Racial Trauma: The African American Experience

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Answer Sheet to NetCE by mail or fax, or complete online at www.NetCE.com. Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

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Faculty Disclosure

Contributing faculty, Tanika Johnson, EdD, MA, LPC-MHSP, LMHC, NCC, BC-TMH, CCTP, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for mental and behavioral health professionals who provide services to African American clients who have experienced racial trauma.

Accreditations & Approvals

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NetCE designates this continuing education activity for 1.5 NBCC clock hours.

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Individual State Behavioral Health Approvals

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About the Sponsor

The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

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Course Objective

The purpose of this course is to provide mental and behavioral health professionals with the knowledge and skills necessary to provide trauma-informed care to African American clients.

Learning Objectives

Upon completion of this course, you should be able to:

1. Define racism and its historical and current manifestations in the United States.
2. Describe the impact of structural racism and related racial trauma on African American individuals.
3. Evaluate the adverse health and mental health impacts of racial trauma on African Americans.
4. Outline approaches to rapport building and mental health interventions best suited for African American clients who have experienced racial trauma.
5. Discuss culturally relevant approaches to promote post-traumatic growth and provide trauma-informed care.

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

African Americans have endured oppression, racism, and trauma since the founding of this country [1]. The maltreatment of slaves and former slaves (who were considered raw material or merchandise) and the legacy of racial subjugation and enslavement resulted in the eradication of fundamental human rights. The traumatic impact of African American hardships is unconcealed in the modern-day circumstances of the African American community. These effects have been termed racial trauma, defined as "events of danger related to real or perceived experience of racial discrimination, threats of harm and injury, and humiliating and shaming events, in addition to witnessing harm to other ethnoracial individuals because of real or perceived racism" [2]. While similar to post-traumatic stress disorder (PTSD), racial trauma is typically the result of ongoing, consistent exposure to race-related stress rather than a single traumatic event.

Diverse cultural views and traditions are intertwined into the foundation of life [3]. Modern society is the most globally mobile in history, and this accelerates the relocation of refugees escaping combat, food crises, violence, and oppression. Frequently, these events coexist with political unrest, ethnocentrism, and racial discrimination and intolerance. As a result, immigrants, refugees, and persons of color are at increased risk for prejudice, hatred, and discrimination. There is significant intersectionality of characteristics and personalities influencing the social landscape in the United States. Any persons who fall outside the hegemonic norms reinforced by structural forces may become an outcast.

For those categorized as outcasts, the sociocultural landscape adds to trauma [3]. Racism embedded in social and legal structures of the United States reinforces racial trauma. In order to grasp the intricacies of trauma and the evolution of its social and cultural framework, an adaptable and all-inclusive model, examining sociocultural factors, is essential for improving diagnosis and treatment.

RACISM: A BASIC OVERVIEW

Very basically, racism is defined as prejudice, discrimination, or antagonism directed against a person or people on the basis of their membership in a minority or marginalized racial or ethnic group. This is often (but not always) paired with a belief that certain racial groups have characteristics that make them inherently superior or inferior.

In the United States, racism continues to be a widespread problem on the individual, cultural, and institutional levels [4]. Racial slurs, exclusion, and degradation are examples of individual and cultural racism and reflect an attitude of superiority. Institutional racism (also referred to as systemic racism) is defined as racism that is codified in a society's laws and institutions and is rooted in cultural stances that are strengthened through tokenism, discrimination, promotion of ethnic majorities in employment settings, segregation, and suppression. Historically, this has included slavery, Jim Crow laws, disenfranchisement, criminal justice racism, and unethical and damaging research practices (e.g., the Tuskegee Study). More recently, racism in the United States has largely (but not completely) switched from explicit acts to more implicit ones. Examples of implicit racism include:

- Microaggression in the form of experiencing low-quality customer service due to an individual's race
- Conditional housing contracts and discrimination in selling or renting homes in specific areas of a community
- Application of laws and stricter sentencing disproportionately to communities of color

Of course, all forms and levels of racism have long-term effects for victims, bystanders, and society in general.

RESPONSES TO RACISM: TRAUMA AND RESILIENCE

The relationship between racism and related adverse physical and psychological effects has been extensively studied and reveals the degree to which African Americans have been at risk due to exposure to stressful life events and persistent trauma, defined as a response to exceedingly harmful events and occurrences in real life and to a universe in which individuals are consistently injured.

Persistent trauma, including oppression and exposure to racism, has unequivocally affected African American's psychological and physical well-being, with end outcomes fluctuating from somatic complaints, depression, and anxiety to post-traumatic stress reactions [1]. Despite the increased risk, a great number of African Americans exhibit psychological resilience rather than psychological distress.

Resilience corresponds to universal protective factors; it is not specific to race or culture. It is a process that evolves throughout a person's lifetime and unfolds from circumstance to circumstance. It is also variable, and an individual can experience and express resilience differently to an identical stressor over time [1]. The development of resilience requires exposure to adversity and positive adaptation. Adversity is any suffering related to unfortunate conditions or events, and traumatic experiences. Positive adaptation is defined as behaviorally manifested social competency or accomplishments in overcoming biologic, psychological, and social challenges throughout a person's life. Hopefulness, inquisitiveness, elevated levels of energy, and the skill to detach and intellectualize problems combined with self-assurance, positive affect, self-efficacy, self-esteem, optimistic emotions, spirituality, and extraversion shield an individual from potentially harmful trauma and promote resilience.

Cultural factors are the cornerstone of understanding resiliency. Cultural socialization and social support networks are facets of African American culture that are protective against psychosomatic stress. Similarly, ideas that foster cultural pride, heritage, and history promote resilience and have generally been correlated with enhanced academic achievement, racial identity development, and positive intellectual and socioemotional results.

Studies show that firsthand knowledge or experiences of trauma increase the likelihood of a resilient reaction [1]. This provides a reasonable rationale for African Americans and other minorities exhibiting more resilience than White Americans.

WHITE PRIVILEGE

Rebecca C. Hong, author of Black Dignity/White Fragility: An Extended Review, emphasizes DiAngelo's analysis of the social construction of race in United States, with its earliest roots emerging with the historical and inhumane acts of colonization, slavery, imprisonment, and systemic injustice [5]. These events, originating from racial prejudice and a belief in white superiority and embraced and preserved by institutions and creeds, have reaped benefits at the expense of manipulating and persecuting minorities. Hong argues that racism is profoundly embedded in the structure of our society and has permitted White Americans to have collective and institutional power and privilege over minorities. Labeling and accepting this power and white privilege allows for a genuine acknowledgement of whiteness as a position and status that has justified beliefs in white supremacy.

