \$60,000. The participant reported that he first sought mental health services from a Marriage and Family therapist due to a history of depression, bullying, and grief and loss. He indicated that he was unsure of the theoretical orientation used throughout his treatment.

The participant sample reflected individuals from several ethnic backgrounds, a balance between male and female genders, and a wide range of income-levels. Participants sought therapy for a variety of presenting concerns. Although the sample was diverse in many ways, there were also several notable similarities within the group. Four of six participants identified with a Christian faith background, which is consistent with much of the literature about the Black American community (Harrell, 2000; Hays, 2009). Additionally, all participants had obtained a minimum of a college degree, with most having obtained a master's. Thus, the sample population had a higher educational level than the average Black American. Similarly, the age range represented within the sample is limited from age 25 to age 32, which limits the ability to capture generational differences.

Interview Themes

The purpose of this study was to analyze the experiences of Black individuals discussing racism in therapy, in order to inform clinicians of potential therapeutic pitfalls and promising practices. The researcher used a semi-structured interview format with categories including race/identity, experiences of racism, therapeutic experiences, and therapy recommendations (see Appendix C). Throughout the interviews, several themes emerged within each category.

Racial Identity

As racial identity was discussed throughout the interviews, several subcategories began to emerge: (a) racial socialization, (b) multiple identities, (c) acceptance, and (d) development. Participants noted that these subcategories all contributed to their overall racial identity. Each topic is discussed further below.

Racial Socialization. Many participants spoke about the role that their parents played in their understanding of racism, and their ability to cope with race-based challenges. Of note, it appeared that male participants within the study had more explicit conversations than female participants about racial identity and experiences of racism. For example, Participant 7 described conversations at home with his parents, which aimed to boost his pride and confidence in his skin color and combat comments he would eventually hear from his peers. He stated:

Having my parents tell me “No, your skin is beautiful,” helped out a lot. Now, I can shake those things off and wear it with a lot of pride...and I think it's helped me in the workforce where the reality is, there's a lot of little subtle microaggressions, little subtle racism, things like that. You have to shake them off, as sad as it is, just because that's what society is. And for us to be able to do our jobs and to move up, there are certain things we have to be able to overcome and move past, so it's helped with that.

Participant 3 also described conversations with his mother about race, which aimed to celebrate difference and minimize shame. He recounted his first memory of these conversations:

First day of kindergarten, I'll never forget this. And I thank her for doing this. My mom pulls me aside and says, “Just remember that you're different,”...I think my parents did a really good job at making me know my worth and teaching me that even though I'm different, it doesn't mean that I'm less than.... So, I'm not surprised when I'm passed up

for an opportunity or when someone says some silly stuff like, “You speak well,” or “You dress well.”

Although racial socialization for some may present as increasing self-confidence and evoking pride in one’s background, another important aspect is discussing the harsh reality of racism faced by the Black community. Participant 2 described frank comments by his mother about unfair treatment he will encounter from others. He reported:

It reminds me of something my mom always says to me and my brother. She says, “Yeah, they can do even worse than you. And guess what, they'll get away with it, and you won't get away with it.”... Any time, in terms of staying out late or stuff like that or even breaking little rules, she would say, “No, no, no, no, no. You cannot. They will get away. You will not. You’ll wind up in jail. You will get the charges. You will be the one.”

Conversely, only one female participant described conversations with her parents about racial identity or race-based stress. However, she reported that the conversations were r confusing and vague. When describing the interactions with her parents, Participant 5 stated:

When I was growing up, my parents would always tell me one day I would understand, because sometimes I would be telling them a story, and they would ask the race of the person I was telling the story about. It would always throw me off. I remember it would make me so mad, I'm like, “Why does that even matter? What does that have to do with anything?” And as a kid growing up, it was weird because it’s like they were raising me to not see color, but then during certain situations, they would ask me questions like that, and it confused the heck out of me because I'm like, “Well, wait a minute, why are you

even asking that? How is that relevant to anything that I'm saying?" And they're just like, "Well, one day, you'll understand, because you're Black."

Participants' experiences of racial socialization during childhood is consistent with literature about racial identity development. Many studies examined the impact of racial socialization and found that racial socialization strengthens identity development for Black American children and adolescents (Harrell, 2000; Lee & Ahn, 2013; Neblett et al., 2009; Scott, 2003; Seaton et al., 2012). Literature also supports the trends identified in this study that racial socialization differs for girls and boys (Davis Tribble et al., 2019; McHale et al., 2006; Winchester et al., 2022). However, specific differences and reasoning appear inconsistent across the literature. Several studies documented that in regard to racial socialization, Black girls report receiving more messages from parents about racial pride but also seem to carry more internalized racism (Davis Tribble et al., 2019; Winchester et al., 2022). However, consistent across all studies, racial socialization is highlighted as an important aspect of Black racial identity development.

Multiple Identities. Participants discussed aspects of various forms of identity across the six interviews. Each individual spoke about the importance of holding multiple identities simultaneously, and the resulting challenges or benefits they experienced as a result. These included conversations surrounding ethnicity, gender, religion, and various micro-cultures they described as impactful to their racial identity. Although all participants self-identified as racially Black, there were differences across ethnic backgrounds and other forms of identity. Throughout the interviews, participants discussed the ways in which they simultaneously navigated multiple aspects of their identity in therapy as well as in their everyday lives. For example, Participant 1

spoke about how cultural expectations for women influences her response to racism at times. She noted:

There's also some self-doubt like, "What if they were trying to be nice?" Or what if I was like, "Really? You can't ask Black people that," and then it hurt their feelings or something. I don't know. But that probably has to do with being a woman. You're supposed to be nice to everyone.

When discussing the decision to attend therapy, Participant 4 reported that she began searching specifically for a Black therapist. However, she stated that once she found a therapist whom she felt would be a good fit, she began to realize that she had not considered the role that intersectionality might play. Within her interview, she described the process of readjusting her expectations for having a racially matched therapist. She stated:

I also realized that being Black is not a monolith; we are all not the same. I realized that, yes, although I was searching for a Black therapist, some Black people grew up differently financially, socially, or regionally. So, I was realizing that as I was going to therapy, and I was like, "Shoot. I picked a Black therapist, and I like them, but they're different. I don't know if they understand me. I'm not even from this side of the country, and they just seem like they grew up differently, or they were socialized much differently than me."

Similarly, Participant 3 described a moment in therapy when his Christian values differed from his experience and reactions as a Black man. When discussing his therapist's comments to him about forgiveness towards police officers who murdered his friend, he stated:

It made me angry and personally, taking off the Christian hat, I don't think there will ever be forgiveness. And if I'm going to be truthful, I think seeing that officer locked up would be the minimum that should happen to him, to be honest with you.

Responses from participants highlight the process of navigating conflict within identities for clients, as well as limited responses from clinicians to acknowledge multiple client identities within the therapy process. Although there appears to be a gap in literature surrounding the process by which individuals navigate conflicting beliefs tied to intersectional identities, identity development models for biracial/multiracial individuals may help in understanding this process. Many identity models exploring biracial identity of various different racial groups have identified an “*alternating*” category, by which individuals alternate back and forth between cultural frames according to situation (Hong et al., 2000; Huynh et al., 2011; LaFromboise et al., 1993; Phinney & Devich-Navarro, 1997). This cultural frame switching was also evidenced by participants in this study as they alternated across identities of race, religion, and gender. Similarly, participants discussed aspects of intersectionality, wherein multiple of their marginal identities were compounded to discuss their concerns. These method of describing concerns is consistent with an intersectional approach, which examines interactions between the interactions of multiple socially constructed categories that lead to unequal treatment (Seaton et al., 2010).

Acceptance. Acceptance was one of the most strongly identified topics regarding racial identity discussed amongst participants. While each participant's experience was different, they all described feeling distanced or rejected by their peers in various settings.

When discussing challenges amongst White peers, several participants described loneliness, confusion, and tension. For example, Participant 4 described differences between

growing up in a multicultural area, and then feeling rejected by her White peers while attending a predominantly White college. She noted:

I realized that racist people are out there, and they will treat you differently because of your skin color, your hair texture, and it wasn't until then that I just felt kind of off.

Everywhere I went, I was used to people liking me and being friendly. Feeling that coldness for the first time was very out of body. I couldn't explain what was happening.

Participant 1 stated:

I think I just feel like I'm not a part of the group, and that's a feeling of pretty much my entire life. But it just sucks when it has to do with race, because then you start thinking, "Do they think they're better than me?" What is this disconnect here? Because they don't actually really know me.

In addition to race-related challenges with out-group acceptance, most participants also discussed challenges with in-group acceptance amongst Black peers. For some, they reported that others were dismissive of them based on cultural differences within the community. For example, Participant 1 stated:

In undergrad, when I was there, people were telling me that I wasn't Black and basically that I was white. I wasn't Black enough, because I didn't really know the slang or the culture, like music, movies, all that kind of stuff. And I was just kind of made fun of because of that.

Colorism and intersectionality were also factors reported as impacting acceptance amongst Black peers. For those with lighter complexions or differing ethnic intersectional identities, they often reported a lack of inclusion. Participant 5 described the observation:

With the Black kids, I noticed growing up, there was always some type of division between the mixed kids or the light-skinned kids and the dark-skinned kids. Even within the Black community, I felt like there was colorism and people still trying to figure out where they fit in.

