Do You See Me? The Compounding Impact COVID-19, Racial Injustice, and White Clients Had on a Black Therapist

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Abstract: The compounding effects of the COVID-19 pandemic alongside racial unrest in 2020 created an unrelenting need for scholarly analysis of the internal and external impact these experiences had on my life. My daily struggles of being a Black woman in America intensified during these unprecedented societal shifts which impacted my experience as a Black mental health clinician in a predominantly white workspace. This scholarly personal narrative conceptualizes these historical events, examined through the lens of Critical Race Theory. The two vignettes provided are lived experiences and illustrate the ways in which white privilege intersects with prolonged racial unrest—compounded by the deleterious effects of COVID-19 on Black clinicians. This scholarly analysis highlights the negative impact that racial injuries can have on Black clinicians who lack protection from repeated racial offenses. Recommendations for critical self-care practices and implications for future research are provided.

***Keywords*:** systemic racism, microaggressions, racial injury, racial trauma, inequity

My Narrative Matters

Social justice and service are two core values embedded in the foundation of social work and have been instrumental within social work advocacy (National Association of Social Workers, 2017). Social workers utilize a plethora of platforms to advocate for social justice and other core values for their clients, communities, organizations, and the causes (interests and principles) that they serve. However, there are times when social workers find themselves in the conflicting role of professionally serving as a clinician while also being subjected to direct racial harm. Ethically, social workers have a duty to do no harm to the client. I firmly believe this principle should be reciprocated for the social worker, with special consideration for racial stress, injuries, and trauma. To further complicate self-advocacy, there remains challenges to advocating for oneself as a Black female social worker in a predominately white workspace. Striving to be an exceptional social worker in a setting where those who work alongside you lack the ability to truly validate your presence (by having an appreciation for vital demographic and cultural differences) can lead to increased racial struggles, injuries, and discrimination (Comas-Diaz et al., 2019). These experiences can best be described as Practicing While Black, and they can be unbearable for the clinician. Throughout this scholarly personal narrative (SPN; Nash, 2019) the words clinician, social worker, provider, and therapist are used interchangeably.

The year 2020 has shown me how unbearable *racial injuries* (racial trauma and race-based stress) precipitated by racial discriminatory events, whether real or perceived to be real, are when compounded by a global health pandemic and magnified racism toward Black individuals in America (Comas-Diaz et al., 2019). This SPN is a depiction of experiences that have meaning

and purpose that can provide others with the type of "self and social insight" (Nash, 2019, p. 24) that is a rarity in the more common types of research. As Nash (2019) explains, one has to be willing to take the risk to narrate their experiences in a way that gives a depiction of the results of the experience(s). For the purposes of this SPN, it is important to use the lens of Critical Race Theory (CRT) as the tenets of CRT support these shared experiences in totality and align with the values of social work (Daftary, 2020).

Critical Race Theory

Critical Race Theory (CRT) examines the relationship among power, race, and racism (Delgado & Stefancic, 2017). CRT was birthed out of two earlier movements, critical legal studies and radical feminism, and is often utilized as a vehicle for challenging racial barriers and approaching and discussing racial injustice (Delgado & Stefancic, 2017). By the 1980s, many of the foundational or inspirational CRT theorists were perplexed at the lack of critical literature, language, and case law addressing race and areas such as but not limited to inequality, sexual difference, and cultural identity (Delgado & Stefancic, 2017). Intellectuals such as Derrick Bell, Kimberlé Crenshaw, and Richard Delgado, amongst others, used their voices and platforms to disrupt the status quo of legal decisions being made without consideration of the fundamental differences experienced within communities of color impacted by poverty, welfare, and criminal and immigration law (Delgado & Stefancic, 2017). For scholars to apply CRT to any injustice, one must first understand the basic tenets. For the purposes of this SPN, I will utilize the following six tenets: racism as ordinary (or permanent); critique of liberalism; whiteness as ultimate property; interest convergence; intersectionality; and unique voice of color (Daftary, 2020; Delgado & Stefancic, 2017; Kolivoski et al., 2014). This SPN reflects my lived experience as a woman of color with the purposes of validating, supporting, and illuminating this experience in the social work profession.