Recognition of white privilege and self-awareness elevates racial dialogue past complicity with the overall political, economic, and social system that persists as a structure [5]. The mainstream political, economic, and social systems, originally created to support Caucasian Americans, are represented in the American entertainment industry, professional sports, government, and education. Systems and structures have historically focused on whiteness as the standard or norm. Hong asserts that [5]:

> When talking to white people about race, DiAngelo exposes common "color-blind" statements, such as "I was taught to treat everyone the same" and "So-and-so just happens to be black, but that has nothing to do with what I'm about to tell you," or "color-celebrate" claims that show they are free of racism, such as "I have people of color in my family" and "I was on a mission in Africa."

These types of statements come from a place of denial—denial of structural advantages offered to White persons and denial of the different experiences and realities of various races and ethnicities [5]. These expressions display a limited understanding of how profoundly socialized whiteness is and the deep-rooted racism that persists in society. This impedes the possibility of having vital interracial conversations about race and the personal, interpersonal, cultural, historical, and structural analysis required to challenge the larger system [5]. In challenging the current racial paradigm, Caucasian Americans are encouraged to respond to feedback regarding uninformed racist attitudes, behaviors, and beliefs with humility, interest, gratitude, and a position to listen, reflect, apologize, believe, process, and seek more clarity and understanding. Hong states that acknowledging white privilege [5]:

> ...is centered on openness and humility and holds the ability to transform individuals and systems that have benefited from systemic racism. It places the onus on white people to educate themselves, be uncomfortable, discuss their own internalized racial superiority, and invest effort in interrupting their own white fragility. DiAngelo recognizes that in order to break from perpetuating racial inequality, white people need to have courage to break from white solidarity, a system that has afforded them unearned privileges, and be accountable for their own racial growth. This is not the responsibility or burden of people of color.

IMPACT OF STRUCTURAL RACISM

As discussed, racism has been identified as a system of advantage instituted by race [6]. Institutional racism permits those in power and who are empowered to regulate the social, economic, and legal outcomes of African Americans and other minorities. By focusing on structural racism, one can recognize the outside forces that require African Americans to develop resilience while highlighting the significance of sustained social justice efforts in eliminating conditions that negatively affect minority populations.

HISTORICAL BACKGROUND

The modern civil rights movement was spurred largely by Jim Crow laws in the South and reactions to legal challenges to segregation and institutional racism. In 1954, the Supreme Court, in the case of Brown v. Board of Education, banned segregated public education facilities at the state level. Many Caucasian Americans had difficulty assimilating this new reality and endorsed institutional practices that restricted the upward mobility of African Americans, such as housing restrictions, educational barriers, and open violence. In 1956, more than 100 congressmen signed a manifesto committing to doing anything they could to prevent desegregation of public schools [7; 8]. Civil rights activists, including most prominently Dr. Martin Luther King, Jr., reacted to this increasing social discontent by promoting and inspiring Americans to live peacefully and amicably with each other. Activists passionately advocated for a society that would develop advantageous conditions for African Americans and all oppressed people.

On August 28, 1963, during the March on Washington for Jobs and Freedom, Dr. King delivered his famous "I Have a Dream" speech, which argued for an end to racial discrimination in the United States and advocated for civil and economic rights [6]. Dr. King envisioned the world as being a place that embraced racial unity of all ethnicities and races, and one in which all are treated honorably, respectfully, and fairly. Although King's dream of

racial harmony is supported lawfully on a national level through the Civil Rights Act of 1964, the effects of institutional racism persist. African Americans remain at increased risk of impoverishment, incarceration, and unwarranted force and homicide by law enforcement compared with Caucasian Americans and most other racial minorities.

RESILIENCE

Resilience is best defined as a vital practice of sustaining positive adaptation and successful coping strategies upon encountering adversity [6]. Academic literature on African American resilience has historically concentrated on the manner in which African American single mothers and children show strength, social networks that promote resilience for African American boys and men, and how resilience correlates to race, love, and nonresident father involvement. Another area of research has been on the prominence of religion for African Americans in conjunction with the strengths of Black communities. Historically, religious involvement and prayer have been symbols of African American resilience; this remains largely true today.

Although resilience has been highlighted as a response to racism, this should not imply that society should be content with the current situation. Instead, society should strive to advance social justice for all Americans, minimizing the need for resilience to racial trauma. Racial discrimination and structural racism adversely impact the individual, family, and collective welfare of minorities, and social justice endeavors have the power to improve the standard of living for these populations.

Structural racism expressed through adverse interactions with law enforcement, mass incarceration, and impoverishment results in dissatisfaction, resentment, anguish, and decreased well-being and longevity [6]. These negative effects should be explored and understood as they relate to clients' experiences and possible trauma exposures. [6].

HOUSING AND POVERTY

Even with the enactment of the Civil Rights Act of 1964 banning housing discrimination, African Americans continue to experience greater rates of poor housing or being unhoused. In the United States, homeownership is considered a main component of economic improvement. However, residential segregation and a racially segmented housing market continue [9]. Unequal access to home loans and the consistent devaluation of homes in Black neighborhoods combine to "constrict the ability of African Americans to build equity and accumulate wealth through homeownership" [9].

African Americans are more likely to be in a lower socioeconomic status than Caucasian Americans, as defined by education, salary, and employment. Low socioeconomic status has been substantially linked to a greater risk for mental health disorders. Even when modified by educational attainment, the unemployment rate for African Americans is substantially greater than their Caucasian counterparts. Employed African Americans are more likely to be in the lowest-paying economic sector.

IMMIGRATION AND MIGRATION

Nearly 46 million people in the United States, or 13.6%, identify as Black and an additional 3% identifies as multiracial [10]. In the United States, the Black population consists of both African Americans, who often have deep roots in the United States tracing back to slavery, and African, Hispanic, and Caribbean immigrants [11]. As such, immigration and migration can significantly impact the Black population.

Immigrant and migrant communities have historically and continue to experience oppression and social and legal challenges; these challenges should be addressed by all Americans [12]. The issue of immigration/migration is linked to the concept of who is able to define the character and future of the United States. Specifically, the racist conception of the United States as a finished product reflecting White ideals is damaging to those who do not fit

into this ideal. Instead, it is helpful in addressing immigration and racism to think of the country as a culturally diverse, unfinished project. In order to achieve success, African American individuals build unified affiliations, coalitions, and alliances with other individuals and work to build a new world. Coalition building with immigrant communities involves focusing on self-awareness and social justice, with the goal of improving conditions for all people. This is considered the anti-racist approach to immigration.

POLICING AND INCARCERATION

Perhaps the most prominent display of racism today is the disproportionate use of force and deaths experienced at the hands of law enforcement. In response, social movements have advocated for law enforcement to treat African Americans with the equal dignity and respect as all Americans. The eradication of structural inequality would alter conditions that increase the risks to physical and psychological security for this population. African Americans are also excessively represented at all levels of the judicial system. They are more inclined to be detained, incarcerated, and sentenced to stricter terms than White Americans. For example, African American adults are 5.9 times as likely their White counterparts to be incarcerated [13]. Racial and ethnic disparities are more marked in men but occur across the spectrum of sex/gender expression. Mass incarceration impacts both the individual and his or her family.

