Practicing While Black: Responding to Everyday Racism in 2020 During Multiple Pandemics

Reshawna Chapple, Ashley Morris, Shelleta Ladonice, Karryl Honeycutt, and Britt Blakey

Abstract: The role of a social worker is inherently challenging, especially during times of crisis, and it becomes particularly triggering for Black female social workers when the crisis is intertwined with racial issues. Amidst the COVID-19 global pandemic's peak, a viral video depicting the police murder of George Floyd exposed America's deep-seated racism. This period saw both Black and white Americans grappling with the dual crises of health and race, leading many to seek support from Black therapists. Utilizing an autobiographical feminist standpoint epistemology (Harding, 2001), four Black female social workers' stories are examined. Our narratives reveal the complexities of navigating multiple pandemics—racial turmoil, COVID-19, global lockdowns, economic uncertainty, political divisiveness, and the aftermath of former president Trump's election refusal, marked by the Capitol insurrection. Our accounts also explore the countertransference experienced in cross-racial and intra-racial therapeutic dynamics, emphasizing the unique significance of self-care for Black practitioners during tumultuous times.

***Keywords*:** Black women, social workers, COVID-19, intersectionality, racism, self-care

Practicing as a social worker during a crisis is inherently demanding, necessitating that the clinician simultaneously provides emotional support to others while grappling with deeply personal issues. Being a Black female social worker during a time of crisis can be incredibly triggering, mainly when the crisis revolves around race. In our work, we have encountered many mental health professionals who suffer from anxiety, depression, and trauma in their own lives; we observe this is often a reason for choosing this profession because of either negative or positive experiences with mental health issues or professionals in the past.

Before 2020, mental health professionals typically addressed their grief, loss, and trauma before assisting clients with similar issues. However, the pandemic altered this dynamic: Clinicians now confront pandemic-related challenges, like financial insecurities and remote work stress, while simultaneously supporting clients through the same issues. We struggle with personal fears for loved ones' health, mirroring our clients' concerns. This shared experience has deeply intertwined clinicians' and clients' issues.

On Memorial Day, 2020, the world was transfixed by a viral video showing the murder of George Floyd, an unarmed Black man, in Minneapolis, MN. A white police officer knelt on his neck for over nine minutes while three other officers either held him down or looked on without intervening (New York Times, 2022). The COVID-19 pandemic has brought society to a standstill, leaving people ample time to watch television and scroll social media. This event ignited a global wave of protests, with millions taking to the streets (Buchanan et al., 2020). Notably, George Floyd was not only unarmed but also accused of a non-violent offense—

allegedly using a counterfeit $20 bill at a convenience store (New York Times, 2020). It appeared that the world, mainly white America, was awakening to the enduring racial crisis that had haunted the country for centuries. Many white individuals began examining the prevailing status quo (Dreyer et al., 2020), including introspection about their privilege.

In today's politically charged climate, the intricate interplay of social identities, privilege, oppression, microaggressions, white supremacy, allyship, and power dynamics has become a focal point, particularly in therapeutic settings. Additionally, the global and US-specific ramifications of the COVID-19 pandemic have exposed the stark injustices, inequalities, and deeply entrenched institutional and systemic racism.

This collection of narratives explores our lived experiences as Black female social workers practicing amidst dual pandemics (racial and COVID-19), global lockdowns, economic instability, emotional turmoil, political polarization stemming from the US presidential elections, and the tumultuous aftermath of former president Trump's election refusal, culminating in the Capitol insurrection on January 6, 2021. During this time, many Americans had to adapt to a sudden and profound shift in their way of life. The rapid onset of illness, death, and restricted hospital visits or funerals added to the collective grief. Over 100 million Americans abruptly lost jobs and faced financial hardship (International Labor Organization, 2021). School closures; suspension of travel, entertainment, and dining out; and the widespread adoption of face coverings transformed daily life within days. Schools shifted to online learning, transforming many unemployed or work-from-home parents into impromptu homeschool teachers. Heightened tensions, fueled by the unpredictability of daily life and exacerbated by racial unrest, created a volatile atmosphere.

