# "White" or Wrong: Reflections on the Impact of Unyielding Whiteness on the Overall Well-Being of Black Practitioners

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**Abstract:** Practicing while Black is similar to driving while Black; what should be routine becomes a minefield and every day is filled with uncertainties. For Black practitioners, navigating unyielding Whiteness in the professional environment is not only costly but also often continuously compromises Black practitioners' well-being. This paper reflects Young's experiences as a Black male licensed clinical social worker and the challenges encountered in navigating a practice environment led by White female clinicians during the convergence of the COVID-19 pandemic and the emergence of the Black Lives Matter movement, demanding an end to ongoing police brutality and racial injustice against Black people. We provide recommendations for both Black practitioners and organizations committed to providing working environments that affirm and ensure racial justice.

***Keywords*:** race, gaslighting, racial battle fatigue

This paper focuses on the experiences of a Black man in the United States who is a licensed clinical social worker and the challenges of practicing while Black. When a Black person chooses to become a full-time therapist, their choice entails certain consequences. Arguably, the most important consequence is that the Black practitioner will face practicing in a field with an extreme racial imbalance because White mental health clinicians vastly outnumber their Black counterparts. Although racial imbalance exists across all professional fields, the lack of racial diversity in the social work field poses a particular challenge for Black male practitioners given the overwhelming majority of masters-level social workers are White (72.6 percent) and/or female (85 percent; Salsberg et al., 2017). Many social work agencies have begun to recognize that in order to adequately meet the needs of their clients of color, mental health agencies need to have clinicians of color on staff. However, too many mental health agencies make the mistake of hiring clinicians whose racial/ethnic identities are similar to those of their clients of color but without taking the key step of adequately assessing the agency's readiness to welcome, support, and sustain clinicians of color, especially Black clinicians. In many instances, the saliency and centrality of Black practitioners' racial identity are often disregarded by their White colleagues.

A Black person's identity as a practitioner does not exempt them from the inevitable and detrimental impact of racism experienced on the individual, institutional, and systematic levels. Indeed, a Black practitioner's repeated experience of microaggressions requires the practitioner to use all their tools for anger management and all their skill in resolving the negative emotions that result from these oppressive situations. However, the ongoing burden and difficulty in resolving the impact of microaggressions can lead to race-related stress, chronic feelings of indignation, or depression as well as poor coping through substance abuse (Franklin, 2004). The combination of the ongoing nature of microaggressions and/or direct racist assaults and the burden of resolving their impact is particularly important at the intersection of being Black while practicing as a mental health professional. For example, consider the stamina needed to simultaneously fulfill the role of a therapist while performing the mental gymnastics that come

with being Black, especially in a practice setting of unyielding Whiteness.

Even though being a Black mental health professional is arduous, having Black therapists in community-based mental health settings is vitally important to these organizations' ability to adequately address the mental health needs of Black clients, especially when clients' mental health is affected by race-related factors. Research on quality of care has shown that when providers overlooked the impact of racism on mental health, their clients of color frequently reported experiencing a subpar quality of care (Jones, 2003). This finding supports the need for Black clients to be matched with Black therapists when it is a good therapeutic match given that few evidence-based interventions are available that specifically address race-related issues such as being racially minoritized[1]. Moreover, these evidence-based interventions include few strategies for coping with racism; Black therapists typically face assisting Black clients with navigating racial trauma but do so with few resources other than a shared identity of being Black. Despite the dearth of culturally relevant interventions, available research underscores the importance of providing culturally relevant services because such services can affect the ways in which racial/ethnic minorities respond to treatment (Meyer & Zane, 2013).

## A Black Therapist's Practice Experience in a Mental Health Setting: A First-Person Reflection

After accepting a position as a therapist in a university counseling center, I was not surprised to learn the center's director, assistant director, and several other staff were White women. As an associate-level clinical social worker, I knew I would have mandatory clinical supervision and, given the racial makeup of the field generally and my agency specifically, I knew my chances of being supervised by a White woman were colossal. Indeed, the director assigned a White woman to be my clinical supervisor.

Although some might argue the selection of a clinical supervisor should be a colorblind decision, the presumption that race is not an intrinsic, key element of a person's identity actually perpetuates racism. For example, the Surgeon General's report on the ways culture, race, and ethnicity affect mental health noted racial/ethnic minorities consistently identified a primary barrier to receiving good quality care was the clinicians' lack of awareness regarding cultural issues and bias (U.S. Department of Health and Human Services, 2001). This same lack of racial/ethnic sensitivity can be extrapolated to the experience of Black clinicians who are negatively affected by the biases and lack of cultural competence of their White colleagues. In my case, the director's selection of a White clinical supervisor marked the start of the familiar feeling of having decisions made on my behalf without considering my race and gender.