Microaggression or Microassault

As I wait patiently for my client to join the teletherapy session, I begin to think about the patient's well-being. I am hopeful that he is doing well. That he is safe and abstaining from opioid use. That even if he is in active substance use that he is cognizant enough to wear a mask to protect himself from contracting COVID-19. Over the past several weeks my client has been having a very difficult time managing his mental health and his substance use disorder. Given the global public health pandemic, my concern for him engaging in any adverse risk-taking behaviors is increasing. By this time, I am conducting all therapy sessions remotely through teletherapy.

Luiggi-Hernández and Rivera-Amador (2020) recognize the importance of providing services to clients through teletherapy during this pandemic, given the decrease in social engagements, resulting in increasing loneliness and feelings of isolation—all a result of the safety precaution mandates, such as social distancing, altering society's normal ways of engaging. While I am

appreciative of the ability to continue working with my clients, I unfortunately have no way of preparing for what it is about to cost me emotionally, mentally, physically, and spiritually.

Vignette I: Heritage

As he joins the session, he begins to smile, and I respond in kind as we greet each other. I begin to engage in my normal routine of completing a check-in and a sense of disbelief sets in as my brain tries to process what I am seeing on my computer screen. I confirm in a matter of seconds that a familiar but remote reference of an object is indeed this object: A confederate flag is hanging on the wall behind my client's head. This intense feeling of disappointment begins to consume me—feelings of violation, disrespect, and disregard. I begin to grapple with the fact that I am experiencing an actual racial *microaggression*, "subtle daily actions of white people against minorities," (Hall & Crutchfield, 2018, p. 492) or possibly even a *micro-assault*, "purposeful discriminatory action," (p. 492) all while providing therapy and giving support to my client. At this exact moment I must make a pivotal decision. Do I ignore this symbol of hate, or do I address it? I begin to wonder to myself: Should I focus on providing *unconditional positive regard*, therapeutic intervention without judgment (Kaluzeviciute, 2020), or proceed with setting clear clinical boundaries regarding my tolerance of unacceptable and harmful client behavior.

Do No Harm

With genuine authenticity, I decided to speak up as my morals were prohibiting me from remaining silent and my ethics kept me from expressing my very raw and intense feelings. My mind and spirit prohibited me from ignoring this blatant symbol of racism that for so many years has been one of the universal symbols of white supremacy. As a clinician your client's safety is always at the forefront of your mind, but what about your own safety? What happens when what may benefit your client can harm you in the process? You strive to do no harm and, when unavoidable, you make the clinical judgment to do the least damage to the client even when it means that the clinician endures racial injuries.

As I type these words, I can vividly recall all the images from the media coverage (only a few months prior to the time of this writing) of extremists, whom I refer to as domestic terrorists, storming the US Capitol. While committing these insurrections on January 6, 2021, they brought with them two very blatant symbolic representations of white supremacy—confederate flags and a noose hanging from makeshift gallows. The nauseating feeling I am experiencing during this client session is the same feeling I felt on January 6, 2021. I begin to brace myself to address my client, and I remind myself to keep my composure at all times. At that moment I am already aware that if I express my disdain with too high of a volume or too intense of a tone, I will be perceived as an "angry Black woman" (Doharty, 2020, p. 255). I'm Black, a woman, but I cannot be angry because white society limits my freedom of expression with damaging labels. However, why should I have to unfairly censor my response? I am the one who is being

violated, being affected by racial injury. I have the right to be angry, don't I? After all, "Blacks have been told lies about slavery; lies about being free, about inclusion, about civil rights … the lies have spanned centuries" (DeGruy, 2017, p. 114). The response my client is about to say to me will be just another lie and minimization to add to the many other false truths that have been stated over several centuries of racist history.

I begin by asking my client the million-dollar question: "You know that I'm Black, right?" The client responds with a chuckle and says yes. I ask, "Are you sure?" and he gains a puzzled look on his face. Then I say to him, "Is that a confederate flag behind you?"