According to the Sentencing Project, "the rise of mass incarceration begins with disproportionate levels of police contact with African Americans. This is striking in particular for drug offenses, which are committed at roughly equal rates across races" [13]. Although drug use rates are roughly the same across race/ethnicities, Black persons are much more likely to be arrested on drugs charges. In 2010, African American individuals were 3.7 times more likely to arrested on cannabis possession charges than White individuals, despite similar usage rates [13].

Interaction with police is also increased among African Americans. While Black drivers are somewhat more likely than White drivers to experience a traffic stop, they are significantly more likely to be searched and arrested [13]. When they are arrested, African Americans are more likely to be denied bail, to have their case taken to trial, and to be more strictly sentenced.

ACCESS TO HEALTH AND MENTAL HEALTH CARE

Individual and systemic racism have resulted in considerable disparities in the rates of access to health and mental health care (including diagnosis, prevention, and treatment) for African Americans, and these gaps adversely impact community health. Historically, slavery, sharecropping, and segregation, as well as other forms of race-based exclusion from health care, education, and social and economic resources, have contributed to disparities in the African American community. Institutional racism is represented in American medical education, medical practice, and scientific studies, all factors that continue to affect the community. Studies reveal that African American or Black patients are [11]:

- More likely to obtain mental health treatment in emergency and hospital settings
- Misdiagnosed or diagnosed at disproportionately higher rates with schizophrenia and other psychotic disorders
- Less likely to be provided antidepressant therapy, even after controlling for insurance and financial conditions

This, along with decreased rates of access to mental health treatment for African Americans, adversely affects physical and mental health and diminishes relationships with the mental health community [11].

Some African Americans view the healthcare system as a racist institution [3]. In general, this has been attributed to a general mistrust of societal institutions [14]. At times, individual experiences or family recollections of racism experienced in health care contribute, and in the United States, there is a history of damaging racism in health care (e.g., the well-known Tuskegee study of untreated syphilis in African American men, the nonconsensual harvesting of cells from Henrietta Lacks for medical research). These historical examples highlight the racial inequities entrenched in American research studies and healthcare systems and emphasize the historical disregard of patient consent and privacy for African Americans. Family and community pressure is another consideration. In one study, African American patients with PTSD refused to access treatment due to shame and fear of family or cultural disapproval [15].

In order to enhance the lives of African American patients, mental health practitioners should strive for an understanding of historical, sociocultural, and individual issues that influence the treatments offered to this population. To this end, and to help alleviate racial and cultural prejudices, mental health providers should:

- Re-evaluate professional practices to determine whether these practices relate to the fundamental values of African American culture, such as family, kinship, community, and spirituality.
- Analyze how apparent racial discrimination may cause hypervigilance, anxiety, or depressive symptoms among African Americans.
- Understand and acknowledge personal biases in treatment and bear in mind that African Americans may feel rejected or disregarded by mental health practitioners who misinterpret expressions of emotion by this population.
- Seek out and learn about the experiences of the local African American community.
- Unite with community organizations and leaders to understand more about the range of African American cultures within the community and opportunities to work in partnership.
- Actively listen and genuinely assess every relationship to develop and improve alliances with patients.
- Accurately screen and follow through with quality assessments that employ a biopsychosocial model.
- Maintain talk therapy as a top priority of treatment models from the beginning and offer consistency in treatment.

HEALTH AND MENTAL HEALTH OUTCOMES

As mentioned, racism, racial bias, and discrimination have been linked to poor physical and mental health outcomes among minorities [16]. Institutional racism is a key social determinant of health, along with educational attainment, housing opportunities, accessible employment, health care, and environment, each of which can negatively impact health.

Implicit bias remains a significant issue in health and mental health care. While implicit bias is distinct from racism, the two concepts can overlap. Implicit bias is very basically defined as unconscious or pre-reflective attribution of qualities (usually stereotypes) to a member of a group. These biases affect one's understanding, actions, and decisions and can be related to racial profiling. For example, young African American men are often presumed to be criminals or delinquents, with providers and authorities assuming they are involved in illegal behavior and unlawful activity. These biases can affect the type of care and treatment offered.

In any client who has experienced trauma, acute stress reactions and/or PTSD should be considered. The actual incidence of race-related PTSD is unclear. Of course, an isolated violent event can be a triggering event for PTSD, but vicarious experiences and racial microaggressions are also contributing factors. This extended and persistent trauma is often referred to as complex trauma. Research indicates that minorities have higher rates of PTSD and experience more severe symptoms than Caucasian Americans [17]. Discrimination contributes to these disparities.

The multifaceted trauma experienced by African Americans impacts extended families, with many generations impacted by impoverishment, physical and sexual abuse, domestic and community violence, separation from family and re-victimization by others, mental health disorders, substance use disorders, and adverse interactions with government entities. This type of collective trauma, experienced over time and across generations, has been termed historical trauma. Typically, complex traumas start in early childhood and can disturb numerous facets of development and sense of self.

As discussed, individual trauma emerges from an incident, series of incidents, or set of situations experienced by the person as physically and psychologically damaging or threatening and having long-term negative consequences on one's holistic health [3]. Providers are increasingly aware of the devastating effects of pervasive trauma beginning in childhood. In theory, a significant proportion of the population has experienced a traumatic event. For example, among women of any race seeking substance abuse treatment and community mental health services, 80% to 90% have experienced intimate partner and/or family violence and trauma, usually throughout their lifetime [3]. More than an estimated 90% of all individuals involved in the legal system requiring treatment for mental health disorders (including anxiety disorder, depressive disorders, personality disorders, substance abuse, and eating disorders) have experienced childhood emotional, physical, or sexual abuse. Taken in aggregate, it becomes clear that trauma is a public health crisis.

Research beginning in the 1990s supports the fact that traumatic events in childhood, including abuse, neglect, racism, and family dysfunction, are directly related to acute physical, mental, and behavioral health outcomes, including depression and suicide [18]. Abuse and neglect during childhood are clear adverse childhood experiences (ACEs), but other examples include witnessing family or community violence; experiencing a family member attempting or completing suicide; parental divorce; parental or guardian substance abuse; and parental incarceration [19]. When experienced in childhood, exposure to racism (e.g., discrimination, stigma, minority stress, historical trauma) is also considered an ACE. However, structural racism is also a factor in many other traditional ACEs, including birth trauma, community violence, housing instability, and poverty. As such, African American adults are more likely than the White population to have experienced ACEs [20]. Adults who experienced ACEs are at increased risk for chronic illness, impaired health, violence, arrest, and substance use disorder [21; 22].

