Counseling Individuals of Color Who Have Experienced Race Based Trauma: Counselors' Experiences with Identifying, Training, Treating, Policy, and Perceived Competency

by

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A dissertation submitted to the Graduate Faculty of
Auburn University
in partial fulfillment of the
requirements for the Degree of
Doctor of Philosophy

Auburn, Alabama
August 6, 2016

Keywords: multicultural competency, racism, race based trauma

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Abstract

The purpose of this study was to examine counselors' professional experiences with race based trauma and investigate an emerging and under researched category of multicultural competency, working with Individuals of Color who have experienced race based trauma. The Race Based Trauma Survey was developed by Dr. Amanda Evans and Carrie Hemmings to examine professional counselors' experiences with the following related to race based trauma; contributing factors, personal training and experience, experiences with identification and treatment, professional policy, and self-reported competency in identifying and providing treatment. Additionally, this study examined the relationship between (a) self-reported competencies and (b) training to identify race based trauma, training to treat race based trauma, and the existence of professional policy on race based trauma that includes treatment recommendations.

The participants for this study consisted of 106 licensed or credentialed professional counselors from across the United States. The data indicated that self-reported competencies were negatively correlated to training to identify, training to treat, and professional policy which supports researchers' findings concerning the need for additional research on racism, racial discrimination and race based trauma as well as effective training and treatment models (Brondolo, Brady, Pencille, Beatty, & Contrada, 2012; Brondolo, Gallo, & Myers, 2009; Bryant-Davis & Ocampo, 2006; Carter, 2007; Carter, et al., 2013; Carter & Forsythe, 2009; Prilleltensky & Gonick, 1994; & Sue, D. W. & Sue, D., 2003).

Acknowledgments

It has been said that we are always in the process of becoming. This quote has been with me throughout my educational pursuits, challenges, and accomplishments. I would like to sincerely thank the following individuals who have traveled with me along my quest in "becoming". I would like to thank my parents, Larry and Lois de Montegre for your love, support and encouragement. I would not be where I am, nor who I am, if not for you! I would like to thank my husband John, and children Jake, Lauren, and Caroline for your patience, understanding, and love throughout the past six years. You are such an important part of my journey, and I'd like to thank you for helping me reach a goal that I have wanted to pursue for over two decades.

Finally, I would like to thank Dr. Evans for the incredible support, encouragement, and guidance you consistently provide. I am forever indebted to you! You challenged me to pursue opportunities for professional development and growth, provided much needed words of encouragement when I became overwhelmed, and taught me so much both within and outside the classroom. You are the type of instructor, advisor, and mentor I hope to one day become.

Table of Contents

Abstract ii

Acknowledgments iii

List of Tables vii

Chapter 1 1

Purpose of Study 7

Significance of Study 8

Research Questions 10

Definitions of Terms 10

Chapter 2 12

Race 13

Definition of Race 15

Race Compared to Culture and Ethnicity 16

Health Disparities Related to Race 16

Racism 17

Individual, Institutional, and Cultural Racism 19

Racism Controversy 20

Post Racial Era Ideology 21

Overt Acts of Racism 22

Covert Acts of Racism/Microaggressions 23
Microinvalidations, Microinsults, and Microassaults 24
The Impact of Racism on Health and Mental Health 25
Race Based Stress and Trauma 28
Multicultural Competency Among Professional Counselors 29
Considerations for Professional Counselors 31
Conclusion 33
Chapter 3 35
Research Methodology 35
Research Questions 37
Participants 37
Procedure 38
Instrument 38
Analysis 40
Summary 40
Chapter 4 42
Demographics 42
Reliabilities 46
Results 48
Research Question 1 48
Research Question 2 48
Research Question 3 52
Research Question 4 52

Research Question 5 53

Research Question 6 53

Summary 60

Chapter 5 61

Overview 61

Discussion of Results 62

Limitations 65

Implications 66

Recommendations for Future Research 67

Summary 68

References 70

Appendix A 92

Appendix B 95

Appendix C 96

Appendix D 97

Appendix E 106

Appendix F 108

Appendix G 109

Appendix H 110

List of Tables

Table 1 45

Table 2 47

Table 3 50

Table 4 51

Table 5 55

Table 6 56

Table 7 59

Chapter I. Introduction

According to the U.S. Census Bureau (2014), 32.6% of America's population consisted of minorities, or non-white individuals. The U.S. Census Bureau also estimated that by the year 2044 non-Hispanic whites will no longer comprise greater than 50% of the population, will experience a decrease of 8.2%, and will then be the majority-minority population. Also, by the year 2060, the two-or more race population is expected to triple in size (an increase of 226%), and Asians will represent the second fastest growing population (an increase of 128%) followed by Hispanics (an increase of 115%) (U.S. Census Bureau, 2014). Hispanics are projected to comprise 29% of the total population compared to non-Hispanics. These projected changes in racial demographics in the United States represent a shift unlike anything the country has witnessed in the past two hundred years, leading to questions regarding race relations. In this chapter a review of race in the United States, including the stress and trauma experienced by Individuals of Color, is provided as well as a discussion of the current research study that examines professional counselors' experiences with various aspects of race based trauma.

Race and Racism

Race and racism have been defined and conceptualized in numerous ways, resulting in a lack of consistency for researchers, practitioners and educators. This lack of consistency has made it difficult to develop assessment measures and treatment strategies for counseling Individuals of Color who have experienced the negative outcomes of racism. Individuals of Color are defined as individuals of non-Caucasian descent. One definition of race, defined in the United States, is a social construction in which people are ranked and grouped by physical

features, language and skin color (Carter et al., 2013). One definition of racism is the belief that people of a specific phenotype and/or ethnic group are inferior, and this provides a rationale for degrading a specific group while maintaining power and control for the dominant group (Bryant-Davis & Ocampo, 2005; Hulteen & Wallis, 1992). Despite the various definitions of race and racism, researchers have found that racism is involved in many aspects of daily living and is a common experience in the United States (Carter et al., 2013). It has been found to be a profound and damaging problem, despite governmental, individual, and group efforts. For instance, racism destroys individuals' self-confidence and identity, leads to internalization of discriminatory messages, prevents achievement of potential, and impacts mental health due to the barriers in accessing and receiving mental health care it creates (Evans, Hemmings, Burkhalter, & Lacey, in press; Williams & Williams-Morris, 2000).

Racism may be either overt or covert in nature (Ponds, 2013). These racially motivated aggressions strike the core of one's selfhood. Overt racism can be found in hate crimes which are defined by Congress as a criminal offense against a person or property based on the offender's bias against an ethnic origin, race, disability, religion, or sexual orientation (Federal Bureau of Investigation, 2014). The Federal Bureau of Investigations' 2014 *Hate Crime Statistics Report* indicated race to be the cause of hate crimes in 48.5% of the reported cases (Hate Crime Statistics, 2014). A few of many recent examples of racially motivated hate crime cases include Trayvon Martin, Andy Lopez, Tamir Rice, and the mass killings committed by Dylan Roof.

In addition to these overt examples of racism, covert racism exists among individuals, society, and institutions. Individual racism occurs on a personal level and is defined as prejudice a person holds who believes that members of a certain racial group are inferior to their own.

Institutional racism is found in organization practices and policies that limit or deny access, result in unfair treatment, or are ignored. Cultural racism is reflected in the norms, values, language, and the denial of cultural styles of non-Whites by dominant cultural group members (Carter, 2007; Carter & Pieterse, 2005; Jones, 1972; Jones & Carter, 1996; Lewis-Coles & Constantine, 2006; Taylor, 1980; Thompson & Carter, 2012). Covert acts often occur in the form of microagressions (Sue, Capodilupo, Torino, Bucceri, Holder, & Esquilin, 2007). Examples of microagressions include racial profiling, racial discrimination, institutional racism, within group racist comments, and outside group racist comments (Evans et al., in press; Sue et al., 2007). Additional examples include racist beliefs, racist behavior, racist attitudes, racial ambivalence, racial resentment, racial vilification, and denial of racism (Evans, et al., in press; Landrine & Klonoff, 1996; Smolicz, 1999; Sue et al., 2007; Utsey, 1999; Utsey & Ellison, 2000). Finally, there are certain assumptions that are reflected through microagressions. These include assumption of intellectual inferiority, criminality, second-class citizenship, inferior status, universality of the individual's experience, superiority of the white cultural values, and communication styles (Sue et al., 2007).

Health and Mental Health Disparities for Individuals of Color

Despite the fact that Individuals of Color are the fastest growing population in America, there is disparity in health care services for minorities. Williams, Neighbors, and Jackson (2008) reported that racial bias may be a neglected determinant of health as well as contribute to health disparities in the U.S. Researchers have found that Individuals of Color who are exposed to perceived discrimination experienced higher levels of illness/health risks including elevated blood pressure, heart disease, low birth-rate, depression, anxiety, substance abuse, psychosis, anger, and other symptomology (Karlsen & Nazroo, 2002; Williams et al., 2008).

Additional disparities exist in mental health care. Researchers have found that racial minorities are underserved by professionals. Carter and Forsythe (2010) conducted a study and reported that fewer than 10% of minorities sought professional help to deal with experiences of racism. The findings of this study suggested that Individuals of Color are likely to either keep their concerns to themselves or share within their personal support systems. They may be hesitant to seek professional assistance because of a lack of training for treating and dealing with race related experiences among counselors, and/or a lack of awareness among counselors concerning racial issues, and/or multicultural training that is too broad or lacks a specific focus on race (Carter & Forsythe, 2010; Helms & Cook, 1999). Additional researchers cited a lack of trust Individuals of Color continued to have for mental health care providers and a viewpoint that does not include professionals as viable resources for dealing with racism (Sanders, Thompson, Bazile, & Akbar, 2004).

Race Based Stress

Researchers reported that there is a general agreement that experiences of racial and ethnic discrimination result in negative psychological outcomes (Carter, 2007; Mossakowski, 2003; Paradies, 2006; Williams & Mohammed, 2009; Williams, Neighbors, & Jackson, 2003). It has also been well documented that Individuals of Color experience significant stress caused by cultural, individual, and institutional experiences with racism (Landrine & Klonoff, 1996; Utsey, 1999; Utsey & Ellison 2000). Scott and Stradling (1992) referred to this as prolonged stress disorder. Chronic racism and discrimination can lead to a wide variety of psychological symptoms including denigration of one's sociocultural in-groups, feelings of helplessness, numbing, paranoid-like guardedness, and medical problems (Krieger, 1990; Newell, 1990; Root, 1992). Additional researchers have found that chronic racism and discrimination can lead to

feelings of anxiety, fear, and the development of Post Traumatic Stress Disorder (Ponds, 2013; Carlson, 1997). Experiences of discrimination and racism resulting in race related stress can potentially result in the development of race based trauma (Carter, 2012). The numerous negative physical and psychological effects of racism, as well as the fact that these experiences have the potential to lead to race based trauma, support further examination of race based trauma among Individuals of Color.

Race Based Trauma

Trauma was previously defined as experiences that cause an individual to feel helpless, hopeless, and afraid for their safety or survival, may be sudden in nature or an accumulation of experiences over time, and is often far subtler than most recognize (Ponds, 2013). However, this definition has recently changed. The Substance Abuse and Mental Health Association (2014) has developed the following working definition of individual trauma: "individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, emotional or spiritual well-being" (p. 7). Researchers have reported that symptoms of trauma caused by racism among Individuals of Color are similar to other causes of trauma because the basis for trauma is one person or group's maintenance of domination, power and control over another's (Carlson, 1997; Hulteen & Wallis, 1992). Race based trauma is defined as emotional, psychological, and physical reactions to personal experiences with harassment and discrimination that cause physical, emotional, and/or psychological pain (Carter, 2007; Evans et al., in press). Numerous researchers have found that discrimination and racism are a source of psychological distress and trauma (Carter & Forsythe, 2009; Carter, 2007; Bryant-Davis & Ocampo, 2005; Loo, Fairbank, Scurfield, Ruch, King,

Adams, & Chemtob, 2001). However, despite the fact that the symptoms of racism induced trauma parallels symptomology from other sources, diagnostic manuals do not include sufficient diagnostic criteria, and researchers do not typically employ measures that focus on racism as a factor in post traumatic stress disorder (Carter, 2007; Carter, 2012; Carter, Muchow, Rangel, & Clayton, 2011; Carter & Forsythe, 2010; Kressin, Raymond, & Manze, 2008). The lack of sufficient diagnostic criteria and research focusing on racism as a factor of race based trauma evidences a lack of resources for professional mental health providers.

Multicultural Competency

Clinicians are ethically responsible for providing multiculturally competent care (MCC) for their clients. Various licensing boards and professional organizations have included multicultural competency in their code of ethics. For example, the ACA Ethical Standards Casebook (2014) stated that counselors: must be culturally sensitive when obtaining informed consent, A.2.c. Developmental and Cultural Sensitivity; respect client rights by maintaining cultural awareness and sensitivity, B.1.a. Multicultural/Diversity; do not discriminate against clients, C.5. Nondiscrimination; and must select appropriate assessments, E.8. Multicultural Issues/ Diversity in Assessment. The U.S. Department of Health and Human Services (2001) stated that multiculturally competent care includes a set of values, behaviors, attitudes, and practices within a system that enables people to work effectively across cultures. It further emphasized the ability to honor and respect beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services. Dunbar (2001) stated that the development of multicultural theory over the past two decades has grown exponentially. This trend has continued.

A specific multicultural competency is working with Individuals of Color who have experienced racism resulting in the possible development of race based trauma (Carter, 2007). An additional definition of race based trauma has been described as the psychological distress and trauma caused by discrimination and racism (Carter & Forsythe, 2009; Carter, 2007; Bryant-Davis & Ocampo, 2005; Loo et al., 2001). It is imperative for practitioners to address multiculturally diverse clients' experiences with hate victimization, or racism, in community, organizational, and interpersonal relationships (Dunbar, 2001). Researchers reported that the effects of racially motivated verbal and physical attacks on racial minorities has been ignored in research and reflects the fact that this element of social disadvantage has not been adequately explored (Brondolo, Gallo, & Myers, 2009; Carter et al., 2013; Carter & Forsythe, 2009; Karlsen & Nazroo, 2003; Prilleltensky & Gonick, 1994).

Purpose of the Study

The purpose of this exploratory study was to examine counselors' professional experiences with race based trauma and investigate an emerging and under researched category of multicultural competency, working with Individuals of Color who have experienced race based trauma. The Race Based Trauma Survey was developed by Dr. Amanda Evans and Carrie Hemmings to examine professional counselors' experiences with the following related to race based trauma: contributing factors, personal training and experience, experiences with identification and treatment, professional policy, and self-reported competency in identifying and providing treatment. Additionally, this study examined the relationship between (a) self-reported competencies and (b) training to identify race based trauma, training to treat race based trauma, and the existence of professional policy on race based trauma that includes treatment recommendations.