He responds, "Yes, but it doesn't mean what you think it means. It means heritage."

As I try to process what is taking place, I begin asking myself through internal dialogue, "Did he just say 'it doesn't mean what you think it does'? Did he really just say that this symbol of hatred means 'heritage'?" I respond by respectfully, with a calm tone, informing him that the flag he is using for wall decor may mean "heritage" to him, but it does not mean the same thing to me. As I look him directly in his eyes with composure but sternness, I am setting a necessary boundary that I, a therapist who is Black, have no interest in nor am I going to tolerate this symbol of oppression. My client, a white man, is not seeing me as an equal and the intent of his choice to display this flag in my purview is both questionable and concerning. Regardless of his reasons, the injury is happening. Moving forward, I was not subject to his wall decor again, but the impact of this encounter will be a lifelong reminder to me that many whites do not believe nor function under the belief that Blacks have the right to equal treatment and equitable resources.

Means to an End

Mosley et al. (2021) emphasize the importance of Blacks being aware of, processing, and combating anti-Black racism. Participants of the study report dealing with the social aspects of racial injury such as isolation, safety concerns in multiple settings (i.e., neighborhood, work, school), and a constant state of worry. Living in a nation where racism is part of the norm and everlasting, Mosley et al. (2021) provide a critical consciousness model as a way to combat racial trauma.

Regardless of their roles, for the provider-client relationship to be healthy and productive, each individual must feel respected. I was the provider, but I was also his means to an end. I was his therapist, the professional in this dyad, and my well-being did not appear to matter to him. His actions are reminiscent of how Blacks have been exploited, mistreated, and abused in many extremes dating back to slavery, especially the Black woman and the Black woman's body. For instance, West and Knight (2017) provide an example of the Antebellum South as it was the norm for enslaved women to be forced to wet nurse white women's children while their own were left without nourishment. This forced practice was considered a form of labor, a means to

an end. No regard was given to these women or their children's needs, as those of white society took priority. Still today, the desires of white people overtake the needs of Blacks. As a result of this historical pattern we (Blacks) hope for the best and brace ourselves for the worst, such as Mosley et al. (2021) referring to the constant state of concern for one's welfare that Blacks face on a continuous basis.

As I ask myself, how does anyone build rapport—a trusting relationship in which they expose their most vulnerable parts of themselves—but make no attempt to be mindful not to cause damage to the one confidant that is their designated safe place? A safe place that happens to be a human being with feelings? It is important to note that at this exact moment, I am already an experienced clinician and specialist in mental health and substance use disorders, but no clinical training prepares you for this moment. I impulsively want to ask him, "You know I actually have feelings and experience emotions, don't you?"

To have no regard for someone who you have a vested interest in exudes white privilege—male white privilege in this situation, to be exact. It is a demonstration of personal gain without taking account for collateral damage. This sadly reminded me of the sick feeling that came over me the first time I watched a video on the racist history of research involving human subjects, hearing and processing that such grossly negligent behaviors were conducted all under the false premise that whites actually thought Blacks did not feel pain (Cronin, 2020). What is even more appalling is the realization of how rampant this deception persisted and how frequently it was used as a justification to withhold administration of any anesthesia during vaginal surgeries as elaborated upon by Cronin (2020). Some of these women were not even documented by name, which further demonstrates the callous nature of how they were viewed and treated. The same sense of callousness continues to perpetuate itself and shows more often than not in many of the relationships I have with white men.

At this exact moment I recognize my desperate need to release my feelings of anger; however, I make the selfless choice to salvage the therapeutic relationship. As my brain was deciphering the automatic thoughts that were flooding my consciousness, I have to weigh what is more important in this exact moment. Is it his well-being and safety or my desire to exhibit self-advocacy while upholding "the values, ethics, knowledge, and mission of the profession" (National Association of Social Workers, 2017, p. 25)? I have an ethical obligation to practice within my discipline with high standards, but I also have an obligation to uphold the value of social justice (National Association of Social Workers, 2017). In the midst of compounded marginalization and oppression—juggling my overlapping identities and roles, my intersectionality (Crenshaw, 1989) of being Black, a woman, and a Christian trying hard to hold on to my spirituality in the midst of ongoing racial trauma—I am struggling and suffering. I choose to hold on tight to the hope and trust I have in God as He is the only source of strength and relief that I know will be effective in helping me manage this crippling racial injury.