These stories challenge the prevailing notion in mental health that assumes that Black, Indigenous, and People of Color (BIPOC) social workers are identical to their white counterparts and share the exact professional needs, as if all social workers are interchangeable—culturally responsive therapy practice stands in contrast to the standardized, one-size-fits-all model of evidenced-based practice, which tends to reflect the dominant culture in its evidence (Whitley, 2007). Previously, it was widely believed that identity played no significant role in counseling service delivery, and mental health training was considered universally applicable (Sue et al., 2009). While recent research has spotlighted culturally responsive interventions, it often assumes the clinician is white (Sue et al., 2009). Thus, we emphasize the structural inequalities and the limited research in this area, underscoring the misconception of uniformity.

By highlighting the experiences of Black female social workers in 2020, we aim to raise awareness about the unique challenges Black counselors face and propose strategies to enhance their well-being and combat social isolation. Alongside practical self-care advice, we aspire to encourage an increase in the representation of Black mental health providers. In 2018, a staggering 84 percent of mental health providers were white (American Psychological Association, 2019), exacerbating racial disparities in mental health care. This accentuates the urgency for more culturally responsive training programs. According to research, most BIPOC

clients prefer practitioners who share their racial and ethnic backgrounds, and mental health outcomes improve when Black clients work with Black clinicians (Williams et al., 2019). We authors of the four autobiographical narratives shared here identify ourselves as Black female social workers, clinicians of intersectional gender and racially marginalized identities, practicing in various clinical settings. The fifth author, who identifies as a white female social worker, chose not to include her narrative to ensure that our four experiences remained central.

Reshawna Chapple is a tenured university professor, practicing clinical social worker, and researcher focusing on educating and mentoring health professionals from underrepresented backgrounds. All authors of this article are practicing, graduate-level clinicians with Master of Social Work (MSW) degrees. Additionally, Ashley Morris and Shelleta Ladonice recently completed PhDs, and Britt Blakey recently completed her MSW degree. In this article, we interchangeably use the terms clinician, counselor, mental health professional, social worker, practitioner, and therapist.

An autobiographical feminist standpoint epistemology (Harding, 2001) was used to share our encounters with discrimination and countertransference. In feminist standpoint theory, perspective and position hold intrinsic value (Yuval-Davis, 2006), making it a fitting framework for our narratives, which were gathered during student mentoring sessions and counselor support groups established and led by Chapple. These weekly meetings served as a forum for mutual support and discussions, encompassing topics such as navigating personal responses to everyday racism and microaggressions, handling countertransference, adopting best practices, and strategies for supporting both clients and ourselves during concurrent pandemics.

Our meetings followed a natural progression, starting with our positionality as Black female social workers amidst the tumultuous events of 2020, then delving into necessary adjustments made in our practice to address microaggressions, countertransference, self-care, and boundaries. These discussions fostered mutual support, improved our comprehension of our intersecting identities and positionality, and enabled us to address countertransference issues, culminating in this article's narratives. To structure these conversations, we categorized them into the following themes: (1) Understanding Intersectional Identity in Practice as Black Professionals; (2) Navigating Intersectional Discrimination, Microaggressions, and Countertransference; and (3) Establishing Healthy Boundaries and Self-Care Practices. Finally, we discuss implications for clinicians who are practicing while Black.

Practicing While Black

Black clinicians face distinct challenges often overlooked or unrecognized by their white counterparts; Black clinicians during concurrent racial, political, and global pandemics face unprecedented and uncharted difficulties (Novacek et al., 2020). A glaring gap exists in the literature about BIPOC and, specifically, Black therapists. Most literature focuses on cultural responsiveness toward BIPOC clients, and what sparse literature there is about Black clinicians primarily stems from graduate student theses and dissertations attempting to augment the meager existing body of work (e.g., Adams, 1994; Daniel-Washington, 2011; Fisher, 2019; Gavel, 2012; Harbin, 2004; Price, 2015; Rosier, 2020). Furthermore, the ongoing pandemic has

generated scant research on counseling during a global crisis and none (at the time of writing) on the unique challenges faced by Black counselors amid a racial pandemic.

