CHAPTER 1

Where Do We Begin?

Racial Trauma and Thinking Beyond Diagnosis

> Black folks come from a history where a woman would be forced to watch as her own child was sold and sent to an unknown place never to be seen again and told to quit crying or get beaten and return to work in the field as if nothing ever happened! Our ability to recover may seem like "natural resilience," but it's resilience born out of our ability to grieve being snuffed out. The only acceptable response to terror was to just . . . recover and get back to IT . . . whatever IT was. And it was taught over and over again.
>
> —MICHAEL, age 70

Sean, a 17-year-old young Black man picks up his phone and sees a text message from his best friend. It reads, "DID YOU SEE THIS?!" Included in the text message is a link that leads Sean to a video of the George Floyd incident. Sean's heart rate starts to go up. He feels his face warming up. He keeps watching. He's seen several videos like this before, but this one feels weird. It's . . . long. He keeps watching, all the way to the end. While watching, Sean mutters his thoughts out loud, even though he is in his bedroom watching alone. "Why does this keep happening? They can just kill us in broad daylight." He feels a lump in his throat. He takes a deep breath and shakes his head. Then he grips his phone and sits still for a moment. Suddenly, Sean throws the phone across the room and screams an obscenity so loud, his mother runs in to ask what is going on.

Two weeks later, while driving home from school, Sean hears a police siren. He checks his rearview mirror and sees he's being pulled

over. Sean doesn't notice it, but he grips the steering wheel with both hands, his heart rate increases, and he starts to feel nervous. He glances at his phone. "Should I pick it up and call someone or record?," he thinks. The officer taps on the window, abruptly making Sean realize he never pulled down his window. "Son, do you know why I stopped you?" Sean just stares. He's sweating a little now, but he can't tell if the officer notices. "No, officer." "Where are you coming from?," the officer asks. Sean looks up nervously and then glances back at his cell phone in the passenger seat. He can't grab it now to record or call anyone. Too late. He answers back, "From school. I live right around this corner." The officer looks at him for a moment. Sean feels as if he could faint from the amount of tension in his body right now. "OK," the officer says," I stopped you because this is a school zone, and you were driving a little too fast. Slow it down. I will let you go since you are so close to home." The officer walks off. Sean leans back in the driver's seat. He puts his hands to his face and can feel the sweat. He drives home thinking, "I could have never seen my mom again. . . ."

Years later, Sean, now 24 years old, has come to your office reporting that he always feels anxious. He doesn't trust work colleagues, has racing thoughts that lead to sleepless nights, struggles with perfectionism at work, and generally never feels "settled." Sean denies any family history of anxiety, depression, or other mental health issues and currently lives alone and works in a corporate setting. He presents with a calm demeanor, makes eye contact, and takes time to ponder his words prior to answering your questions. When you ask about any history of a traumatic experience, Sean says he can't think of anything significant.

When clients enter treatment, as clinicians, we use what they tell us their presenting issue is and ask questions or offer measures to ascertain a deeper understanding of what challenges they are facing, in order to come up with a strategy to treat them. If a client comes in expressing that anxiety is their current major stressor, we tend to use that as an entry point to take a deeper dive to better understand how it affects their life and figure out a plan. What if a client has a hard time articulating what exactly is going on? In Sean's case, where would you even begin if he does not seem to have a sense of where this anxiety is coming from? Would you know what to ask him?

Much has been written in academic literature about the impact of **trauma** on brain development and long-term health, and about the way those impacted learn how to survive in the world. Research has found that early and chronic exposure to adverse childhood experience and adverse community environments can lead to tremendous stress, hypervigilance, and overall distressing thoughts and feelings about oneself and others. Repeated exposure to stress and trauma results in a person's vigilance for spotting threat becoming overactive, triggering the body's stress response (think: fight-or-flight response) so often that it becomes the default response to stressors of any magnitude (Felitti et al., 1998; Harris, 2018; Dye, 2018; Cronholm et al., 2015; Winfrey & Perry, 2021). This extra sensitivity to threat is not an indication that a person is broken or doing anything wrong. They have simply adapted to a world that puts them in situations where the risk of not being ready for threat is high. In the words of one of our adolescent clients, "I stay ready so I never have to GET ready." "Staying ready" is a natural and adaptive response to an environment that feels unpredictably yet chronically unsafe or threatening. The short-term benefit is the perceived feeling of control and preparation, but being in a constant state of readiness has both psychological and physiological impact.