Maintaining, Strength, and Coping

There were days I relied on my internal coping skills, and I came up short multiple times, experiencing anxiety way beyond my norm, especially on days when all my many worlds (obligations and roles) collided. There were days that were so anxiety-provoking that the Generalized Anxiety Disorder–7 Likert scale rolled its eyes at me. As an experienced clinician, I learned years ago the benefit of a therapist having their own therapist. There was a point in my life when I allowed myself to be worried about the stigma of a therapist having a therapist. Oh, how quickly that goes away when you see people who look like you, who are going through similar suffering, with no clinically trained outlet. I express to those in therapy and considering therapy that if your therapist does not have a therapist, you need a new therapist. Of course, it rolls off my tongue with slight humor, but every inch of my being means it. In addition to my God, my therapist, and having faith in the hope that the anguish would loosen its grip so that I could breathe … I also had my family. I had a supportive, God-fearing husband who was my human Likert scale. My husband of 12 years who, on days I functioned in a vacuum of survival, made sure that our children, ages seven and three at the time, were okay and ensured they were thriving.

I would be negligent if I did not expand on the spiritual component of my survival, especially since the racial stress, resulting in racial injuries accompanied by ongoing trauma, never ceases. Knowing that this is my reality I must remain anchored in a source that never ceases to provide me with strength and relief. “Humble yourselves, therefore, under God’s mighty hand, that he may lift you up in due time. Cast all your anxiety on Him because He cares for you” (*Holy Bible, New International Version Online*, 1973/2019, 1 Peter 5:6–7). On days I forget to do as this scripture states, the stress and injuries are harder to endure. On the days that I remember to do exactly as this scripture states, the impact becomes easier to endure. I am well aware, without any doubt, that the God I believe in and serve is the primary reason I am able to maintain my sanity.

To provide a more contextual understanding, it is important for the reader to know that in the midst of dealing with difficult dyads on many levels, I was also working on a doctoral degree in social work. Yes, I decided to start a doctoral program, three months before a global health pandemic hit, and the heightened media coverage of never-ceasing racial unrest. One baseless murder of a Black person after another intensified my never-ending anguish. Listening to those who desired to be allies make their feelings the center of Black peoples’ pain just frustrated me more. As a social worker, it is engrained in me to help others; however, when that helping relies on me personally teaching non-persons of color how to not oppress me in their efforts to support me, I resisted. I resisted teaching my white colleagues how to treat me with the same level of respect, courtesy, and deference that someone with my expertise and non-melanated skin tones would receive. Academia is rewarding, and learning is limitless, however it is also a prime example of systemic and institutional racism. The irony of having to teach my professors and academic colleagues on how to treat me was exhausting.

Silence is Never an Option

As a mother I struggle with what exactly I should say to my children. Not saying anything will never be an option. I am an advocate. I am hopeful that my now four-year-old son will not remember this time period. With wishful hope, by the time he is no longer considered a cute little toddler, I will not have to fear him being looked at as a grown Black man—as a threat—by those who do not resemble him, before he reaches legal voting age. Gibson (2018) expounds upon the fact that Black boys are depicted as dangerous, giving Western society justification for the callousness with which Black boys are murdered by police. In desperation, I need positive and substantive systemic changes to occur in America.