An extensive history of injustice and hostile societal treatment has resulted in complex and collective traumas in African American communities. These trauma histories include mutual, historical encounters across generations (e.g., lynchings, slavery, police brutality, mass incarceration). Historical and modern-day encounters with racial discrimination are persistent reminders of the constant dehumanization and devaluation of African Americans.

Historical trauma narratives include public reminders of chronic mass traumas, structural inequalities, dominant cultural narratives, and public symbols, as well as family or personal stories, which may include perceived historical loss and discrimination, microaggressions, and personal trauma [16]. Of course, historical trauma is not limited to the African American community; it applies to numerous populations that have historically been ostracized and oppressed, including Asian Americans, Hispanics, Indigenous peoples, gender and sexual minorities (also referred to as lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual/ally or LGBTQIA+), religious minorities, undocumented immigrants, women, and disabled persons. If an individual's cultural identity interconnects with multiple marginalized groups, then he or she may encounter many forms of historical trauma. Key terms when treating historically marginalized populations include [16]:

- Historical trauma narratives: Stories of historical trauma, including oppression, injustices, or disasters, experienced by a population.
- Contemporary reminders of historical trauma: Ongoing reminders of past trauma in the form of publicly displayed photographs and symbols as well as contexts, systems, and societal structures and individually experienced discrimination, personal traumatic experiences, and microaggressions.
- Narrative salience: The current relevance or impact of the historical trauma narrative on the individual and/or community.
- Health impacts: Historical traumas may lead to a range of adverse health outcomes, including risks for PTSD and symptoms of anxiety and depression.
- Microaggression: Historically, an everyday, subtle, and nonverbal form of discrimination. Today, the term is used to describe both verbal and nonverbal subtle forms of discrimination that can be experienced by any marginalized population.

The American Psychiatric Association recommends the following steps when providing services to oppressed minorities [16]:

- Use the revised fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR) to provide an assessment framework of an individual's mental health, especially as it relates to sociocultural context and history.
- Perform a Cultural Formulation Interview (CFI). This is a set of 16 questions that providers may use to obtain culturally relevant information during a mental health assessment. This instrument examines the impact of culture upon an individual's clinical presentation. The CFI identifies four domains: cultural definition of the problem; cultural perception of cause, context, and support; cultural factors affecting self-coping and past help seeking; and cultural factors affecting current help seeking.
- Consider using the CFI's 12 supplementary modules to gain additional insights into specific patient groups. Modules exist for immigrants and refugees, children and adolescents, older adults, and other special populations.
- Affirm the importance of cultural competency training for providers including (but not limited to) learning about implicit bias, microaggressions, trauma-informed care, and culturally sensitive treatment.

- Consider the cumulative and overlapping impact of historical trauma and microaggressions upon the mental health of people belonging to multiple marginalized populations, known as intersectionality.
- Emphasize self-care for all patients by encouraging healthy routines for sleep, diet, exercise, and social activities. Consider the role of self-affirmations, vicarious resilience, meditation, yoga, and other forms of traditional, alternative, or complementary care in mental health.
- Increase social supports for patients by engaging their family, social networks, and community in their care, as appropriate.
- Stay abreast of current news and events, particularly those that may affect specific marginalized patient populations. At the same time, try to be mindful to avoid information overload, which may contribute to provider burnout.
- Work with religious and spiritual leaders to provide faith-based mental health care, as appropriate.

TRAUMA- AND STRESSOR-RELATED DISORDERS

Racial trauma or race-based traumatic stress is the stressful effect or psychological distress resulting from an individual's experience with racism and discrimination [23]. Stress responses to racial trauma involve heightened vigilance and suspicion, greater sensitivity to threat, sense of a foreshortened future, and maladaptive reactions to stress (e.g., violence, drug use). Aside from stress responses, racial trauma can also lead to adverse effects on physical and mental health.

Stress is a natural, biological response (physiologic and cognitive) to circumstances identified as threats or challenges. Most stresses of daily life are manageable with appropriate coping skills and support networks. However, longstanding and extensive exposure to stressful and negative experiences, particularly without positive mitigating factors, can be harmful.

When an individual receives or foresees a threat, the brain's limbic system, or survival brain, delivers a distress signal that releases stress hormones [23]. This is the typical bodily reaction considered essential for survival. If an individual experiences chronic stress, there is a continuous stream of stress hormones and he or she remains hypervigilant to their environment. Due to the pervasiveness of racial discrimination, racial minorities usually experience this heightened stress. Systemic racism, routine racial discrimination, and the dread prior to racist incidents can cause minorities to live in a perpetual state of stress, leading to adverse physical effects such as hypertension, increased blood glucose levels, and cardiovascular disease.

In the DSM-5, several trauma- or stress-related disorders are identified, including PTSD, acute stress disorder, adjustment disorders, reactive attachment disorder, and disinhibited social engagement disorder [24]. Aside from being triggered by exposure to real or threatened violence or injury/death, these disorders are characterized by hyper-arousal, intrusion, avoidance, and negative cognition/mood symptoms.

Exposure to race-related trauma may be the originating factor in the development of an adjustment or stress disorder [23]. This effect is exacerbated by the increasing impact of multiple traumas, such as community violence, financial and/or housing insecurity, and victimization. Practitioners should take into account the adverse effects of racial trauma on their clients and use that as a mechanism for trauma-informed practice.

Many mental health practitioners fail to acknowledge racism as a trauma unless a person encounters an overt racist event (e.g., a violent hate crime) [25]. This limits the effectiveness of interventions and can damage rapport with the client. (It is also a potential failure of the practitioner to practice culturally competent care.) It is vital to recognize that a minor event can elicit traumatic responses. If asked about an overt event, minority patients may fail to report or correlate cumulative experiences of discrimination with PTSD or mental disorder symptoms. The notion of trauma as an isolated event is often insufficient for culturally diverse populations. Therefore, it is critical for practitioners and scholars to create a more thorough understanding of trauma experienced by minorities.

IMPACT OF SEX AND GENDER ON AFRICAN AMERICAN HEALTH AND MENTAL HEALTH

As discussed, oppression can occur on several levels, and the intersection of multiple potential areas of oppression can further impact health and mental health outcomes. For example, the stereotype of the strong Black woman could potentially contribute to African American women failing to access treatment for mental health issues such as trauma. Help- and information-seeking behavior related to male gender identity is another factor that affects African American men's health.

In general, men are reluctant to seek care or talk about their health because they see such help-seeking as a sign of weakness or vulnerability and a threat to their masculinity. This is a reflection of the traditional construction of gender roles and identity, whereby boys are taught that self-reliance and stoicism are preferred. Men who embrace these gender ideals are less likely to engage in preventive medical treatment and mental health treatment. In the Black population, men have reported to avoid healthcare services because of fears and concerns about their negative health behaviors and history [26]. For example, Black men have reported avoiding screening for prostate and colorectal cancer because they see these procedures as "violating their manhood" [26; 27].