Staying ready has hidden and long-term health risks. These include anxiety, fear, social withdrawal, depressed mood, avoidance, and even substance use to cope with the feelings of any of these symptoms. Some other ways chronic stress exposure can show up is in a person's trying to "disappear" to avoid being targeted, or to behave and be perfect so they will not be attacked. Consider the example of Sean. He is describing anxiety, isolation and lack of trust with colleagues, perfectionism, and feeling on edge. For clinicians who want to better understand the impact of racism in the lives of Black clients and how it relates to trauma, it is critical to have foundational knowledge of what is known about trauma, **toxic stress**, and their links to racism in America.

Trauma, Toxic Stress, and Neurobiological Impact

In 1998, the Adverse Childhood Experiences (ACE) Study was published. Based on many accounts, it was received unceremoniously by

professionals in the medical field (Burke-Harris, 2018). Physicians were reticent to adopt the idea that medical health outcomes were connected to social or psychological experiences from a patient's life. The study origins are based in an observation that Vincent Felitti made in a weight-loss program he was running in his lab. Successful weight-loss patients who later gained their weight back attributed this weight gain to reasons rooted in social and psychological factors (e.g., weight being a protective factor to ward off sexual assault was reported by one of the patients). The original ACE study (Felitti et al., 1998) was born when Felitti presented his initial hunch regarding the relationship between poor health outcomes and early childhood adversity. He partnered with colleagues from the Centers for Disease Control (CDC) to conduct this groundbreaking epidemiological study. Although it took over a decade for the ACE study to gain much attention, the findings from it were fairly astounding, indicating a high dose–response relationship between early exposure to adversity and adulthood illnesses and conditions that were tied to some of the top causes of early death in adulthood. In the original ACE study, 10 items were identified as ACEs, including situations like living with a parent with mental illness, growing up with a parent who physically or sexually abused you, and witnessing domestic violence. The sample was overwhelmingly white and mostly male, but yielded remarkable results that led to subsequent research expanding on the initial study (Felitti et al., 1998).

One of these subsequent research studies—the Philadelphia Urban ACE Survey (2012–2013)—examined the methodology of the ACE study, while adding potential stressors to the original 10 items in an effort to explore the impact of racism, witnessing violence, and living in neighborhoods that respondents identified as unsafe. The sample reflected more diversity in terms of race and gender identity of the respondents. Overall, the Philadelphia ACE study revealed that not only were respondents endorsing ACEs at a higher rate, but also they had higher rates of the downstream illnesses mentioned above, compared to those in the original ACE study. The findings of the Philadelphia Urban ACE Survey indicated the need for services that not only address the *interpersonal* adversity but the *environmental stressors* that exacerbate poor health outcomes for youth and adults seeking care. Philadelphia had a population of 1.2 million people at the time of the survey. It was diverse in terms of

race and education, thus making it an ideal population to expound on the work done in the original ACE study. It also helped to contribute to making the case for what we now often refer to as "social determinants of health" because it included environmental stressors such as racism as adverse childhood experiences.

Psychological trauma is often described as an experience or collection of experiences that overwhelms a person's sense of control over their life, resulting in extreme stress, vulnerability, and lack of predictability, leading to an inability to experience a sense of *felt* safety (Blaustein & Kinniburgh, 2018). The terms **complex trauma** and **psychological trauma** are used interchangeably in some literature. Scholars in the field of traumatic stress research have often encouraged clinicians to take the approach with clients that comes from the place of asking, "What *happened* to you?" as opposed to "What is *wrong* with you?" If we embrace this clinical approach to care, then we cannot deny in good faith that the way people are treated can have an impact on their *felt* sense of safety and security in their lives. This is why racism in all of its forms in the lives of Black clients has to be a part of a clinician's knowledge base.

Trauma and racism are inextricably linked based on a broad overview of the literature on the role race plays in how people view themselves, the world, and others. There is not a single area of society in American life that has not been impacted by the legacy of racism. Whether it is laws that prohibited where pools could be built to prohibit Blacks from swimming, voting procedures that were designed to increase barriers for Blacks to vote, prohibitions on the way American history is taught, or where one is allowed to live—the impact of slavery, racism, and segregation in America has permeated the experience of our lives to the point that we may not even notice it.

Or, not *all* of us notice it.