Significance of the Study

This study was significant for several reasons. No study of this type existed in the research on race based trauma. Researchers recommend that in order to effectively treat race based trauma, counselors must first be educated and trained to acknowledge it (Bryant-Davis & Ocampo, 2006; Carter, 2007; & Sue, D. W. & Sue, D., 2003). However, clinicians who strive to do so may find it difficult to locate adequate resources and training opportunities. This can be problematic for practitioners for a variety of reasons. First, the research and development of race based trauma is in the early stages of conceptualization, study, and research. Some contemporary researchers state that discrimination and racism can be included in the rubric of trauma (Carter, 2007; Ford, 2008). However, procedures for doing so are still in development. The Race-Based Traumatic Stress Symptom Scale (RBTSSS) has been developed to assist practitioners in assessing for race based trauma (Carter et al., 2011). However, due to the paucity of such instruments, practitioners have a lack of resources to guide them in assessing for race based trauma (Carter, 2011). Second, although the existing research on multicultural competency, racism, and post traumatic stress disorder is vast, the existing literature on race based trauma is lacking. Third, there is disparity among researchers concerning the use of terminology when referring to race as well as trauma resulting from racism and discrimination. These include: race, culture, and ethnicity; and race based trauma, race based traumatic stress, race based traumatic stress injury, insidious trauma, intergenerational trauma, racist incident based trauma, psychological trauma, societal trauma, and others (Neville, Brendesha, & Utsey, 2008). Some researchers use these terms interchangeably, diminishing clarity and understandability among readers. Others refer specifically to one descriptor or the other. Fourth, some researchers have stated that the continual exposure to racism can lead to the development

of post traumatic stress disorder symptomology (Bryant-Davis, 2007; Ponds, 2013; Sanchez-Hucles, 1999). Therefore, some argue that the criteria for diagnosing post traumatic stress disorder should be expanded to adequately diagnose the trauma of racism (Newell, Brandesha, & Utsey, 2008). Sanchez-Hucles (2008) proposed that the established conceptions of post traumatic stress disorder be expanded to include racial and ethnic discrimination and oppression as aspects of trauma. However, the current diagnostic criteria for post traumatic stress disorder does not include the trauma of racism, nor do all researchers recommend that it should. Finally, practitioners who wish to treat race based trauma will struggle to find empirically validated methods for doing so. Carter and colleagues (2011) stated that a great deal of research exists on the effects of racism on mental health, and that what is absent is a way to analyze how race based experiences are related to individual's psychological and emotional reactions and the effects on mental health. The outcome of this study provides counselors and researchers with information regarding reported rates of training in identifying and treating race based trauma among Individuals of Color, and how the presence, or lack of training as well as the existence of professional policy on race based trauma that includes treatment recommendations, affects counselors' self-reported competency.

The findings also contribute to existing research on multicultural competency with a focus on counseling Individuals of Color who have experienced race based trauma. This contribution could lead to (a) an increase in awareness of race based trauma among counselors, (b) an increase in counselors' dedication to provide effective therapeutic practices through continued education and training, (c) an increase in training opportunities focused on counseling Individuals of Color who have experienced race based trauma, and (d) inclusion in the limited

research on race based trauma that could lead to future studies and publications, and new racially sensitive and appropriate assessment measures and treatment strategies for counselors.

Research Questions

This study addressed several research questions.

Q1: To what extent do counselors report addressing issues of race based trauma in counseling sessions?

Q2: What factors do counselors identify that contribute to race based trauma?

Q3: To what extent have counselors received training to identify race based trauma?

Q4: To what extent have counselors received training to treat race based trauma?

Q5: To what extent do counselors' professional practice have a policy on race based trauma that includes treatment recommendations?

Q6: What is the relationship between (a) the rate of perceived competencies among professional counselors and (b) training to identify race based trauma, training to treat race based trauma, and the existence of professional policy on race based trauma that includes treatment recommendations?

Definitions of Terms

Individuals of Color: individuals of non-Caucasian descent.

Race based stress: significant stress caused by cultural, individual and institutional experiences with racism (Landrine & Klonoff, 1996; Utsey, 1999; Utsey & Ellison 2000). Experiences of discrimination and racism resulting in race related stress can potentially result in the development of race based trauma (Carter, 2012).

Race based trauma: emotional, psychological and physical reactions to personal experiences with harassment and discrimination that cause pain (Carter, 2007; Evans et al., in press).

Chapter II. Literature Review

The U.S. population is rapidly changing due to immigration and differential fertility rates (Bobo & Fox, 2003). Approximately 32.6% of the United States' population consists of ethnic minorities (U.S. Census Bureau, 2014). Weinrich and Thomas (2002) stated that Individuals of Color will be the numerical majority between the years of 2030 and 2050, and the U.S. Census Bureau (2014) supported this statement by citing that the majority-minority cross-over will occur in 2044. The U.S. Census Bureau also made the following projections for the upcoming 44 years. The native born population is estimated to increase by 62 million, or 22%. The foreign-born population will increase by 36 million, or 85%. This means that the foreign born population will comprise 19% of the United States' total population. The Bureau also reported that the two or more race population is the fastest growing population, will triple (an increase of 226%) by 2060, grow from 8 million to 26 million, and account for 6.2% of the total population. The second fastest growing population is projected to be Asian (an increase of 128%), representing 9.3% of the population by 2060, followed by Hispanic (an increase of 115%), representing 29% of the total population as opposed to 81% of non-Hispanics. Modest growth is expected of the last three racial groups identified by the U.S. Census Bureau. Native Hawaiians and other Pacific Islanders are expected to increase by 63% and represent less than 1% of the population by 2060. Black Americans are expected to increase by 42%, and represent 14% of the population as compared to 13% in 2014, and Native American and Alaska Native will represent just over 1% of the population. The non-Hispanic white population is estimated to decrease by 8% and represent 44% of the population. Additionally, by 2060, 64% of children

will belong to racial and ethnic minorities. The majority-minority cross-over for children is projected to occur in the year 2020. Despite these statistics that indicate that America is becoming increasingly diverse and will become a plurality nation by 2044, it is a nation that continues to struggle with acceptance, inclusion, and respect of its diverse population.

Race

The definition of race has evolved throughout America's history. During the nineteenth and twentieth centuries, views of race were scientifically accepted through essentialism and biological theories that were based on the belief of genetic transmission (Allen, 1994; Harris, & Sim 2001; Gould, 1981; Smedley, 1998; Takeuchi & Gage, 2003). These theories upheld the belief that race was the cause of physical, mental and moral characteristics and placed races in hierarchies which viewed whites as the superior race (Takeuchi & Gage, 2003). Smedley (1999) stated that the idea of race was associated with disposition and morality. During the nineteenth century almost all scientific thought accepted race inferiority (Haller, 1971). Darwin's classification of species coincided with classification systems which justified slavery and supported the economic structure (Feagin, 2000). Racial stratification was created by slavery, forced migration of Native Americans and Hispanics, and immigration laws that restricted life opportunities (Feagin, 2000). It was perpetuated through the belief that biological traits are fixed and constant over time, and racial groups have physical, moral, and mental traits that place them in a hierarchy, with whites being the superior race (Harris & Sim, 2001). After the turn of the century, scientists recognized that assumptions of race are based on stereotypes and prejudices tied to some physical trait (Omi & Winant, 1994). Graves (2011) stated that in the 1920's, scientists replaced the biological theory of race due to scientists finding there was no way to distinguish groups based solely on genetic material. It is important to clarify that even though

scientist disproved genetics being associated with race, this notion persisted and still does today (Bamshad & Olson, 2003; Hernstein & Murray, 1994; Rushton, 2000). The biological theory of race was replaced with the theory of racial assimilation, developed by Robert Park. This theory encouraged assimilation through intermarriage, encouraged the public to stop thinking of race in order to close the distance between races, and focused on issues of identity and place in society (Takeuchi & Gage, 2003; McKee, 1993). During the 1950's and 1960's, scientists recognized there was no evidence to support Park's theory, and began to support educational programs that focused on the history of racial groups and empathy. During this time, the civil rights movement was key in policies and programs designed to resolve racial inequalities and tensions. Also during this time, focus was on the larger context of racialized social structure rather than racist ideologies alone (Bonilla-Silva, 1997). During the 1970's, scientists realized that education alone could not dispel stereotypes, conversely, it could actually reinforce hostilities (Stangor & Jost, 1997). During the 1980's and 1990's, studies focused on socio-economic status as an explanation for race differences. The focus on social class became a more common explanation for race differences because some still viewed race as biological, some were hesitant to make inferences that could be seen as blaming the victim, there was difficulty fitting racial paradigms into the health, social, and political circumstances of Latina(o) and Asian immigrants, race was seen as a Black and White issue, some researchers and policy makers viewed programs to assist the poor as having a greater political appeal than promoting racial justice, and issues of race and racial justice were no longer prominent on the national agenda (Takeuchi & Gage, 2003). Weinrich and Thomas (2002) stated that race does not adequately explain the human condition, and attempts to invoke race as such contributes to America's preoccupation with skin color.

Definition of Race

The concept of race has been contested and problematic in that it is unclear about what it refers to, what it means, and what kind of category it is (Carter & Pieterse, 2005; Ikeunobe, 2013). As previously stated, it has been defined in the United States as a social construction in which people are ranked and grouped by physical features, language, and skin color (Carter et al., 2011; Carter et al., 2013). Some researchers have proposed to do away with the concept of race altogether, conceptualizing that race has been documented as unscientific, arbitrary, and exists primarily on a social basis (Appiah, 1990; Corlett, 2005). However, other researchers have found the effects of racism, racial classification, racial categories, and inequality continue to have a negative effect for some Individuals of Color and remain ingrained in the United States' customs, laws, and traditions which create barriers to equality (Carter & Pieterse, 2005; Carter, 2007; Coverdill, Lopez, & Petrie, 2011; Jones, 1991; Landrine & Klonoff; 1996; Omi & Winant, 1986; Smedley, 1999). One of the most profound historical and contemporary uses of racial categories in America is in establishing legal and social customs that exist on the institutional level, maintain social stratification, and are reflected in individual belief systems (Carter & Pieterse, 2005). The utilization of racial categories in denying equal opportunity and access to power, as well as desired goods and resources, reflects that race is particularly meaningful (Williams & Williams-Morris, 2000).

Thompson and Carter (2012) stated that race previously and currently is a social construct created by White Europeans and Americans to elevate the white race and justify the exploitation and oppression of certain racial groups based on the presumption of inferiority in intelligence, morality, physical appearance, and culture. Our laws, language, education system, public policies, and religious systems all reflect the preferences of the dominant racial/ethnic

group (Carter, 2004). Marger (2002) stated that each of the minority groups she identified, Blacks, American Indians, Hispanics, and Asians, are in continuing and considerable conflict with dominant group members and institutions. When preferences for physical characteristics are paired with judgements and sentiments about the superiority of these beliefs, and when this is combined with the power to enforce one's preferences and prejudices, racism is a likely result (Dobbins & Skillings, 2000).

Race Compared to Culture and Ethnicity

The definition of race is often used interchangeably with culture and ethnicity. Important differences in the definitions are often not understood by most Americans. Culture is defined and thought of as a learned pattern or system of meaning passed down from generation to generation (Thompson & Carter, 2012). There is some overlap between race and culture due to theorists utilizing cultural characteristics in the determination of race. Ethnicity refers to natural origin or religious group solidarity and is often used as a euphemism for race (Carter & Pieterse, 2005). Using ethnicity to denote race does not account for ethnic variations among Individuals of Color. For instance, Asians are Korean, Japanese, Chinese, and Vietnamese; Native Americans are Seneca, Miami, Sioux, Hopi, Navajo, and Blackfeet; and Blacks are American, African, Jamaican, and English (Carter & Pieterse, 2005). Important differences in these terms include: race, as opposed to culture and ethnicity, is defined primarily by skin color and physical features which are then associated with intellectual, moral and cognitive dispositions; ethnicity does not define a place in the social hierarchy, but race does; one's ethnic group can change over time, but one's race does not; and ethnicity does not define a specific or singular culture, yet race does (Helms, 1996). Helms (1995) stated that ideas concerning racial group membership have

endured for over four centuries whereas ethnic identification is often lost after three in order for the person to blend into mainstream America.

Health Disparities Related to Race

Race is associated with negative health outcomes (Aneshensel, 1992; Anderson, 2013; Kwate et al., 2003; Okazaki, 2009; Paradies, 2006; Peters, 2006; Schwartz & Meyer, 2010; Williams & Williams-Morris, 2000). Individuals of Color experience health care disparities that exist for many reasons, such as unequal access to social, educational, and material resources which have both direct and indirect effects on health status (Adler & Snibbe, 2003; Adler & Rehkopf, 2008; Gallo & Mathews, 2003). These inequalities result in racial minorities being less likely to have health insurance, experiencing racial attitudes and discrimination among providers, and having unequal access to quality health care (Cain & Knighton, 2003; Klonoff, 2009; Smedley, 2012). Racial disparities also lead to higher morbidity and mortality rates, and chronic/disabling illnesses (Klonoff, 2009; Nazroo, 1998; Williams, 2005). Racial minorities are documented to have higher rates of obesity, infant mortality, heart disease, stroke, and shorter life spans (Garcia & Sharif, 2015). Racial disparities in health care are pervasive as most of the top fifteen leading causes of death are experienced at higher rates among racial minorities including; heart disease, cancer, stroke, diabetes, kidney disease, hypertension, liver cirrhosis, and homicide (Williams & Mohammed, 2009).

Despite racial minorities' increased need for healthcare, they are less likely to access it for several reasons. Policies and practices in health care systems and the way health care is financed and delivered result in tiered systems with unequal health care quality (Smedley, 2012). Due to recognized patterns of over reliance on medication, misdiagnosis, restricted forms of care, and disparities in service, Individuals of Color tend to mistrust and disengage in health service

and seek healthcare alternatives (Brown, Ahmed, Gary, & Milburn, 1995; Buser, 2009; Davis, 1997; Klonoff, 2009). In addition, racial minority immigrants may experience language barriers further complicating this issue, and counselors may be hesitant to speak about issues regarding race for fear of offending the client (Dobalian & Rivers, 2008; Williams & Keating, 2005). The U.S. Department of Health and Human Services (2001) reported that under-utilization of services may exist due to the aggregated effect of these factors.

Racism

Racism is a term that was not formally defined, used, or accepted until the 1960's, despite the fact of its existence for centuries (Carter, 2007). Racism is conceptualized and defined in numerous and various ways. Racism is prejudice based on the belief that members of a different racial group or of a specific phenotype or ethnic group are inferior (Bryant-Davis & Ocampo, 2005; Carter & Pieterse, 2005). Racism reflects stereotypes, and implicit and explicit beliefs that serve as the rationale for treatment of group members (Takeuchi & Gage, 2003). However, these definitions do not reflect the fact that racism results in individual, societal, and institutional disparities, as well as unfair treatment, opportunity, laws, and policies, nor the fact that racism ensures the dominance and power of the predominant race over minorities. Dobbins and Skillings (2000) defined racism as either overt or covert, physical or mental, unsolicited and unwanted discrimination and/or violence that exists within individuals, institutions, and cultural transactions. Racism is an ideology and set of practices that seeks to legitimize the superiority of the predominant race as well as the inequality faced by minority groups, resulting in power imbalances that leads to incomplete citizenship, undervalued rights, recognition and participation, and diminished social inclusion (Dobbins & Skillings, 2000; Saloojee, 2003). Racism maintains power and control while providing a rationale for degrading a specific group

and exists in employment, education, housing, healthcare, and the judicial system (Dominelli, 2008; Hulteen & Wallis, 1992; Shavers, V. & Shavers, B., 2006). The International Convention on the Elimination of All Forms of Racial Discrimination (1969) defined racial discrimination as:

> any exclusion, distinction, restriction, or preference based on race, color, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment, or exercise on an equal footing of human rights and fundamental freedoms in the political, economic, social, cultural, or any other field of public life. (p. 165)

Although many Americans conceptualize racism as an individual or hate group offense, racism exists among America's institutions, in its policies and programs, and is reflected in its culture (Carter, 2007).