As for my seven-year-old daughter, some of our most difficult conversations as a family were multi-part efforts explaining racism—why *racism is ordinary*, the hatred and discriminatory actions towards Blacks and other persons of color, is normal (Delgado & Stefancic, 2017), even in 2020. The topics were varying—a mix of basic questions and those that were complex and confusing to a seven-year-old. Why circumstances will never improve for us Blacks unless there is an *interest convergence*, where whites give Blacks rights and equality only when it benefits them (Kolivoski et al., 2014). Why some whites treat us differently with little to no consequences because white society sets the norms, states what is valued as property, and determines the measure by which everything else in this nation is compared to as part of *whiteness as ultimate property* (Kolivoski et al., 2014)—and has existed since the creation of the US Constitution. Why when my daughter gives me a confused look and seeks deeper understanding of the historical origins of racism, I will have to educate her on the Three-Fifths Compromise, wherein Northern and Southern states agreed to count slaves as three-fifths of a white person's representation for delegate seats and as property for economic investment (DeGruy, 2017). I will have to converse with my daughter about how we are the descendants of an American lineage that were considered only property.

In addition, I will have to explain why in the downtown area of our community, people are marching and protesting against the death of yet another Black person—yes, even whites who are allies will protest with Blacks as they believe in *liberalism*, neutral approaches of equality (Kolivoski et al., 2014), but this cannot exist in a world where access to resources has never been equitable. I will have to explain why, as Bogues (2020) describes,

> Blackness as a visual marker produces within the dominant common sense the death of the Black person. Black life becomes disposable, is a lack … the black body has no escape. Its public presence is an affront, it must be tamed, put back in its place. It must be not allowed to breathe, because breath is life and for the black body to breathe means it has life. (p. 5)

I must explain why there is undeniable truth in what Bogues (2020) expresses, making me even more reluctant and fearful for my daughter to be a part of these protests—for my husband and I

to understand that she is just as much affected by systemic racism as we are, regardless of her single-digit age. Most worrisome, I must have the discussion with our daughter that attending a march could mean life or death. To see the look on my daughter's face when I tell her "If anything happens, no matter what, you do exactly as Dad tells you to do." Then to say to my husband, "Bring my baby back safe." Even at such a young age she understands that we are treated differently. She understands that in America a Black person "can dream, as long as you can breathe / you can be the … President of United States / and get murdered right on these streets / welcome to America / land of the brave and home of the free" (Trotter & Matthews, 2021).

However, in spite of all that she must be educated on, until God sees otherwise, I will continue to use my unique voice of color to provide my experiential knowledge, first-person account of oppressive experiences (Delgado & Stefancic, 2017; Kolivoski et al., 2014) that are real, traumatic, cause long-term negative effects, and are just as prevalent today as they were 100 years ago. I will continue to share with my daughter the power we each hold in speaking our truths, especially against forms of oppression such as racism, in all its many forms. She will know that although it is taxing, overwhelming, and just pure exhausting at times, social workers like her mother understand the importance of speaking out against the effects of racial injury and trauma and race-based stress.

There should always be a level of accountability that white people will need to be willing to assume when it comes to choosing to be ignorant towards those with various degrees of melanin and the inhumane acts toward them over several centuries. I think about the countless times I have heard non-persons of color say, "*I* didn't do it," or "Why are you blaming me for the past?" amongst other comments. Reluctantly, I do admit there is some truth to those statements—then my response becomes, "What are you willing to do to move toward equity and equality for people like me?" Some whites have been willing to have those uncomfortable conversations and when they express how "uncomfortable" that feeling is, I usually reply, "Imagine feeling like that every day." With some, reality starts to set in. With others, their demeanor presents as if they couldn't care less.

I also have asked and will continue to ask myself, "What am I [actively] doing to be a part of the solution?" Kendi (2019) asked a thought-provoking question that people of non-color should consider when making generalized kneejerk responses to the history of slavery and racism in this nation: "What side of history will we stand on?" (p. 22). Kendi provides his scholarly opinion on how someone may say they are not a racist, however they support a racist policy, which makes them a racist. In direct contrast, an anti-racist would be an individual who supports policies and advocates via actions to demonstrate they are anti-racist. In addition, Kendi (2019) perfectly stated, "No one becomes a racist or antiracist. We can only strive to be one or the other" (p. 23). I do agree that when you fail to take action your complacency or silence is only perpetuating the problem. I, too, must hold myself accountable for how I stay engaged in being a part of the solution.