Moreover, the impact of racism has been identified by the American Academy of Pediatrics as a social determinant of health, indicating that racism results in youth exposure to stressors and systemic barriers that affect not only their access to care, but also their biology and predisposition to ailments later in life that are tied to inflammation (Trent et al., 2019). **Race-based traumatic stress** can be both direct and indirect. Direct exposure may be interpersonal, such as when a person is called a racial slur, whereas indirect exposure can take the form of **vicarious**

trauma, akin to what Sean experienced when he viewed the video of George Floyd's murder. Though he did not experience the violence himself, he clearly had watched videos like that enough times that they caused him to have understandable panic when he was later pulled over by the police officer.

Key Terms for the Reader

In this book, we discuss the impact of racism and how systemic racism has and can lead to the experience of microaggressions, discrimination, and race-based trauma and traumatic stress. We define these terms here for reference throughout this text. For more on terminology, please see the glossary at the end of the book.

Racism: The 2024 edition of the *Merriam-Webster Dictionary* defines racism as "the systemic oppression of a racial group to the social, economic, and political advantage of another."

Microaggressions: *Merriam-Webster* also defines microaggressions as "a comment or action that subtly and often unconsciously or unintentionally expresses a prejudiced attitude toward a member of a marginalized group (such as a racial minority)."

Racial trauma/race-based traumatic stress: Racial trauma refers to the elevated stress that people of color experience—often unknown to them—that exacerbates symptoms that may have already existed, or newly form, as a result of repeated adverse experiences, related to their race. This includes personal experiences of racism or racial **discrimination**, but has also been linked to vicarious traumatization when witnessing or repeatedly learning of negative racial experiences of people within the same group. For Black clients, seeing the sometimes fatal outcomes of other Black people impacted by racism and discrimination amplifies their fear.

It is critical that as clinicians, we adopt person-centered language when talking about racial trauma in clinical settings. For example, psychologists have been encouraged to shift language and use phrases

like "person *with* depression" or "person *affected by trauma*," rather than "depressed person" or "traumatized person." The reason for this was to ensure that a patient's identity is not their illness or experience. To that end, it is important for clinicians to understand that racial trauma is something that *happens to* people. It would not be person-centered language to say that a person or group of people are racially traumatized, but rather that they are affected by race-based traumatic stress. By using this language and understanding that racial trauma, like any other trauma, happens to people, we take the stance as the clinician to help clients understand the systems that have impacted their lives, rather than making their experiences their identities. To do that, we must self-examine and ask ourselves if we actually *believe* racism is something that exists and affects the lives of Black people in America. If you are reading this book, you must have some level of willingness to learn more.

People Are Not Broken, but Systems Are

Gara et al. (2019) published findings from an archival data review of medical records in a large behavioral health care system. Gara concluded that Black patients diagnosed with schizophrenia met criteria for major depression at higher rates than non-Latino whites. Gara went on to hypothesize that routine screening for major depression in community mental health settings may reduce racial disparities in the diagnosing of more severe mental health diagnoses like schizophrenia in Black clients. Barnes (2008) also discussed this phenomenon of Black clients disproportionately being diagnosed and medicated for serious mental illness such as schizophrenia or psychosis when severe depression or other mood disorder may have been a more precise and accurate diagnosis. Gara's work, as well as Barnes's, are consistent with findings from other studies that identified the significant trend of diagnosing Black clients with more severe mental health diagnoses and of underdiagnosing illnesses such as depression, posttraumatic stress disorder (PTSD), obsessive–compulsive disorder (OCD), and the like. What is also so concerning about these findings is that serious mental illnesses like schizophrenia are usually "rule-out" diagnoses, meaning that in order to diagnose them, the symptoms cannot be better accounted for by other mood disorders.

The trend in our field to underdiagnose mood disorders in Black clients specifically means that there is clear bias in how symptom presentation is interpreted by providers. These biases have significant impact: A schizophrenia diagnosis versus one of severe depression is represented very differently to the public and can lead to more **stigmatization** and discrimination. And at a base level, assigning an incorrect diagnosis also means a person would not receive the proper treatment for their presenting problem. In an epidemiological study published in the *American Journal of Public Health*, Gibbs et al. (2013) found that African Americans exhibited more chronic, persistent symptoms of anxiety while also having lower treatment rates and poorer treatment outcomes. Through their research, Gibbs et al. (2013) explained how misdiagnosis stemming from racism leads to cultural mistrust, which could possibly account for decreased likelihood for African Americans to seek treatment. As clinicians, if we are truly committed to doing the nuanced work of recognizing the operation of race-based bias in our field, we must consider this history of misdiagnosis when working with Black clients and examining their mental health histories.