Participant 5 later described her own experience with colorism based on other's assumptions that she was multiracial/multiethnic. She noted:

I've experienced colorism within the Black community, especially when I was little, like being picked on for not being darker, being made fun of because they thought, "Oh, she's mixed," which wasn't acceptable to them. Even when I turned and told people, "This is not the situation here," it didn't matter. I found myself constantly in situations where people would tell me what my race was, and it didn't matter what I said. But it just got to the point where I just thought, whatever you want to think I am, okay.

Participant 2 described a similar set of experiences based on his Egyptian heritage. Despite having two Black parents, one of whom is African American and one of whom is Egyptian, he noted that other Black individuals often rejected his Blackness. He commented:

With Blacks, I feel like at times, people don't paint me for Black. And so, sometimes, it's like, I have to prove it to them. But I don't necessarily feel like I ever do. Recently, I was dating this girl, and because it was Black History Month, she would tell me, "It's only half your month, because you're Egyptian and Black." And I'd say, "Egyptian is Black." She told me, "No, you're not."

Colorism was described by participants with darker skin tones as well. For example, Participant 7 spoke to the challenges that presented with a combination of cultural differences with Black peers, in addition to having darker skin. He stated:

I dealt with things like being called Oreo or things of that nature, especially early on. I had a friend group of all White kids because that's what was around. There was literally one other Black kid in my school. So, once you got to middle school, it merged a little bit. I was hearing things I hadn't necessarily heard before as far as being made fun of for my skin color. And it was weird just coming from other people of my ethnicity, because I was expecting to be welcomed a bit more, and it wasn't necessarily like that. It was a bit of a culture shock.

Participants throughout the interviews described a lack of acceptance beginning during childhood. Many recounted experiences in which they were rejected by peers of different cultures, as well as by other Black individuals. While there is limited research surrounding the topic, both in-group and out-group acceptance has been discussed within the literature. For example, Seaton et al. (2009) suggest that ethnic minority youth often experience racism and discrimination during childhood. Other studies show that it is common for Black individuals to be discounted or rejected by other Black individuals, for reasons including immigration status (Whittington et al., 2021), colorism and social context (Harvey et al., 2005), and multiracial/multiethnic identity (Franco & Franco, 2016; Franco et al., 2016).

Development. Many participants described a process through which they discovered their current views on their racial identity. Overall, the development described by participants seemed largely influenced by the aforementioned factors of racial socialization and intersectionality, which led to their understanding of history. Across interviews, when describing their current identity, all participants reported feelings of pride. For example, Participant 3 described a sense of pride associated with Blackness and Haitian heritage, based on the resilience rooted within the culture's history. He stated:

I think Haitian people just have a sense of pride about their culture, their heritage. We're the first Black independent nation to gain their independence from a European power. So, I carry that with me. I don't think it's right to separate myself from Black and African American—we all fall under the same spectrum. But there is that sense of pride from being Haitian, if you will.

Participants who identified as African American reported a similar sense of pride. For example, Participant 4 cited that her sense of pride stemmed from her social context. She stated, "I grew up around Black people. I've always loved being Black. I feel good about my identity as a Black person. I've never wanted to be anything else other than Black. Yeah, I love it." Conversely, Participant 5 described her struggle to develop pride in her Black/African American identity. She stated:

The times where I was reminded I was Black, it was a negative thing, like, being followed in the store. Or even at school, Black kids have it so hard, and the school system doesn't even realize that. K-12, you're learning about the American hero, and you're not even learning the right story. And then any time that Black culture is brought up in school, it's always linked to slavery. So, for a little kid growing up, that's what you learn your identity is from; I descend from slaves, and that's it. That's what you get, not I descend from kings and queens from a different land, a different nation. We had our own language. We had our own community. We had our own currency. We had our own hierarchy. We had all of these systems in place. And even if you don't identify as African American, just being Black in general, there's power in your ancestry. And Black kids don't have that.

When discussing the development of one's racial identity, participants acknowledged upbringing and knowledge of Black history across interviews. These findings are reflective of previous research surrounding racial socialization, Black history knowledge, and racial identity development. For example, research by Adams-Bass et al. (2014) found that in a sample of African American youth, those with higher Black history knowledge were better able to identify stereotypes and less likely to endorse negative stereotypes as valid representations of Black people (internalized racism). The study also suggested that Black history was strongly associated with racial socialization and racial identity for Black youth, which is consistent with racial development described by participants.

Experiences of Racism

Consistent with the inclusion criteria for the current study, all participants reported a history of personal experiences related to racism. In addition to the experiences they discussed with their therapy providers, the participants also discussed numerous other encounters with racism throughout their lives. Across interviews, themes of police encounters and microaggressions arose as types of experiences with racism. Themes of emotional responses to racism were also highlighted by interviewees. Additionally, the participants spoke about the use of community support and expressive arts as methods to cope following racist experiences.

Police Encounters. When describing personal experiences of racism, more than half of the participants reported negative encounters with the police as their most salient confrontation. Each narrative described an incident of police misconduct with elements of racial profiling and intimidation. Many participants described feelings of confusion and reported that their encounters began with minor traffic infractions, which were met with overreactions by police. For instance, Participant 7 recalled, "I got pulled over for a rolling stop and had five cops roll up

on me, and I was like, ‘Why? What's going on here?’” Similarly, Participant 5 felt fearful and confused after a traffic violation which resulted in being pulled over. She stated:

They blocked us in, and my husband went to get out of the car because technically, we hadn't been pulled over. There were no lights, no sirens, they didn't say, “Hey, pull over,” or “Stay in your vehicle.” But it was obvious that something was happening...when my husband tried to get out of the car, they started yelling at him to get back in the car and to not move as if we were being detained for something... It made me wonder, if we were White, would this have happened to us? I was terrified. I couldn't trust it. I immediately felt like crap.

Participant 3 also described his fear connected to an overreaction by officers during an interaction with the police. He reported that his encounter was an incident of police brutality involving himself and several friends. He stated:

I had a friend who was shot and killed by a police officer, and I was there for the incident.... There were police officers who drew their weapons on us...who were literally laughing and telling jokes, as my friend bled out. After the whole situation, the city where this police officer was working at was named police officer of the year. After that, we had to go to court to seek justice for him and deal with the corrupt justice system. Dealing with a corrupt judge who wouldn't allow our side of the party to mention certain things.

Participants reported narratives that revealed tension between the Black community and the police. This has been well documented within the literature and is also reflected in current events, such as the murder of George Floyd, Ahmaud Arbery, and Breonna Taylor. Research surrounding the topic demonstrates that the Black community consistently reports high rates of negative police contact, including harassment, police brutality, and poor service to 9-1-1 calls

(Payne et al., 2017, Weitzer et al., 2008). Recent studies also document the disconnect between law enforcement officers and the Black community, with findings that police officers do not believe that tension exists in part due to violence initiated by law enforcement officers (Calvert et al., 2020). Notably, in this study, participants discussed similar difficulties, including overreactions by law enforcement officers, which evoke feelings of fear, confusion and anger.

Microaggressions. All participants reported difficulty with microaggressions in various settings. Many reported that microaggressions at school and in the workplace were the most difficult to manage, due to limitations on their ability to respond and still be considered professional. For example, when describing interactions with her peers in school, Participant 1 stated:

I think most of the discomfort that I had was in the form of jokes. People would tell racist jokes all the time, and if I were ever to get irritated with someone or visibly become upset, then people would always be like, “Oh, she’s about to act Black,” and it was kind of like this warning like, “Oh, she’s going to act Black.” And I was just standing there kind of frustrated.

Similarly, Participant 4 also discussed frustrations in the workplace. She stated that several comments have been made which suggest perceptions about her intelligence. She noted, “I would just say just in the workplace and educationally.... People don't expect me to be educated, or I guess me having a master's degree is a surprise, which I don't know why.”

For Participant 4, her most difficult experiences with workplace microaggressions involved situations with her boss. She reported, “I just noticed it was always a harsher response or harsher tone towards the Black people or people she just didn’t really like.” Lastly, Participant

3 also spoke to these workplace challenges, while further identifying a need for intervention in this area. Specifically, he stated:

There has been microaggressions and racism that I've dealt with going up the corporate ladder. I actually think that could be a very good niche service—counseling for minority corporate professionals. I think that's needed, because we get to a point in our career where we start experiencing imposter syndrome. We start feeling like there is a ceiling, which people of other cultures don't really experience. I think that would be a wonderful niche if that started to be addressed.

When discussing microaggressions, most participants discussed occurrences of microaggressions in academic and occupational settings, which is also emphasized within research. These challenges with microaggressions are based on unwelcoming environments, which are influenced by institutional racism, and limited diversity of employees in high positions of power (DeCuir-Gunby et al., 2020; McCabe, 2009). The literature describes microaggressions in the workplace as being primarily microinsults, including ascription of intelligence, assumptions of criminality, and pathologizing cultural values/communication styles (DeCuir-Gunby et al., 2020). Research supports that microaggressions impact African Americans throughout the entire educational pipeline and have a negative effect on mental, physical, and emotional wellbeing, which can also impact their academic performance (Parsons, 2017; Smith et al., 2020). Additionally, increased racial microaggressions were predictive of lower job satisfaction for African American individuals (Smith et al., 2020). Participant responses in the current study also reflect job dissatisfaction, difficulties in academic settings, and a desire for mental health intervention to mitigate the impacts of microaggressions, all consistent with documented concerns (Parsons, 2017; Smith et al., 2020).