Individual, Institutional and Cultural Racism

Racism is involved in many aspects of daily living and is a common experience in the United States (Carter et al., 2013; Garcia & Sharif, 2015). Most individuals would not consider themselves racist yet they may still have racial biases and engage in subtle and unconscious racially motivated behaviors (Gaertner & Dovidio 2006; Sue et al., 2007; Thompson & Carter, 2012). Many immigrants and minority group members report that they experience macro and microagressions on a regular basis (Sue et al., 2007). Racism goes beyond individual attitudes and personal exchanges and is found in institutional policies and societal norms; and operates at the individual, institutional, and cultural levels (Carter, 2007; Carter & Pieterse, 2005; Jones, 1972; Jones & Carter, 1996; Lewis-Coles & Constantine, 2006; Taylor, 1980; Thompson & Carter, 2012). Individual racism is defined as prejudice that a person holds who believes that members of a certain racial group are inferior to their own. Institutional racism is defined as the outcomes that result from organization practices and policies that limit or deny access, result in

unfair treatment, or are ignored. Cultural racism is reflected in the norms, values, language, and denial of the cultural styles of non-Whites by dominant cultural group members (Carter & Pieterse, 2005; Lewis-Coles & Constantine, 2006). An important consideration is that racial discrimination can exist between racial minority groups (Kohatsu et al., 2000; Mack, Tucker, Archuleta, DeGroot, Hernandez, & Cha, 1997). Although the literature on racism has primarily focused on White and Black racism, additional minority groups have been found to experience similar encounters with racism, including Asians, Latina(o)s, Native Americans/Native Alaskans, multi-racial individuals, and racially diverse immigrants (Douglas, Saenz, & Murga, 2015; Kohatsu, Victoria, Lau, Flores, & Slazar, 2009; Shattell & Villalba, 2008).

Racism Controversy

Racism continues to be a profound and damaging problem in the United States, despite governmental, individual, and group efforts to address the history of racial injustice and oppression (Carter, 1995; Jaynes & Williams, 1989; Omi & Winant, 1986, 1994; Prilleltensky & Gonick, 1994). Dalal (2008) stated that despite the fact that liberal democracies are founded on equality and social justice, some groups are far worse off than others. Numerous empirical studies show how racism and white privilege continue to exist in housing, income and wealth, health, law, education, and the workforce (Shams, 2015). Despite these findings, researchers have found that there is widespread denial of racism among the public (Douglas et al., 2015; Essed, 1991; Feagin & McKinney, 2002; Goldberg, 2008; Lentin & Titley, 2011; Sue, 2010). Some researchers also uphold this view (Appiah, 1990; Corlett, 2005; D'Souza, 1996; Goldberg, 2008; Lentin & Titley, 2011; Thernstrom & Thernstrom, 1997; Wilson, 1980). However, instances of overt and covert racism and discrimination continue to exist and researchers warn against accepting the fantasy of a post-racial era which maintains that racism no longer exists

(Ono, 2010). Racism (overt or covert) is real, and no matter how much denial exists, it continues to weigh heavily on the psychological and physical health adjustment of African Americans and other minority groups (Stevenson, 1994). Members of non-dominant groups are the targets of overt and covert institutional power manipulations. The systematic advantages that are experienced by the dominant group are self-perpetuating and leave little motivation for those in power to change it (Dobbins & Skillings, 2000; Helms, 1992). Furthermore, "it is difficult to bring about reform to improve the situation of immigrants of color and to provide them with a route to citizenship status when so many Americans, from corporations to consumers, gain because immigrants' racialized and/or undocumented status maintains their vulnerability" (Douglas et al., 2015, p. 1449).

Post-Racial Era Ideology

Today, some propose that America faces a new era in race relations, termed the post-racial era, which maintains that the category of race no longer makes sense and that we have moved beyond race, racial categories, racism, and treating minorities differently because of racial characteristics (Ikuenobe, 2013). These views are evident in eliminativist theories of race and the behavioral theory of racism (Ikuenobe, 2013). Eliminativist theories of race strive to eliminate the discourse on the concept of race because it maintains we do not have adequate criteria for race that can group individuals in distinct races. The behavioral theory of racism acknowledges that racism must occur in obvious harmful interactions, and since these do not exist today, America is in a post-racial era and moved beyond race and racism (Ikuenobe, 2013). Many individuals in American society demonstrate color-blind racism, which also denies that racial issues matter nor have meaning, focuses on meritocracy, and denies the fact that subtle forms of racism exist today (Bonilla-Silva, 2003; Bonilla- Silva, 2015; Burkard & Knox, 2004;

Ikuenobe, 2013; Neville, Worthington, & Spanierman, 2001). Color-blind racism attributes societal problems to a lack of effort rather than racism, which blames the victim, and rationalize that those minority groups who cannot succeed in American Society are culturally inferior (Bonilla-Silva, 2004; Burkard & Knox, 2004). Color-blind racism is subtle and sophisticated, is effective in maintaining the status quo, and is associated with the idea of racism without racists (Bonilla-Silva, 2014; Bonilla-Silva, 2015). There are four central frames that are identified by color-blind racism. These are abstract liberalism, naturalization, cultural racism, and minimization of racism (Bonilla-Silva, 2014). Abstract liberalism allows whites to oppose practical approaches to dealing with racial inequality by believing in their reasonable and moral nature. Naturalization explains racial matters as a consequence of natural occurrences or tendencies. Cultural racism uses cultural arguments to minimize racist patterns. Minimization of racism maintains that discriminatory acts no longer affect the lives of Individuals of Color (Bonilla-Silva, 2003; Bonilla-Silva, 2014; Neville, Coleman, Falconer, & Holmes, 2005; Neville et al., 2001). The relevant features that ought to exist within a post-racial era do not, which indicates that a post-racial era has yet to materialize (Ikuenobe, 2013).

Overt Acts of Racism

Researchers have listed overt acts of racism that included harassment, verbal or physical attacks, or threats to livelihood (Bryant-Davis & Ocampo, 2005). Other researchers listed overt acts that included: harassment, threat, social avoidance, exclusion, and discrimination (Brondolo, Gallo & Myers, 2009; Shavers V. & Shavers, B., 2006). With advancements in technology, Americans are able to readily learn of instances of injustice, racism, and domestic terrorism. The Federal Bureau of Investigations' *2014 Hate Crime Statistics Report* indicated race to be the cause of hate crimes in 48.5% of the reported cases (Hate Crime Statistics, 2014). Public outrage

has intensified as news reports, video, and photos continue to surface that depict racially motivated acts. A few of many recent examples of racially motivated hate crime cases include Freddie Gray (a twenty-five year old Black victim), the mass killings by Dylan Roof against Black Americans, Bang Mai (a sixteen-year old Vietnamese victim), Jordan Gruver (a sixteen-year old Native American victim), Trayvon Martin (a seventeen-year-old Black victim), Andy Lopez (a thirteen year old Latino victim), Ousmane Zongo (a West African immigrant victim), Aiyana Stanley-Jones (a seven-year old Black victim), Chen Tsu (an eighteen-year old Asian victim), and Tamir Rice (a thirteen-year old Black victim). These are only a few of numerous examples of racially motivated hate crimes committed in America.

Since the election of the first African American president, there has been a rise in hate activity, hate groups, and online hate sites (Tynes, Umana-Taylor, Rose, Lin & Anderson, 2010). As technology has advanced, new forms of hate crimes have emerged in the form of internet hate sites, blogs, and social networks (Klein, 2012). The internet is a convenient means of transmitting hate due to its wide usage, anonymity, ease of distorting information, and the freedom it provides individuals to publish and propagate whatever material they choose (Glaser & Kahn, 2005; Kahn, 2005; Klein, 2012; Kang, 2000). Despite the continued existence of overt acts of racism, covert acts, whether intentional or unintentional, have become far more prevalent and remain pervasive in today's society (Dobbins & Skillings, 2000; Sue et al., 2007).

Covert Acts of Racism/Microaggressions

Covert acts of racism, such as microagressions, reflect the attitudes and beliefs about individuals of certain races (Sue et al., 2007). They convey ambivalence, contempt and/or disregard, promote defensive thinking, and have an additive effect over time (Franklin & Boyd-Franklin, 2000; Pierce, 1998, 1992). Microaggressions exist in cultural, individual and

institutional environments. Nine categories of microagressions documented by Sue et al. (2007) include: alien in one's own land, ascription of intelligence, color blindness, assumption of criminality, denial of racism, myth of meritocracy, pathologizing communication styles and cultural values, second-class status, and environmental invalidation. Other researchers have listed examples of microagressions that Individuals of Color face on a continuous basis including: racial vilification, racial profiling, institutional racism, discrimination, racial ambivalence, denial of racism, and racist beliefs, behaviors, and attitudes (Evans et al., in press; Landrine & Klonoff, 1996; Smolicz, 1999; Sue et al., 2007; Utsey, 1999; Utsey & Ellison, 2000). Racial minorities can internalize racist attitudes and stereotypes (Paradies, 2006). Several interpretations that reflect the meaning Individuals of Color give to microagressions include: you do not belong, you are abnormal, you are intellectually inferior, you are not trustworthy, and you are all the same (Sue, Capodilupo, & Holder, 2008). These interpretations represent themes of invisibility, forced compliance, loss of integrity, powerlessness, and pressure to represent one's group. These affect individuals' behavior, cognitive reasoning, coping strategies, psychological well-being and worldview over time (Sue et al., 2008).

Microinvalidation, Microinsults, and Microassaults

In addition to defining microagressions, Sue et al. (2007) defined:

> microinvalidation as communication that excludes, negates or nullifies a person of color's psychological thoughts, feelings or experiential reality; microinsults are characterized by communication that conveys rudeness and insensitivity and demeans a person's racial heritage and identity; and microassaults are an explicit racial derogation characterized primarily by a verbal or nonverbal attack meant to hurt the intended victim through name-calling, avoidant behavior, or purposeful discriminatory actions. (p. 274)

Microaggressions, microinvalidation, microinsults, and microassaults contribute to negative mental effects among Individuals of Color. They are also mechanisms that communicate

Individuals of Color are a problem, contribute to their marginalization through ethnocentrism, bar them from participation, and contain them through suppression by intimidation, pacification, and the majority rule (Franklin & Boyd-Franklin, 2000).

The Impact of Racism on Health and Mental Health

Racism is a social determinant of health that works counter to the goals of health and mental health professionals (Garcia & Sharif, 2015). Racism can impact health in a variety of ways that include: stress caused by reduced access to employment, housing, and education, increased exposure to risk factors, adverse cognitive/emotional processes, diminished participation in healthy behaviors and increased engagement in unhealthy behaviors, and physical injury as a result of racially motivated violence (Paradies et al., 2015). Numerous researchers have documented negative health consequences for individuals who have experienced racism and/or discrimination (Clark, Anderson, Clark, & Williams, 1999; Harrell, Merritt, & Kalu, 1998; Williams & Williams-Morris, 2000; Williams et al., 2008). Examples of negative health and mental health outcomes include: higher rates of raised blood pressure, increased psychological distress, depression, and stress (Karlsen & Nazroo, 2002; Schwartz & Meyer, 2010). Recent research focuses on how racism impacts the health of minorities in the United States and has resulted in empirical evidence documenting the psychiatric impact of discrimination and harassment, as well as perceived experiences of racism, that result in decreased levels of life satisfaction, distress, anxiety, mood disorders, and compromised well-being (Anderson, 2013; Carter & Forsythe, 2009). Researchers have reported that African Americans, Latina/o Americans, Asians, Native Americans/Alaskan Natives, multiracial individuals, and immigrants experience immediate distress when experiencing microagressions, and the accumulation of these experiences has a detrimental effect on their well-being (Douglas

et al., 2015; Nadal et al., 2011; Nadel, Rivera, Forquer, & Rangel, 2010; Nadel et al., 2014; Shattell & Villalba, 2008; Sue et al., 2007; Sue et al., 2008; Sue, Nadal, Capodilupo, Lin, Torino, & Rivera, 2008). Depression, stress, isolation, psychological distress, suicidal ideation and anxiety can result from perceived racism (Brown, et al., 2000; Kessler, Mickelson, & Williams, 1999; Krieger, 2000; Nadel, Griffin, Wong, Hamit, & Rasmus, 2014; Schulz, Gravlee, Williams, Israel, Mentz, & Rowe, 2006). Additional consequences of racism and discrimination include internalized devaluation, assaulted sense of self, internalized voicelessness, anger, decreased self-esteem, and rage (Fernando, 1988; Griffin, 1991; Hardy, 2013; Landrine & Klonoff, 1996). More extreme reactions to racism result in maladaptive coping strategies that include: suicide, displaced hostility or aggression, domestic violence, substance abuse, or sexual promiscuity (Krieger, Carney, Lancaster, Waterman, Koshelva, & Banaji, 2010; Utsey & Payne, 2000). Brown (2003) attributed mental health problems that arise from stressful circumstances and cognitive states of emotional distress to racial stratification. Pierce (1995) compared the effects of racism to that of terrorism because victims are consistently defensive and adapting to face oppression, victimization, and domination that could lead to psychological exhaustion. Comas-Diaz (2007) similarly stated that exposure to racism increases behavioral exhaustion and psychological distress.

In an effort to understand the relationship between racist incidents and emotional stress, Carter and Forsythe (2010) conducted a study that examined Individuals of Colors' experiences with racism and the stress these experiences caused. Participants included 324 Blacks, Latinos, Asians, Native Americans, and Biracial individuals. The Racial Discrimination Experiences Questionnaire (RDEQ) was modified and utilized for this study as well as the Emotions and Coping Checklist (EC). Of the total participants completing the survey 91.4%, or 296

Individuals of Color reported they had experienced racial discrimination. Of these, 78% reported that the experience was somewhat, very, or extremely stressful, while 21% reported experiencing little or no stress. Fifty-one percent reported that the stress they experienced did not last a long time (less than one month), 44% reported feeling stressed between 2 months and a year or longer, and 54% reported that the incident had a significant impact on them. Carter and Forsythe (2010) further explored the help-seeking behaviors of Individuals of Color to address race based stress and trauma. Participants were given a checklist of 17 people/roles and were asked to indicate who they sought help from. Fifty-seven percent stated they had sought help, while 43% did not. The most frequent source of help was from a friend 41%, followed by a family member 28%, and finally, a spouse or colleague 17% each. Under 10% of participants indicated that they sought help from professionals, identified as counselors, teachers, professors, psychologists, lawyers, religious leaders, psychiatrists, medical doctors, social workers or healers. Carter and Forsythe (2010) stated that overall, Individuals of Color either keep their concerns about experiences with discrimination to themselves or share them within their personal support systems, and that their findings support previous research, listing Landrine and Klonoff (1996) and Carter et al. (2005) as examples.

