BLACK MENTAL HEALTH CLINICIANS' EXPERIENCES AND LESSONS FROM THE INTERSECTING CRISES OF BLACK MENTAL HEALTH, COVID-19, AND RACIAL TRAUMA: AN INTERPRETIVE PHENOMENOLOGICAL STUDY

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ABSTRACT

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This study explored the experiences of African American mental health clinicians' during the intersecting crises of the Black mental health crisis, the highly publicized racial tension tied to extrajudicial violence and over-policing of Black Americans, and the COVID-19 pandemic. The pandemic started a global crisis that affected millions of people's physical and mental health and overall well-being. Shared trauma explores the duality of mental health clinicians' personal and professional experiences. Grounded in critical race theory and models of trauma, this study explores Black mental health clinicians' lived experiences and lessons. This is an interpretive phenomenological study with narrative interviews of 10 mental health clinicians who provided services to at least 50% Black clientele before the advent of COVID-19. The study explored how Black mental health clinicians providing mental health care fared, personally and professionally, during COVID-19 and with racial upheaval: How did they adapt their lives and practices? What did they learn personally and professionally during these crises? Data were collected in individual qualitative interviews and analyzed using Saldaña's first-cycle and second-cycle thematic coding model. Themes that emerged were (a) anxiety and fear regarding the unknown of COVID-19; (b) anger towards the continued racism and over-policing and killing of the Black community; (c) the importance physical activity and therapy as a clinician as means of self-care (d) connection to others to help with emotional support and the isolation of COVID-19; (e)

transitioning to telehealth from in-office clinical services; (f) increase in demand of services, and (g) increase in demand for the expertise of Black clinicians, specifically. Understanding the lived experiences of Black mental health clinicians during these crises informs future practices of clinicians by teaching how to optimize health and well-being for self-care and not to burn out. The findings also encourage the development of more clinicians of color to serve the Black community and clients with trauma-informed and racially-informed care. This dissertation is available in open access at AURA (https://aura.antioch.edu/) and OhioLINK ETD Center, (https://etd.ohiolink.edu).

Keywords: mental health clinicians, pandemic, Black mental health, PTSD, vicarious trauma, compassion fatigue, COVID-19, leadership, critical race theory, interviewing, phenomenology

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Ubuntu, I am because we are.

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CHAPTER I: INTRODUCTION

Background: Intersecting Crises

In March 2020, the United States of America was battling multiple crises at once: the COVID-19 pandemic, racism, and deteriorating mental health. Black mental health professionals were already dealing with high demand because of the racial tension in the United States (Novacek et al., 2020), and COVID-19 only made it increasingly hard for clinicians of color because of pre-existing mental health crises and social determinants (Novacek et al., 2020). This study explores the experiences of African American mental health professionals navigating these crises in both personal and professional realms as they dealt with the devastation of the COVID-19 pandemic and the shared race-based trauma that affected their own and their clients' mental health.

The COVID-19 pandemic started a global crisis that affected the physical and mental health and overall well-being of millions of people. COVID-19 is an acute respiratory syndrome that is highly contagious (Centers for Disease Control and Prevention, 2023). Globally, COVID-19 led to high death rates and hundreds of thousands hospitalized (Lipscomb & Ashley, 2020). The severity and contagious nature of COVID-19 led to stay-at-home orders and social distancing measures (Choi et al., 2020; Lipscomb & Ashley, 2020) which put a lot of stress on mental health care and the general public. Black communities were disproportionately affected by COVID-19 pandemic (Novacek et al., 2020). Many psychological stressors surround grief, loss, loneliness, sickness, dying, isolation, quarantining, social distancing, safety, and caregiving. Stress, anxiety, and post-traumatic stress disorder (PTSD) surrounding COVID-19 were made worse and exacerbated issues for those with pre-existing mental health conditions (Choi et al., 2020; Lipscomb & Ashley, 2020; Rajkumar, 2020).

Racial Violence

While the United States was attempting to grapple with COVID-19, the deaths of George Floyd, Ahmad Arbery, and Breonna Taylor brought to the world's attention again the racial tensions and civil unrest in America. Police killings of unarmed African Americans impact the victim, the family, their communities, and Black America as a whole. We watched it on television and social media; the world was watching "targeted murder" by those who were to "protect and serve," which produced increased anger, fear, trauma, and caused a racial awakening (Bor et al., 2018; Lipscomb & Ashley, 2020). There was increased media coverage, global protest, and racial tension with the killings of these unarmed African Americans[1] (Dukes & Kahn, 2017; Lipscomb & Ashley, 2020), increasing racial trauma and worsening the crisis in mental health care in Black communities.

COVID-19 Pandemic and Mental Health

In March 2020, the World Health Organization declared the COVID- 19 to be a global pandemic. By April 2021, the United States had lost more than 550,000 lives to COVID-19, and more than 30 million cases had been diagnosed (Centers for Disease Control and Prevention, 2023). The severity and contagious nature of COVID-19 led to stay-at-home orders and social distancing measures (Choi et al., 2020; Lipscomb & Ashley, 2020).