Trends of attributing more severe characteristics to Black people span other sectors of American life beyond mental health. Black children in school settings receive detentions and out- of-school suspensions at higher rates than their white counterparts. (Young & Butler, 2018). As recently as 2016, medical students were found to endorse beliefs about Black patients having higher tolerance for pain, which has resulted in denying these patients pain medication when presenting to hospitals (Hoffman, Trawalter, Axt, & Oliver, 2016; Washington, 2006). The lack of trust in the reporting of symptoms can result in Black patients feeling suspicious of medical health services. In mental health settings, there is evidence of more serious diagnoses being assigned to Black Americans, resulting in their being prescribed stronger medications or more frequently being referred for hospitalization than white patients with similar symptom profiles. Biases about Black people in mental health settings also result in their being labeled as "difficult" or "noncompliant," based on their behavior and decisions stemming from their mistrust of health care systems. Similarly, Black youth are more likely to be labeled as "oppositional" or "psychotic" than their white counterparts (Gara et al., 2019; Washington, 2006; Henderson et al., 2015).

Clinicians working with Black clients should consider the impact of bias by reflecting on our own training. How much formal training did we get in our graduate programs about race-based traumatic stress? Although the terms "complex trauma" and "trauma-informed care" are common in mental health care agencies, many education programs in behavioral health devote a handful of lectures, if that many, to discussion specifically about trauma—for the general population. Discussions about race are often relegated to an end-of-semester lecture, treated as a special topic of sorts. With the gaps in culturally focused training for students in clinical training programs, practitioners have to seek additional knowledge and experience to understand the impact of bias, discrimination, and systemic racism in other ways—frequently, postgraduate studies and jobs. Clinicians looking for more training on race-based trauma can find it by seeking literature and continuing education opportunities that are specific to the topic. The clinicians who seek these training and experiential opportunities are self-selecting, of course, already recognizing how important and valuable these topics and considerations are to their work as clinicians.

Clinicians and graduate students in training can also engage in experiential learning in both formal and informal settings. Comfort with talking about unfamiliar or uncomfortable topics is necessary for mental health providers, and conversations about race should be viewed no differently. The more practice one engages in, the better one becomes. The topics outlined in this text can offer some ideas on how to take advantage of clinical opportunities to talk about race, racism, discrimination, and the like with clients.

Looking at Your Own Racial Identity

As Kenneth Hardy clarifies: "Our difficulty [in meeting the needs of youth of color in treatment] is not just because of greater 'pathology' or 'resistance' as some assert. Rather, we fail to appreciate the ways in which race is entangled in their suffering" (Hardy, 2013, p. 24). When Hardy (2023) explains this concept, he refers to it as "invisible wounds." These wounds may not even be understood by those scarred by them, for lots of reasons we will discuss in this and subsequent chapters. Clinicians who

understand these wounds will better conceptualize the client's reported experience while considering the backdrop of racism and its sometimes blatant—but often insidious—role in a client's clinical presentation.

In the book *Racial Trauma: Clinical Strategies and Techniques for Healing Invisible Wounds* (2023), Hardy discusses seven invisible wounds of racial trauma. They are internalized devaluation, an assaulted sense of self, psychological homelessness, voicelessness, loss and collective grief, orientation toward survival, and rage. Hardy also emphasizes that in order for clinicians to be able to address racial trauma, they must first engage in self-reflection and adopt a racial lens. This makes sense because if a clinician understands their own **racial identity** and the areas of power and **privilege** in the spaces they occupy, they can more comfortably have conversations about these topics. Our role as clinicians, after all, is to be able to have the tough conversations that the friends, family, or acquaintances of our clients may not want or be able to have. If we shy away from the topic, clients may sense our hesitation, making the therapy room yet another unsafe space for them. In Sean's case, one of his self-reported symptoms was the need to be perfect. People who are perfectionists are often good at sensing if they are approved or disapproved by someone. If he senses a clinician's unwillingness to address trauma, racism, or discrimination, he may not bring it up in an effort to spare the clinician from having to bring up the topic, which only worsens the wound of having to appear perfect and pulled together, even when he is scared and anxious.