Navigating our intersectional identity as Black female social workers in America is a multifaceted journey shaped by the nation's racial history and the pervasive influence of white supremacy. Identity encompasses not only race but also social class and power dynamics. White supremacy fosters a false sense of inherent superiority, credibility, and worth among white individuals, establishing a power imbalance that extends across social, economic, and political realms (Beliso-De Jesús & Pierre, 2020; Saad, 2020). However, in the therapeutic relationship, the counselor assumes the authoritative role, which may cause friction in the cross-racial counselor-client dyad (Gavel, 2012). Addressing race can benefit the therapeutic relationship in white counselor–Black client dyads (Day-Vines et al., 2018; Knox et al., 2003); however, Gavel (2012) discovered that for Black clinicians, it entails a more intricate process involving careful consideration of trust within the therapeutic relationship, therapist and client self-awareness, client comfort, and stage of therapy.

Intersectional Identity

Intersectionality examines how our marginalized identities intersect and influence various aspects of our personhood, forming the foundation of all social interactions (Crenshaw, 1991; Hancock, 2007; Hulko, 2009). This analytical framework enables us to grasp how intersecting identities like race, gender, class, sexuality, and disability simultaneously impact the experiences of marginalized groups. Rather than treating these identities as separate entities, intersectionality views them as necessarily interconnected and inseparable (Crenshaw, 1989). It goes beyond merely tallying up the discrimination tied to each identity and aims to comprehend how the amalgamation of these identities collectively shapes an individual (Yuval-Davis, 2006). Jordan-Zachery (2007) uses intersectionality to describe her identity as a Black woman. She states,

> "When you look at me, what do you see: a woman who is black or a black woman?" In my eyes, this is a moot question since my blackness cannot be separated from my womaness. I am not sure if I want them to be separated. What I want is for individuals not to use my social location to justify punishing me or omitting me from the structures and practices of society. Sometimes my identity is like a "marble" cake, in that my blackness is mixed intricately with my womaness and therefore cannot be separated or unlocked. (p. 261)

When a group of people live at the margins because of their intersectional identities, they become invisible (Chapple et al., 2021). Our identities are inseparable; they continually interact to shape our experiences. When racism is present, sexism may also be a factor, and vice versa. The farther someone is from dominant identities (e.g., heterosexual, cisgender, white, able-bodied, male, etc.), the greater the likelihood of encountering discrimination in their lives.

Reshawna Chapple

I identify as a Black female social work professor and licensed clinical social worker. I am a social justice scholar whose areas of clinical practice and research include intersectional identity, mental health disparities, and access to culturally responsive services for Black women, Deaf women, persons with disability, and other historically marginalized communities.

> *Put the mask on yourself before assisting others*. If 2020 taught me one thing, it would be to roll with life's challenges because neither my clients nor my students care if I am struggling. In 2020, several pivotal events occurred in my personal and professional life: I earned tenure and promotion to associate professor; my youngest child graduated from college; I started a private practice, training, and consulting business; and I began construction on a new house. Unfortunately, these milestones were overshadowed by the murders of George Floyd, Breonna Taylor, and other unarmed Black people; COVID-19; and the presidential election. I felt I was being pulled in a million different directions the entire year. Everything was a challenge. It was the most difficult year I had in all my years of teaching. Many of my students, especially those who had grown up in conservative households, struggled with the idea of learning about diversity from a Black female professor. Often, I would remind my students of the National Association of Social Workers (2021) *Code of Ethics* and the principles of dignity, respect, and the value of every human being; however, it became more critical for them to feel comfortable than to learn about social work practice. Equally, my clients, many of whom were white men, struggled to challenge their Trump-loving friends or parents. The sessions would follow the same pattern: "Dr. Chapple, how do I speak to my parents, friends, or partner about the importance of voting for a Democrat in this year's election/wearing a mask/the importance of quarantining?" They would say, "They do not listen to me, which is frustrating." They would also talk about how important social justice issues are and use the killing of George Floyd as an example. I would listen intently and offer strategies, all while struggling to keep my composure. It never failed: I was consistently asked about 10–15 minutes into the conversation if it was appropriate for them to discuss these topics with me and if I was okay to talk about it. I appreciated the sentiment, but it is my job to discuss these things, and if I did not feel emotionally safe, this was not the time and place to disclose that. As a Black woman and especially as a Black female social worker, I have been trained to focus on my client's feelings while disregarding my own. That is especially difficult to do when the world is on fire and I am mentally and emotionally exhausted.