Among men who do have physician office visits, many are not forthcoming about symptoms or information they seek [28]. Because of their traditional discomfort with expressing feelings and emotions, they are less likely to seek help for psychosocial problems or emotional symptoms [29; 30]. Men tend to be more motivated to seek health care for male-oriented conditions, such as erectile dysfunction or sports-related injuries, or when their health or symptoms interfere with their routine activities [30].

Theoretically, there may be racial differences in culturally acceptable gender roles and masculine identity [4]. For African American men, slavery, a matriarchal family and community structure, and the civil rights movement are intertwined with gender identity. Franklin and Boyd-Franklin theorized that African American men repeatedly feel invisible due to cross-racial relations, which leads to issues associated with negative self-identification, adverse coping strategies, and elevated stress responses. Feelings of invisibility are strengthened by cultural and environmental factors, such as media stereotypes, microaggressions, and discrimination [31]. Furthermore, invisibility syndrome impedes African American men's difficulties with identity formation and help seeking.

There also appear to be differences in the impact of perceived racial discrimination in African American women and men. In one study following 681 Black youths for 18 years, racial discrimination was associated with negative mental health consequences for both genders [32]. However, Black boys and men seem to be more susceptible than Black girls and women to the psychological effects (e.g., anxiety, depression) of an increase in racial discrimination over time.

RAPPORT BUILDING AND INTERVENTION PLANNING

ACKNOWLEDGING AND ADDRESSING RACE

Compared with Caucasian Americans, African Americans are less likely to follow through with or take advantage of health and mental health services [4]. Historical factors, such as the exploitation of African Americans in clinical trials, institutional racism, and biased healthcare services, have contributed to this disparity. The underutilization of healthcare services results in shorter lifespans, increased morbidity and mortality, and undiagnosed, misdiagnosed, and/or untreated health and mental health disorders. African American men are less likely than women to engage in therapy, preventive health services, and other healthcare services. Even today, African American men are one of the most underserved minority groups.

A myriad of factors, including genetics and cultural beliefs and practices, impact the symptoms and mental health disorders that occur in a particular population and a specific client. These same factors often impact a client's help-seeking behaviors. Work, Cropper, and Dalenberg state [33]:

> Despite evidence that ethnic minorities may experience higher rates of stressors and exposure to high-magnitude stressors and traumatic events, the non-Caucasian population of the United States is actually less likely to seek treatment than their Caucasian counterparts. Research has suggested that this may be the product of a social stigma against seeking services in many cultures, the fear of exposure of personal information to outsiders, the experience of misuse of information by authorities, and lower likelihood of access to culture-friendly explanations of available treatments.

Minorities who engage in mental health services are mainly connected with a practitioner of an ethnic/racial background in contrast to their own and therefore may feel uncomfortable discussing their experiences or may have cultural differences in help-seeking behaviors. Research on cross-racial therapeutic dyads has found client dissatisfaction and a lack of sensitivity in the way race was introduced by the therapist [33]. It is important to note that professionals have a responsibility to address any discomfort they may have discussing race and racism so it does not affect their clients. Work, Cropper, and Dalenberg recommend the following approaches to race-related issues [33]:

- Tackle the subject of race as theoretically important to therapeutic issues and talk therapy.
- Recognize any challenges with verbally communicating racial connections and disparities.
- Reflect upon acknowledging racial privilege.
- Discover opportunities to enhance racial sensitivity and awareness of cultural stereotypes.
- Advance clinical training.
- Expand community outreach endeavors.

For a variety of reasons, practitioners are often hesitant about introducing racial issues in counseling or therapy [33]. However, providers who openly communicate and display competency for race-related issues are more effective in their work with minority clients. Early conversations regarding the client's goals and expectations can influence the progression of therapy, offering opportunities to discuss any challenges or concerns and diminishing the power differential. These interactions should particularly refer to the advantages and disadvantages associated with a cross-racial pairing of therapist and client, if present. Acknowledgment of the limited expertise of the provider on cultural differences when establishing rapport offers a safe path for client correction of the provider or recommendations of alternative explanations of behaviors.

When discussing race and culture in therapy, it can be challenging for the client to verbalize cultural beliefs or practices that may be shared with or that diverge from those of the provider [33]. It is vital to discuss the indistinctness of culture to those dwelling within it. As discussed, cultural norms about symptoms or belief expressions impact the nature of therapy, and the likelihood that a communication challenge or different perspective may have a cultural bias should be explored. In addition to acknowledging the subject of race, providers should contemplate the therapeutically appropriate timing of addressing racial experiences. A colorblind approach is often ineffective and can impede therapy. This can also be true when the client and provider are both African American. It is vital not to assume a shared belief system or trauma history based only on shared race or ethnicity; however, appropriate sharing or supporting may be more effective in these dyads.

If a provider is Caucasian American, verbal recognition of his or her experienced privileges can offer a powerful therapeutic exchange [33]. Multicultural competency is essentially intended to enhance the provider's knowledge of cultural differences and potential stereotypes, but it is not possible to have an awareness of all stereotypes. Over the course of therapy, the provider should offer the client a safe environment to examine these stereotypes. In these discussions, the goal is for the client to understand the provider's awareness of the stereotypes and their potential negative impact on his or her life. By normalizing anxieties and fears in discussions of race and by using role-playing and experiential exercises, practical beneficial gains can be made.

In addition, providers may benefit from preparing acceptable language to initially raise the issue of race in the therapeutic relationship. This can be accomplished by seeking experts and/or mentors in the community and by researching appropriate terminology and approaches. Instead of focusing efforts solely on becoming an expert in a client's culture, providers should work toward fostering a safe environment to freely discuss disparities and acknowledge a shared discomfort on the subject of racial differences [33].

POST-TRAUMATIC GROWTH STRATEGIES

If untreated and unprocessed, the effects of race-based trauma can develop into depression, anger/rage, and a battered sense of self [4]. Mental and behavioral health professionals should strive to uncover, acknowledge, and treat these wounds. Strengths-based, activity driven, and preventive choices are approaches for enhancing African American clients' engagement in therapy.

While providing therapy services to African American clients that address race-based trauma, post-traumatic growth strategies are recommended [4]. Traumatic events challenge a person's previously held beliefs about the world and can affect how they define themselves and others. Discovering meaning or purpose in the trauma allows individuals to develop effective coping and self-care skills.

Although exposure to trauma has proven to have many adverse effects on physical and mental health, the possibility for positive change after hardships, torment, and suffering has long been established [4]. Modern researchers refer to this phenomenon as post-traumatic growth. An opposite extreme to PTSD in the spectrum of reactions to trauma, post-traumatic growth encompasses the resilience and growth that can ensue when a person develops meaning from a traumatic event. In one study, resilience was the most common outcome of potentially traumatic events [34]. The literature is mixed, however, on outcomes of trauma for those who live in contexts of ongoing war and chronic terrorism [35].