I was one of two male clinicians and the only Black male clinician on staff. I quickly discovered the long-term effect of skewed research on clinicians' practice. Several authors have established that researchers in the fields of health and science have often overlooked Black men (e.g.,

[1] Please note, we use the term "minoritized" rather than "minority" to highlight the social oppression and power imbalance exerted by dominant groups (i.e., numerically larger) that minoritizes individuals. Many people prefer "minoritized" because the label "minority" can suggest they are somehow lesser or subordinate to the larger, dominant group.

Hankerson et al., 2015). Given the lack of research attention focused on Black males, White clinicians are often not only ill-prepared to work with Black clients who identify as male but also ill-prepared to work with colleagues who are Black males. This realization led me to develop anxiety about the quality of the supervision that I would receive, especially given my desire to focus on treating mental health issues among Black male students. I was particularly anxious about my supervision because the existing literature has shown that weak and ineffectual supervisory relationships can negatively impact the supervisee's clinical competence, and thereby, negatively impact clients (Jang et al., 2019).

## Race: The Elephant in the Room

Despite my concerns about receiving culturally competent supervision, I quickly discovered the topic of race was not openly discussed in the center. Because of the center's implicit policy of avoiding racial topics, I became uncomfortable navigating race-related issues during supervision. Clinical research has reported when racial/ethnic minoritized supervisees do not feel comfortable discussing their race-related concerns with their supervisor or when the supervisory relationship excludes racial/ethnic issues, then White clinical supervisors are more likely to commit microaggressions (Constantine & Sue, 2007). For example, during one supervision session in which I was attempting to explain the constructs of colorism and hair texture bias that exist within the Black community, my supervisor asked, "Do you have 'good' hair?" After several experiences that shone a light on these "not-so-micro" aggressions, I noticed my colleagues exhibited a pattern of focusing on their intentions while neglecting the cumulative harmful impact of their words and actions on their Black colleagues.

Although it was neither easy nor comfortable to call out my colleagues on issues regarding race, I knew remaining silent would be a disservice to myself, my colleagues, and our clients. When I reported my experiences of microaggressions and other race-related issues to the center director, her response was to ask me to "assume best intentions" when interacting with other staff members. Because of the director's response, I started to lose trust in the "thing" in my gut that lets me know when I am being mistreated. During staff meetings, I would often speak up about racial issues; however, after several instances of clinicians excusing their microaggressions by focusing on their intentions instead of their impact, I questioned if I was being too harsh or overly critical of my colleagues. Listening to my gut started to feel risky and unsafe, especially given the lack of hard evidence to support my claims of racial insensitivity among my colleagues. In addition to lack of hard evidence, the "optics" of the situation might suggest my colleagues were doing their best to be racially sensitive. Colleagues frequently pulled me into meetings as a representative of the Black community; what they saw as "calling in" to learn more and understand the Black experience felt to me like an interrogation I had to endure. At this phase in my career, I could not have been more aware of the consequences and impact of practicing while Black.

## Gaslighting

Practicing in a professional environment ill-prepared to support a Black male therapist and surrounded by White clinicians, who might have been well intentioned but unconcerned with

how their behavior affected me, had a significant negative impact on my professional confidence. Equally important, the extent of the negative impact was amplified by gaslighting. A person involved in gaslighting seeks to manipulate another person into thinking their perceptions of reality are mistaken, and thereby, accept the manipulator's claims of reality (Fuchsman, 2019). The gaslighting I encountered was so frequent that I questioned if enduring gaslighting was one of the "other duties assigned" in my position description. Gaslighting is an experience that the victim cannot easily articulate or pinpoint for others, especially when the gaslighting happens outside of intimate relationships and when race is involved. Whenever I summoned the strength to address microaggressions or gaps in my White colleagues' understanding of Black experiences, I was often met with an automatic defense of the colleague attempting to convince me the "real" problem lay in *my* perception of the situation; that is, I should have experienced their actions differently. Not surprisingly, having conversations about race with White colleagues often led to my feeling bruised, very sensitive, and as if my ability to regulate complex emotions had vanished. I began questioning and doubting the legitimacy of any experience regarding race. I even questioned if I had become committed to misunderstanding my White colleagues.

After several instances of problematic interactions related to race, I began to feel that self-advocacy was futile whereas keeping quiet started to feel sustainable. This U-turn in my own thinking prompted me to wonder about the relationship between experiencing racism and maladaptive coping. Some researchers have suggested that some Black individuals develop adaptive strategies to decrease the likelihood of experiencing discrimination—then, when faced with discrimination, these individuals process discrimination as mental stress rather than depression, with this adaptive strategy serving as a protective factor against developing a chronic mental health disorder (Bowser, 1981).