Emotional Responses

Throughout the interviews, participants described their emotional responses to racism. Although physical and somatic symptoms varied, themes of anger, confusion, anxiety, and self-doubt/doubt related to racist experiences emerged as being the primary responses in the aftermath of racist encounters. For instance, Participant 2 stated the following when describing his reactions:

My heart is racing, my palms are sweaty, I'm alert, I feel like I can hear my heart pounding in my chest a lot of times, and I feel like my ears are ringing...even to the point that sometimes it makes me sick to my stomach. I feel like I'm nauseous, or I have an instant headache that comes on. But with that, it ends up like anger and like confusion.

Similarly, Participant 5 described anger and confusion when witnessing acts of racism or experiencing it first-hand. She noted:

I'm angered, because I literally can't understand why someone would want to kill somebody or hurt them or basically erase them off the face of the earth because of something that they literally have no control over. So that's usually my first immediate response is just anger, and I guess you could say confusion. Because I'm the type of person where I try to put myself in other people's shoes to understand as much as I can, and that's just something I can never—I don't see a justification, ever, to just hate someone because they're Black.

Participant 4 described the mental process of working through her emotional responses. She reported:

For me, it's always been a mental battle. I've always felt gaslit. I've always questioned—when racism happened to me, I would question my reality or question, oh, did they really

mean that, try to give the benefit of the doubt. Some anxiousness, some anger because there's times I catch it, and there's words I want to say back, but I don't have the words in the moment. But for the most part, it's been a mental battle. I guess being gaslit is the best way to describe it.

Participant 1 described a similar process wherein she questioned her thoughts and emotions related to a situation. She stated:

I've tried to think of comebacks, like, "Oh, what can I say next time?" But every single time it happens, I just—it's almost like a fight, flight, or freeze kind of thing, and I don't want to be rude, but then after the fact, I wish I was rude so that they would know that it's not okay to say that. And then there's some self-doubt, like "What if they were trying to be nice?" Or, "What if I was like "Really? You can't ask Black people that," and then it hurt their feelings or something.

Although several emotional responses were reported following a racist incident, the most common responses in this study were feelings of anger, fear, and confusion. The relationship between negative and vulnerable emotional states, including but not limited to emotions of anger, fear, sadness, and confusion in the aftermath of a racist experience, is well documented by researchers (Brondolo et al., 2008, 2009; Broudy et al., 2007; Carter & Reynolds, 2011; Catagnus et al., 2021).

Community Support. One of the most common ways that participants described caring for themselves after an incident of racism was through community support. They reported that speaking with friends, family, and other people in the Black American community was a method they used prior to attending therapy and after learning new coping techniques. Many described

community support as being extremely helpful in reducing race-related stress. For example, Participant 2 stated:

I do a lot of meditation, but I also have a group of friends, or even now, my mom and stuff like that or my brother and my sister-in-law, that I could talk to about things that really upset me in terms of encounters of racism that I have.

Participant 7 described a similar use of family support, but also noted the importance of adjusting his expectations for responses from his support system. He stated:

I feel, particularly for those types of issues, I have experts already in those fields, like with my parents. I know they're not therapists, and that's something I had to learn as well, that they're not necessarily going to empathize or understand the same things or respond the same way, but I'd rather have their experience.

For some participants, use of community support was reported, but described as discussing race-based difficulties with Black friends, family, and mentors when feeling they had no other options. Although the support allowed space for venting, participants described feeling that their emotions were not resolved. For example, Participant 4 stated:

Once I became more comfortable with sharing experiences, I would talk to friends, talk to family, talk to my mentors. That was pretty much because I felt like, I didn't have a solution to remedy it. So, I just kind of left it there.

Conversely, some participants reported that when they use community support to cope with symptoms of race-based stress or trauma, they are left feeling disappointed by the responses they receive. For example, Participant 1 described a situation wherein she felt that her experience was minimized by a family member. She stated:

I remember talking to my sister. We were in a hotel, and some White lady was like, “Oh, I love your hair. Is it all yours?” And I came back to the breakfast table, and I was so mad. And I was like, “What is it with all these white people asking us if our hair is real? I can’t believe they have the audacity to say that. It’s so annoying.” And she basically was like, “Well, she didn’t mean anything by it,” and basically defending the lady, and I was like, “Never mind.” And I was just really mad. So that’s kind of how I deal with it is just to tell someone about it or just be upset about it.

Participant 5 also spoke about challenges when discussing race-based incidents with loved ones. She noted:

You're in that moment and then you're out of that moment, and it still stays with you. You still think about it, and you're still, like, “Are you serious right now? Did that really just happen?” Then wanting to talk to your family and friends about it, but then sometimes that turns into, everyone's outraged and “is this really helping my emotional state right now, or is it just getting me even more amped up and then I have a group of my loved ones all pumped up?”

While the use of social support from other Black individuals was reported as being helpful by some participants, others described it as being unhelpful or adding to their level of distress. The variability of this coping method is also reflected in other research on this topic. Use of a community support network is consistently described as a coping method employed by Black individuals following a racist encounter (Ajrouch et al., 2010; Franklin, 2019; Scott, 2003). However, when examining the value of community support, Ajrouch et al. (2010) found that support helped provide some protection from everyday stress but did not offset the acute distress brought on by day-to-day discrimination.

Expressive Arts. Throughout the interviews, participants repeatedly mentioned expressive arts as a method of coping in the aftermath of race-based stress and trauma. For all who discussed the method, it was described as being central in their healing process. Notably, Participant 3 described feeling deeply connected to a specific music album. When discussing coping in the aftermath of a traumatic police encounter, he stated:

I locked myself in my college dorm room, and I listened to Kanye West’s “My Beautiful Dark Twisted Fantasy” believe it or not. Everyone who tried to talk to me, I felt like they didn’t understand...I really connected with Kanye’s album and that next album that they created.

Participant 7 also described music as being a central part of his healing process, in addition to many other forms of expressive arts. He noted:

I write it out, and I normally will share it somewhere for the world to see, have a dialogue about that to a certain degree. And then the last piece are just poetry and music. I’m a big poetry guy. There’s a YouTube channel that has all these great spoken word poets that always had fantastic poems about police brutality and just about racial issues and things of that nature. So I have these poems that I go to and I can connect with when I’m feeling that way, and they help me process it, help me grieve it when I need to cry it out or things of that nature and move forward. So those were the big pieces for me back then and still to this day, even with the therapy.

Multiple participants described helpful coping techniques utilized outside of the therapy space, including the use of expressive arts. These techniques appear to be a topic that is minimally documented within the literature with regard to race-based stress and trauma. One recent study found that music was a common preferred coping mechanism within a sample of

young Black men struggling with race-based stress and trauma (Bauer et al., 2020). However, there is a lack of further available research examining this topic. When considered more broadly, as an aspect of strengths based coping within the Black community, the literature offers some support. For instance, strengths-based coping is often described as an imperative aspect of therapy when discussing wellness in the Black communities (Harrell, 2000; Hays, 2009). These strengths-based techniques are typically noted broadly, with only few examples such as spirituality. Results from this study suggest that expressive arts may be an additional strengths-based coping method applied within the Black community.

Therapy Experiences

When discussing therapy encounters, participants described their expectations prior to beginning treatment, which were sometimes, but not always, met. Additionally, they reported various therapy experiences that were positive, reflective of promising practices for clinicians to follow, or negative, described as pitfalls to avoid.

Expectations. One important aspect of each individual's reported therapy experience was their expectations for therapy. Several participants discussed expectations about how their therapists would look and how their looks would contribute to the ability of the therapist to understand and respond. For example, most participants reported initial preferences for a Black therapist, based on expectations. Participant 4 stated, "I thought having a Black therapist—somebody who looks like me, who identifies as Black—I thought that was important because to me, I'm like, 'Okay. I won't have to explain so much.'" Similarly, Participant 7 reported that despite recognizing a need for counseling services, his expectations about the therapists prevented him from seeking a therapist. He reported:

I probably walked in to the counseling center to get services maybe four, five separate times and never signed up. The idea that I'm going to get some old, White dude that's never going to understand what I'm going through or understand my situation or understand what therapy is like—what are the chances I'm going to get a therapist that's going to be even remotely like me or is going to understand me? I talked myself out of it every single time. That was how I went through undergrad.

Participant 3 described similar concerns about therapists, regardless of racial background, being able to understand his experiences with race-based trauma. He noted:

I didn't think a therapist would understand what I was going through, how I was feeling. Even my closest friends, my roommates at the time, I don't necessarily think that they understood. And even though I'm in the counseling profession—like I got my master's in mental health counseling, bachelor's in psychology—I still felt like this was something that I was just going to have to go through myself. I don't know if it was the shock, I just didn't, I had no enthusiasm to reach out to someone.

Despite their initial positive and negative expectations, many participants reported that their experience did not match their initial beliefs. For instance, Participant 1 discussed having positive expectations for her therapist, which she was later disappointed by. She noted:

It sucks because you're hopeful that you're going to get therapy to have someone to talk to about this, and they're going to help me professionally. And then it's like, "Oh, that's not going to happen." And then you don't feel as safe and understood about certain things. And then you're kind of wondering, well, should I have another therapist? I don't know. If a therapist doesn't respond very well to you talking about racism, you take it

personally. And you're like, I'm Black, so if we can't talk about race and if you don't understand that, you can't understand me.