Vignette II: The "N-Word"

The "N-word" has been documented amongst scholars as the "nuclear bomb" of racial slurs (Holt, 2018, p. 2). The racial slur that the "N-word" derives from is so "inflammatory" that it is implied with just a single letter (Holt, 2018, p. 2). I continue to have an internal ongoing tug of war with holding myself accountable for (doing my part) dismantling a systemically racist system that I didn't create and having clients who assume that just because I am Black, they can have conversations with me about the "N-word."

It is 11 pm. My client has just left me a voice message in extreme distress as her partner keeps calling her a "nigger lover." I am listening to the voice message, she is crying hysterically, and her sense of urgency is provoking a multitude of emotions within me. She is presenting to be actively in a crisis by the tone of her voice and I, the clinician, the social worker, am now genuinely concerned for her welfare. I am even more so concerned because she is hysterical and requesting a response. I am in a conflicting state of shock and confusion, and unscholarly thoughts are automatically crowding my mind. I replay the message again and again to fully comprehend the words she is saying to ensure there is no indication of imminent safety concerns, but unfortunately in my intent to ensure her safety I jeopardize mine, mentally and emotionally. I am telling myself that my client has a plethora of issues—but listening to someone talk about being called an "N" lover while Black will not be one.

A few days go by before I address this with the client. I know that without a high likelihood of countertransference, I am no longer able to provide therapy to this patient. I know that I am no longer capable of providing unconditional positive regard, nor do I desire to do so. I know I must draw a line as my self-preservation is depending on it. I need to create an impenetrable boundary as, once again, I am left vulnerable without good cause, purpose, or sufficient support. In addition, I am apprehensive about ceasing to provide services to this client, but this also resolves as she states during our phone conversation that she feels that I am a good person to talk to about being called that specific racial slur, as I am Black and if "anybody understands" she is confident it would be me. Next, she begins to tell me that this racial slur is just a [expletive] word, and if anyone has an issue with it, that is their problem. She begins to repeat the racial slur and does so three times: N-word, N-word, N-word, consecutively. I realize she has just given me confirmation that this therapeutic relationship is null and void.

The Only One

Being the only Black therapist in a small-staffed clinic became very isolating and implosive as no one understood my parallel emotional struggles that were constantly colliding. My Black skin knew no difference between my professional or personal persona. Being Black transcended all aspects of my life. There was nowhere to escape the perception that others had about my Black skin. My Black skin was everywhere I went. The reflection from the light that beamed off my melanated skin projected itself into every space I entered. Well, that is at least how I felt all

the time as my pigment made its entrance in the spaces I frequented. I can recall being in a multidisciplinary meeting and out of around 21 people, I was the only Black person in attendance. Was I the only minority? No—however, I wondered if anyone else in the room also noticed that I was the only one who looked like me. A sense of pride and isolation settled in, both at the same time.

At work, within my department, no one would speak on the racial unrest, the tension, the continuously televised killings of George Floyd, Breonna Taylor, and countless others. It was suffocating me. I would often think to myself, "We are all masters-level therapists!"—yet speaking *around* the issue became the norm. The entity that I worked for constantly spoke on COVID-19 and all the ways that we could seek support for this health pandemic. In my perception, race relations were often mentioned at the end of important employee news updates or buried in between other relevant information. I took major issue with this as racial unrest was analogous to a pandemic and was not something that should be placed in the "other" or "in addition to" category.

Racial unrest has been—was—and will always be an issue of all humanity until the need for scholarly narratives such as this one become obsolete. Until then, the importance of personal experiences of oppressed and marginalized populations must be captured and shared and the only way I believe we can truly capture the essence of these experiences is through narratives. SPNs must be shared for academic and professional growth (Nash & Viray, 2013).