## Consequences of Racism for Black Practitioners

After several reports of microaggressions and difficulty facilitating conversations regarding race, the counseling center director acknowledged the possibility of a misalignment in the center's values and culture that needed to change to create a more culturally inclusive and supportive work environment for all staff. To that end, the director formed a task force to meet weekly and discuss ways of improving the center's values to align with the ideals of a racially just and inclusive work environment. The group consisted of Black and White clinicians, including the center director and assistant director. However, after several weeks of meetings that focused on analyzing the center's values and culture, the director announced the review had been shelved and no more meetings would be held because a few of the White clinicians on staff had expressed discomfort with the process. For me, the director's decision to halt all efforts toward holding the center and staff accountable for racist attitudes and behaviors sparked the initiation of my "racial battle fatigue."

The term *racial battle fatigue* was coined by William Smith (2004) to describe the mental, emotional, and physical strain people of color are likely to experience while living in and navigating historically White spaces. In turn, living with this chronic strain and ongoing stressors often leads to Black people experiencing one or more psychophysiological symptoms

that can range from anxiety, to frustration, to fear/resentment, to anger/depression, to headaches, to a pounding heart rate, to high blood pressure, and to sleep disturbances (Smith, 2004). Even though I was a young man who tried to live an active and healthy life, I experienced physical symptoms of racial battle fatigue. After months of navigating the center's racially toxic environment, I was not surprised when my primary care provider voiced her concern about my elevated blood pressure, even recommending that I quit my job because "no one under 30 should have blood pressure this high!"

Hypertension was not the only symptom of racial battle fatigue that I or my Black colleagues experienced. In advocating for health awareness in the Black community, each of us had engaged in countless conversations with colleagues, friends, and family members regarding the various ways racial trauma affects the physical health of Blacks. For example, research has suggested that even the *anticipation* of experiencing discrimination or prejudice can trigger psychological and cardiovascular stress responses (Sawyer et al., 2012). Additionally, research has well established that stress is linked to increased likelihood of cardiovascular problems such as diabetes, hypertension, and stroke (American Psychological Association, 2012; Steptoe & Kivimäki, 2012; Torres & Nowson, 2007). Without any sign that the center's environment might improve, continuing to work in a racially insensitive environment progressively took its toll and made my racial battle fatigue worse. Arguably, the worst point occurred during the aftermath of the murder of George Floyd, when another Black therapist and I were expected to counsel and support Black students without the director or our colleagues considering the possibility that we were also experiencing racial battle fatigue. Moreover, the racial insensitivity permeating the center's culture kept the director and other clinicians from recognizing that Black clinicians, like me, not only experience ongoing racial stress but also feel the burden of the cumulative racial stress across the history of America. For Black clinicians, the murder of Black lives at the hands of White police officers are not isolated instances of racial injustice, but events that echo lynching of Blacks in the 1800s, 1900s, 1930s, 1955, and today.

Another challenge Black practitioners face when working in a society that includes structural, institutional, and systemic racism is their own baggage in the form of the belief that Blacks must work at least twice as hard as their White counterparts. This belief exists within the larger Black community and comes with a plethora of negative consequences. This phenomenon is often apparent in what social epidemiologist Sherman James called *John Henryism*, taking the name from an American folklore hero who was a Black man famed for being able to work longer, harder, and more efficiently than a machine (James et al., 1983). James coined the term as a "synonym for prolonged, high-effort coping with difficult psychological stressors" (Wigger, 2011, para. 3). The health effects of John Henryism result from expending high levels of effort over prolonged periods to cope with persistent external stressors (e.g., racial discrimination), which leads to accumulating high physiological costs (Wigger, 2011). James and colleagues (1983) described these high-effort coping strategies as sustained, unyielding efforts to cope with racial barriers. Given the amount of physical and mental energy people of color must devote to overcoming racial barriers while adjusting to psychosocial stressors, high-effort coping strategies can be particularly detrimental to their physical and emotional health. For example, research has shown hypertension is one of the physical health consequences of John Henryism (James et al., 1983), with some suggesting the causal agent of Blacks' heightened susceptibility

to hypertension is the unrelieved psychosocial stress generated by the environments in which Blacks live and work (Wigger, 2011).

Being a Black practitioner in an environment that did not foster holistic wellness would exact a high personal cost at any time, but the cost was especially high in 2020 with the convergence of the global pandemic, the uprising of the Black Lives Matter movement, and the sociopolitical chaos that disproportionately affected Black people. Given the costs in this context, I reluctantly made the decision to resign.

## Recommendations for Organizations

If social work agencies are to provide high-quality, culturally competent mental health care for clients of color, then these agencies need to employ clinicians of color. However, in a field in which the professional workforce is predominantly White, how can agencies best support and retain clinicians of color?