Some experts frame post-traumatic growth as a coping technique, while others posit that it is actually an effect of positive coping after a traumatic event [4]. Regardless, individuals who experience post-traumatic growth may display a heightened sense of kindness and empathy toward others, improved intimate relationships, and a genuine appreciation for life. Persons with these types of reactions to trauma report increased levels of independence/self-efficacy, better control over themselves and their environment, more positive interactions, a willingness to grow, improved self-acceptance, and the faith that they have uncovered their purpose in life [4].

It is important to note that race-based trauma does not need to meet a minimum level of severity in order to induce post-traumatic growth (or PTSD, for that matter). African American individuals are repeatedly subjected to implicit racial discrimination, resulting in verbal, behavioral, and environmental humiliations that nonetheless convey aggression or dehumanization due to their race. As these microaggressions accumulate, feelings of loneliness, loss of self-control, emotional detachment, intrusive rumination, and reduced self-care can follow. Interventions that promote post-traumatic growth emphasize the individual experience, recognize environmental conditions reinforced by trauma, and are exemplary tools when providing services to African American clients. Evidence-based interventions to promote post-traumatic growth include trauma-focused cognitive-behavioral therapy and written or verbal self-expression [36].

Intrusive or excessive rumination on traumatic events can be harmful to growth and healing. Certain models of cognitive processing encourage post-traumatic growth, while others are associated with negative outcomes [4]. Specifically, active coping styles have been positively linked to post-traumatic growth. Active coping strategies are characterized by directive problem-solving techniques, actively seeking social support, and employing reappraisal methods to reassess the situation. In contrast, passive coping strategies emphasize avoidance and techniques such as distancing, escaping, wishful thinking, and self-control. Mental health professionals should focus on positive cognitive processing practices. Promoting post-traumatic growth among African American clients involves a combination of cultural competence and the application of practices tailored for the care of trauma survivors. As discussed, enhancing one's cultural competence requires self-awareness and a working knowledge of cultural traditions and culturally appropriate interventions. Awareness of power, privilege, and racial oppression is also relevant.

CULTURALLY RELEVANT INTERVENTIONS TO PROMOTE POST-TRAUMATIC GROWTH

As discussed, acute traumatic responses result from a normal reaction to overwhelming stress and may be construed as a set of adaptive survival mechanisms that become pathologic if the traumatic experience remains unresolved or when the precipitating event(s) have passed. With repeated or chronic trauma exposure, such as that experienced by racial minorities, the effects of unresolved trauma are pervasive and become the central organizing structure around which profound neurobiologic adaptations occur [37; 38].

The symptom profile of complex trauma/PTSD recognizes deficits in emotional, social, cognitive, and psychologic competencies as the result of a failure to develop properly or deterioration from prolonged trauma exposure. Thus, treatment for complex trauma emphasizes reduction of psychiatric symptoms and, equally important, improvement in key functional capacities for self-regulation and strengthening of psychosocial and environmental resources. Loss of psychosocial resources, including deficits in self-efficacy, prosocial behaviors, or social support, is common and contributes to the severity and chronicity of PTSD symptoms.

Therefore, strengths-based interventions to improve functioning, contribute to symptom management, and facilitate patient integration into family and community structures are integral to each phase of treatment [39; 40].

THE ROLE OF RUMINATION

After a traumatic event, an individual may engage in a process to restructure his or her view of the world and to encourage positive growth by developing meaning from the trauma [4]. The recommended process for developing meaning starts with substantial rumination, which can create a state of sustained heightened stress and hypervigilance for the individual and requires support and significant coping skills. With sustained hypervigilance, individuals escalate to deliberate rumination. This thoughtfulness can result in meaning-making approaches, decreased stress and related symptomatology, and the development of post-traumatic growth. However, it is common for post-traumatic growth and event-associated distress to co-exist until the traumatic event has been resolved and/or fully processed. Instead of avoiding rumination, which would impede growth, providers should encourage safe rumination practices.

In order to diminish stress symptomatology during rumination, clinicians should incorporate post-traumatic growth approaches, integrating meaning-making and stress reduction techniques, when providing services to clients who have experienced race-based trauma [4]. Potentially useful interventions include:

- Refuting cognitive distortions
- Offering psychoeducational training on mindfulness and relaxation techniques
- Identifying healthy and effective coping skills
- Commemorating one's individuality (including race, gender, sexuality, age, etc.) through meaning-making activities

STRENGTHS-BASED APPROACHES

Personality, social, and psychosomatic factors all add to post-traumatic growth, and acknowledging individual strengths can help foster healthy cognitive processing [4]. Personality traits positively correlated with post-traumatic growth include extraversion, openness, agreeableness, conscientiousness, and optimism, and providers can promote these traits by fostering an environment that encourages self-efficacy and accentuates self-esteem. Collective memory exercises, narrative therapy, and an Integrity Model approach may all be helpful. The Integrity Model involves five distinct steps: safety, stability, strength, synthesis, and solidarity, and has been particularly recommended in work with men [41]. Strengths-based and solution-focused methods may be particularly valuable for African American male clients, as these offer problem-focused interventions consistent with typical male preferences for therapy [4].

It is vital that people individually evaluate the traumatic event and recognize and accept that their response to it is normal. Clients experiencing an increased awareness of harm or danger during the event may be better able to access post-traumatic growth. This association may be the result of increased self-awareness and sense of control. Some have suggested that in order for growth to occur, trauma has to be substantial enough to cause the individual to question earlier viewpoints, triggering rumination and reflection. If a viewpoint is not challenged or is reinforced by the traumatic event, post-traumatic growth may be less likely [4].

Mental health practitioners should consider providing strengths-based assessments and therapeutic interventions that focus on maladaptive thoughts (i.e., thought-stopping techniques and cognitive restructuring) to all individuals presenting with race-related trauma. By concentrating on strengths and positive cognitions, practitioners can help African American clients practicing resilience exercises

evaluate individual experiences and potential coping techniques. Psychoeducational strategies, justification of the client's encounter, and collaboratively encouraging and supporting the individual can improve service delivery.

CREATING A SAFE ENVIRONMENT

Addressing race-based trauma and post-traumatic growth requires practitioners to have training in and comfort with discussions of racism, discrimination, and race-based trauma [4]. Caucasian practitioners in particular may consider incorporating techniques to aid in creating a safe environment for race-based conversations with minority clients.