Ashley Morris

I identify as a Black clinical social worker. I currently see clients in private practice while pursuing doctoral studies. While advocating for my clients, I am reminded of the importance of self-advocacy and self-compassion.

> *Black therapists matter, too.* As a Black clinician in 2020, I discovered the need to engage in more self-care, change how I approached each session, and address potential

triggers and countertransference. Due to the year's unusual circumstances, we were forced into a situational entanglement with our clients. This was not countertransference; this was life in 2020. These times were unprecedented and likely the most challenging we will experience as clinicians. However, if you were a Black clinician, you could expect that the feelings were exacerbated and compounded by systemic and institutional racism. While these forms of discrimination can be traumatic for Black individuals, Black counselors were using their best skills to cope with the added responsibility of supporting clients through these shared experiences. Therapists are human, and as such, we can be triggered. Though we may have been activated, we could not allow our feelings to interfere with our client's therapeutic process and needs, so we remained in the moment, present with our clients. That is work—extensive work—to be able to do that successfully. Imagine now that work had to be done, session after session, because a Black man was brutally murdered by a police officer the day before, and every single one of your clients needed to process it. How long were you, as the counselor, allowed to process it for yourself?

Shelleta Ladonice

I identify as a Black Haitian American social worker. I am a doctoral student. The murders of unarmed Black people in America led to my desire to embrace the cultural pronunciation of my name and focus my research on Black immigrants.

Social workers are essential. The social worker's job carries the responsibility of advocacy in practice, research, and academia. In March 2020, schools were moved online due to the COVID-19 pandemic. I continued working with a student virtually who required time and creativity to build a relationship. One day, I met with her mother and noticed a Confederate flag on her shirt. Immediately, a wave of fear, hurt, and anger flooded over me—but I had to remain professional. I kept glancing at it several times while trying to focus on our meeting. I began to question whether I was the best fit for her daughter. I questioned whether or not the symbolism of that flag had something to do with the working relationship. I did not want to feel differently about my student or project my hurt onto her. While I continued providing the best service, I could not forget seeing that flag on her mother's shirt, nor did I want to. I drove past several to and from work, but this time felt different. Maybe it was the increasing media coverage of Black men and women killed by police or the feeling of betrayal because her mother was always kind. During that unforgettable moment, something changed, and I knew I had to keep my feelings in check.

One of the ways I am coping with racial injustice is by addressing diversity in teaching and research. As an instructor, I purposefully insert discussions on cultural differences and considerations into every lesson. Bringing awareness to cultural diversity in assessment, diagnosis, and treatment approaches is a path toward healing and a better future. The pandemic allowed me to self-reflect and shift my priorities. I did a great deal of self-talk, reassuring myself that every practitioner and researcher has a preferred population, so I should not feel guilty for mine. Who is gonna have my people's back like

I will? The racial injustice and social justice movements brought many emotions to the surface: fear, anger, sadness, inspiration, and hope. The pandemic sat the world down and became a time of honest reflection. While this article speaks to social work practice, being Black isn't something that only impacts our practice but also how we see ourselves as individuals. As much as we attempt to draw professional boundaries, our personal lives and experiences still filter into the other areas of life.

Karryl Honeycutt

I identify as a first-generation, Black Caribbean licensed clinical social worker raised in America. I practice psychotherapy, clinical consultation, and social work advocacy. As a Black female practitioner during the pandemic, I found myself face-to-face with the same challenges as those I support personally, professionally, and socially.

Hats vs. lenses. We often discuss the various roles or personas we adopt, akin to wearing different hats we can take on and off as needed. However, practicing in 2020 was distinct because we could not simply swap one "hat" or persona for another. We were navigating grief and trauma alongside everyone, including our clients. Historically, we could enter a session with a clear idea of which hat to wear. Nevertheless, during the pandemic, addressing traumas with clients demanded wearing multiple hats, and given the intersection of our identities, we often had no choice in selecting which hat to wear.

I cannot *not* be any of my identities. Regardless of the hat I may put on, I am never not Black; I am never not a woman. Moreover, I can never not think through that lens. It has been difficult because I have had to be more mindful about which identities should be prioritized in my decision-making with clients. So, the intersectionality of my identity influenced my work, making it more complex to navigate. However, it encouraged me to incorporate more tools to guide how I made decisions and approached the work in front of me.