My experiences, my pain, my dilemmas were nothing like my peers'. In my attempt to obtain support regarding the racial slur situation, as the nature of the language in the voice message was beyond offensive and I was coming to terms with the fact that the therapeutic relationship was now altered beyond repair, I sought administrative guidance from management. Trying to consult regarding this oppressive and racist dilemma with two non-Black males, one being a self-proclaimed "redneck," was frustrating to put it lightly. The other desired to be supportive despite previous differences of professional opinions, but this resulted in me being addressed one too many times in that authoritative white male tone that exudes, to me, the "I am the boss hear me roar" persona. It is all in the tone, the looks, the questioning of my certainty when I provide pertinent and/or relevant information. Even as I write my story, I worry about the backlash of sharing my truth, however all of it is vital to understanding the multilayers and complexity of the impact that racial traumatic stress and racial injuries are having on Black clinicians. As 2021 continues, remnants of 2020 linger like an antibiotic-resistant infection. This reflective narrative provides one of many experiences Blacks and other persons of color have experienced for hundreds of years—but 2020 shed undeniable light on the systemic and historically ingrained mindsets of many non-persons of color. The state of Black people and systemic genocide is not a new phenomenon; however, COVID-19 has brought unprecedented coverage into everyone's home through multiple media platforms. This has only magnified the impact of the traumatic events.

Taking the Responsibility Off of the Survivors

Until 2022, the *Diagnostic and Statistical Manual of Mental Health Disorders-5* (DSM-5) did not take into account racial and cultural differences when diagnosing symptomology related to stressful or traumatic events. In addition, the DSM-5 did not take into account individuals who have been continuously exposed to cumulative events related to race and culture, and it therefore lacked an appropriate use when determining diagnoses for individuals impacted by trauma specifically related to racial stress, racial injury, and racial unrest. A race-based category for trauma is still absent, and I remain in support of *not* including one as it would be inappropriate and counterproductive for blame and accountability to be placed on the survivors of this form of trauma. Exposures to race-related trauma are based on external factors such as systemic racism, discrimination, harassment, and hatred that is taught and passed down from generations, amongst other irrational beliefs about or toward someone based on race as Carter (2007) expounds on in "Racism and Psychological and Emotional Injury: Recognizing and Assessing Race-Based Traumatic Stress." Those affected by this type of trauma have no control over how society has, can, or will treat them. The primary actions a survivor of racial trauma can take are to treat the symptoms, because the problem itself can only be ceased by those inflicting the trauma.

Carter (2007) and Carter and Pieterse (2020) make valid points as to why the DSM-5 would not be the appropriate place to classify race-based trauma and why (when diagnosed) Post-Traumatic Stress Disorder is a misdiagnosis of race-based trauma. Carter and Pieterse (2020) deem race-based trauma to be more accurately depicted as "psychological and emotional injuries than as psychiatric disorders" (p. 86) due to the cause not being dispositional but deriving from sociopolitical environment, making the events situational.

In 2022, the APA issued a text revision of the DSM-5 claiming that steps were taken to provide information on symptom variation based on race, how culture may affect pathology, and diagnosis prevalence among different racial groups, as well as how to avoid misdiagnosis due to race and racial oppression. However, many of my original concerns remain unwavering:

1. Survivors of racial trauma would be given a mental health disorder diagnosis resulting in an inaccurate depiction of that individual's mental health. Race is a societal social construct and the person who is subject to racial injuries cannot change their racial identity to lessen their risk of exposure to racial harm.

2. The responsibility of mitigating the trauma would be placed on survivors and neglects all responsibility and accountability from those causing racial injuries–both individually and systematically.

3. Racial injury can transpire through multiple mechanisms such as symbols and language symbolic of racism, differentiating racial trauma from Post-Traumatic Stress Disorder.

4. Encounters of race-based stress and injuries are non-pathological and therefore any version of the Diagnostic and Statistical Manual of Mental Health Disorders would not be the appropriate platform to use for categorization.

5. In lieu of seeking to diagnose race-based stress and further stigmatize those subjected to it, the profession should adopt standardized assessment tools that can validate and measure racial stress, injury, and trauma as an effective way for capturing the effects of exposure.

The Impact of Racial Stress/Injury/Trauma

Nadal et al. (2017) completed a study using measures specifically related to measuring the effects of microaggressions on physical health, and the findings included significant correlations regarding physical functioning, role limitations due to physical problems, role limitations due to emotional problems, decrease in energy and increase in fatigue, decline in emotional well-being, decrease in social functioning, and increase in pain. There were a total of 277 participants, all persons of color, of which 54 identified as Black. In sum, the general decline of the participants' overall physical health was associated with microaggressions experienced by each individual. The Racial and Ethnic Microaggressions Scale (REMS) and the RAND-36 were the measurement tools used for this study.