The Centers for Disease Control (2023) acknowledged that feeling stress during the COVID-19 pandemic is natural (Purtle, 2020). As it did globally, COVID-19 put a lot of stress on mental health care and the general public in the United States. Many psychological stressors surround grief, loss, loneliness, sickness, dying, isolation, quarantining, social distancing, safety,

[1] In this study, I use "African American" and "Black" interchangeably throughout to refer to people born in America who identify as Black or African American.

and caregiving (Killgore et al., 2021). Stress, anxiety, and post-traumatic stress (PTSD) surrounding COVID-19 were making these worse and exacerbated issues for those with pre-existing mental health conditions (Choi et al., 2020; Lipscomb & Ashley, 2020; Rajkumar, 2020). Shanahan et al. (2022) found an overall increase in stress and anger, with a predictor for the emotional distress of COVID-19 being emotional distress; other stressors included lifestyle and economic disruption and hopelessness. During the pandemic, the world went on lockdown. The lockdown consisted of policies and restrictions on the ability to leave the house, leave the country, and how to interact with the world and others (Babore et al., 2020). The lockdown increased anger, stress, and anxiety in many people (Babore et al., 2020; Rajkumar, 2020), not just in the United States. For instance, eight countries on psychological well-being during the COVID-19 pandemic found relatively high rates of anxiety, depression, PTSD, psychological distress, and stress in the general populations, with greater risks among women, younger adults (age 40 or younger), people with chronic or psychiatric illnesses, unemployment, student status, and frequent exposure to media regarding COVID-19 (Xiong et al., 2020). In Italy, where some of the strictest and quickest lockdown measures were taken in the wake of COVID-19, 595 healthcare workers were surveyed regarding their stress, coping, and demographics; findings indicated that having a positive attitude and positive outlook was a protective factor of the stress of COVID-19 (Babore et al., 2020). And, in another study in April 2020, research on 317 participants in Poland found that basic hope mediates the relationship between stress and meaning in life and life satisfaction, which both work together to lower anxiety and COVID-19 stress (Trzebiński et al., 2020). In sum, distress related to COVID-19 was widespread.

The COVID-19 pandemic had physical effects on people as well as many psychological effects (Babore et al., 2020). Mental health providers shared many of the same experiences and

impacts of the COVID-19 pandemic as their clients. Mental health providers had to stay at home, manage personal and family needs, manage caseloads, disrupt the routine of clinical practice, technological changes, health insurance changes, and decrease resources (Lipscomb & Ashley, 2020).

COVID-19 and the Black Community

Many people lost their lives during the COVID-19 pandemic, but the Black community is overrepresented among reported coronavirus cases, hospitalizations, and deaths (Milam et al., 2020; Reyes, 2020; Yancy, 2020). The infection rate for predominantly Black counties in the United States is three times higher than for predominantly White counties, and the death rate is six times higher (Reyes, 2020; Yancy, 2020). In a report issued by the National Institute of Health, Reyes (2020) remarked,

> According to the World Health Organization's report *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*, "poor and unequal living conditions are the consequences of deeper structural conditions that together fashion the way societies are organized—poor social policies and programs, unfair economic arrangements, and bad politics." This toxic combination of factors as they play out during this time of crisis, and as early news on the effect of the COVID-19 pandemic pointed out, is disproportionately affecting African American communities in the United States. (Reyes, 2020, p. 299)

African Americans have historically been disproportionately diagnosed with chronic diseases such as asthma, hypertension, and diabetes—underlying conditions that may make COVID-19 more lethal (Milam et al., 2020; Reyes, 2020). One of the highest risk factors for COVID-19-related death among the Black community is hypertension (Reyes, 2020). Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases, said, "It is not that [African Americans] are getting infected more often. It's that when they do get infected, their underlying medical conditions . . . wind them up in the ICU" (as cited in Lovelace, 2020, para. 3).

There are many different theories that exist as to why the Black community is disproportionately affected by the COVID-19 pandemic. All the theories address a long-standing history of systematic racism, health care disparities, and racism (Milam et al., 2020). COVID-19 caused many people to be furloughed from their jobs, work and learn from home, and underprivileged Black communities with limited internet and wi-fi service and workers with diminished access to adequate technological equipment (Yancy, 2020) made it harder, too.

At the height of COVID-19, it was recommended that more testing be done in minority communities; however, due to medical/healthcare mistrust, many Black communities were not getting tested (Reyes, 2020). Even though COVID-19 testing was covered at no cost, there was a mistrust of receiving a bill for the test and fear of other financial outcomes if someone tested positive (Reyes, 2020).