Countertransference

As Black counselors practicing during the racial pandemic, we had the excruciating but beautiful opportunity to guide our Black clients through a harrowing time as we were navigating it ourselves; thus, our Black clients became a source of fulfillment and nourishment. At the same time, we were tapped out. Lipscomb and Ashley (2020) stress the point that we, as Black clinicians, "used the connection, the shared experiences, and our activation to inform our clinical lens during this time" (p. 232). There is no culturally responsive canon of evidence-based models and practices to use when working with Black clients, so we are forging our own out of shared lived experiences, making it up as we go along, validating and holding their pain while honoring our own.

Countertransference occurs when the words or actions of a client trigger a counselor (Freud, 1910/1959). Often, this phenomenon happens at a subconscious level. Jones-Smith (2018) states that countertransference influences the therapeutic relationship and course of treatment. In the

above example, countertransference can be positive and aid in the therapeutic process because of the deep, unspoken connection of shared experiences. Naturally, in the ordinary course of therapy, topics arise that the counselor may feel strongly about. When Black counselors are in a cross-racial therapeutic dyad, countertransference can hinder progress as feelings and triggers come up for the clinician, especially given the historical context of racism in America.

Cultural countertransference is "a matrix of intersecting beliefs and experiences that take place within the counselor both consciously and unconsciously" (Jones-Smith, 2018, p. 43), which includes the clinician's beliefs and biases about the identities of both them and the client, their worldview, and their value system. White people are often conditioned not to recognize their whiteness or the privilege it affords (McIntosh, 1989/2019). Consequently, white clients may unconsciously commit microaggressions, microinsults, and microinvalidations (Delapp & Williams, 2015). The Black clinician is tasked with regulating her emotions and maintaining composure, even when triggered by the client, all while prioritizing the client's well-being. This responsibility can be exceptionally overwhelming. Race significantly influences American relationships, including the cross-racial therapeutic dynamic, where racism is a prevalent concern (Price, 2015). White clients' sudden acknowledgment of historical racial violence and dynamics can be jarring, as Black clinicians are unaccustomed to hearing them accept or explore these truths. Given that white individuals are often discouraged from discussing race and may have never examined their whiteness about others, they may inadvertently make inappropriate, insensitive, or overtly racist remarks.

Honeycutt recounts facing questions like, "Why do Black people get offended when…?" and "Why don't y'all just…?" These questions seemed straightforward to address in the past, but in 2020, they became profoundly triggering. Despite the available information online, the responsibility once again fell on the Black social worker to respond while maintaining composure, as they are professionals. When these microaggressions or overt acts of racism occur, Black therapists often face further microaggressions or microinvalidations when seeking support from white supervisors lacking multicultural or culturally responsive supervision training (Constantine & Sue, 2007). Whether dealing with clients, supervisors, or strangers, Black social workers continually assess how to handle each situation, moment by moment, weighing consequences, staying composed, readjusting, refocusing, recalibrating, and repeating. The therapeutic microaggression mirrors the broader challenges they navigate daily.

Chapple recalls instances of countertransference that manifested in different ways with clients, colleagues, and students:

> I worked with a client for months to gain the courage to leave her abusive husband. We made a safety plan and discussed risks. As we began to execute the plan, I helped her with strategies to learn to love and accept herself for who she was. As we were working on her getting more comfortable with her decision, she asked for my assistance to prepare for an event she wanted to attend but feared her husband would also be there. We worked on strategies for her to remain calm if she saw her husband. She attended the event and later told me it was a unique, uplifting experience. Eventually, she revealed that it was a Trump rally. The event I helped prepare my client to attend was a Trump Rally. This

> news rattled me to my core; it is not my practice to tell my clients whom to vote for or how to feel about politics, but all of the unhealthy traits in her husband that she was trying to get away from were shared by Trump.
>
> In addition to working with an influx of new clients, there was a bevy of requests for me to do anti-racist/culturally competent training for agencies. In these training sessions, I would often work with people and try to explain some of the nuances of race-based mental health disparities and racial trauma that Black individuals were going through. In one of my training sessions, listening to therapists of color outline their struggles with white clients and feeling dismissed by their bosses, there was a specific instance in which I had to gather myself because the emotions were so overwhelming; I found myself transfixed by my past traumas, flooded with images of racism I had experienced in my life.