Counselors often focus on substance abuse, family problems, psychological issues, behavioral problems and affect disorders rather than the negative effects of racism (Hardy & Qureshi, 2012). The effects of racially motivated verbal and physical attacks on racial minorities have been ignored in research and reflects the fact that this element of social disadvantage has not been adequately explored (Karlsen & Nazroo, 2002). Garcia and Sharif (2015) stated that in order to improve health outcomes among Individuals of Color, racism must not only be addressed by those who work with minorities, but by all health professionals, researchers,

students, and practitioners. These researchers warn that failing to examine the multiple ways in which racism is a social epidemic that plays a dominant role in communities will result in falling short of local, state, and national goals to eliminate health disparities that exist due to race.

Race Based Stress and Trauma

As previously mentioned, Individuals of Color experience significant stress caused by cultural, individual, and institutional experiences with racism (Landrine & Klonoff, 1996; Utsey, 1999; Utsey & Ellison 2000). Numerous studies have reported adverse mental health associated with racial discrimination and racism (Carter, Lau, Kirkinis, & Johnson, 2015; Lee & Ahn, 2011, 2012; Pasco & Richman, 2009; Pieterse, Todd, Neville, & Carter, 2012). However, less research and fewer studies have focused on exposure to racism and traumatic reactions. Several studies that have focused on traumatic reactions found that race based trauma results from racism related stress (Carter, 2007; Carter et al., 2013; Carter et al., 2015; Carter, Pieterse, & Munchow, 2015; Loo et al., 2001). Additional researchers have found positive associations between Individuals of Color who have experienced racism and trauma-related symptoms (Ford, 2008; Khaylis, Waelde, & Brice, 2007; Pieterse, Howitt, & Nadoo, 2010). These studies have also found that race related stress was a strong predictor of race based trauma that resulted in depression, anger, physical symptoms, avoidance, hypervigilance, low self-esteem, and psychological harm. Although race based stress is detrimental to the mental health of Individual of Color, race based trauma is more severe and is understood by the nature of the stressor(s) and type of reactions to the stressor(s). It differs from other forms of trauma in that the person is not targeted randomly, but due to their race, and the incident occurs because of stereotypes and stigma that results in a societal response of victim blaming and attribution (Bryant-Davis & Ocampo, 2006; Carter 2007; Henderson & Sloan, 2003).

Although the symptoms of racism induced trauma parallel symptomology from other sources, diagnostic manuals do not include sufficient diagnostic criteria, and researchers do not typically employ measures that focus on racism as a factor in post traumatic stress disorder (Carter, 2007; Carter, 2012; Carter et al., 2011; Carter & Forsythe, 2010; Kressin et al., 2008). The lack of sufficient diagnostic criteria and research focusing on racism as a factor of race based trauma evidences a lack of resources for professional mental health providers. Perhaps for these reasons, identifying and treating the hidden wounds of racial trauma is rarely a focal point of intervention among professionals (Hardy, 2013).

Multicultural Competency Among Professional Counselors

Professional counselors must meet multicultural competencies adopted by various professional organizations such as The American Counseling Association (*ACA*) and its divisions, the Council for Accreditation of Counseling and Related Educational Programs (*CACREP*), the American Psychological Association (*APA*) and others (Weinrach & Thomas, 2002). The American Counseling Association has worked since 1982 to define and operationalize multicultural counseling competencies (Sue, Arredondo, & McDavis, 1992; Sue et al., 1982). The Association for Multicultural Counseling and Development *(AMCD)* published *Operationalization of the Multicultural Counseling Competencies* in 1996, written by Arredondo, Toporek, Brown, Jones, Locke, Sanchez, and Stadler. The American Counseling Association *(ACA)*, American Psychology Association *(APA)*, American Association for Counseling and Development *(AACD)*, the Association for Counselor Educators and Supervisors *(ACES)* and many other organizations have adopted multicultural competencies and included them in their ethical standards (Sue et al., 1992).

Professionals have been seeking ways to provide multicultural training and promote efficacy. Sue et al. (1982) listed knowledge, awareness, and skills as key components of cross-cultural competency and training. Sam Johnson developed a course entitled "Cross-Cultural Counseling Laboratory" to teach multicultural competency and used small group structured interviews as a means to increase cultural awareness of others and self (Carter, 2003). However, Carter (2003) found Johnsons' and previous attempts to teach multicultural competency focused on becoming aware of one's worldview and the cultural experience of the minority individual. Due to these perceived limitations, Carter developed the Racial-Cultural Counseling Competence *(RCCC)* model which focuses on the person as counselor (Carter, 2001). This model recognizes that each counselor-in-training brings to the profession a personal life that includes what he/she was taught about him or herself as a racial-cultural person. Students are taught to view themselves through the lens of reference groups (Carter, 2001). Each individual's social identity and group affiliations both assist and deter counseling relationships and interventions. A major goal of the RCCC training is to heighten awareness of the ideas, behaviors and feelings they have learned about race. In order to be a competent counselor, one must be culturally competent (Carter, 2001; Sue, 2001).

Although courses specifically dedicated to multicultural competency can enhance cross-cultural competency among students, researchers agree that racial-cultural counseling competence is complex, multifaceted and cannot be acquired through a single course (Carter, 2003; Carter, 1995; Helms & Cook, 1999; Sue, 2001). Rather, these researchers recommended that race and cultural competencies should be integrated within the entire counseling curriculum and continue to be developed throughout an individual's lifetime.

Considerations for Professional Counselors

Despite the fact that racism and racial discrimination have been documented to cause negative psychiatric and emotional consequences, mental health assessments and guidelines tend to exclude racism, resulting in a lack of understanding concerning the mental health effects of racism (Brondolo, Gallo, & Myers, 2009; Carter et al., 2013; Carter & Forsythe, 2009; Prilleltensky & Gonick, 1994). Furthermore, most mental health professionals have little guidelines or knowledge on how to explore the effects of racism in clients' lives (Masko, 2005). Numerous researchers document the widespread ineffectiveness of traditional counseling approaches and techniques when applied to racial and ethnic minority populations (Bernal & Padilla, 1982; Casas, 1982; Casas, Ponterotto, & Gutierrez, 1986; Ibrahim & Arredondo, 1986; Smith, 1982; Sue, 1990; Sue, D. W. & Sue, D., 1990; Sue et al., 1982). Counseling professionals need to recognize that race, culture, and ethnicity are functions of each of us and are not limited to just minorities (Sue, D. W. & Sue, D., 1990).

Psychological and psychiatric diagnostic systems do not recognize the fact that racism is a stressor that can cause emotional harm and injury, and it is very difficult to measure the extent in which individuals experience racism (Karlsen & Nazroo, 2002). Limitations were found in 34 previous measures developed to assess for racism and race related stress. Most were developed for African Americans and student samples, were general in nature, were not developed using theoretical models for scale development, and researchers did not report psychometric data (Carter et al., 2013; Kressin et al., 2008; Gee, 2002). Furthermore, despite the fact that racism induced trauma parallels symptomology from other sources, diagnostic manuals do not include sufficient diagnostic criteria, and researchers do not typically employ measures that focus on

racism as a possible factor in Post Traumatic Stress Disorder (Carter, 2007; Carter, 2012; Carter et al., 2011; Carter & Forsythe, 2009; Carter & Forsythe, 2010; Kressin et al., 2008).

In 2013, Robert T. Carter developed the Race Based Traumatic Stress Symptom Scale (*RBTSSS*) that was based on existing measures of Race Related Stress and Carter's 2007 model of Race Based Traumatic Stress Injury in which he proposed that a person's reaction to racism would consist of a cluster of symptomology that would indicate a traumatic stress reaction (Carter & Sant-Barket, 2014). The RBTSSS was designed to assist mental health care providers in assessing for stress and trauma that resulted from racism, but did not meet the guidelines for post traumatic stress disorder, and to assess the psychological and emotional stress reactions to racism and racial discrimination (Carter & Sant-Barket, 2014). The RBTSSS scale initially assesses for two of three symptoms that must be present for race based trauma to be present: (a) The person's experience must be sudden, unexpected and emotionally painful, (b) Next it assesses for hypervigilance, intrusion or re-experiencing, and avoidance or numbing, which are important but not necessary, and (c) Finally, the scale measures symptom clusters including depression, anger, physical symptoms, low-self esteem, and other symptomology that results from experiences of racism (Carter & Sant-Barket, 2014). Despite the usefulness of this scale in counseling American racial minorities, Carter and Sant-Barket stated that a limitation of the scale is that it is not clear how the assessment would apply to immigrants of color.

An additional challenge to treating racism concerns the variance among the complex and contested meanings of race, discrimination, and racism, and variance in terminology when referring to trauma caused by discrimination and racism that includes: race based trauma, race based traumatic stress, insidious trauma, intergenerational/historical trauma, racist incident based trauma, psychological trauma, societal trauma, and race based traumatic stress injury (Bobo &

Fox, 2003; Neville et al., 2008; Wilson, 1989; Winant, 2000). Some researchers use these terms interchangeably, diminishing clarity and understandability among readers. Others refer specifically to one descriptor or the other. Researchers have found that clear definitions and measurement of race, ethnicity, minority, racism, and discrimination are also needed for valid interpretations of research results (Carter & Forsythe, 2010; Ford, 2008). Practitioners are reacting to a wave of culturally diverse ideologies and people without a foundation to respond in contextually consistent ways, leading some to feel overwhelmed (Gallardo, Johnson, Parham, & Carter, 2009).

Conclusion

Researchers have reported that although individual sanctions are needed to address racism, change will occur when people change through awareness, sensitivity, and multiculturalism (Dobbins & Skillings, 2000). Public health and mental health professionals must be committed to achieving the utmost health for all and professionals in the field must recognize the pervasiveness of racism and actively engage in seeking racial justice (Garcia & Sharif, 2015). Although counselors are ethically responsible for utilizing multiculturally sensitive and appropriate assessments and interventions, many may find it difficult to access models to identify and treat race based trauma. Existing models fail to include strategies to manage the interpersonal and emotional harm caused by racism (Brondolo, Brady, Pencille, Beatty, & Contrada, 2012). Evidence also suggests that mental health professionals might have difficultly with race based trauma since Individuals of Color typically do not directly discuss experiences with racism and counselors are often not trained to, nor do they seek training, for addressing significant issues of racial issues or experiences (Carter & Forsyth, 2010; Sanders Thompson et al., 2004).

Researchers emphasize that clinicians must confront racism, include race-conscious curricula, incorporate models, theories, and methodologies include training beyond academia, support additional racism-related research, and develop testing measures for assessment and modalities for treating the effects of racism, race based stress, and race based trauma (Brondolo, Gallo, & Myers, 2009; Brown, 2008; Carter & Reynolds, 2011; Ford, 2010; Jones et al., 2008; Krieger, 2003; Kumagai & Lypson, 2009; Tabloada, 2011; Thomas, Quinn, Butler, Fryer, & Garza, 2011; Williams & Mohammed, 2009). An urgent need exists for new interventions to reduce the psychological effects of racism, and further research to develop appropriate assessments and strategies that are not applied as universal theories based on white populations (Brondolo, Gallo, & Myers, 2009; Carter & Forsythe, 2010; Moradi & Risco, 2006; Williams & Williams-Morris; 2000). Future research on race based trauma and the development of racially appropriate assessments will assist counselors to more effectively meet the needs of Individuals of Color and treat their experiences with racism (Carter & Forsythe, 2010).

Chapter III. Methodology

This study explored previously collected data obtained through the Race Based Trauma Survey on counselors' identification of factors that may contribute to the development of race based trauma, training on identifying and treating race based trauma, self-reported competency on identifying and treating race based trauma and the existence of professional policy on race based trauma that includes treatment recommendations. Additionally, the relationship between (a) counselor's self-reported perceived competency and (b) training on identifying and treating race based trauma and the existence of professional policy on race based trauma that includes treatment recommendations was analyzed. Participants were recruited through postings on helping professional listservs. Demographic information was collected on age, race/ethnicity, highest level of education, professional discipline, professional licenses and certifications, and approximate household income. This chapter includes the methods used to conduct the study, the list of research questions, a description of the research participants, a description of the survey instruments, a description of the data collection procedures, and a review of the methods for data analysis.

Research Methodology

An exploratory survey research design was chosen to provide greater understanding of counselors' experiences with race based trauma, and to look for gaps in identifying and treating race based trauma in counseling sessions as well as in the existence of professional policy on race based trauma that includes treatment recommendations. This study also examined the relationship between (a) the rate of perceived competencies among professional counselors and

(b) training to identify race based trauma, training to treat race based trauma, and the existence of professional policy on race based trauma that includes treatment recommendations.

An exploratory survey research design was chosen because it was the most appropriate and useful research design for projects that address a subject about which there are high levels of uncertainty and ignorance, and when the problem is not very well understood (i.e., very little existing research on the subject matter) (van Wyk, n. d.). Exploratory research is used to identify environmental obstacles in which the problem resides, lacks formal structure, is flexible in nature, and the main point is to conduct inquiry into a topic, gather information, and share that information with readers (Brizee, 2010).

As previously reported, there is a paucity of literature on the trauma of racial discrimination and harassment. The small amount of research available is confounding and provides little benefit to counselors. Upon reviewing the literature, Evans and Hemmings (2015) developed the Race Based Trauma Survey to explore counselors' experiences with race based trauma (See Anderson, 2013; Bobo & Fox, 2003; Bonilla-Silva, 1997, 2014; Bryant-Davis, 2007; Bryant-Davis & Ocampo, 2005; Bryant-Davis & Ocampo, 2006; Carter, 2007; Carter & Forsythe, 2009, Carter et al., 2013; Carter & Reynolds, 2011; Carter & Sant-Barket, 2014; Corlett, 2005; Dunbar, 2001; Essed, 1991; Ford, 2008; Gaertner & Dovidio, 2006; Hardy, 2013; Helms, 1999; Loo et al., 2001; Manges et al., 2015; Root, 1992; Sanchez-Hucles, 1999, 2008; Utsey, 1999; Williams, 2013). The Race Based Trauma Survey was disseminated to counselors in the summer of 2015. The results from this exploratory study could lead to further research on identification and treatment recommendations in counseling individuals who have experienced race based trauma, lead to heightened awareness of race based trauma among researchers and

counselors, encourage researchers to develop racially sensitive assessment measures and treatment strategies, and lead to improved mental health care for Individuals of Color.

Research Questions

The research questions for this study were:

Q1: To what extent do counselors report addressing issues of race based trauma in counseling sessions?