Participant 4 reported that despite having a Black therapist, she realized a need to adjust expectations for what her therapist was able to offer in sessions. She stated:

I was seeking more of a professor, a teacher. What do I do in this situation, or what is this? If somebody does this, what can I say back? How do I address that? I was looking for more of like a mentor, a teacher, a professor, or something or somebody who's trained in racism trauma or something. She'd never cut me off. She just asked me questions and see how I felt about things. If she did have something to say, it was something very gentle, very light. I could tell that she would allow me to unpack it, but I don't think she was equipped with the skills to train me through that, which is I think is a good thing, because I don't think you're supposed to be a therapist to somebody in something you're not trained in. So, I guess I respected that.

Conversely, some participants reported that they were surprised that they were able to connect with therapists, despite their differences. Participant 3 reported:

That first session, I admit it, it lasted 15 minutes. I was like, "Listen. There's nothing that we're going to talk about." I gave him the name of my friend. I gave him timeframes and when things happened. I literally gave him homework to do research and present it in a way where I felt like he actually gave a shit about helping me. And then we can have a conversation. So, he really had to do his homework to build trust. And once he did, I opened up, regardless of things.

Across the interviews, many participants reported that they held several expectations about therapy and providers' ability to understand and help them. Although the expectations held

by each participant differed, their expectations were a barrier in treatment and often did not match their experience. This is consistent with findings of Thompson et al. (2004), which suggested that in a group of African American participants, many expected psychologists to be older, White males who could not be understanding of the economic and race-based realities they faced.

Pitfalls. Throughout the interviews, several pitfalls for working with Black American clients struggling with race-based stress or trauma were identified by participants. The following themes emerged: (a) challenging experiences of racism, (b) colorblindness, (c) ethical violations/inattention, and (d) cultural countertransference.

Challenging Experiences of Racism. When discussing experiences of racism during counseling sessions, several participants reported that their therapist questioned their experience as potentially not being related to racism, and this frequently added to the distress experienced by the individual. Participant 2 described this experience during his interview, and he cautioned therapists by stating:

I would say not to challenge your client, because you're actually hindering them. And I think that a lot of times when we experience racism, we think, "Did that happen?" Even if it's a microaggression. "Was that really racist? Is that what you're saying?" So sometimes, when we're being vulnerable enough to bring that into the room, the worst thing you can do is make it seem like they're crazy or that they're blowing something out of proportion.

Similarly, Participant 4 discussed the importance of allowing the individual to define and characterize their own experience. She stated, "Don't tell anybody what their experience is. Just listen. Don't try to—I think they know this already—don't try to fix it, but just hear it, whatever

it is.” Participant 1 discussed the role that minimization plays when challenging one’s experience of racism. She warned:

Don’t talk about how the aggressor didn’t mean it or maybe it wasn’t that bad or whatever. It doesn’t matter. It doesn’t matter. To me, impact is so important. People need to know that if they do or say a certain thing, it might affect someone negatively.

Many participants cautioned clinicians about attempts to challenge their experiences of racism or the intentions of the perpetrator. This is a phenomenon described throughout the literature when discussing cross-racial therapy. Chang and Berk (2009) relate the experiences to a concept known as microinsults, wherein the individual challenges the experiential reality, thoughts, or feelings of a person of color by excluding, negating, or nullifying their described experience. Additionally, the research discourages clinicians from questioning whether an individual or family may be misconstruing their experiences and considers it to be harmful to the therapeutic process (Constantine, 2007; Kelly et al., 2020). According to Sue et al. (2007), denying or challenging a client’s experience with racism may be a factor in treatment dropout.

Color Blindness. Two of the participants discussed frustrations with therapists ignoring their cultural background. Both participants reported that these frustrations presented after experiences where the therapist did not successfully address challenges with racial stress.

Specifically, Participant 2 interpreted his experience by stating:

It’s almost like you want me to leave part of myself outside of the door, but then you're like, be honest with me, right? It's like this Freudian concept of, we bring our representation into therapy. But we're not bringing our whole self.

Participant 4 reported similar frustrations. After taking a great deal of time to find a racially matched therapist, she received responses based on colorblind therapy treatments. She stated:

I really like my therapist, and I would just challenge her. I'd be like, "Can you stop with the script? I'm a Black woman." I literally said this. I was like, "I know you're trained. All those psychology theories, they're written by White men, most of them. I'm a Black woman. I know White men don't know anything about the life that I live. You're a Black woman. You have some experience with working with women of trauma in the inner city. Stop with the script. Help me." And I really went to that limit.

One third of participants in this study reported concerns that their therapist struggled to provide therapy that considered their cultural reality and context, which impacted their overall satisfaction with the therapeutic relationship. Research suggests that when working with African American counseling clients, the therapists' level of color blindness was directly related to their capacity for empathy, and also their level of attribution of client responsibility for solving their own problems (Buckard & Knox, 2004). However, studies note that despite use of this approach by many clinicians, a color blind approach could have profoundly negative effects on the therapy process when working with African American clients (Constantine, 2007).

Ethical Violations/Inattention. Two of the participants reported receiving low quality mental health treatment. For both participants, the main factor negatively impacting treatment was a lack of attention by the therapist during session. Participant 1 reported:

There were several things. Honestly, I think she needed to retire. I think she would mix me up with other clients, because she'd be like, "Oh, how's Roy?" And I'm like, "Who's

Roy?” Or I would talk about someone we talked about before, and she couldn’t really remember. Sometimes she’d be falling asleep a little bit.

Similarly, Participant 2 reported that his therapist was not fully present during sessions.

He stated:

He often does his notes when we're actually in therapy together; but he doesn't do my notes. He's doing the previous clients' notes. If I'm sitting here talking to you, and I'm doing somebody else's notes, I can only be with you a little bit of the time. I would have loved to have somebody who gave me their full attention, but he's like, "I'm so swamped. This is what we have to do."

Two of six participants also reported that their therapist engaged in behavior consistent with ethical violations. These violations, described by participants, included their mental health provider being inattentive during therapy sessions, thereby diminishing the quality of therapy. This speaks to the well-documented issues with the quality of mental health services provided to ethnic minority clients, including those who identify as Black or African American. The USDHHS (2001) described healthcare disparities for communities of color, including poorer quality of mental health services. In one study, many Black mental health clients described a lack of attentiveness and unprofessional/unethical behavior by therapists, including coming to sessions late, canceling sessions, answering the phone or doing paperwork during sessions, or violating confidentiality (Chang & Berk, 2009).

Countertransference. Most participants discussed countertransference when addressing questions about how clinicians responded to topics of racial stress and trauma. For some participants, lack of an obvious negative countertransference was described as helpful in the therapy process. For example, Participant 3 stated:

I was able to speak freely and candidly about my feelings towards racism and my feelings about how I didn't think we were going to mesh at first, because he was a White Caucasian male. I think him being open to having that discussion and not being irritated or frustrated that I brought that up, I think that was something that worked well, in our favor, to get therapy done.

Additionally, Participant 3 later cautioned counselors about countertransference when working with Black survivors of racism. He noted that "they should avoid placing blame and doubt in their clients. They should avoid putting their own perspectives on experiences of their clients." These warnings were consistent with the negative experiences of multiple participants. For example, Participant 1 described challenges with therapist countertransference when she discussed a racist experience. She recounted:

She, in turn, gave me this story about being a young Jewish girl in her neighborhood and how she was treated differently, because she was Jewish. And after her story ended, I was kind of sitting there like, "Okay." And she was like, "I was telling you that because I want you to understand that I know what it's like to be treated differently," but that did not help me. I was just like, "This doesn't feel therapeutic right now."

Similarly, Participant 2 described an experience where he felt that his counselor's response was impacted by countertransference. He stated:

I feel like maybe he has his own ideas of what it means to be Black, and maybe I don't fit into that frame. I think maybe darker skin, right, if I had the same complexion as my brother, and I told him, this is what happened, he would say, "Oh, yeah, I understand." But maybe to him, I looked more Hispanic. I looked more like him, and he's like, that's

not what happened. He's like, that's not what was going on. Because I felt like he fought me pretty hard on that, and I didn't appreciate that.

Across participants, the need for space to discuss their experiences freely, without therapists having their own reaction to the topic, was crucial. Clinicians who created an adequate space for this were described positively, whereas those who had strong reactions were described as being ineffective and unhelpful. Research examining cross-cultural therapy dynamics reports similar results and highlights the need for therapists to be aware of their own racial identity and any transference or countertransference that may be interfering in the counseling relationship (Constantine, 2007; Constantine & Kwan, 2003; Fauth & Nutt Williams, 2005). In regards to racially matched therapy for Black or African American clients, topics such as transference and countertransference appears to be a gap within the literature. However, in this study, participants who reported countertransference responses from therapists were working with mental health practitioners of a different race.

Promising Practices. Participants described several promising practices that were helpful when discussing incidents of racism: (a) active listening, (b) validation/affirming racial experiences, and (c) authenticity.

Active Listening. Across participants, one promising practice that was highlighted in every interview was the importance of the therapist listening to what the client said about their identity, reality, and experiences. When discussing this topic, Participant 4 stated, "I would say as much as possible to learn that person and the environment they come from and the environment they're currently in. Just hear them out totally. Everyone is different." Other participants highlighted the importance of therapists' responses and actions in order to

demonstrate to the client that they are listening. For example, Participant 1 stated the following, when discussing a positive experience with her second therapist:

When I did mention that things bothered me, she was supportive or actively listening. I don't think I really wanted much from her except to be able to express how frustrating it could be talking to my boyfriend, and her commenting on how difficult it must be for me to have to explain to someone the appropriate way to talk about a Black person's experience.