Morris reflects on staying centered and managing countertransference during therapy sessions:

> Black people have been outraged by systemic and institutional racism for years, but we are even more outraged during the pandemic, and now other non-Black bodies are paying attention. We are hurt, outraged, and frustrated, but not all feel the same. During this time, I faced the challenge of my career because of the feelings of those who would dispute the argument that Black lives matter. I began to reflect on several questions, such as, can a clinician who identifies as LGBTQ counsel a homophobic client? Can a Black clinician counsel a white nationalist? We are taught to meet clients where they are, but what if their behaviors and perspectives are marginalizing and racist to you as the clinician? How much are we, as clinicians, required to endure? How much of our mental health do we have to be willing to challenge to support the client?
>
> As I explored my role in promoting social justice and addressing race-related issues, I found myself feeling guilty that I was unable to attend protests on the Saturday following George Floyd's murder. I felt a pull to participate, but my client's schedule was full. As I reviewed my schedule for the day, I realized that every client happened to be Black. My immediate thought was that they would want to process the hurt, despair, frustration, anger, and other emotions they were feeling due to the police brutality and systemic racism impacting our community. The guilt of failing to attend protests subsided as I realized my role: supporting my clients, helping them process and cope, and supporting their mental and emotional health goals. My clients did not censor themselves; they shared precisely how and what they felt, one of them declaring, "Today, more than ever, I appreciate having a Black therapist and knowing that you truly understand, and you feel this, too." That client was right, and I appreciated that I could be in the water with them rather than pulling them out of the water because sometimes, that is what we need.

Ladonice discusses her transition from school social worker to PhD student:

> In the fall of 2020 (during the presidential election), I worked as a graduate teaching assistant in which we were on Zoom due to the pandemic. One of my roles was to help

> manage the chat during lessons. During a lesson on cultural competence (including cultural humility), a white student typed a question into the chat, asking why cultural competence needed to be discussed. I immediately felt angry. I marveled at how, in light of all that happened regarding racial injustice and the protests only months earlier, a student could ask why this was important. I wondered whether this was a sincere question from a student who wanted to know how cultural diversity related to social work practice or if this was coming from a student who was annoyed and felt it was unimportant. I wanted to address the question by asking for its motive. I wanted to know if this was an attempt to devalue the necessity of becoming culturally aware and culturally sensitive as students preparing to become future practitioners—but I was not the professor. Thankfully, the professor responded quickly and passionately with what appeared to be the assumption that it was a sincere question. We later discussed the incident. She also had the same initial reaction that I did—anger, wondering what the motive was behind the question, especially in light of current events surrounding racial injustice. I felt validated. At the same time, while the topic is critical to both of us, we were triggered differently—she is white, and I am Black. I carried that incident with me throughout the semester, on edge every week and concerned about the possible mindset of future white social workers. If we are honest, we can see issues of racism and ethnocentrism among some of our white social work practitioners of today.

Honeycutt states:

> I was contacted by a Black therapist who was looking for therapeutic support for her child and decided that I would be a good fit because the child could relate to me. This should have been a red flag for me. As a Black therapist, there were many layers of countertransference at play, and I should have taken a step back to untangle my emotions and consider the implications of taking on another clinician's son as a client. I could identify with her experience as a Black woman and a mother. Since this was not her child's first experience with therapy, and she had explicitly referred to needing a Black therapist, I was pretty sure that racism or microaggressions were part of the story, which can be triggering for a therapist, as well. I wanted badly to help, even though my caseload was beyond full at the time. I immediately started feeling inferior, with a significant amount of imposter syndrome, since this new client was the child of a clinician. Would I do a good job? Could I be impartial? I began to think about my intersecting identities: As a mother, I understood this mother's need to ensure that her child was receiving the best care; as a Black woman, I understood this mother's need to be seen, heard, and understood by professionals without having to explain or teach about being Black. Ultimately, I took on the client, but I had to establish firm boundaries with the mother regarding discussing her son's treatment. It would be a challenge, but who else could she turn to?