Q2: What factors do counselors identify that contribute to race based trauma?

Q3: To what extent have counselors received training to identify race based trauma?

Q4: To what extent have counselors received training to treat race based trauma?

Q5: To what extent do counselors' professional practice have a policy on race based trauma that includes treatment recommendations?

Q6: What is the relationship between: (a) reported perceived competencies in providing counseling services and (b) training to identify race based trauma, training to treat race based trauma, and the existence of professional policy on race based trauma that includes treatment recommendations.

Participants

One hundred and six licensed and credentialed counselors participated in this study. This included masters and doctoral level practitioners. For this specific study, participants were 19 years of age or older, had a graduate degree in counseling and were either licensed or credentialed. A gPower analysis was utilized to determine the number of participants needed for statistical significance and results indicated N=84. Of the 160 surveys collected, 134 were completed by counselors.

Procedures

Following the IRB approval (see Appendix A), clinicians were recruited (see Appendix B) by posting on helping professional listservs including: The Alabama Counseling Association (*ALCA*), American Counseling Association (*ACA*), Association for Humanistic Counseling (*AHC*), American College Counseling Association (ACCA), American Mental Health Counseling Association (*AMHCA*), and the Counselor Education and Supervision Network (*CESNET*). These listservs were chosen based on the desired sample of professional counselors and counselor educators. Interested participants were provided a direct link to Qualtrics which included the Information Letter (see Appendix C) and the Race Based Trauma Survey (see Appendix D). The surveys were examined to screen for ones that needed to be excluded for patterned answers or for being incomplete. After the surveys were screened for inclusion, data were analyzed using SPSS software.

Instrument

The survey for this study was developed by Dr. Amanda Evans and Carrie Hemmings due to lack of an existing measure to address counselors' experiences with various aspects of race based trauma. Race based trauma is defined as emotional, psychological and physical reactions to personal experiences with harassment and discrimination that cause pain (Carter, 2007; Evans et al., in press). The researcher developed questions were based on a literature review of multicultural competencies, race and racism, health disparities in health and mental health care among Individuals of Color, race based stress and trauma, and implications for counselors (See Anderson, 2013; Bobo & Fox, 2003; Bonilla-Silva, 1997, 2014; Bryant-Davis, 2007; Bryant-Davis & Ocampo, 2005; Bryant-Davis & Ocampo, 2006; Carter, 2007; Carter & Forsythe, 2009, Carter et al., 2013; Carter & Reynolds, 2011; Carter & Sant-Barket, 2014;

Corlett, 2005; Dunbar, 2001; Essed, 1991; Ford, 2008; Gaertner & Dovidio, 2006; Hardy, 2013; Helms, 1999; Loo et al., 2001; Manges et al., 2015; Root, 1992; Sanchez-Hucles, 1999, 2008; Utsey, 1999; and Williams, 2013).

The Race Based Trauma Survey consists of a total of 28 questions and was estimated to take approximately 20 minutes to complete. All questions were either rated on a Likert scale, were multiple choice, multiple response, or open-ended. The first question asked if the participant agreed or disagreed to take the survey. Those that agreed were taken to question 2 and those that did not agree were taken to the end of the survey. The next five questions were demographic in nature. Questions 7-12 pertained to professional discipline, professional licenses and certifications, typical population, type of counseling and work environment, and years of experience. Questions 13-27 pertained to discrimination and race based trauma. Questions 27_5 "I have been prepared to identify race based trauma: 27_6 "I have been prepared to treat race based trauma" 27_7 "I am comfortable addressing race based trauma in session" and 27_8 "I feel competent addressing issues related to race based trauma in session" were used to compute the competency score. These questions were answered on a 7-point Likert scale that included: (1) strongly agree, (2) somewhat agree, (3) agree, (4) neutral, (5) somewhat disagree, (6) disagree, and (7) strongly disagree. The competency score was calculated by summing all scores for each of the four questions and dividing by the number of participants (103). Additional questions that were utilized in this study asked participants to identify factors they believe contribute to the development of race based trauma, their experiences with training to identify and treat race based trauma, the existence of professional policy for race based trauma that includes treatment recommendations, the rate participants reported counseling clients who reported experiences with race based trauma, and perceived competency in identifying and treating race based trauma.

Analysis

Data collected from The Race Based Trauma Survey was analyzed using the Statistical Package for Social Sciences (SPSS), Version 23. Research questions 1, 2, 3, 4 and 5 included descriptive statistics. Research question 6 was analyzed using bivariate correlation and multiple linear regression. For the bivariate correlation, all variables were considered to determine if a relationship existed. For the multiple linear regression, the relationship between the criterion variable (a) self-reported competency score and the predictor variables (b) training to identify race based trauma, training to treat race based trauma and the existence of professional policy on race based trauma that includes treatment recommendations was analyzed. The competency score was computed by summing the responses for each of four questions rated on a Likert scale ranging from: (1) strongly agree, (2) somewhat agree, (3) agree, (4) neutral, (5) somewhat disagree, (6) disagree, and (7) strongly disagree, and dividing by the number of participants (103). These four questions were: (a) I have been prepared to identify race based trauma, (b) I have been prepared to treat race based trauma, (c) I am comfortable addressing race based trauma in session, and (d) I feel competent addressing issues related to race based trauma in session. The mean for each individual question was also analyzed.

Summary

In this chapter, participant recruitment, procedures for distribution and collection of data, instrument development, and data analysis were included to provide an overview of the study. In summary, included participants were licensed or credentialed counselors from across the United States. The instrument was The Race Based Trauma Survey that was developed by Dr. Amanda Evans and Carrie Hemmings after a thorough review of relevant literature. The analysis consisted of descriptive statistics, bivariate correlations, and multiple linear regression. Data

were analyzed using SPSS software, Version 23. The results from this exploratory study could lead to further research in identification and treatment recommendations when counseling Individuals of Color who have experienced race based trauma, lead to heightened awareness of race based trauma among researchers and counselors, and encourage researchers to develop racially sensitive assessment measures and treatment strategies.

Chapter IV. Results

This chapter includes the study's participant selection criteria and an explanation of the coding procedures utilized. Demographic information and the results of frequency and descriptive statistics, bivariate correlations, and regression analysis are also included.

Demographics

Participants for this study were recruited across the United States through helping professionals organizational listservs, with a desired participant pool of licensed and/or certified counselors. A total of 160 surveys were received. The selection criteria for this study included (a) aged >19, (b) licensed or certified in the field of counseling, and (c) completed survey with the exception of the optional open-ended final question. Of the 160 total cases, 54 were omitted because they did not meet one or more of the selection criteria. Eighteen did not identify as counselors. Ten identified as marriage and family therapists, 2 as psychologists, 5 as social workers and 1 as a psychiatric RN. Thirty-six participants did not indicate licensure or certification in counseling, and 33 participants did not complete the survey.

Data for the 106 participants who met selection criteria were then recoded for consistency due to the open ended nature of the demographic questions. Inclusive age brackets of (a) 25-35, (b) 36-45, (c) 46-55, (d) 56-65 and (e) 66-75 were established and participants' ages were coded accordingly. Individuals were categorized as African American for participants who identified as Black or African American, White for Caucasian or White, Biracial for two reported races, Asian, Latina/o and Pacific Islander as reported, and preferred not to say for participants who indicated this preference. State licensure credentialing titles varied nationwide. Therefore,

selected participants were categorized as licensed counselor if they reported associate or full licensure according to individual state laws. (See Appendix E for a listing of credentialed titles by state). Participants were categorized as certified if they reported school or national certification in counseling. All participants who indicated licensure were categorized as licensed counselor despite any additional licenses and/or certifications reported. Participants were categorized as either mental health counselors or school counselors based on the reported licensure or certifications. Finally, inclusive years of practice brackets of (a) 1-5, (b) 6-10, (c) 11-15, (d) 16-20, (e) 21-25, (f) 25-30 and (g) over 30 were established and participants' years of practice were coded accordingly.

Demographic information obtained for this study was derived from all 106 selected participants and included (a) age, (b) gender, (c) highest level of education, (d) professional discipline, (e) professional licensure/certification, (f) race/ethnicity, and (g) years of practice. The majority of participants included 82 (77.4%) females compared to 22 (20.8%) males, and 2 (1.9%) transgender. The majority 45 (42%) were between 25-35 years of age, 17 (16%) between 36-45, 22 (20.8%) between 46-55, 15 (14.2%) between 56-65, and 7 (6.6%) between 66-75. Most 74 (69.8%) identified as White, 16 (15.1%) African American, 2 (1.9%) Asian, 1 (.9%) Pacific Islander, 7 (6.6%) Biracial, 4 (3.8%) Latina/o, and 2 (1.9%) preferred not to say. The majority 62 (58.5%) highest level of education was a masters' degrees in counseling, 4 (3.8%) EdS, 14 (13.2%) PhD students, and 26 (24.5%) PhDs/EdDs. Most, 96 (90.6%) were mental health counselors and 10 (9.4%) were school counselors. The majority, 88 (83.0%) reported licensure and 18 (17%) reported certification. Finally, the majority 39 (36.8%) reported between 1-5 years of practice, 20 (18.9%) reported 6-10 years, 9 (8.5%) reported 11-15 years and 16-20

years, 8 (7.5%) reported 21-25 years, 5 (4.7%) reported 26-30 years, and 4 (3.8%) reported over 30 years. See table 1 for full demographics.

Table 1

Demographic Description

Descriptor	Variable	Number	Percentage
Gender	Female	82	77.4%
	Male	22	20.8%
	Transgender	2	1.9%
Age	25-35	45	42.5%
	36-45	17	16.0%
	46-55	22	20.8%
	56-65	15	14.2%
	66-75	7	6.6%
Race/Ethnicity	White	74	69.8%
	African American	16	15.1%
	Asian	2	1.9%
	Pacific Islander	1	.9%
	Biracial	7	6.6%
	Latina/Latino	4	3.8%
	Preferred not to say	2	1.9%
Highest Level of Education	Masters	62	58.5%
	EdS	4	3.8%
	PhD Student	14	13.2%
	PhD/EdD	26	24.5%
Professional Discipline	Mental Health Counselor	96	90.6%
	School Counselor	10	9.4%
Professional License/ Certification	Licensed Counselor	88	83.0%
	Certified Counselor	18	17.0%
Years of Practice	1-5	39	36.8%
	6-10	20	18.9%
	11-15	9	8.5%
	16-20	9	8.5%
	21-25	8	7.5%
	26-30	5	4.7%
	Over 30	4	3.8%

Reliabilities

The means, standard deviations, and reliability scores for the Race Based Trauma Subscale are outlined in Table 2. Using Cronbach's Alpha, an internal consistency analysis was performed to determine reliability coefficients that reflect consistency within the survey questions and the level at which the survey questions measure for intended outcomes. The Race Based Trauma Survey Subscale appeared to have good internal consistency, $\alpha = .897$, with a mean of 3.42 and standard deviation of .6862. This indicates all items correlated with the total scale, with an average of .775 and a range of .701 - .830. Reliability coefficients for the four subscale items were .795 (I have been prepared to identify race based trauma), .830 (I have been prepared to treat race based trauma), .701 (I am comfortable addressing race based trauma in session), and .774 (I feel competent addressing issues related to race based trauma in session). Since each item contributed to the reliability of the scale, each was retained with the remaining items.

Table 2

Reliability Analysis of Race Based Trauma Survey Subscale

Measures	Mean	Standard Deviation	Reliability
Race Based Trauma Survey Subscale	3.42	.6862	α = .897
Q 27_5	3.81	1.686	
Q 27_6	4.16	1.638	
Q 27_7	2.65	1.377	
Q 27_8	3.06	1.533	

Note: Q 27_5 I have been prepared to identify race based trauma, Q 27_6 I have been prepared to treat race based trauma, Q 27_7 I am comfortable addressing race based trauma in session, Q 27_8 I feel competent addressing issues related to race based trauma in session.

Results

Research Question 1

As part of an exploratory study, research question 1 examined the extent that counselors had worked with clients who reported experiences with race based trauma. All 106 participants answered this question. Seventy-five (70.8%) reported that they had worked with clients who reported experiences with race based trauma, and 31 (29.2%) reported they had not. This indicates that nearly 2/3 of the participants had worked with clients who reported experiences with race based trauma.

Research Question 2

Research question 2 examined which factor(s) counselors identified that contribute to the development of race based trauma. Participants were asked to select all that apply from nine possible contributing factors, as well as a tenth category of other with the option to add additional factors. Table 3 outlines the number of factors identified by all 106 participants with a mean of 7.54 and a standard deviation of 2.431. Three (2.8%) identified one factor, 4 (3.8%) identified two, 3 (2.8%) identified 3, 6 (5.7%) identified four, 7 (6.6%) identified five, 4 (3.8%) identified six, 8 (7.5%) identified seven, 10 (9.4%) identified eight, 50 (47.2%) identified nine, and 11 (10.4%) identified ten that included other response(s). This indicates that the majority of participants 60 (56.6%) selected either 8 or 9 of the 9 provided options. The other responses are provided in Appendix F.

Table 4 outlines the factor(s) identified that contribute to the development of race based trauma. Ninety-four (88.7% of total cases) identified covert acts of racism, 89 (84.0% of total cases) identified hate crimes, 89 (84.0% of total cases) identified institutional racism, 85 (80.2%

of total cases) identified microagressions, 81 (76.4% of total cases) indicated outside group racist comments, 92 (86.8% of total cases) identified overt acts of racism, 91 (85.8% of total cases) identified racial discrimination, 88 (83.0% of total cases) identified racial profiling, 75 (70.8% of total cases) identified within group racist comments, and 15 (14.2% of total cases) indicated other. This indicates that the participants' responses were fairly evenly distributed among the nine provided factors. The other category responses are outlined in Appendix F.

Table 3

Number of Factors Identified

Number of factor(s)	Frequency	Percentage
1	3.0	2.8%
2	4.0	3.8%
3	3.0	2.8%
4	6.0	5.7%
5	7.0	6.6%
6	4.0	3.8%
7	8.0	7.5%
8	10.0	9.4%
9	50.0	47.2%
10	11.0	10.4%
Total	106	100.0%

Table 4

Factor(s) Contributing to Race Based Trauma

Factor	Number	Percentage of Cases
Covert acts of racism	94	88.7%
Hate crimes	89	84.0%
Institutional racism	89	84.0%
Microaggressions	85	80.2%
Outside group racist comments	81	76.4%
Overt acts of racism	92	86.8%
Racial discrimination	91	85.8%
Racial profiling	88	83.0%
Within group racist comments	75	70.8%
Other	15	14.2%

Research Question 3

Research question 3 examined the extent counselors had received training to identify race based trauma. Of the 106 participants, 35 (33.0%) reported receiving training to identify race based trauma while 71 (67.0%) reported they had not. The 35 (33.0%) respondents who indicated they had received training(s) to identify race based trauma reported receiving one type of training, 14 (40%), and two, three, and four types of training, 7 (20%) each. These 35 participants were then asked a multiple response question concerning the nature of training(s) received. The types of training identified were continuing education 24 (69%), integration into coursework 22 (63%), integration into supervision 18 (51%), academic/advising meeting 9 (26%), and other 4 (11%). Among the 35 participants who reported they had received training to identify race based trauma, most reported 2 to 4 types of training that included continuing education and integration into coursework and supervision. The responses to other types of training are outlined in Appendix G.