Participants who did not have a positive experience discussing racism during sessions described active listening as something their clinician could improve. For example, when asked how his therapist could have better responded, Participant 2 stated, "Him actually listening to what I was saying, because I felt like he wasn't listening." All participants described listening as a crucial aspect of therapy when working with Black or African American individuals struggling with race-based stress or trauma. Although the technique may seem obvious, many participants reported that their therapist did not appear to be listening to them during sessions. Additionally, the connection between race-based stress and trauma and the therapist's listening skills is not well researched. When considered broadly, microcounseling skills, including active listening, aid with development of cultural awareness and culturally effective helping strategies (Kabura et al., 2005; Nwachuku & Ivey, 1991). However, these studies do not directly discuss active listening specifically, nor was it directly connected to Black therapy clients.

Validation/Affirmation. In addition to demonstrating that they are listening, participants also discussed the importance of feeling validated by their therapist, particularly the validation of emotions surrounding racist experiences. For example, Participant 3 stated:

I think the fact that he shared some sort of sentiment to how I was feeling. He validated some of my feelings of anger. I think that was important as well, especially being that he was of the dominant—him being of a White culture.

Similarly, Participant 5 described validation in her experience discussing racism with her therapist. She noted:

She did acknowledge, “I can't understand how you feel. I can't put myself in that position.” She acknowledged that she's in a place of privilege, and she can't try and make that work for me. And even that, I still appreciate it because it's, like, okay, she's acknowledging my feelings without trying to make it seem like, “Oh, well, this is normal. This is something that everyone goes through,” or “This is something that is just a part of life.” So, if anything, I would say she was just more helpful in just opening that space and allowing me to get out what I needed to get out at that whole, and that in itself was helpful.

Participant 7 described a similar experience, wherein his therapist affirmed his experience and validated his overall emotional journey. He stated:

He'd break down the experiences that he's had with other clients that were going through similar situations. He said, “Of course, I haven't had these similar situations, but I've had clients that have talked about these things, and they mentioned that they made him feel like this, this, and this.” And I thought, “Yeah, that's exactly how I felt.” He did a good job of finding ways to validate it without having to say, “Well, yeah, I had that exact same experience.” And I think that was the key, was that there were not many points where I was like, “Yeah, he doesn't get it.”

When discussing validation from her therapist, Participant 1 noted the role of body language. She stated, “It was validating, because I might say something and even if she just nods her head, I can tell that she understands by her facial expressions.” When participants described their therapist’s response as unhelpful, they cited the lack of emotional validation or that the therapist did not affirm their reality. Participant 2 reported his experience:

When I was explaining to him what happened, his response wasn’t very reaffirming. He didn’t necessarily paint it as racist, he just painted it as if maybe it had nothing to do with that. And I was like, “No, it did. I know what this was about. I have experienced this before.” And so, I felt like the whole entire session I was sitting there trying to explain to him why I was so angry, because I knew exactly what was happening.

When considering helpful techniques to address race-based stress and trauma, all participants described validation as an important tool. Participants who noted that their counselor validated or affirmed their experiences of racism reported positive experiences. Similarly, participants who felt that their therapist neglected to validate their experience described their therapist as causing further harm or being unhelpful. This is consistent with previous studies on providing culturally competent therapy. Studies caution therapists not to begin with supposition when discussing instances related to racism and discrimination with Black clients (Hays, 2009; Kelly, 2006). Instead, it is suggested that validation be utilized, until the client feels believed, before moving on to an assessment of an incident’s relevance to the client’s presenting concerns (Hays, 2009). Studies in cross-racial therapy also note that validation and responsiveness to expressed needs play a significant role in client satisfaction with the therapist (Chang & Berk, 2009).

Authenticity. During interviews, three of the six participants discussed the topic of therapist authenticity. For Participant 5, she highlighted her therapist's authentic presence as being one of the factors that was helpful in her sessions. She stated:

I think she could've started off with, "Hey, I know you're African American, and this is a really difficult time for African Americans right now, so how are you?" You're obviously trying to just check that box to say that you did it, but it's not being real about it, just genuinely.

When discussing pitfalls for therapists to avoid, Participant 3 highlighted a similar desire for their therapist to be authentic in the room. He stated, "They should avoid coming off as disingenuous and not authentic." Several other participants also noted that it was important for therapists to remain authentic or genuine in the therapy room when working with Black clients struggling with race-based stress. Previous studies also reported this as a crucial aspect of therapy when working with ethnic minority communities, given community mistrust based on a history of exploitation (Chang & Berk, 2009). When examining cross racial therapy, Chang and Berk (2009) also reported that clients who considered their clinicians to be authentic in therapy were more likely to be satisfied with their experience.

Therapy Recommendations

In addition to the various pitfalls to avoid and promising practices for therapy sessions, participants provided recommendations to increase clinicians' awareness and understanding. Specific themes that emerged within these recommendations include the following: (a) history, (b) research/consultation, and (c) intake questions.

History

When offering recommendations to clinicians who wish to be helpful, all participants described therapist self-education on Black history and events as crucial. While these recommendations were described differently across interviews, the idea of continuing the learning process as a therapist remained the same. When discussing self-education by providers, Participant 1 emphasized the importance of educating oneself on history in order to better understand the historical trauma experienced within the community. She stated:

It's like some people won't see how serious it is and why people are angry, and it's like then you must not know about American history and everything that Black people have had to go through. You need to know about redlined district. You need to know about segregation. You need to know about lynching. You need to know about slavery. You need to know about everything, because people are this angry because it's been happening for so long. What's happening today is just different versions of what has happened in the past.

More specifically, Participant 3 described recommendations for educating oneself on current events and specific situations relating to the individual. "My suggestion would be, if the client went through something specific, try to understand that. I would educate myself, as much as possible, on what's going on through the perspective of African Americans." Participants urged clinicians to first educate themselves on the history and struggles of Black populations. Literature surrounding the topic makes a similar suggestion to explore racial concerns. The American Psychological Association (2017, p. 4) provides a set of multicultural guidelines, stating "Psychologists aspire to recognize and understand historical and contemporary experiences with power, privilege, and oppression." Similarly, Constantine (2007) suggests that

counselors explore the history and racial/ethnic reality of the Black community, as well as self-exploration of one's own identity and connection to the topic. Counselors who neglect to engage in this self-education process may experience countertransference, as well as difficulties exploring racial challenges in therapy (Constantine, 2007). Additionally, research findings note that African American clients often seek confirmation of a therapist's level of cultural humility, sensitivity, and lack of prejudice before engaging in services with the clinician (Dana, 2002; Davey & Watson, 2008).

Research/Consultation

Most participants recommended that therapists continue to consume research about racial stress and trauma and consult with a colleague when they have clients struggling with these challenges. When discussing this need, Participant 1 highlighted the importance of moving beyond taking only the minimum requirement of courses to understand. "People need to personally research. Definitely take classes—multiple classes—and really listen to your clients." Participant 3 also advised providers to research and, additionally, discussed the inclusion of consultation. He noted: "Do some research...I would, maybe, lean on expertise of colleagues who provide similar services, if that's something that's not in that clinician's wheelhouse."

Participant 7 emphasized the importance of overall cultural competency when providing recommendations. "Make sure you ask questions. Staff, make sure you're culturally competent. Ask your colleagues questions. Do trainings. Make sure that you feel as competent as you can, right?"

Lastly, for clinicians who are not skilled in this area and do not take the time to utilize the above steps, Participant 3 advised, "They probably shouldn't take on Black clients who are dealing with racism."

Many participants suggested research and consultation for clinicians who wish to be helpful when treating race-based stress and trauma. This is further highlighted within the multicultural guidelines offered by the American Psychological Association (2017) for working with diverse populations. Further research suggests that when therapists do not make efforts to increase cultural competence and humility through research and consultation, clients tend to report higher levels of dissatisfaction with therapy (Chang & Berk, 2009).

Intake Questions

Half of the participants in the current study suggested that clinicians include questions about identity, racism, and discrimination in intake documents and interviews. When discussing this topic, Participant 5 related identity, racism, and discrimination to other aspects of development. She stated:

I feel like for the majority, they do often ask about your childhood or your upbringing, at least some portion of it, to try to gauge how you became who you are. And I don't always think that they include race in that because race is like this taboo thing, and people would rather just stay completely away from it than to dive in because they don't want to hit a landmine. But I think it should be included in those childhood questions.

Participant 2 provided a similar suggestion and noted that all forms of discrimination should be included within the intake. “I think it should be somewhere on the intake. Like, have you ever experienced racism? Have you ever experienced sexism? Have you ever experienced...whatever?” However, Participant 1 recommended that, specifically when working with Black clients, clinicians should inquire about race due to it being a salient aspect of identity for many. “We live in America, where people of color—it’s just like you’re going to experience

some form of racism. So, I think if I saw a question on an intake form about racism, I would think, ‘This makes sense.’”

Several participants in this study recommended the inclusion of questions about identity, race, and discrimination in the intake. This recommendation is consistent with several recommendations within the research. For example, King and Borders (2019) suggest that by broaching the conversation of racial identity in initial sessions, clients perceived their providers as being more culturally competent and able to handle conversations about racism.

Chapter V: Discussion

The purpose of this study was to examine the therapy experiences of Black or African American individuals struggling with race-based stress and trauma. Findings from this study revealed four significant areas of focus to better prepare clinicians treating these areas of concern. The categories highlighted include: (a) racial identity, (b) experiences of racism, (c) therapy experiences, and (d) participant recommendations for clinicians. Collectively, these categories provide a foundation for understanding common racial experiences for Black individuals and further connect to the client's experience within the therapeutic space.