Self-Care

Existing literature on clinician self-care targets white practitioners (Daniel-Washington, 2011). This bias is rooted in the fabric of white supremacy and colonialism ingrained in American

society. However, Black clinicians often adopt different stress management strategies compared to their white counterparts. For instance, religion, spirituality, and the Black church hold significant roles in African American life, with prayer and fellowship serving as vital self-care rituals not adequately covered in the literature (Blank et al., 2002). Black and white clinicians cannot engage in self-care in the same manner. A standard recommendation, going for a walk outside, is something often taken for granted by white individuals but may not always be safe for Black people due to the historical risk of confrontation, challenge, or harm for merely existing as a Black person in America. These added stressors, combined with assisting clients in navigating racial issues during times of heightened racial tension, contribute to burnout and compassion fatigue.

Burnout and compassion fatigue are pervasive issues in helping professions, prompting a recent surge in emphasis on self-care (Posluns & Gall, 2020). The constant exposure to others' problems can take a toll on practitioners, potentially impacting clients' treatment progress. Despite existing research on therapists and their self-care practices, the unprecedented nature of managing stress as a clinician during a global health crisis applies universally, regardless of racial or ethnic background. The COVID-19 pandemic has created a shared experience worldwide, with experts foreseeing an increased need for psychological intervention and guidance to cope with its emotional and psychological effects (Rokach & Boulazreg, 2020). This demand extends to clinicians, who must manage their stress while aiding clients. Additionally, Black practitioners face their stress, triggers, and trauma related to the racial pandemic, police brutality, and heightened racism surrounding the 2020 presidential election. Beliard et al. (2018) emphasize the importance of self-care and supervisory support for practitioners of color in addressing race and culture-related issues in therapy. Self-care is crucial for all clinicians but especially vital for clinicians of color, who navigate not only standard stressors but also racism, microaggressions, cultural insensitivity, and a lack of cultural support (Beliard et al., 2018).

Chapple states:

> As alluded to previously, several events signaled significant loss and chaos that would occur in 2020: The death of Kobe Bryant and the loss of a sentimental item occurred in January; the loss of my wedding ring occurred in February; I learned I earned tenure and promotion to associate professor via an awkward Skype conversation; and my youngest child, a senior in college, was sent home from a London social work internship focusing on HIV education and testing in March. As it became evident that we would have to shut down in March, it became imperative to think about self-compassion. I quarantined with my husband, youngest child, and three dogs; it was challenging but comfortable. I converted my in-person classes to Zoom, increased my virtual counseling caseload, mentored counselors in online teletherapy practices, and tried to support my family, friends, students, and clients through unimaginable loss. Some of my students missed Zoom classes due to a lack of internet access or computers; many were thrust back into unhealthy living situations or were embarrassed to turn on cameras because of a lack of privacy. Some students became unhoused due to dorms closing; others missed assignments because they lost jobs or loved ones due to illness or contracted COVID-19.

> I could not have imagined what the next year would entail, but it became clear that self-care was survival.

Morris:

> Many people, such as spouses, do not understand. Sometimes, I wanted to take the day off, but my husband would say, "Isn't this your job?" As clinicians, we often place unreasonable expectations on ourselves to be well and perceive others as expecting us to be well. We are trained and provided the knowledge and tools to address mental illness and are therefore presumed likely to address our mental and emotional health issues adequately. We face the same challenges our clients face; often, they know what to do but require more support regarding how to do it and how to find the motivation to follow through. Sometimes, the problems seem insurmountable; the critical factor is knowing when to step back and allow yourself respite. Rest, recovery, and self-care are essential to gathering the energy and motivation to follow through with interventions. Rest also enhances the mental clarity to know what and when to execute. Suppose we fail to accept that we are human and, therefore, are not impervious to mental and emotional health challenges. In that case, we do not allow ourselves respite and recovery. This is especially difficult for clinicians who feel their clients genuinely need them at this time. However, we must ask ourselves, "Do my clients need me, or do I need my clients? Have I supported their self-sufficiency and validated them as the leader in their process? How much of me do they need, and how much do I have to give?" Of course, we should not abandon our clients, but when we notice that our obligations interfere with our mental and emotional health, we must re-explore our commitments.