Research Question 4

Research question 4 examined the extent counselors had received training to treat race based trauma. Of the 106 participants, 20 (18.9%) reported they had received training to treat race based trauma and 86 (81.1%) reported they had not. The 20 (18.9%) respondents who indicated they had received training(s) to treat race based trauma reported receiving one type of training 9 (8.5%), three types of training 5 (4.7%), four types of training 4 (3.8%), and two types of training 2 (1.9%). These 20 participants were then asked a multiple response question concerning the nature of the training(s) received. The types of training(s) identified were continuing education 14 (70%), integration into coursework 11 (55%), academic

advising/meeting 8 (40%), integration into supervision 8 (40%), and other 3 (15%). Among the 20 participants who reported they had received training to treat race based trauma, most reported one type of training that included continuing education. Responses to other types of training are outlined in Appendix H.

Research Question 5

Research question 5 examined the extent counselors' had a professional policy on race based trauma that includes treatment recommendations. Of the 106 participants, 13 (12.3%) reported their professional practice had a policy on race based trauma that includes treatment recommendations and 93 (87.7%) reported it did not. This indicates that the vast majority of participants did not have professional policies on race based trauma that includes treatment recommendations.

Research Question 6

Research question 6 examined the relationship between the criterion variable competency score, and the predictor variables (a) training to identify, (b) training to treat, and (c) professional policy on race based trauma that includes treatment recommendations. Prior to running the multiple linear regression, a bivariate correlation indicated a significant relationship among 5 of 6 total correlations at $p < .001$, see table 5. There was a significant correlation between the competency score and training to identify race based trauma ($r = -.504$, $p < .001$), training to treat race based trauma ($r = -.454$, $p < .001$), and professional policy ($r = -3.64$, $p < .001$). There was also a significant correlation between training to identify and training to treat ($r = .571$, $p < .001$), and training to identify and professional policy ($r = .417$, $p < .001$). These findings reflect that there was a decreased perception of competency among those participants who had training to identify race based trauma, training to treat race based trauma, and/or had a professional policy

on race based trauma that includes treatment recommendations. Table 5 outlines the correlations among study variables.

Table 6 outlines the frequencies for the individual competency questions that were used to calculate the average competency score. One hundred-three (97.2%) answered these questions and 3 (2.8%) did not. Q 27_5 “I have been prepared to identify race based trauma” had frequencies of (a) strongly agree 6 (5.7%), (b) agree 21 (19/8%), (c) somewhat agree 27 (25.5%), (d) neutral 8 (7.5%), (e) somewhat disagree 20 (18.9%), (f) disagree 16 (15.1%), and (g) strongly disagree 5 (4.7%). Q 27_6 “I have been prepared to treat race based trauma” had frequencies of (a) strongly agree 3 (2.8%), (b) agree 15 (14.2%), (c) somewhat agree 27 (25.5%), (d) neutral 9 (8.5%), (e) somewhat disagree 23 (21.7 %), (f) disagree 19 (17.9%), and (g) strongly disagree 7 (6.6%), Q 27_7 “I am comfortable addressing race based trauma in session” had frequencies of (a) strongly agree 22 (20.8%), (b) agree 34 (32.1%), (c) somewhat agree 21 (19.6%), (d) neutral 14 (13.2%), (e) somewhat disagree 9 (8.5%), (f) disagree 2 (1.9%), and strongly disagree 1 (.9%). Q 27_8 “I feel competent addressing issues related to race based trauma in session” had frequencies of (a) strongly agree 15 (14.2%), (b) agree 29 (27.4%), (c) somewhat agree 24 (22.6%), (d) neutral 17 (16.0%), (e) somewhat disagree 7 (6.6%), (f) disagree 10 (9.4%), and (g) strongly disagree 1 (.9%). This indicates that the majority of participants most frequently answered somewhat agree, somewhat agree, agree, and agree to the competency score questions respectively.

Table 5

Correlations Among Study Variables

	Comp. Score	Training ID RBT	Training Treat RBT	Policy
Comp. Score	____			
Training ID RBT	-.504***	____		
Training Treat RBT	-.454***	.571***	____	
Policy	-.364***	.417***	.196	____

Note: *** $p < .001$

Table 6

Frequency of Responses for Competency Score

	Q 27_5	Q 27_6	Q 27_7	Q 27_8
	Frequency (%)	Frequency (%)	Frequency (%)	Frequency (%)
1 Strongly Agree	6 (5.7%)	3 (2.8%)	22 (20.8%)	15 (14.2%)
2 Agree	21 (19.8%)	15 (14.2%)	34 (32.1%)	29 (27.4%)
3 Somewhat Agree	27 (25.5%)	27 (25.5%)	21 (19.8%)	24 (22.6%)
4 Neutral	8 (7.5%)	9 (8.5%)	14 (13.2%)	17 (16.0%)
5 Somewhat Disagree	20 (18.9%)	23 (21.7%)	9 (8.5%)	7 (6.6%)
6 Disagree	16 (15.1%)	19 (17.9%)	2 (1.9%)	10 (9.4%)
7 Strongly Disagree	5 (4.7%)	7 (6.6%)	1 (.9%)	1 (.9%)
Total	103 (97.2%)	103 (97.2%)	103 (97.2%)	103 (97.2%)
Missing	3 (2.8%)	3 (2.8%)	3 (2.8%)	3 (2.8%)
Total	106 (100.0%)	106 (100.0%)	106 (100.0%)	106 (100.0)
Mean:	3.81	4.16	2.65	3.06

Note: Q 27_5 I have been prepared to identify race based trauma, Q 27_6 I have been prepared to treat race based trauma, Q 27_7 I am comfortable addressing race based trauma in session, Q 27_8 I feel competent addressing issues related to race based trauma in session.

The competency score questions were answered on a 7-point Likert scale that included: (1) strongly agree, (2) agree, (3) somewhat agree, (4) neutral, (5) somewhat disagree, (6) disagree, and (7) strongly disagree. The overall competency score was calculated by summing all scores on the 7 point Likert scale for each of the four questions and dividing by the total number of participants (103). The overall mean was 3.42 and the standard deviation was .6862, indicating that participants' somewhat agreed to overall self-reported competency. The individual question means were calculated by summing the scores for each question, and dividing by the total number of participants (103). The results each items' means are as follows: Q 27_5 "I have been prepared to identify race based trauma" had a mean of 3.81, Q 27_6 "I have been prepared to treat race based trauma" had a mean of 4.16, Q 27_7 "I am comfortable addressing race based trauma in session" had a mean of 2.65, and Q 27_8 "I feel competent addressing issues related to race based trauma in session" had a mean of 3.06. These results indicate that on average, participants agreed they felt comfortable addressing race based trauma in session, somewhat agreed they had been prepared to identify race based trauma and felt comfortable addressing race based trauma in session, and were neutral about being prepared to treat race based trauma.

A multiple linear regression analysis was conducted to evaluate the relationship between the criterion variable a) competency score and the (b) predictor variables training to identify race based trauma, training to treat race based trauma, and the existence of professional policy on race based trauma that includes treatment recommendations. The predictor variables were entered in a multiple linear regression model predicting perceived competency. Table 7 outlines the results of the regression analysis which indicate the model was significant, $f(3,99) = 16.086$, $p < .001$.

The linear combination of measures was significantly related to competency with an adjusted R^2 = .307. The model R^2 of .307 indicates that the model explains approximately 31% of the variance observed in the competency score. At the significance level $p < .05$, all predictor variables were significant. Training to identify (B = -.788 p = .014), training to treat (B = -.910, p = .011), and professional policy (B = -.816, p = .031). These findings support the idea that training to identify, training to treat, and the existence of professional policy had a negative relationship with self-reported competency, yet other factors that have not been identified exist. Table 7 outlines the regression analysis.

Table 7

Regression Analysis of Criterion Self-Reported Competency Score and Predictors Training to Identify RBT, Training to Treat RBT, and Professional Policy

Research Q6	Adjusted R^2	F (*p*)	Beta
	.307	16.086 (3,99) <.001	
Training to Identify RBT			-.788
Training to Treat RBT			-.910
Professional Policy			-.816

Summary

This section included demographic information, frequency and descriptive statistics, and the results of the statistical analysis of data collected through dissemination of the Race Based Trauma Survey. It also included an explanation of selection criteria and coding procedures utilized. The study was designed to examine the extent that counselors had worked with clients who reported experiences with race based trauma, the factor(s) counselors identified that contribute to the development of race based trauma, the extent counselors' professional practice had a policy on race based trauma that includes recommendations, and the extent counselors had received training to identify and treat race based trauma. Furthermore, the study examined the relationship between (a) reported competency score and (b) training to identify race based trauma, training to treat race based trauma, and the existence of professional policy on race based trauma that includes treatment recommendations. A bivariate correlation and multiple linear regression analysis were utilized to examine the possible influence of training to identify race based trauma, training to treat race based trauma, and the existence of professional policy on race based trauma the includes treatment recommendation on counselors' reported competencies.

Chapter V. Discussion

The purpose of this study was to explore counselors' experiences with race based trauma. Race based trauma is defined as emotional, psychological and physical reactions to personal experiences with harassment and discrimination that cause pain (Carter, 2007; Evans et al., in press). More specifically, the purpose was to examine the extent of trainings to identify and treat race based trauma as well as the existence of professional policies on race based trauma that included treatment recommendations. For this study, participants completed the Race Based Trauma Survey. This chapter will discuss the results of the study based on descriptive statistics, bivariate correlation and linear regression analysis for the six research questions. Limitations, implications, and recommendations for future research are also provided.

Overview

As previously discussed, counselors have the ethical responsibility to provide multiculturally competent care (ACA Code of Ethics, 2014). Researchers have indicated that an important aspect of providing multiculturally competent care includes the awareness of race, racism and discrimination, and how these may contribute to, or be the source of, the problems Individuals of Color experience (Carter, 1995; Carter, 2001; Carter, 2003; Dunbar, 2001; Evans et al., in press, Helms & Cook, 1999; Sue, 2001). Researchers have also found that often, these topics are not broached in the counseling relationship due to counselors' unease, fear of saying the wrong thing and offending the client, lack of specific multicultural training that focuses on race, discrimination, and racism, or from a lack of understanding of the importance these issues have in the lives of Individuals of Color (Carter & Forsythe, 2010; Dobalian & Rivers, 2008;

Helms & Cook, 1999; Sanders et al., 2004; Williams & Keating, 2005). It has been stated that the paucity of research, literature, assessments, treatment guidelines, and training opportunities can make it challenging for counselors who treat Individuals of Color that have experienced race based trauma (Carter, 2007; Carter, 2012; Carter et al., 2011; Carter & Forsythe, 2010; Kressin, Raymond, & Manze, 2008). This prompts the general question, "What experiences with race based trauma do counselors report?"

Discussion of Results

The majority of participants, 75 (70.8%) reported that they had worked with clients who had experiences with race based trauma, and 31 (29.2%) indicated they had not. This finding supports previous research that indicates racism continues to be a profound and damaging problem and is involved in many aspects of daily living among Individuals of Color in the United States (Carter, 1995; Carter et al., 2013; Jaynes & Williams, 1989; Omi & Winant, 1986, 1994; Prilleltensky & Gonick, 1994). The finding also supports research that has found the effects of racism, racial classification, racial categories, and inequality continue to have a negative effect for some Individuals of Color (Carter & Peiterse, 2005; Carter, 2007; Coverdill, Lopez, & Petrie, 2011; Jones, 1991; Landrine & Klonoff; 1996; Omi & Winant, 1986; Smedley, 1999). Additionally, this finding supports previous research that reports the prevalence of race based trauma, resulting from experiences with discrimination and racism, among Individuals of Color (Carter & Forsythe, 2009; Carter, 2007; Carter et al., 2013; Bryant-Davis & Ocampo, 2005; Loo et al., 2001).

Participants most frequently identified the following factors that contribute to the development of race based trauma: covert acts of racism (88.7%), hate crimes (84%), institutional racism (84%), microagressions (80.2%), outside group racist comments (76.4%),

overt acts of racism (86.8%), racial discrimination (85.8%), racial profiling (83%), and within group racist comments (70.8%). The majority of participants, 71 (67%), selected between eight and ten factors. This finding supports previous research that identifies both overt and covert factors that can have a negative psychological impact and/or lead to the development of race based stress/trauma among Individuals of Color. For example, researchers have listed overt acts of racism that included harassment, verbal or physical attacks, threats to livelihood, social avoidance, and exclusion (Brondolo, Gallo & Myers, 2009; Bryant-Davis & Ocampo, 2005; Shavers V. & Shavers, B., 2006). Additional researchers have listed examples of microagressions that Individuals of Color face on a continuous basis including: racial vilification; racial profiling; institutional racism; discrimination; racial ambivalence; denial of racism; and racist beliefs, behaviors, and attitudes (Evans et al., in press; Landrine & Klonoff, 1996; Smolicz, 1999; Sue et al., 2007; Utsey, 1999; Utsey & Ellison, 2000).

The majority of participants indicated they had not received training to identify race based trauma 71 (67%), while 35 (33%) indicated that they had. Of those who had received training to identify race based trauma, the most frequently reported types of trainings were: continuing education 24 (31.2%), integration into coursework 22 (28.6%), and into supervision 18 (23.4%). Additionally, the majority of participants 86 (81%), indicated they had not received training to treat race based trauma and 20 (18.9%) indicated they had. Of those who received training to treat race based trauma, the most frequently reported types of trainings were: continuing education 14 (31.8%), integration into coursework 11 (25.0%), academic advising/meeting 8 (18.2%) and integration into supervision 8 (18.2%). Finally, the majority of respondents 93 (87.7%) indicated their professional practice did not have a professional policy

on race based trauma that includes treatment recommendations, while 13 (12.3%) indicated it did.

The low percentage of counselors who reported training to identify and treat race based trauma is consistent with research indicating a paucity of training opportunities (Carter, 2007; Carter, 2012; Carter et al., 2011, Carter & Forsythe, 2010; Hardy, 2013; Kressin et al., 2008). In addition to the low reported rates of trainings, the low percentage of counselors who reported having a professional policy on race based trauma that includes treatment recommendations supports research indicating a need for training beyond academia, additional racism-related research, and the development of testing measures for assessment and modalities for treating the effects of racism, race based stress, and race based trauma so that policies can be developed (Brondolo, Gallo, & Myers, 2009; Brown, 2008; Carter & Reynolds, 2011; Ford, 2010; Jones et al., 2008; Krieger, 2003; Kumagai & Lypson, 2009; Tabloada, 2011; Thomas, Quinn, Butler, Fryer, & Garza, 2011; Williams & Mohammed, 2009).