When considering one's reaction or response to experiences of racism, it is important for clinicians to first understand the client's history and relationship to their racial identity. With regard to the racial identity of those interviewed, results highlighted the significance of racial socialization, social acceptance, the balance between multiple identities, and the development of racial identity as contributing factors to how participants understood themselves racially. While all participants in this study identified as racially Black, they also discussed other aspects of their identity that contributed to their racial understanding, including ethnic background, immigration status, gender, skin color, religion, and the geographic location in which they were raised. Findings highlighted the diversity amongst Black individuals in the United States, while also demonstrating the complexities of navigating multiple identities. When discussing racial experiences, participants alternated between aspects of their identity when there was a conflict between expectations associated with each role. This topic appears to be a gap in the literature and may be similar to the approach described in multiracial identity development research (Hong et al., 2000; Huynh et al., 2011; LaFromboise et al., 1993; Phinney & Devich-Navarro, 1997). Participants also described challenges with clinicians not attending to their various identities

during sessions. This may be partially related to the lack of literature surrounding the topic. While there is a body of literature surrounding intersectionality, or compounding areas of marginalization, a review of literature produced limited information about navigating conflicts between multiple salient identities.

Findings about racial socialization mirrored previous literature, which states that Black individuals who received racial socialization during childhood feel a stronger sense of pride and understanding of the challenges associated with their racial identity (Harrell, 2000; Lee & Ahn, 2013; Neblett et al., 2009; Scott, 2003; Seaton et al., 2012;). Additionally, differences between men and women were observed in relation to the topic. Female participants either did not discuss racial socialization at all during interviews or reported confusing messages from their parents during childhood. This builds on results from previous studies suggesting that women are socialized to race differently than men (Davis Tribble et al., 2019; McHale et al., 2006; Winchester et al., 2022). However, gender differences in racial socialization were not examined further, due to the scope of this study. Notably, results of the current study also suggest that racial socialization played a role in the development of participants' racial identity over time. Upbringing and knowledge of Black history were described as factors that strengthened their relationship to Black identity, whereas a lack of accurate history and an absence of racial socialization were described as challenges in Black identity development.

Significant challenges with acceptance based on race were also reported by all participants. In addition to experiences of rejection and discrimination from other racial groups, the participants described a lack of acceptance from other Black individuals. Specifically, the participants reported within group rejection from Black peers based on hobbies and interests, colorism, and ethnic identity. These findings support a small body of research that reports that

Black individuals often experience discounting or rejection of one's Black identity by their peers (Franco & Franco, 2016; Franco et al., 2016; Harvey et al., 2005; Whittington et al., 2021). This was discussed by all participants within the study and provides significant information regarding the impact of racism on the Black community, demonstrating that internalized racism is also a major contributor to race-based stress.

As participants discussed specific experiences of racism, police encounters emerged as a common theme. Findings revealed that amongst interviewees, two thirds reported personal negative interactions with the police wherein law enforcement officers overreacted, harassed the individual, or engaged in police brutality. Those who did not disclose personal encounters with the police discussed media images and recent police brutality cases as stressors impacting their comfort level when engaging with police. Moreover, encounters with law enforcement may provoke feelings of anxiety and fear for many in the Black community.

In addition to police related concerns, findings revealed that microaggressions were a common source of race-based stress. Participants described this form of racism as occurring mostly in educational and workplace settings. The impact of the microaggressions included job dissatisfaction, challenges in academic settings, and desires for mental health interventions to decrease the emotional toll.

Across the experiences of race-based stress and trauma described, the most common reactions were emotional responses. Specifically, participants described feelings of fear, confusion, and anger. These responses are also well documented within the literature as common emotional reactions in the aftermath of racist events (Brondolo et al., 2008, 2009; Broudy et al., 2007; Carter & Reynolds, 2011; Catagnus et al., 2021). Findings in this study revealed the use of community support as a method of coping with the above-mentioned symptoms. Although

community support was reported as a coping skill by most participants, results were mixed as to the helpfulness of the tool. Some felt that talking with other Black family members and peers helped to reduce their levels of distress, whereas others described it as only being partially helpful. Participants described limitations, such as minimization/denial of racist experiences by one's support system, emotional responses by family members, and lack of changes to one's own emotions after discussing with their support system, related to this coping method. Research examining this topic suggests that it is a common coping skill for the Black community, may provide some protection from everyday stress, but does not offset the acute distress of day-to-day racism (Ajrouch et al., 2010).

When discussing coping skills, two male participants described the use of expressive arts following racist incidents. Specifically, listening to music, writing songs or poetry, and watching videos of spoken word poetry related to the topic were described as methods of art used to cope with stress and trauma. This finding expands on very limited research findings, which revealed that music was a common preferred coping mechanism within a sample of young Black men struggling with race-based stress and trauma (Bauer et al., 2020). However, this topic appears to be a gap in the literature and may benefit from further research.

With respect to therapy itself, many participants reported either positive or negative expectations about the therapist and what their therapy experience would entail. For example, participants described expectations related to therapists' race, therapists' ability to understand presenting concerns, the type of interventions used during sessions, and an ability to trust the clinician/form a therapeutic alliance. Regardless of whether these preconceived beliefs were positive or negative in nature, most participants found that their beliefs were a barrier to treatment and ultimately did not match their experience.

Findings related to participants' therapy experiences were separated into two categories: pitfalls and promising practices. Common pitfalls reported across interviews included challenging experiences of racism, cultural countertransference, colorblindness, and ethical violations/inattention. Challenging experiences of racism and cultural countertransference were two pitfalls related specifically to discussions of race-based stress and trauma in therapy. Several participants stressed that clinicians avoid challenging client experiences of racism or minimizing the intentions of the aggressor. Previous literature suggests that this is an issue that often arises within cross-racial therapy and is an example of a microinsult that can further a client's distress or lead to dropout (Chang & Berk, 2009; Constantine, 2007; Kelly et al., 2020; Sue et al., 2007). Similarly, results from the current study demonstrated multiple instances of cultural countertransference when discussing race-based stress, which is consistent with pitfalls found in past studies examining cross-racial therapy (Constantine, 2007; Constantine & Kwan, 2003; Fauth & Nutt Williams, 2005). Participants described these responses as ineffective, unhelpful, and damaging to the client's sense of ability to openly discuss race-based challenges.

General pitfalls related to working with Black clients included colorblindness and ethical violations. Colorblindness was associated with dissatisfaction for many participants. Multiple participants noted that their therapists were not considerate of their cultural context and reality, which negatively affected the therapeutic relationship. These findings were consistent with cautionary statements reflected in the literature (Buckard & Knox, 2004; Constantine, 2007). Findings also revealed that multiple participants received counseling that was lower in quality. They reported that their counselor would confuse them with other clients, appear to be falling asleep during session, and work on notes for other clients during session, all of which suggested to participants that their therapist was not paying attention to the discussion. These clinical

behaviors demonstrate neglect towards clients and are reflective of ethical violations.

Unfortunately, this is not a new issue being brought up by Black therapy clients. Several studies demonstrate that Black clients receive a poorer quality of mental health treatment and often report barriers such as coming to sessions late, canceling sessions, answering the phone or doing paperwork during sessions, or violating confidentiality (Chang & Berk, 2009).

In addition to the several pitfalls noted by participants, they also identified several promising practices. Specific findings suggested that listening, validation/affirmation, and authenticity were all promising practices for clinicians to adopt. Participants reflected a desire for therapists to demonstrate basic skills, showing that they were empathetic to their clients. Additionally, the use of authenticity was described as important, particularly for those struggling with race-based stress. Notably, all helpful interventions described by participants were supportive therapy techniques and not specific to a theoretical orientation or model. One potential explanation may be that most participants were unsure of the therapy style used during their described course of treatment. A second explanation for the inclusion of only supportive therapy techniques may be that several participants received lower quality care, where basic techniques were not utilized. Although many of the suggestions offered may seem like basic standards of therapy, the supportive therapy techniques discussed may highlight the importance of avoiding the use of minimization, blame, and other harmful practices, which are common with this population.

As interviews concluded, participants offered tips for clinicians who wish to be helpful. One recommendation included the need for therapists to educate themselves on the history of Black oppression, as well as current events in the Black community. This also included the importance of making efforts to integrate and understand differences across the Black

community related to multiple aspects of identity including ethnicity, geographic location, gender, spirituality, and sexual orientation. These recommendations are consistent with initial steps highlighted in the multicultural guidelines of the American Psychological Association (2017). This recommendation is also described in the literature as a crucial factor in therapy with the African American population (Constantine, 2007; Dana, 2002; Davey & Watson, 2008). A second recommendation offered by participants was the need to research and consult about race-based stress and trauma when treating Black clients. This is also consistent with literature, which states that higher levels of dissatisfaction with therapy are reported when therapists do not make efforts to increase cultural competence and humility (Chang & Berk, 2009). Lastly, participants suggested that therapists include questions about identity, race, discrimination, and racism during the intake process. Participants noted that having these types of questions on the intake would increase comfort surrounding the topic and would be an appropriate time to ask about these experiences. These findings support research by King and Borders (2019), which suggests that asking questions about racial identity during initial sessions led to perceptions of therapists as being more culturally competent.