Ladonice:

> In addition to coping through teaching, I practice self-care by setting strict boundaries about what, when, and if I will watch videos or read articles related to racism and discrimination. I must protect my peace, which means I must be in charge of what I let into my emotional space and when—if ever. As practitioners, we teach our clients how to set and maintain boundaries. We teach them that they do not have to attend to everything around them that is crying out for their attention. As Black clinicians, we need to practice what we teach. Another way I practice self-care is by being in a community with other therapists of color, where I can safely process my experiences (including my most recent experience with microaggression), share my concerns, give and receive support, and discuss ways to move forward—emotionally and practically. Having a community of therapists of color has been a consistent, invaluable blessing. Above all, my spirituality has been the anchor for my well-being. Being connected to God through prayer and music therapy keeps me grounded. It reminds me that the hatred and suffering I see now will not always exist, so I move forward each day, hoping for a better future.

Honeycutt:

> My self-care practices have included increasing my intentionality about the activities I participate in training, learning circles, and social events. Additionally, I have increased my physical activity and found ways to enjoy movement within the safety of my home while seeking safe out-of-home experiences. My self-care has also included attending to my self-talk and being mindful of my thoughts to create a healthy internal environment. With each injustice toward a Black person, I noticed that there was more work to be done within myself. When an issue of injustice presented itself in session, I could better recognize it as a trigger and seek professional support from peers and mentors to work through the countertransference that it presented.

Blakey:

> This article intentionally centers on Black experiences; as a white collaborator working with Black colleagues, I assumed a supportive role as a writer and editor, opting not to contribute to the narratives. Countless articles exist that focus on the experiences of white clinicians. Additionally, because of the way I have structured my life, it is not uncommon for me to be the only white person in a group of BIPOC individuals. Though this is neither intimidating nor uncomfortable for me, I realize this type of self-awareness is not always the norm for white clinicians. However, it is my reality and a privilege.

Discussion

Often, as Black social workers, we must help our BIPOC clients process the same racial trauma that we are experiencing while assisting white clients in managing disputes over racial climate, Black Lives Matter, or politics—or console them as they experience guilt or confusion while confronting their white privilege. All of this is occurring during a pandemic that disproportionately impacts Black Americans. Navigating this triple-faceted pandemic requires rigorous self-care. Prioritizing our well-being during these trying times enables us to manage the emotional roller coaster and demonstrates to our clients the significance of consistent self-care practices.

When it comes to our intersecting identities, we cannot, as Black female social workers, proclaim the existence of one identity that is absent from the others. We pridefully embrace our Black female identities as we navigate our challenging yet rewarding profession. The following are some tips and suggestions for fellow Black clinicians, which we have personally incorporated into our lives. These practices have helped us maintain our equilibrium, prevent countertransference, and manage the demands of multiple roles as wives, mothers, daughters, sisters, and social workers:

1. Check in with yourself every morning about how you are feeling. You have a right to feel sad, angry, exhausted, fearful, anxious, depressed, or numb. This can be a sign of vicarious trauma or simply a survival mechanism. Be honest with yourself; look at your schedule and try not to schedule challenging clients together or schedule clients back-to-

back. It would help if you had time to decompress and expel the negative energy we sometimes take in from clients.

2. Try to limit your consumption of news and social media. Adjust your phone and computer notifications. Many of us lose productivity when we are highly emotional or stressed.

3. Process your feelings with your therapist, spiritual advisor, or emotionally safe BIPOC and white allies. Allow yourself to be vulnerable and resist the urge to minimize your feelings. This is your opportunity to work through your feelings and concerns.

4. Start a self-care routine: Use meditation, grounding activities, yoga, stretching, or breathing exercises to calm your body and your mind.

5. Set boundaries and consider muting or blocking toxic individuals or anyone who causes you to feel overwhelmed or stressed. Just because you are a therapist does not mean you need to take in negative energy in your personal life.

Many view counseling as a part of our life, not just a career. However, we cannot be effective if we are depleted or stressed; we cannot pour from an empty cup. Being a clinician in 2020 was physically, mentally, and emotionally exhausting because it meant carrying an additional burden of unreasonable expectations. Some therapists felt uncertain; others were triggered and overwhelmed. Nevertheless, we are resilient, and we discovered support in each other, colleagues, and co-workers with shared experiences, and sometimes even through online clinician support groups. Setting boundaries and establishing connections became crucial for coping with unprecedented times and unique challenges.

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