A significant finding of the study was that although the majority 75 (71%) of participants reported working with clients who reported experiences with race based trauma, the majority also reported not having received training to identify race based trauma, training to treat race based trauma, nor had a professional policy on race based trauma that includes treatment recommendations. Furthermore, the predictor variables training to identify race based trauma, training to treat race based trauma, and the existence of professional policy on race based trauma that includes treatment recommendations were negatively correlated to reported competencies. This negative correlation is remarkable due to the frequent recommendation that counselors seek training to increase their multicultural competency as well as the recommendation that in order to effectively treat race based trauma, counselors must first be educated and trained to acknowledge

it (Bryant-Davis & Ocampo, 2006; Carter, 2007; & Sue, D. W. & Sue, D., 2003). Researchers have also stated that counselors are ethically responsible for utilizing multiculturally sensitive and appropriate assessments and interventions, however many may find it difficult to access models to identify and treat race based trauma; and most that exist fail to include strategies to mange the interpersonal and emotional harm caused by racism (Brondolo, Brady, Pencille, Beatty, & Contrada, 2012). Although racism has been found to cause negative psychiatric and emotional consequences, mental health assessments and guidelines tend to exclude racism, resulting in a lack of understanding concerning the ensuing mental health effects (Brondolo, Gallo, & Myers, 2009; Carter et al., 2013; Carter & Forsythe, 2009; Prilleltensky & Gonick, 1994). The negative correlation between (a) reported competencies and (b) training to identify, training to treat, and professional policy support these researchers' findings on the need for additional research on racism, racial discrimination and race based trauma as well as effective training and treatment models.

Limitations

There were several limitations to this study. Initially, the Race Based Trauma Survey was designed due to lack of an existing measure, and since the current study was the first to collect data with this instrument, information concerning its validity is insufficient. The validity was addressed by conducting a pilot study. However, disseminating the study to larger audiences would allow for additional validity analysis. Next, the study was exploratory in nature and was not designed to include all competencies regarding race based trauma. Since participants self-reported competencies, and due to the subjective nature of responses, possibility exists for bias and/or social desirability influences. Graham, McDaniel, Douglas and Snell (2002) report that social desirability may result in inflated correlations among variables. A final limitation

involves the educational, practicum, internship and supervisory differences in licensing requirements across the United States. Currently, licensing requirements are not standardized and this may have resulted in variance among education, training and experience among participants.

Implications

With the continual growth of minority populations in the United States, the prevalence of mental health disparities for Individuals of Color, and the critical objective among counselors to provide multiculturally competent care, the implications are huge for counselor educators, supervisors, clinicians and researchers. The results of this study contribute to the existing research that indicates Individuals of Color are experiencing discrimination, harassment and racism that could result in negative psychological outcomes including race based trauma (Carter, Lau, Kirkinis, & Johnson, 2015; Ford, 2008; Khaylis, Waelde, & Brice, 2007; Lee & Ahn, 2011, 2012; Pasco & Richman, 2009; Pieterse, Todd, Neville, & Carter, 2012; Pieterse, Howitt, & Nadoo, 2010). Additional researchers emphasize that clinicians must confront racism, include race-conscious curricula, incorporate models, theories and methodologies, include training beyond academia, support additional racism-related research and develop testing measures for assessment and modalities for treating the effects of racism, race based stress, and race based trauma (Brondolo, Gallo, & Myers, 2009; Brown, 2008; Carter & Reynolds, 2011; Ford, 2010; Jones et al., 2008; Krieger, 2003; Kumagai & Lypson, 2009; Tabloada, 2011; Thomas, Quinn, Butler, Fryer, & Garza, 2011; Williams & Mohammed, 2009). It is most likely that all professional counselors will treat individuals who have experienced negative emotional, psychological and/or physical consequences among Individuals of Color who have experienced discrimination, harassment and racism.

Another implication for counselors regards this study's finding that few counselors have received training to identify race based trauma, and even fewer had received training to treat race based trauma. With 70.8% of counselors indicating that they had worked with clients who had reported experiences with race based trauma, and only 33% reported training to identify, and 18.9% reporting training to treat, counselors may find themselves addressing issues in which they may not be sufficiently prepared. Furthermore, counseling professionals may find it difficult to access such trainings.

Similarly, counselors may find it difficult to locate assessments and treatment strategies for working with Individuals of Color who have experienced race based trauma. Carter and Forsythe (2010) reported that future research on race based trauma and the development of racially appropriate assessments will assist counselors to more effectively meet the needs of Individuals of Color and treat their experiences with racism. Counselors can engage in, support and solicit additional research in these areas.

Recommendations for Future Research

Since this study was the first study of its kind, several future research recommendations were apparent following an examination of the study's findings and limitations. Since 70.8% of participants reported working with Individuals of Color who had experienced race based trauma, future research to examine the extent clients sought treatment to specifically address these experiences is needed. Similarly, the extent in which counselors broached the topics of race, discrimination, racism and race based trauma is recommended.

Additional research is needed to examine the assessment and treatment strategies employed by counselors when working with Individuals of Color who have experienced race based trauma, as well as how counselors became aware of these methods. In this study, a limited

number (33%) of participants indicated they had been trained to identify race based trauma and fewer (18.9%) reported they had been trained to treat race based trauma. Research that further examines the types and content of training for identifying and treating race based trauma counselors received would be an important finding. Similarly, research on the development of trainings, assessments and treatment strategies is greatly needed. This research would prove beneficial for counselor educators, supervisors, and clinicians.

Future research recommendations also include an examination of client satisfaction among Individuals of Color who have discussed issues of race based trauma in session with professional counselors. A study of this kind could provide valuable information for counselors regarding the reasons for satisfaction/dissatisfaction, information pertaining to what these clients would have, or did, find beneficial, and additional information concerning the clients' perceptions about the counselors' effectiveness.

Finally, future research recommendations include studies that would examine ways to incorporate discussions of discrimination, harassment, and racism that lead to race based trauma into the classroom, supervisory experience, workshops, and counseling session. This research would provide valuable resources for counselors, supervisors and professors.

Summary

This chapter provided an overview of the study, discussion of results, limitations, implications, and future research recommendations. The results of this study support the necessity for future research regarding identifying and treating race based trauma, the development of measures to assess for race based trauma, treatment methods and strategies for treating race based trauma, and reasons Individuals of Color who have sought counseling to

address issues of race based trauma are either satisfied or dissatisfied with the counseling experience.

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Appendix A. IRB Approval

AUBURN UNIVERSITY INSTITUTIONAL REVIEW BOARD for RESEARCH INVOLVING HUMAN SUBJECTS

REQUEST FOR EXEMPT CATEGORY RESEARCH

For Information or help completing this form, contact: **THE OFFICE OF RESEARCH COMPLIANCE**, 115 Ramsay Hall
Phone: 334-844-5966 **e-mail:** IRBAdmin@auburn.edu **Web Address:** http://www.auburn.edu/research/vpr/ohs/index.htm

Revised 2/1/2014 **Submit completed form to IRBsubmit@auburn.edu or 115 Ramsay Hall, Auburn University 36849.**

Form must be populated using Adobe Acrobat / Pro 9 or greater standalone program (do not fill out in browser). Hand written forms will not be accepted.

Project activities may not begin until you have received approval from the Auburn University IRB.

1. **PROJECT PERSONNEL & TRAINING**

PRINCIPAL INVESTIGATOR (PI):

Name Amanda M. Evans **Title** Assistant Professor **Dept./School** SERC

Address 2068 Haley Center **AU Email** amt0004@auburn.edu

Phone 334.844.7695 **Dept. Head** Dr. E. Davis Martin

FACULTY ADVISOR (if applicable):

Name _____ **Title** _____ **Dept./School** _____

Address _____

Phone _____ **AU Email** _____

KEY PERSONNEL: **List Key Personnel (other than PI and FA).** Additional personnel may be listed in an attachment.

Name	Title	Institution	Responsibilities
Carrie Hemmings	Doctoral Student	Auburn University	Assist data collection & analysis

KEY PERSONNEL TRAINING: **Have all Key Personnel completed CITI Human Research Training (including elective modules related to this research) within the last 3 years?** ☑ YES ☐ NO

TRAINING CERTIFICATES: Please attach CITI completion certificates for all Key Personnel.

2. **PROJECT INFORMATION**

Title: Race-Based Trauma and Discriminatio: A Mixed Methods Study

Source of Funding: ☑ Investigator ☐ Internal ☐ External

List External Agency & Grant Number: _____

List any contractors, sub-contractors, or other entities associate with this project.

_____

List any other IRBs associated with this project (including those involved with reviewing, deferring, or determinations).

_____

FOR ORC OFFICE USE ONLY

DATE RECEIVED IN ORC: 1-13-15 by QB APPROVAL #: _____

DATE OF IRB REVIEW: _____ by _____ APPROVAL CATEGORY: _____

DATE OF ORC REVIEW: _____ by _____ INTERVAL FOR CONTINUING REVIEW : _____

DATE OF APPROVAL: _____ by _____

COMMENTS:

The Auburn University Institutional Review Board has approved this document for use from 5/8/15 to 5/7/18 Protocol # 14-582 EX 1505

1 of 3

3. **PROJECT SUMMARY**

a. **Does the research involve any special populations?**

- ☐ YES ☑ NO **Minors (under age 19)**
- ☐ YES ☑ NO **Pregnant women, fetuses, or any products of conception**
- ☐ YES ☑ NO **Prisoners or Wards**
- ☐ YES ☑ NO **Individuals with compromised autonomy and/or decisional capacity**

b. **Does the research pose more than minimal risk to participants?** ☑ YES ☑ NO

Minimal risk means that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests. 42 CFR 46.102(i)

c. **Does the study involve any of the following?**

- ☐ YES ☑ NO **Procedures subject to FDA Regulation** Ex. Drugs, biological products, medical devices, etc.
- ☐ YES ☑ NO **Use of school records of identifiable students or information from instructors about specific students**
- ☐ YES ☑ NO **Protected health or medical information when there is a direct or indirect link that could identify the participant**
- ☐ YES ☑ NO **Collection of sensitive aspects of the participant's own behavior, such as illegal conduct, drug use, sexual behavior or use of alcohol**
- ☐ YES ☑ NO **Deception of participants**

If you checked "YES" to any response in Question #3 STOP. It is likely that your study does not meet the "EXEMPT" requirements. Please complete a PROTOCOL FORM for Expedited or Full Board Review.
You may contact IRB Administration for more information. (Phone: 334-844-5966 or Email: IRBAdmin@auburn.edu)

4. **PROJECT DESCRIPTION**

a. **Subject Population** (Describe, include age, special population characteristics, etc.)

This study will examine Race-Based Trauma through quantitative and qualitative methods. For the quantitative portion, helping professionals will be provided the Race-Based Trauma Survey and Everyday Discrimination Measure (EDM) (see Appendix B). For the qualitative portion, individuals from underrepresented racial groups will be recruited to participate in an online interview and complete the EDM measure. Together, the data collected in this study, might provide key information for counseling professionals. Participants will include individuals of color and helping professionals of all races age 19+.

b. **Describe, step by step, all procedures and methods that will be used to consent participants.**

☐ **N/A (Existing data will be used)**

All participants will be recruited via targeted online mailings.These mailings will be in the form of email requests (see appendices) informing potential participants of the study. Interested individuals can visit the Qualtrics link. Prior to beginning the interview/survey, participants will be presented with a locked Information Sheet for which they must consent before beginning the study. Participants may stop participating at any time.

c. **Brief summary of project.** (Include the research question(s) and a brief description of the methodology, including recruitment and how data will be collected and protected.)

This mixed methods study will examine if helping professionals address issues of race and discrimination in counseling. For the helping professionals, we plan to administer the Race-Based Trauma Survey and Everyday Discrimination Model (see Appendix B) we plan to examine how helping professionals respond to issues of race and discrimination. For the individuals of color, we plan to offer qualitative interviews (Q1: Describe your experiences with racism; Q2: Please describe a specific instance that you were discriminated based on your race; Q3 How have you overcome instances of racism and results obtained from the Everyday Discrimination Scale (Appendix B). Prior to interviews, we will administer the demographics questionnaire and The data gleaned from these instruments will be analyzed comparatively to data obtained from individuals of color in our phenomenological qualitative analysis. The research questions for this study are: R1: Are helping professionals identifying issues of race-based trauma in working with people of color? R2: Do individuals of color report experiences with race-based trauma? R3: What are the recommendations people of color report in addressing/treating issues related to race-based trauma? Data will be collected by helping professionals and interviewing individuals of color in Alabama and Georgia. We plan to recruit 80 to 100 helping professionals and up to 25 African American individuals for this study. Recruitment: 1. Helping professional participants will be recruited through a targeted listservs for helping professionals (e.g., Alabama Counseling Association, Georgia Counseling Association) and random identification using helping professional websites (example: we will identify a large majority of helping professional websites serving GA and AL residents and then randomly select a percentage of participants from this list). 2. Individuals of color will be recruited using recruitment materials posted at counseling centers and college campuses message boards in GA and AL (Appendix C). Interested participants will contact the PI via email. The data will be collected by the PI and Co-PI. All information collected will be marked confidential and identifying information will not be included. The data will remain in a locked box in the PI's campus office.

How data collected/protected:

d. **Waivers. Check any waivers that apply and describe how the project meets the criteria for the waiver.**

- ☐ **Waiver of Consent (Including existing de-identified data)**
- ☑ **Waiver of Documentation of Consent (Use of Information Letter)**
- ☐ **Waiver of Parental Permission (for college students)**

e. **Attachments.** Please attach Informed Consents, Information Letters, data collection instrument(s), advertisements/recruiting materials, or permission letters/site authorizations as appropriate.

Signature of Investigator _____ Date 12/2/14

Signature of Faculty Advisor _____ Date _____

Signature of Department Head _____ Date 12/2/2014

3 of 3

Appendix B. Recruitment Letter

Dear Helping Professional,

I am a Doctoral student in the Department of Special Education, Rehabilitation and Counseling at Auburn University. I would like to invite you to participate in a research study I am conducting with Dr. Amanda Evans, a faculty member in the Department of Special Education, Rehabilitation and Counseling at Auburn University, to examine helping professionals' preparedness to address issues of race-based trauma in counseling. You may participate if you identify as a helping professional.

Participants will be asked to complete an online survey and this should take about 15-20 minutes of your time. The information collected in this study will be used to explore race based trauma and discrimination. There are no risks associated with this study.

If you would like to know more information about this study, there is an Information Letter attached to this email and you are also welcome to contact Dr. Amanda Evans at amt0004@auburn.edu.

If you decide to participate, please read the Information Letter available at the beginning of the survey accessible through this link https://auburn.qualtrics.com/SE/?SID=SV_72tNDaZEV962W3P.

If you have any questions, please contact Dr. Amanda Evans at amt0004@auburn.edu or 334.844.7695.