Observations

The researcher observed several remarkable patterns across participant interviews. Notably, when discussing encounters with microaggressions and covert racism, most participants minimized their experiences. At the start of the interviews, many compared experiences with racist microaggressions to experiences of racial trauma, such as police brutality or other forms of physical violence. They appeared to use these differences to dismiss or diminish the significance of their own racist experiences. Words such as *just* and *only* were used to describe the racist incidents, followed by statements by participants that they have never experienced any

significant forms of racism. However, the participants later described the racist situations and challenges as being extremely impactful, which was the reason for many to discuss it in therapy. These contradictory statements may be related to the common experiences of minimization and microinsults by others, which have been internalized. A secondary explanation may be that participants are comparing their daily experiences of racism to the current sociopolitical context and frequent hate crimes in the media.

Similar observations were seen in relation to participant therapists. Participants with positive therapeutic experiences with their therapists, were often less critical and had difficulties describing pitfalls in the therapeutic relationship. They reported that the therapist did a great job, but also added that they are considering switching to a therapist who would better understand them culturally if they were to seek mental health services again in the future. This phenomenon is similar to the compartmentalization of race described in previous studies. For example, Chang and Berk (2009) found that clients minimized the salience of cultural differences between themselves and the therapist, as well as the importance of racial, ethnic, and cultural factors on their presenting problems. However, they also demonstrated conflicting attitudes later in their narratives, which were viewed by researchers as compartmentalization of race in order to feel more satisfied with the therapy experience (Chang & Berk, 2009).

Lastly, notable themes of invisibility appeared across topics and participant interviews. Although invisibility was not explicitly named as a challenge, participant responses throughout the interviews are reflective of struggles to be seen and heard by others, including their mental health clinician. These challenges highlight a phenomenon known as the “invisibility syndrome,” which suggests that repeated experiences with microinsults can result in internal feelings of not being seen as a person of worth (Franklin & Boyd-Franklin, 2000). Emotional responses to

racism, including doubt, anger, and confusion, are also consistent with a perceived lack of visibility. However, the challenges described by participants move beyond perceptions and worries by survivors and demonstrate a lack of effort by peers and clinicians to truly see the individual. This is evidenced in experiences described by participants. For instance, despite feelings of pride associated with their race, participants described a lack of acceptance from Black and non-Black peers, underrepresentation in various settings, minimization when discussing experiences of racism, and experiences with therapists engaging in microinsults, lack of attention, and colorblindness. Similarly, promising practices and recommendations provided by participants focused on efforts to increase visibility and to demonstrate that the individual is truly being heard and understood. This observation demonstrates the importance of the participant's recommendations for therapists. Research, consultation, self-education on Black history, and intake questions about discrimination are necessary minimum efforts for therapists of all racial backgrounds and needed to increase the visibility and amplify the voice of Black clients in counseling.

Contributions of Findings

This study offers several contributions to the current body of literature on providing counseling services to Black and African American clients. First and foremost, findings add to a limited pool of research about what Black clients believe to be helpful, and not helpful, with regard to therapy discussions about race-related stress and trauma. While there are many articles and books discussing racial identity development and cultural concerns, such as race-based stress and trauma, there is limited research surrounding specific therapy techniques for managing these concerns. Of the existing studies, only a few focus on the perspective of the client to provide pitfalls and promising practices and most do not highlight therapy cases specific to racism and

discrimination (Chang & Berk, 2009; Constantine, 2007; Thompson et al., 2004). Additionally, the literature suggests that many clinicians lack confidence in their understanding and ability to discuss topics related to racism and discrimination (Chang & Berk, 2009). By utilizing a phenomenological approach, this study highlights the client perspective, while also aiming to increase clinicians' understandings of specific interventions to address race-based concerns.

A secondary contribution, which was highlighted, was participant discussion of race, racism, and development of racial identity. Although the focus of this study was on counseling experiences when discussing race-based stress, it is essential to first understand participants' experiences with racism and overall relationship to their racial identity. Findings related to these topics may help clinicians develop an increased awareness of challenges and strengths from childhood through adulthood, associated with a positive connection to Black racial identity. The results emphasize client conceptualizations of their own identity development, which may relate to Black racial identity models such as Cross' Nigrescence Model (Cross et al., 1991), while also bridging connections to the literature discussing race-related stress.

Limitations

Despite the strengths offered by this study, several limitations also exist. For instance, while genuine efforts were made to obtain a diverse set of participants, many similarities such as age range and advanced levels of education exist across the sample. All participants within the study were between the ages of 27–32, which may skew the concerns and preferences described here. Additionally, all participants in this study had a bachelor's degree at minimum and many had obtained or were actively pursuing master's and doctoral degrees. These similarities in educational attainment may contribute to common themes, such as microaggressions in educational and workplace settings and the overall level of distress described by the participants.

Previous studies examining racial stress of Black individuals in higher education suggest that individuals with higher levels of education tend to report more racial stress due to increased involvement in predominantly White institutions and more awareness of systemic racism (Smith et al., 2020). It is also important to note that four of the six participants' degrees were master's degrees in psychology. These commonalities may further skew the data obtained within this study and impact the overall generalizability of the findings. Although it is likely that a broader range in age group and education level would reveal challenges with similar race-related concerns, there may be generational differences based on sociopolitical context that were not represented within this sample. Similarly, age, education, and occupation may have limited the study's ability to capture some distinctions in therapy preferences.

Future Research

It is imperative that studies continue to examine the use of therapeutic interventions and treatment models for Black Americans struggling with racialized stress and trauma. This study contributes to the current body of literature by helping to establish a foundation for understanding helpful and unhelpful therapy techniques provided for Black race-based stress and trauma. Results suggested several supportive therapy techniques helpful to those discussing issues of racism and discrimination in the therapy room. However, no themes were produced to support a specific model or orientation of therapy as being more or less helpful. A lack of findings in this area may be related to participants being unaware of the style of therapy used in their treatment and not necessarily suggestive that supportive therapy is the best way to treat race-based stress. A secondary explanation for an emphasis on supportive therapy techniques may also be related to a history of low-quality therapy for Black clients. While not all participants specifically experienced low-quality therapy, most noted that they have considered

finding a different therapist who may better respond to their cultural concerns and strengths. Future research may build on findings about supportive therapy techniques by conducting studies comparing specific models and orientations, such as womanist approaches, Afrocentric models, EMDR, and CBT trauma protocols, with cultural adaptations, which have been discussed in the literature as therapy treatment options (Bryant-Davis & Ocampo, 2006; Villena-Mata, 2002; Williams & Frame, 1999; Williams et al., 2014; Wyatt, 1990).

The phenomenological approach utilized here allows for a more in-depth perspective of a few participants and should be expanded upon in future studies. Within the sample, only one participant described experiences working with a racially matched therapist. This suggests the current study is more reflective of cross-racial counseling, and future studies may benefit by studying the responses of racially matched therapists when managing client struggles with racism and discrimination. Similarly, only one participant in the current study described symptoms related to race-based trauma. Future studies may benefit from conducting a more in-depth study on the experiences of those dealing with racialized trauma.

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APPENDIX A

IRB Approval



Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: January 26, 2021

Protocol Investigator Name: Sheriece Hooks

Protocol #: 19-03-1026

Project Title: Counseling Black and African American Survivors of Racism: Promising Practices and Pitfalls

School: Graduate School of Education and Psychology

Dear Sheriece Hooks:

Thank you for submitting your application for expedited review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

Based upon review, your IRB application has been approved. The IRB approval begins today January 26, 2021, and expires on January 25, 2022.

The consent form included in this protocol is considered final and has been approved by the IRB. You can only use copies of the consent that have been approved by the IRB to obtain consent from your participants.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and will require a submission of a new IRB application or other materials to the IRB. If contact with subjects will extend beyond January 25, 2022, a continuing review must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

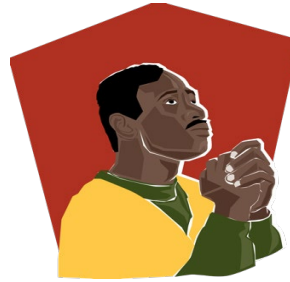
Judy Ho, Ph.D., IRB Chair

cc: Mrs. Katy Carr, Assistant Provost for Research

Appendix B
Recruitment Flyer

ATTENTION BLACK & AFRICAN-AMERICAN INDIVIDUALS!

Black and African American volunteers who have discussed issues of racism with a therapist wanted for a research study



Do you identify as Black or African-American, are over the age of 18, and have received counseling services?

If so, we are conducting a research study to analyze and explore the ways in which Black and African-American individuals experience counseling following encounters with racism.

Who can participate?

- Participants must be 18 years or older
- Participants must identify as Black or African-American
- Have attended counseling in the past or are currently receiving counseling services
- Have experienced one or more forms of racism, and discussed it in therapy

What is involved?

- The study will include an audio recorded interview which will last approximately 1.5 – 2 hours.
- Participants will receive \$25 for their time

For more information, please contact:

Principle Investigator

Sheriece Hooks, M.A.

Dissertation Chair

Thema Bryant-Davis, PhD

APPENDIX C

Recruitment Email

From: Sheriece Hooks
To:
Date:
Subject: Requesting assistance in study about racism

To whom it may concern:

My name is Sheriece Hooks, and I am conducting a research study along with my dissertation chair, Thema Bryant-Davis, Ph.D., at Pepperdine University. The study will examine promising practices and common pitfalls in counseling Black and African-American individuals who have struggled with racism. I would like to request your permission to recruit participants for this study from your facility. Attached is the flyer (8.5" x 11") that we are using for recruitment, which provides potential participants information about the study and my contact information.

If you are willing, please contact me via email at [REDACTED] at your earliest convenience. I look forward to hearing from you.