Torres-Harding et al. (2012) conducted a study using The Racial Microaggression Scale (RMAS) with a sample size of 377 persons of color (150 of the participants identifying as Black) with a mean age of 26.7. Almost half of the participants were students, and the other half were nonstudents recruited from the community. There were 28 whites included in the sample size, accounting for 10.2 percent of the sample. The RMAS measured the following factors: feeling invisible or being treated less than; being criminalized, portrayed as low-achieving, or considered from an undesirable culture; subjection to sexual stereotypes or sexualization; treatment as a foreigner or as someone who "does not belong"; and environmental invalidations. The findings suggested that the RMAS was a reliable tool able to measure microaggressions across multiple groups of persons of color (Asian, Middle Eastern, Latino, and Black).

Carter and Pieterse (2020) devoted an entire book to measuring and capturing the effects of racism. Under the primary investigation of Dr. Carter, three studies were completed laying the groundwork for the development of the Race-Based Traumatic Stress Symptom Scale (RBTSS). The scale was formed with the symptomology identified in the studies, including, but not limited to, the following: depression and anxiety, guilt or shame, somatic reactions (headaches, stomach pain), avoidance or numbing, and arousal or hypervigilance. All symptoms were self-reported, then clustered together utilizing Exploratory Factor Analysis (EFA), which resulted in the identification of seven distinct groups. Those seven symptoms' scales were identified as "depression, intrusion, anger, avoidance, low self-esteem, hypervigilance, and physical reactions with internal consistency" (p. 110). Construct validity and reliability of the RBTSSS was established utilizing EFA.

The REMS, AND-36, RMAS, and RBTSSS all show a correlation between race-related stress and health. This supports the need to thoroughly address systemic racism which can cause race-based stress, and, if unresolved, will most likely lead to race-based injury and race-based trauma.

Recommendations

Self-Care Options: Tried and True

My approach is to first, pray and seek God always. I feel there is no mystery to the known fact that Blacks have utilized God as a source of strength since the beginning of time. If you believe in God and have a relationship with Him, become even more acquainted with Him, for the obstacles involved in combating systemic racism are relentless work. If you identify with an alternate higher power or more so with the universe, tap into this source of strength, as you will need it. Second, if you do not have a therapist, get one. Yes, Black people do go to therapy and it works. If you have one and the relationship is stagnant, ask yourself if it is in that state due to your doing (lack of engagement and/or transparency) or due to a lack of compatibility. Whatever the cause, address it and do your work to address your own racial stress and injuries. Just like I tell my patients, I tell you: You are worth it. Do your work. You deserve it. Third, determine which battles are worth your energy as advocating for yourself in addition to advocating for your patients can leave you depleted with no reservoir. Fourth, within the perimeters of social distancing and keeping yourself and others safe, identify what you enjoy (healthy coping behaviors) and be intentional about scheduling your "me time," "family time," or some other type of protected time that you need to pour back into yourself. Fifth, be your brothers'—and sisters'—keeper by developing and supporting your peer network.

Racism is isolating enough. If you sense others like you may benefit from an encouraging word, an act of kindness, say it, do it. There have been several times when those simple but much needed acts of kindness gave me hope. Just know that sometimes if you get an inclination to *do* it is okay to follow through as that particular moment is not about you.

Additional Recommendations: Practice and Future Research

1. As a Black clinician it is important that you identify and clearly define your boundaries with your patients and with your colleagues with consideration to your racial and emotional safety and well-being.

2. Advocate for use of race-related stress, microaggressions, and/or other discrimination-related scales (measures) to be utilized at your place of practice if there are clients who could benefit from having their health status more accurately depicted.

3. Further development of specialized research on how best to support Black clinicians, best practices to repair race relations, and action plans to implement race reconciliation.

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