Practitioners have a responsibility to recognize and identify trauma and should work to help process the trauma in the absence of rationalizing, correcting, or altering the viewpoint of the client. Clients assessing and exploring the importance of experiences of discrimination and racism benefit from talks centered on coping, resilience, and meaningful living without minimization of the experienced trauma. Practitioners may further help their clients with pinpointing useful coping strategies and promoting positive emotional functioning. Some individuals will relate feelings of invisibility, pressures of gender norms, and self-fulfilling prophecies. While it is important to recognize and validate this experience, practitioners should help clients identify skills that are gained through processing pain and distress. This can include exercising empathy for all victims of oppression and discrimination and becoming a change agent for future generations of African Americans.

SOCIAL SUPPORT

Social support is defined as access to individuals who offer compassion, solidarity, and coping support [4]. In the African American community, social support often involves sharing encounters and occurrences as a method of coping with racism. Social support systems may include family members, friends, neighbors, colleagues, ministers, or more formal social or activist groups. For clients with specific mental health needs, support groups, 12-step programs, and group therapy may be appropriate sources of support. These supports provide an adaptable shield against stress and are an opportunity to promote diversity and healthy coping. Individuals with good social support report a sense of connectedness and mutual understanding of racist encounters.

Contentment with social supports has been correlated with increased post-traumatic growth and reduction of PTSD symptoms in war veterans [42]. Furthermore, a strong, healthy support system may further contribute to the safety of self-disclosure. As such, social support has a clear role in promoting post-traumatic growth, with impact on a client's coping style, cognitive processing, and meaning-making expression [4]. Professionals should focus on identifying environmental supports as opposed to barriers. Meeting a client in a relaxing community-based setting, welcoming supportive individuals to therapy sessions, and encouraging discussions with social communities are all advantageous.

RELIGION AND SPIRITUALITY

Some have argued that religion and spirituality in African American culture are shaped by political and social contexts, particularly issues of race/racism, slavery, oppression, justice, and liberation [43; 44]. Notions of being freed from bondage, as espoused in Christian tenets, resonated with many slaves. It is important to remember this historical backdrop and how it continues to influence the views and coping mechanisms of African Americans today.

Spirituality for African Americans has been referenced in the following manner [45]:

> Faith in an omnipotent, transcendent force, experienced internally and/or externally as caring interconnectedness with others, God, or a higher power; manifested as empowering transformation of and liberating consolation for life's adversities; and thereby inspiring fortified belief in and reliance on the benevolent source of unlimited potential.

God, Allah, and figures of a higher being are viewed as conquerors for the oppressed. Consequently, religious and spiritual orientations are often used among African Americans both to deal with and construct meaning from oppression and promote social justice and activism [43].

In African American culture, a deep belief in spiritual and church-based practices can safeguard against trauma or it can be an obstacle for accessing treatment, as the church is a source of coping (sometimes to the detriment of other options). Devotion to religion, active engagement in spiritual activities, reflective prayer, willingness to transform, and a desire to explore perplexing questions connected to one's faith have all been positively associated with post-traumatic growth [4]. Membership in a religion or spiritual group offers a social support network, explanations for adverse experiences, and strategies for active coping following a traumatic event (or continued trauma). Acceptance, hope, life satisfaction, and stress-related growth have been reported results of positive religious coping strategies [46]. Conversely, negative religious coping (e.g., believing in a vengeful God, spiritual dissatisfaction) is predictive of PTSD symptoms. Survivors of racial trauma may be faced with reforming their views of the world and of God/a higher power as a result of a traumatic event. In these cases, clients are compelled to examine prior beliefs about religion and spirituality to develop a new belief system or to devote themselves more fully to an existing system.

Practitioners should integrate religion and spirituality into mental health care as appropriate [4]. In instances of race-based trauma, practitioners may aid clients with exploring their existing value system (e.g., beliefs, preconceptions, contradictions). At a minimum, three areas should be explored in a spiritual assessment: denomination or faith, spiritual beliefs, and spiritual practices [47]. If, in the initial assessment, it is clear that neither spirituality nor religiosity plays a dominant role in a client's life, it should not be a focus of interventions moving forward. If the practitioner finds that either spirituality or religiosity is a key dimension, a more comprehensive assessment is required. Practitioners may gain more understanding of their client's identity by inquiring about their viewpoints of life and their significance and purpose, with spirituality as a component of this overall assessment. This can be used to drive conversations of race and build rapport. In clients for whom it is important, emphasizing the significance of religion and spirituality may open opportunities for social support networks, active coping, and meaning-making.

In general, incorporating religion and spirituality into practice should not be spontaneous [48]. It should be thoughtful and systematic. In some cases, such as when a patient feels rejected by God/higher power or has been abused by a spiritual/religious leader, attempts to include spirituality/religion can trigger trauma reactions and anxiety [48].

TRAUMA-INFORMED CARE

It is important to use a trauma-informed approach when assessing and caring for potential victims, which requires that practitioners understand the impact of trauma on all areas of an individual's life [49]. Physical, emotional, and psychological safety is at the heart of trauma-informed care. This approach allows for trust-building and continued communication, both vital to ensuring that patients receive the care and support they require.

Being trauma-informed is a strengths-based approach that is responsive to the impact of trauma on a person's life. It requires recognizing symptoms of trauma and designing all interactions with victims of racial trauma in such a way that minimizes the potential for re-traumatization. This involves creating a safe physical space in which to interact with clients as well as assessing all levels of service and policy to create as many opportunities as possible for clients to rebuild a sense of control. Most importantly, it promotes empowerment and self-sufficiency.

When providing trauma-informed care, the practitioner should acknowledge that an individual's specific life experiences will affect his or her responses to traumatic events and opportunities for support and care. Because trauma is a societal problem, trauma-informed care should be practiced throughout health care and educational, legal, and governmental agency settings. In the clinical setting, trauma-informed care requires shaping every patient encounter in a way that empowers recovery and inspires resilience.

Trauma-informed care is based on the values of encouragement, options, cooperation, credibility, security, and client autonomy [3]. Frequently, traumatic events signify removal of power; affectively caring for trauma survivors therefore entails being cognizant of the power dynamic between client and practitioner. When individuals feel a sense of control over their lives and power over treatment and care, the process of healing and recovery accelerates. Encouragement involves recognizing and using patients' strengths in the beginning of treatment rather than focusing on diagnoses, vulnerabilities, or victim status. Truthfulness involves conveying clear-cut and reasonable expectations of the treatment process and fulfilling one's obligations. Likewise, promoting client autonomy through collaborative treatment planning is a crucial aspect of trauma-informed care. Providers and clients should be partners in care and mutually participate in care provided by the entire interprofessional team (including health and mental health practitioners, ancillary staff, community members, and family, as appropriate).