Sincerely,

Sheriece Hooks, M.A.

APPENDIX D

Informed Consent

PEPPERDINE UNIVERSITY

Graduate School of Education and Psychology

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

Counseling African-American Survivors of Racism: Pitfalls and Promising Practices

You are invited to participate in a research study conducted by Sheriece Hooks, M.A., doctoral candidate, and Dr. Thema Bryant-Davis, Ph.D., professor of psychology at Pepperdine University, because you are an adult who has struggled with racism and has sought therapy services. Your participation is voluntary. You should read the information below, and ask questions about anything that you do not understand, before deciding whether to participate. Please take as much time as you need to read the consent form. You may also decide to discuss participation with your family or friends. If you decide to participate, you will be asked to sign this form. You will also be given a copy of this form for you records.

PURPOSE OF THE STUDY

The purpose of the study is to look at the experiences of Black and/or African-American individuals and the counseling process. We hope to use what we learn from the study to better understand helpful practices for treating race-based stress or trauma, as well as pitfalls to avoid. This study also aims to educate mental health professionals about how to approach topics such as racism within the therapy room.

STUDY PROCEDURES

If you volunteer to participate in this study, you will be asked to take part in a one-time interview, consisting of the completion of a survey and an interview lasting about 1.5-2 hours in length. The first survey is a demographic survey that will ask you questions about your age, various identities, and occupational/educational history. The interview will ask you about the following: your racial/ethnic identity, your understanding of racism, your experiences with racism, your symptoms, and your experiences in counseling, and recommendations to therapists who may want to be helpful. The interview will be audio-recorded, with the audio-recorder placed in the interview room and operated by the researcher. You will not be able to participate in the study, if you do not wish to be audio-recorded.

POTENTIAL RISKS AND DISCOMFORTS

This study poses no more than minimal risks for participants. Potential risks associated with participation in this study include the possibility of experiencing minor psychological discomfort

due to the interview containing questions about your history with racism. If you happen to experience discomfort during the interview process, please tell the researcher. The researcher is clinically trained, and will be prepared to provide you with relaxation and grounding exercises to reduce discomfort and distress. You also may discontinue your participation at any time. Due to California law, the interviewer will also abide by mandated reporting laws determined by the state of California, which may also pose a potential legal risk for participating in the study. Further information regarding these reporting laws is discussed below under “Confidentiality” and “Suspected Neglect or Abuse of Children.” Furthermore, you will also be provided with a list for referrals and resources for support, helplines, and local mental health services.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

While there are no direct benefits to the study participants, there are anticipated benefits to society. The findings of this study will have important implications, including providing increased knowledge to therapists about best practices and common pitfalls for treating Black or African-Americans struggling with race-based stress or trauma.

PAYMENT/COMPENSATION FOR PARTICIPATION

For participation in this study, there will be compensation in the form of a \$25 gift-card, should you choose to participate in and complete the interview.

CONFIDENTIALITY

I will keep your records for this study anonymous as far as permitted by law. However, if I am required to do so by law, I may be required to disclose information collected about you. Examples of the types of issues that would require me to break confidentiality are if you tell me about instances of child abuse, elder abuse, or the abuse of a disabled adult. Pepperdine’s University’s Human Subjects Protection Program (HSPP) may also access the data collected. The HSPP occasionally reviews and monitors research studies to protect the rights and welfare of research subjects. The data will be stored on a password protected computer in the principal investigators place of office at the Pepperdine University West Los Angeles Clinic. The data collected will be de-identified and identified by a code for confidentiality purposes. The audio-recordings, transcribed interviews, and subsequent data will also be de-identified and identifiable only by numeric code. Consent forms will be stored separately from interview materials in order to protect the confidentiality of participants. This data will also only be accessible by the researcher, and will be destroyed once it is no longer being utilized for this research study after a minimum of three years.

Under California law, the researcher(s) will not maintain as confidential, information about known or reasonably suspected incidents of abuse or neglect of a child, dependent adult or elder, including, but not limited to, physical, sexual, emotional, and financial abuse or neglect. If any researcher has or is given such information, he or she may be required to report this abuse to the proper authorities.

PARTICIPATION AND WITHDRAWAL

Your participation is voluntary. Your refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. The investigator may also withdraw you from this research if you appear to be under the influence of alcohol or another substance at the time of the interview, or if you show signs of psychological discomfort or distress throughout the interview process.

ALTERNATIVES TO FULL PARTICIPATION

The alternative to participation in the study is not participating or completing only the items which you feel comfortable.

EMERGENCY CARE AND COMPENSATION FOR INJURY

If you are injured as a direct result of research procedures you will receive medical treatment; however, you or your insurance will be responsible for the cost. Pepperdine University does not provide any monetary compensation for injury.

INVESTIGATOR'S CONTACT INFORMATION

I understand that the investigator is willing to answer any inquiries I may have concerning the research herein described. I understand that I may contact Sheriece Hooks, M.A. at Sheriece.Hooks@Pepperdine.edu or her supervisor, Dr. Thema Bryant-Davis email at thema.s.bryant@pepperdine.edu, if I have any other questions or concerns about this research.

RIGHTS OF RESEARCH PARTICIPANT – IRB CONTACT INFORMATION

If you have questions, concerns or complaints about your rights as a research participant or research in general please contact Dr. Judy Ho, Chairperson of the Graduate & Professional Schools Institutional Review Board at Pepperdine University 6100 Center Drive Suite 500 Los Angeles, CA 90045, 310-568-5753 or gpsirb@pepperdine.edu.

SIGNATURE OF RESEARCH PARTICIPANT

I have read the information provided above. I have been given a chance to ask questions. My questions have been answered to my satisfaction and I agree to participate in this study. I have been given a copy of this form.

AUDIO/VIDEO/PHOTOGRAPHS (If this is not applicable to your study and/or if participants do not have a choice of being audio/video-recorded or photographed, delete this section.)

- I agree to be audio/video-recorded*
- I do not want to be audio/video-recorded*

Name of Participant

Signature of Participant

Date

SIGNATURE OF INVESTIGATOR

I have explained the research to the participants and answered all of his/her questions. In my judgment the participants are knowingly, willingly and intelligently agreeing to participate in this study. They have the legal capacity to give informed consent to participate in this research study and all of the various components. They also have been informed participation is voluntarily and that they may discontinue their participation in the study at any time, for any reason.

Name of Person Obtaining Consent

Signature of Person Obtaining Consent

Date

APPENDIX E

Demographic Questionnaire

Demographic Questionnaire

Instructions:

Please provide a response for each of the following questions:

1. What is your age? _____

2. What is your gender?

Male

Transgender

Female

Other: _____

3. What is your marital status?

Single

Married

Separated

Divorced

Widowed

4. What is your annual income (or combined annual income if you have a spouse)?

Less than \$35,000

\$35,000 to \$60,000

\$60,001 to \$70,000

\$70,001 to \$80,000 .

\$80,001 to \$90,000

\$90,001 to \$100,000

Greater than \$100,000

6. With which sexual orientation do you identify?

Heterosexual

Gay/Lesbian

Bisexual

Asexual

Other: _____

7. With what denomination or faith tradition do you most closely identify?

8. Are you currently employed?

No

Yes

If so, what is your most recent job title? If not, when was your last job, and what was your most recent job title?

9. What is your highest level of education obtained?

Less than High-School

High-School/GED

Some College .

Associates Degree

Bachelor's Degree

Masters/Doctoral Degree .

10. What type of mental health professional did you seek treatment with?

- | | |
|---|---|
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Marriage and Family
Therapist | <input type="checkbox"/> Trainee/Intern/Student |
| <input type="checkbox"/> Licensed Clinical Social
Worker | <input type="checkbox"/> Don't know |

11. What style of therapy was used by your therapist?

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> CBT | <input type="checkbox"/> Don't Know |
| <input type="checkbox"/> Psychodynamic | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Multicultural | |

APPENDIX F

Interview Questions

Interview Questions

1. What do you think/feel about your identity as an African-American person?
2. People define racism in different ways, what does racism mean to you?
3. Racism affects people in different ways, when you have encountered racism, how has it affected you? (physical sickness, numb, sadness, anxious, etc)
4. How did/do you cope with the experiences of racism before seeking therapy treatment?
(What is noticed in the moment, and how do you care for yourself in the aftermath)
5. What led you to seek treatment (want to know if it was related to the racism or not)?
6. What race was the therapist? Did the race of the therapist make a difference?
7. What race was the person who committed the most significant racist experience for you?
8. Did you experience racism while in therapy?
9. Did you discuss experiences of racism in therapy?
10. Did you bring up the topic of racism, or did the therapist?
11. Based on your experience, would you prefer for the therapist to introduce the topic of racism, or would you prefer to wait and let you bring it up if you feel it is important?
12. Did you feel comfortable addressing these issues in therapy? Why?
13. Can you give me a sense of the type of racist experiences you have encountered?
14. Do you feel that treatment was helpful in addressing issues of racism? If so, what was done to make you feel this way?
15. Was there anything that the therapist said or did that you liked related to your experiences with racism?
16. Was there anything that you wish the therapist did differently related to your experiences with racism?

17. Did you feel like talking about your experiences of racism in therapy decreased your level of distress?

18. were there any changes over the course of therapy in the symptoms you were experiencing as a result of racism? If so, how did they change?

19. Do you have any advice or recommendations you would give a therapist who wants to be helpful to clients who are experiencing racism? Pitfalls to avoid?