Using a Racial Trauma Lens to Conceptualize Sean's Case

It is likely that Sean could go to a therapist for treatment about his anxiety and the subject of his race never comes up. From psychotherapy research, we know that clinicians will often not ask clients about things they are not familiar with or feel incapable of treating. Because Sean is coming into treatment years after he was pulled over by a policeman and had an intense feeling of fear, he may not even realize how the traffic stop affected him. And if history has taught us anything, it is likely that he has continued to experience or bear witness to racial injustices during the time that has elapsed since that encounter with police as a teenager.

There are myriad direct and indirect ways that a clinician could approach Sean therapeutically that will facilitate discussion about his experiences related to race, racism, and discrimination. These talks can then connect to his presenting issue of anxiety. For clinicians that are just beginning to focus on integrating these conversations in their therapeutic style, it may feel more comfortable to be less direct and to give space for Sean to bring questions about race and racism to the forefront. Skilled clinicians with more experience and comfort having targeted discussions about race may take a more direct approach. Either approach can be fruitful. And if nothing else, either sends a message to the client that the clinician is willing and able to talk about what many in the public domain deem to be taboo or too provocative to discuss outside of family and friend circles. Here are some ways that a clinician can ask a client about the impact of race and culture:

INDIRECT PROMPTS

"Can you tell me more about prior times in your life where you felt very anxious or fearful?"

"Tell me more about your family. What were some of the important lessons/values you grew up with?"

"You mentioned you feel like you have to be perfect at work and you don't trust your coworkers. Can you say more about that? What is the risk of making mistakes?"

DIRECT PROMPTS

"In what ways has your identity or cultural background impacted your expectations of yourself?" (Identities can include sex, gender, race, religion, etc.)

"I know that in many Black families, children learn about how to be in spaces where they may encounter prejudice or race-related stress. Was this your experience?" (If affirmative, inquire about how that has affected the client's life in positive and challenging ways.)

These are just a few examples; we'll present more later in the book. By broaching topics of race and culture early on in treatment, at least

making it known to a client like Sean that the clinician is comfortable talking about these topics, the therapist can help him to feel like the therapy room is a place where he can have more control and comfort in what is discussed. Trauma—in all of its forms—results in a person feeling an overwhelming loss of control, predictability, power over self, and psychological safety (Blaustein & Kinniburgh, 2018). Incorporating elements into therapy sessions like control, comfort, and ability to set the pace of the interaction can help healing begin.

Thinking Ahead: Approaches to Care

Understanding race-based traumatic stress can help us to think more creatively about how to apply treatment approaches in more culturally responsive ways. It could be easy for a clinician who uses a more cognitive-behavioral approach to aim to help Sean identify his cognitive distortions and to challenge automatic thoughts. But should he challenge them? What is at risk if he does that? Are such cognitions distorted? Or, is Sean's need to be "perfect" and steer clear of work colleagues a strategy for survival that has worked well for him, even though the result is severe anxiety and social isolation? As noted earlier, part of your therapeutic approach may be to let the client lead and share what is on their mind with infrequent interruption from you in a session. Would Sean treat that as an opportunity to show that he is a "good patient"? Would he come in each week with an agenda of his talking points and seek your reassurance that he is doing therapy the *right* way? In the next chapter, we will talk about how interventions can be updated and adapted to better meet the needs of Black clients.

In this chapter, we discussed the foundational knowledge that helps us, as providers, to understand the undercurrent of racism that can impact the worldview and coping strategies employed by Black clients. Again, understanding this information is not meant to engage in reductionist approaches to mental health care. As with any approach to treatment, tailoring to the individual experiences of Black clients is important. In subsequent chapters, we discuss how clinicians can improve their skills in identifying whether and how racism, discrimination, racial trauma, and microaggressions impact the lives of Black clients in therapy.

CHAPTER TAKEAWAYS

- Trauma and racism are inextricably linked, as racism permeates so many facets of American life. For Black clients, while they may not readily identify racism or race-based stress as central to their presenting problem, a clinician can consider it in conceptualizing their case if they have reason to believe that it will help them better understand their client's experience.
- Racial trauma is *not* a diagnosis. Rather, racial trauma can impact the severity of diagnosable mental health conditions, and conceptualizing a case using a racial trauma lens may aid the clinician in taking approaches to care that are culturally responsive.
- While clinicians may have concerns about broaching subjects such as race and other cultural factors impacting their clients, raising such topics may help to promote more connection between them and clients who are experiencing distress that might be linked to racism, discrimination, or microaggressions.