Thank you for your consideration,

Carrie Hemmings
Doctoral Student Auburn University

Amanda M. Evans, PhD, LPC, NCC
Auburn University

Appendix C. Information Letter

AUBURN
UNIVERSITY

COLLEGE OF EDUCATION

DEPARTMENT OF SPECIAL EDUCATION, REHABILITATION, COUNSELING/SCHOOL PSYCHOLOGY

INFORMATION LETTER
for a Research Study entitled
"Race Based Trauma and Discrimination: A Mixed Methods Study"

You are invited to participate in a research study to explore the race-based trauma and discrimination as experienced by people of color living and the attitudes of helping professionals in addressing race based trauma. The study is being conducted by Amanda M. Evans, Assistant Professor in the Auburn University Department of Special Education, Rehabilitation and Counseling (SERC), Carrie Hemmings, Kristine Ramsay and Juanita Barnett, Doctoral Students in the SERC Department. You were selected as a possible participant because you are a helping professional age nineteen years of age or older.

What will be involved if you participate? Your participation is completely voluntary. If you decide to participate in this research study, you will be asked to complete assessment instruments and a demographics questionnaire. Your total time commitment will be approximately twenty minutes.

Are there any risks or discomforts? There are no risks identified in participating in this study.

Will you receive compensation for your participation? No, participants will not be compensated for their participation in this study.

Are there any costs? There are no costs associated with this study.

If you change your mind about participating, you can withdraw at any time by closing your browser window. If you choose to withdraw, anonymous data, will not be withdrawn. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University, the Department of Special Education, Rehabilitation, and Counseling or the CED Program.

Any data obtained in connection with this study will remain anonymous. We will protect your privacy and the data you provide by not collecting identifiable data and securing collected data. Information collected through your participation may be published in a professional journal or presented at a professional conference.

If you have questions about this study, please contact Amanda M. Evans at amt0004@auburn.edu or 334.844.7695 at Auburn University.

If you have questions about your rights as a research participant, you may contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone (334) 844-5966 or e-mail at hsubjec@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION ABOVE, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, PLEASE CLICK ON THE LINK BELOW.
YOU MAY PRINT A COPY OF THIS LETTER TO KEEP.

Amanda M. Evans 5/8/2015 *Carrie Hemmings* 5/5/2015

"The Auburn University Institutional Review Board has approved this document for use from May 8, 2015 to May 7, 2018. Protocol #14-582 EX 1505."

The Auburn University Institutional Review Board has approved this document for use from 5/8/15 to 5/7/18. Protocol # 14-582 EX 1505

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Auburn, AL 36849-5222
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Appendix D. Race Based Trauma Survey

Race-Based Trauma Study

Q1
- ❍ I agree to participate in this study. (1)
- ❍ I do not agree to participate in this study. (2)

If I do not agree to participa... Is Selected, Then Skip To End of Survey

Q2 What is your gender?

Q3 What is your age?

Q4 What is your race/ethnicity?

Q5 What is your highest level of education?

Q6 What was your household's approximate combined income last year?

Q7 What is your professional discipline? Select all that apply.
- ❑ Marriage and Family Therapist (1)
- ❑ Mental Health Counselor (2)
- ❑ Psychiatrist (3)
- ❑ Psychologist (4)
- ❑ Rehabilitation Counselor (5)
- ❑ School Counselor (6)
- ❑ Social Worker (7)
- ❑ Other (8) _____

Q8 List your professional licenses and certifications.

Q9 With which population do you typically work?

Q10 What type of counseling do you provide? Select all that apply.
- ❑ Family (1)
- ❑ Group (2)
- ❑ Individual (3)

Q11 Where do you provide counseling? Select all that apply.

- ❑ Advocacy Center (1)
- ❑ Agency (2)
- ❑ Hospital (3)
- ❑ In-Patient Facility (4)
- ❑ Non-Profit Organization (5)
- ❑ Out-Patient Facility (6)
- ❑ Private Practice (7)
- ❑ School (8)
- ❑ Other (9) _____

Q12 How many years have you been a practitioner?

Q13 Awareness of Race-Based Trauma. Race-based trauma is defined as emotional, psychological and physical reactions to personal experiences with harassment and discrimination that cause pain (Carter, 2007; Evans, et al., 2015). Experiences with race-based trauma can impact one's self-concept, identity development and ability to cope. In extreme cases, the term race-based traumatic stress is used. Race-based traumatic stress is characterized by: "a) an emotional injury that is motivated by hate or fear of a person or group of people as a result of their race; b) a racially motivated stressor that overwhelms a person's capacity to cope; c) a racially motivated, interpersonal severe stressor that causes bodily harm or threatens one's life integrity; or d) a severe interpersonal or institutional stressor motivated by racism that causes fear, helplessness or horror" (Bryant-Davis, 2007, p. 135). or horror" (Bryant-Davis, 2007, p. 135). Race-based trauma may present in the counseling relationship and practitioners may demonstrate a range of responses to this information. The following questions address issues related to discrimination, racism and race-based trauma.

Q14 In your day-to-day life, how often do any of the following things happen to you?

	Almost everyday (1)	At least once a week (2)	A few times a month (3)	A few times a year (4)	Less than once a year (5)	Never (6)
You are treated with less courtesy than other people are. (1)	❍	❍	❍	❍	❍	❍
You are treated with less respect than other people are. (2)	❍	❍	❍	❍	❍	❍
You receive poorer service than other people at restaurants or stores. (3)	❍	❍	❍	❍	❍	❍
People act as if they think you are not smart. (4)	❍	❍	❍	❍	❍	❍
People act as if they are afraid of you. (5)	❍	❍	❍	❍	❍	❍
People act as if they think you are dishonest. (6)	❍	❍	❍	❍	❍	❍
People act as if they're better than you. (7)	❍	❍	❍	❍	❍	❍
You are called names or insulted. (8)	❍	❍	❍	❍	❍	❍

You are threatened or harassed. (9)	❍	❍	❍	❍	❍	❍

Q15 If you answered these questions with a response of "a few times a year" or more frequently, what do you think is the main reason for these experiences?

- ❑ Your Ancestry or National Origins (1)
- ❑ Your Gender (2)
- ❑ Your Race (3)
- ❑ Your Age (4)
- ❑ Your Religion (5)
- ❑ Your Height (6)
- ❑ Your Weight (7)
- ❑ Some other Aspect of Your Physical Appearance (8)
- ❑ Your Sexual Orientation (9)
- ❑ Your Education or Income Level (10)
- ❑ A Physical Disability (11)
- ❑ Your Shade of Skin Color (12)
- ❑ Your Tribe (13)
- ❑ Other (14) _____

Q16 Have you personally experienced race-based trauma?

- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Which of the following do you believe...

Q17 Did you seek counseling to address this issue?

- ❍ Yes (1)
- ❍ No (2)

Q18 Which of the following do you believe contributes to the development of race-based trauma? Please select all that apply.

- ❑ Covert Acts of Racism (1)
- ❑ Hate Crimes (2)
- ❑ Institutional Racism (3)
- ❑ Microaggressions (4)
- ❑ Outside Group Racist Comments (5)
- ❑ Overt Acts of Racism (6)
- ❑ Racial Discrimination (7)
- ❑ Racial Profiling (8)
- ❑ Within Group Racist Comments (9)
- ❑ Other (10) _____

Q19 Have you received training to identify race-based trauma?

- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Have you had training on identifying ...

Q20 What was the nature of this training? Select all that apply.

- ❑ Academic Advising/Meeting (1)
- ❑ Continuing Education (2)
- ❑ Integrated into Coursework (3)
- ❑ Integrated into Supervision (4)
- ❑ Other (5) _____

Q21 Have you received training to treat race-based trauma?

- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To The following questions pertain to yo...

Q22 What was the nature of the training? Select all that apply.

- ❑ Academic Advising/Meeting (1)
- ❑ Continuing Education (2)
- ❑ Integrated into Courses (3)
- ❑ Integrated into Supervision (4)

Other (5) _____

Q23 The following questions pertain to your observations and experiences of race-based trauma when working with clients. Does your professional practice have a policy or procedure that includes recommendations for treating race-based trauma?

- ❍ Yes (1)
- ❍ No (2)

Q24 Have you worked with clients who reported experiences with race-based trauma?

- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Please rate the following items.

Q25 Have you ever had discussions concerning a client's experiences with race-based trauma?

- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Please rate the following items.

Q26 Indicate with whom you had this discussion. Select all that apply.

- ❑ Colleagues (1)
- ❑ Counselor (2)
- ❑ Faculty Member (3)
- ❑ Peers (4)
- ❑ Site Supervisor (5)
- ❑ University Supervisor (6)

Other (7) _____

Q27 Indicate the level that you either agree or disagree with the following statements:

	Strongly Agree (1)	Agree (2)	Somewhat Agree (3)	Neutral (4)	Somewhat Disagree (5)	Disagree (6)	Strongly Disagree (7)
My profession is aware of race-based trauma. (1)	❍	❍	❍	❍	❍	❍	❍
My profession is receptive to reports of race-based trauma. (2)	❍	❍	❍	❍	❍	❍	❍
My profession supports identifying race-based trauma. (3)	❍	❍	❍	❍	❍	❍	❍
My profession supports treating race-based trauma. (4)	❍	❍	❍	❍	❍	❍	❍
I have been prepared to identify race-based trauma. (5)	❍	❍	❍	❍	❍	❍	❍
I have been prepared to treat race-based trauma. (6)	❍	❍	❍	❍	❍	❍	❍
I am comfortable addressing race-based trauma in session. (7)	❍	❍	❍	❍	❍	❍	❍

I feel competent addressing issues related to race-based trauma in session. (8)	❍	❍	❍	❍	❍	❍	❍
I think that race-based trauma is a problem. (9)	❍	❍	❍	❍	❍	❍	❍
I am confident that race-based trauma will be addressed in our society. (10)	❍	❍	❍	❍	❍	❍	❍

Q28 Discuss your experiences with race-based trauma in counseling.

Appendix E. List of Professional Counselors' Credentials

AMERICAN COUNSELING ASSOCIATION

2011 Statistics on Mental Health Professions

(information provided is for the highest level of licensure)

State	Professional Counselors		Marriage & Family Therapists		Social Workers	
	Title	Counts	Title	Counts	Title	Counts
Alabama	LPC	1,628	LMFT	209	LCSW-PIP	621
Alaska	LPC	474	LMFT	92	LCSW	413
Arizona	LPC	2,330	LMFT	320	LCSW	2,067
Arkansas	LPC	1,000	LMFT	100	LCSW	1,465
California	LPCC	0*	LMFT	31,077	LCSW	18,342
Colorado	LPC	4,717	LMFT	653	LCSW	4,223
Connecticut	LPC	1,707	LMFT	1,023	LCSW	5,365
Delaware	LPCMH	359	LMFT	14	LCSW	669
D.C.	LPC	1,596	LMFT	136	LICSW	2,901
Florida	LMHC	7,784	LMFT	1,545	LCSW	10,070
Georgia	LPC	4,406	LMFT	698	LCSW	2,853
Hawaii	LMHC	208	LMFT	224	LCSW	636
Idaho	LCPC	629	LMFT	220	LCSW	894
Illinois	LCPC	5,910	LMFT	495	LCSW	10,467
Indiana	LMHC	1,604	LMFT	953	LCSW	3,996
Iowa	LMHC	780	LMFT	181	LISW	1,646
Kansas	LCPC	445	LCMFT	343	LSCSW	787
Kentucky	LPCC	957	LMFT	489	LCSW	1,986
Louisiana	LPC	2,372	LMFT	903	LCSW	2,683
Maine	LCPC	870	LMFT	79	LCSW	2,511
Maryland	LCPC	2,402	LCMFT	186	LCSW-C	7,584
Massachusetts	LMHC	4,643	LMFT	719	LICSW	11,935
Michigan	LPC	5,682	LMFT	712	LMSW-C	13,785
Minnesota	LPCC	224**	LMFT	1,334	LICSW	3,719
Mississippi	LPC	1,032	LMFT	249	LCSW	727
Missouri	LPC	3,912	LMFT	196	LCSW	4,809
Montana	LCPC	1,023	LMFT	42*	LCSW	619
Nebraska	LIMHP-CPC/LPC	301**	LIMHP-CMFT/LMFT	50**	LIMHP-CMSW/LCSW	205**
Nevada	LCPC	42*	LMFT	727	LCSW	622
New Hampshire	LCMHC	608	LMFT	84	LICSW	905
New Jersey	LPC	2,677	LMFT	562	LCSW	7,900
New Mexico	LPCC	1,610	LMFT	263	LISW	1,567
New York	LMHC	4,200	LMFT	755	LCSW	24,823
North Carolina	LPC	4,543	LMFT	645	LCSW	5,122
North Dakota	LPCC	370	LMFT	36*	LICSW	260
Ohio	LPCC	4,338	LIMFT	182	LISW	7,416
Oklahoma	LPC	2,981	LMFT	534	LCSW	1,500
Oregon	LPC	1,629	LMFT	475	LCSW	2,835
Pennsylvania	LPC	4,347	LMFT	451	LCSW	4,562
Puerto Rico	LPC	2,500	no licensure	NA	LSW	TBD
Rhode Island	LCMHC	391	LMFT	96	LICSW	1,590
South Carolina	LPC	1,658	LMFT	225	LISW-CP/AP	710
South Dakota	LPC-MH	179	LMFT	95	LCSW-PIP	237
Tennessee	LPC/MHSP	1,225	LMFT	343	LCSW	2,089

Texas	LPC	14,595	LMFT	2,808	LCSW	6,576
Utah	LPC	630	LMFT	448	LCSW	2,658
Vermont	LCMHC	612	LMFT	43	LICSW	906
Virginia	LPC	3,334	LMFT	818	LCSW	5,231
Washington	LMHC	4,520	LMFT	1,151	LICSW	3,219
West Virginia	LPC	1,038	LMFT	2*	LICSW	306
Wisconsin	LPC	2,686	LMFT	712	LCSW	3,464
Wyoming	LPC	721	LMFT	88	LCSW	448

U.S. TOTALS	120,429 202,924	54,785

*Licensure recently established; state board in process of implementing law.
**Recently enacted law establishes a new tier of licensure; state board in process of implementing law.

American Counseling Association – 2011

Appendix F. List of Other Contributing Factors of Race Based Trauma

1. Cultural beliefs

2. Affirmative action

3. Other cultural factors as well—e.g., the ways in which race is constructed in the context of other social locations

4. Structural oppression

5. Lack of discussion of the legacy of slavery; Australia has national "Sorry Day" - we need that.

6. Ignorance

7. News, Media, larger social/societal coverage/responses/attitudes toward racially charged events, etc.

8. Fear

9. Denial of differences

10. Media portrayals

11. Structural racism, internalized racism, colorism, subtle racism, systemic racism

12. Effects of economic deprivation on health and development

13. Media

14. Family racism

Appendix G: List of Other Trainings to Identify Race Based Trauma

1. Wellness Warriors Institute, S. Central Fnd, Anchorage

2. Sharing experiences with people who have experienced this

3. Faculty training

4. I received training through Crossroads Antiracism--Jessica Vazquez Torres Organizer/Trainer She is amazing!

Appendix H. List of Other Trainings to Treat Race Based Trauma

1. Previous employer provided education regarding race-based trauma for the Native American population.

2. Conference