Security is a core principle of trauma-informed care, and this is manifested in many areas [3]. The basis is good clinician-client rapport. Shared respect is critical to a patient's feeling of psychological well-being. Security can also be fostered by a positive and safe physical setting. For clients who are acutely ill, both the illness experience and treatment process can produce trauma. This is particularly true if involuntary detainment or hospitalization is necessary, but exposure to other individuals' narratives of experienced trauma or observing atypical behaviors from individuals presenting as violent, disorganized, or harmful to themselves can also be traumatic. As such, care environments should be controlled in a way to minimize traumatic stress responses. Trauma-informed care providers will keep this in mind when structuring the environment (e.g., lighting, arrangement of space), creating processes (e.g., layout of appointments or care systems, forms), and providing staff guidance (e.g., nonverbal communication, intonation, communication patterns). During each encounter, the client's perception of safety is impacted by caretakers and ancillary staff.

Trauma-informed approaches are the standard of care whether or not a client has disclosed or experienced trauma [3]. Therefore, trauma-informed approaches can be initiated even before providers have knowledge of clients' traumatic experiences or have completed a full assessment.

The first step is to establish safety, security, and harmony with clients—the basics of client-centered care. The next consideration is individualized treatment. Trauma-informed care requires acknowledgement of the exclusivity of individual experiences, which are impacted by a collection of factors, including race, culture, ethnicity, nationality, sex/gender, age, and socioeconomic status.

CULTURAL AWARENESS AND HUMILITY

It is within and across a cultural framework that individuals create their truths, values, and personalities. The multifaceted relationship between experiences, individual biology, psychological resilience, cultural context, and social supports is both a source of trauma and of resilience building. Patients carry all of these factors into the clinical encounter.

Traumatic experiences do not occur outside of cultural perceptions, and cultural and societal structures impact and occasionally trigger trauma [3]. For example, racial trauma can result from work-related incidents or hate crimes, or it could possibly be the outcome of a buildup of microaggressions and cumulative minor occurrences relating to routine rejection. Ranjbar et al. states [3]:

> Although some patient populations may be more susceptible to trauma exposure on the basis of sociodemographic circumstances, culture is one of the mitigating factors that play a role in the variability of individual response to potentially traumatic events.

The cultural elements of African American culture and family cohesion may reinforce resilience, promote healing, and/or minimize the impact of trauma. In one study, high levels of resilience were noted in a sample of primarily trauma-exposed, inner-city African American adults [3].

In order to best meet the needs of clients who are culturally diverse, clinicians should explore their own self-identity, culture, individual history, and implicit biases [3]. Instead of working from the belief that patients from certain cultures or social environments require specific treatment, clinicians should reflect on culture being a vehicle for strength and a tool for healing. For clients whose histories include deeply distressing circumstances (e.g., warfare, sexual abuse, violence, racism), traumatic encounters will affect their cultural identity and worldview, potentially resulting in significant adverse mental and physical health effects. Healing focuses on the crossroads of trauma and culture.

While culture is an undeniably important aspect of mental health assessment and treatment, it is not possible for a clinician to know everything about a client's culture. Cultural humility is an open-ended approach to understanding, whereby the clinician approaches every encounter with an appreciation for the unknowability of culture [3]. The extent that culture is entrenched in personality, biology, individuality, and psychology is to some extent indescribable. Cultural humility involves acknowledging cultural experience as not fully analyzed or understood but appreciated and respected. Vital components of this approach are shared learning, crucial self-awareness, identification of power imbalances, and acknowledgment of the reality of implicit biases. Its practice can generate civil alliances and institutional liability.

In the clinical context, cultural humility can be the guiding notion for the practice of trauma-informed care in focusing and empowering patients to focus on healing and avoiding dominating the session. Clinicians should be open to being educated about ways a client's cultural background may play a part in the healing journey [3]. This may require connecting with family members or community organizers to incorporate cultural resources into the treatment plan or using cultural contacts to initiate constructive healing work. Because response to and affiliation with one's cultural upbringing, experiences of racism, and healthcare experiences are unique to each person, every client and every encounter should be approached humbly and with an open mind.

ETHICAL CONSIDERATIONS

Trauma-informed care, cultural humility, and addressing racial trauma are all in alliance with the ethical principles of autonomy, beneficence, nonmaleficence, and competency [3]. In general, all mental health providers should work to identify and eliminate discriminatory policies, demonstrate compassion, recognize patients' human rights and dignity, engage in lifelong learning, and contribute to the growth of society and community health. Culturally respectful encounters with patients from a variety of cultures contribute to the clinician's personal and professional development. In codes of ethics and ethical literature, there has been a move away from the term "cultural competence" and toward "cultural awareness," a change that acknowledges the fact that improving one's knowledge and appreciation of diverse cultures is an ongoing process. A vital aspect of this process is openness to new information and change. All clinicians should allocate time for self-reflection and analysis of their own cultural beliefs, experiences, and biases. After every encounter, reflect on whether the client's needs were paramount and remain the focus of ongoing treatment; ethical responsibility necessitates that the patient's interests be the utmost goal. Treatment approaches and diagnoses should evolve along with the client.

Trauma-informed care adapts to the principles of ethical practice established in the mental health fields [3]. Every decision and approach should be made with consideration of the professions' codes of ethics and ultimate purposes.

ADVOCACY AND SOCIAL JUSTICE

Racism occurs at interpersonal, environmental, institutional, and cultural levels, and eradicating racism and racial trauma necessitates interventions on every level (e.g., individuals, families, communities, and the entire nation). This should include advocacy and implementation of policy changes that eradicate structural racism in communities. As Congresswoman Shirley Chisholm said, "Racism is so universal in this country, so widespread and deep-seated, that it is invisible because it is so normal" [50]. National issues such as mass incarceration, employment disparities, and the achievement gap should be addressed in order to reduce structural racism, alleviate some racial trauma experienced by African Americans, and improve socioeconomic position and related helplessness. One example of a macro-level intervention to address systemic racism is taking steps to improve the education system to better reflect African Americans' lives, culture, history, and experiences, with particular attention to the punitive approach to educating African American boys.

CONCLUSION

Acknowledgment of the historical context of racism and its current implications is a vital aspect of providing care to a diverse population. Mental health practitioners, medical providers, researchers, community leaders, advocates, activists, and laypersons should work to prevent and effectively treat the psychological and physical distress experienced as a result of the racism faced by African American clients.

Although continuously encountering racism and intersectional trauma, African Americans have often adopted positive adaptations, and it is important to recognize the inherent empowerment that can result with survival of chronic race-related trauma. Cultural awareness, responsiveness, and sensitivity improve relationships with clients and allow for provision of the best quality care. This includes the implementation of race-informed therapeutic practices and techniques that promote resilience and intraindividual and interpersonal healing and wholeness of minorities. A trauma-informed approach to treatment recognizes that healthcare systems and providers should have a comprehensive picture of a patient's previous and current life situation in order to offer successful and healing treatment. Implementing trauma-informed practices may increase patient commitment and treatment compliance, improve health outcomes, and enhance provider and staff well-being.

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