An urgent need exists for agencies and institutions to adopt trauma-informed practices (Esaki et al., 2022) to better serve not only their traumatized clients but also their Black employees who navigate race-based trauma every day. Moreover, there needs to be greater accountability from the highest level of leadership and diversity, equity, and inclusion officers to ensure organizations are engaging in rigorous, ongoing self-evaluation as well as periodic outside evaluations to assess the organizational values and their alignment (or lack thereof) with socially just, inclusive, and anti-oppressive practices. In the absence of this level of accountability, anti-racism work will only lead back to *White centering*. White centering is a multi-faceted form of White privilege in which White persons maintain a central focus on *their* experience and intentions in interactions with persons of color (Cadet, 2020). For example, when a Black person tells a White person that an action or behavior was harmful to them as a person of color, the White person becomes defensive, often claiming the other person is overreacting or attempting to dismiss the harm done by claiming good intentions (Cadet, 2020). Rather than the White person listening and learning from what the Black person is saying about the impact of their behavior, White centering keeps the focus on the White person's feelings and their comfort in the situation rather than advancing support and advocacy for Black lives (Cadet, 2020).

Last, all organizations should consider their capacity to support, engage, and retain racial minorities and address organizational values or culture that pose potential threats to Black practitioners' well-being. Moreover, it is critically important to emphasize increasing the racial and cultural competence of non-Black clinicians within mental health is not and must not become the responsibility of Black clinicians. However, listening to Black practitioners' experiences is vital in drafting action plans to create culturally sensitive and psychologically safe working environments. We do not wish to be "White," and how Black practitioners show up is not wrong. As Black practitioners, our professional success and personal well-being should not be contingent on our ability to coddle Whiteness.

## Recommendations for Black Practitioners

The authors of this paper present the following recommendations and reminders for Black practitioners who are working in spaces that are not racially just. We understand that some folks are not able to walk away from their current practice setting and some might have no desire to leave their current practice. However, developing self-care rituals to preserve physical and mental health is vital for navigating the complexities of practicing while Black.

First, for every Black practitioner working in an environment that perpetuates racial injustice, it is vitally important they understand they are not alone. Others have navigated the trenches of Whiteness and likely have practical measures to recommend that will enable practitioners to feel protected and able to maintain their self-esteem even when faced with discriminatory workplace encounters.

Second, one of the greatest strengths and traditions in the Black community is the family (e.g., Belgrave et al., 2021; Franklin, 2007; Hill, 1999). Thus, it may be helpful for Black practitioners to seek support from family members around issues experienced at work, as well as seek out support and advisement from trusted mentors. However, it is also vital that Black practitioners go beyond their family and mentors to increase and strengthen their social support systems. For example, this intentional action might include attending a support group for Black practitioners. If such a group does not exist, then practitioners should consider the cost-benefit to themselves of creating a support group to foster community and safety among their Black colleagues. Black practitioners in rural areas with few, if any, other Black clinicians, could consider forming a support group for Black professionals or finding a similar support group in a nearby metropolitan area.

Third, even though the work environment might not feel like a safe space, we encourage Black practitioners to enforce their personal boundaries as one means of creating a personal safe space. Today's Black clinicians are practicing in an era in which several organizations and institutions are seeking to make work environments safe for Black practitioners; however, the processes that challenge biases and shake the status quo to engender myriad changes can be difficult for Black people to navigate when White people become defensive. In such instances, we recommend that Black practitioners exercise their freedom to walk away and to create a safe space for themselves. For example, if a Black practitioner becomes aware of their colleagues' gaslighting or holding Black practitioners responsible for educating White colleagues on race-related issues, creating a safe space might be simply walking away from racially insensitive colleagues. Because no one can control the actions of others, it is vital that Black practitioners set their boundaries, including what they will do when a boundary is triggered.

Although the ideal is to engage in practices that foster healing from racial trauma, it is equally important to engage in daily practices that provide a temporary relief from racial stress. Engaging in a daily routine of stress relief activity is essential to Black practitioners' ability to improve and maintain their mental health as well as their cognitive agility and acuity. Such activity could include deep breathing exercises or practicing mindfulness mediation. Breathing intentionally and peacefully aids meditating to access the higher, more steady self, enabling the

practitioner to explore what the higher version of the self has to offer them in the present moment. Others might find stress relief and empowerment through participating in spiritual activities such as prayer, reading scriptures, and listening to spiritual music. Another method to release stress is in journaling, using writing to process negative experiences and to purge negative emotions out of their mind, body, and soul. Let the negative experience take residence on paper. Stress relief can also be found in physical activity. Engaging in joyful movement not only honors what the body can do but also unlocks tension and allows it to exit the body. We recommend engaging in healthy and mindful eating. Eating to fuel the body can be a relief valve when food is eaten with awareness and intention, honoring the taste, smells, textures, and temperatures of what is consumed. Last, a great stress reliever is making some noise! Talk, sing, shout, or laugh out loud! Do not become or stay silent: Share your experiences with a trusted person or a therapist. You deserve to be heard.

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