The Mental Health Crisis in the Black Community

In the United States, one in five adults will experience mental illness, and 46% will be diagnosable at some point in their life (Substance Abuse and Mental Health Services Administration, 2020). Many mental health agencies, such as Mental Health America and the National Institute of Mental Health, report that some of the worse mental health-related outcomes such as the highest suicide rate and second-highest drug-related deaths exist in the United States (Substance Abuse and Mental Health Services Administration, 2020). Mental Health America (2023) reports that mental illness among the Black American population increased between 2008 and 2018. According to SAMHSA's 2018 National Survey 4.8 million (16%) of Black America reported having a mental health condition and 1.1 million, about 22.4% over the past year, reported a serious mental health condition (Substance Abuse and Mental

Health Services Administration, 2020). When discussing the prevalence and impact of mental health in the United States, Shim et al. (2014) stated,

> Mental disorders are among the most prevalent, chronic, and disabling health conditions; they touch all Americans in some way. Although these disorders have biological correlates, they are also substantially influenced by modifiable social, economic, and environmental conditions that affect individuals and whole communities, neighborhoods, and populations. (p. 22)

The United States Surgeon General (U.S. Department of Health & Human Services, 1999) and the World Health Organization (2001a, 2001b) cited stigma as a key barrier to successful mental health treatment engagement (Corrigan et al., 2005). Mental health stigma refers to societal disapproval, or when society shames people who live with a mental illness or seek help for emotional distress, such as anxiety, depression, and other psychological disorders (Mental Health America, 2023). According to the National Institute of Mental Health (2020),

> Stigma is a negative and often unfair social attitude attached to a person or group, often placing shame on them for a perceived deficiency or difference to their existence. Individuals or groups can apply stigma to those who live a certain way, have certain cultural beliefs, or make lifestyle choices, or to people living with health conditions, such as mental illnesses. (as cited in MedicalNewsToday, n.d., paras. 10–11)

Not only are mental health conditions increasing, but the stigma toward mental illnesses remains.

Stigma regarding mental illness has many indicators that are tied to race, ethnicity, and socioeconomic status. The World Health Organization (2001a) stated that "Stigma, discrimination, and neglect prevent care and treatment from reaching people affected with mental illness" (para. 2). Rates of major depressive episodes and other symptoms of mental illness are rising sharply among African Americans (Substance Abuse and Mental Health Services Administration, 2020). African Americans of all ages are more likely to be victims of serious violent crimes than white counterparts, making them more likely to meet the criteria of a

diagnosis of mental illness such as post-traumatic stress disorder (PTSD), depression, and/or anxiety (Office of Minority Mental Health, U.S. Department of Health and Human Services, 2017). Even with the prevalence of mental illness in the African American community, many are not accessing services. The American Psychiatric Association (2017) reported that only one in three African Americans who need mental health care receives compared with non-Hispanic Whites. African Americans with any mental illness have lower rates of any mental health service use including prescriptions medications and outpatient services, but higher use of inpatient services (Substance Abuse & Mental Health Services Administration, 2020). African American perceptions of mental illness and treatment for mental illness have contributed to the consistent lack of utilization of services. Thompson et al. (2004) reported that findings from the National Survey of Black Mental Health indicated that African Americans average few sessions of treatment and often terminate with their outpatient mental health services earlier than Caucasians.

Research often indicates that religious observance, fear of exhibiting weakness, and the dismissal of mental illness issues are often reasons that African Americans do not seek mental health treatment or services (Harris et al., 2020). Other barriers to addressing this alarming problem include existing cultural norms, financial issues, insurance issues, mistrust of systems, labeling, fear of misdiagnosis, and lack of knowledge (Harris et al., 2020; Thompson et al., 2004). As demonstrated in the literature, barriers to access and utilization of mental health treatment for African Americans can be individual and personal as well as structural and systemic (Harris et al., 2020; Snowden, 2001; Thompson et al., 2004).

In addition to the personal internal role of stigma, there is also a communal experience of stigma as it relates to admitting weakness or seeking assistance from others. There is stigma

around the idea or notion that one should be able to handle their stressors and "issues" on their own. As has been demonstrated in the literature, African Americans often rely strongly on the idea that a person should not look to others for support, especially for emotional pain (Harris et al., 2020). Goffman (1963) argued that "asking for help" is viewed as a weakness that makes one stand out from peers, and persons seeking help are often seen as damaged, broken, and, ultimately, less desirable that those who handle their problems on their own. This phenomenon often leads those in the African American community to discount those who struggle with mental illness. Unfortunately, the prominent role afforded stigma as a barrier to African Americans seeking to address mental illness issues continues to this day (Harris et al., 2020; Snowden, 2001; Thompson et al., 2004). Black mental health clinicians providing mental health treatment services are working to address a high demand from a community not always receptive to the service and treatment, breaking down communal stigma and systemic barriers. Understanding the state of Black mental health in the United States is pivotal in understanding the total role that the Black mental health clinician holds in the Black community.

Purpose of Study

The purpose of this study is to explore the experiences of Black clinicians in delivering mental health care during the COVID-19 pandemic with its accompanying mental health crises and the documented and highly publicized emergence of racial crises tied to extrajudicial violence and over-policing. Before the pandemic, the Black community already had a high need for mental health treatment services, but it only worsened with never-ending racial tension and COVID-19. As professionals, many Black mental health clinicians had to navigate the increased and complex demands for services because of these multiple traumas while also navigating their personal feelings, trauma, and losses. What did Black mental health clinicians experience

personally and professionally? What did they learn that helped clients and themselves? These lessons may be relevant to Black mental health care practitioners going forward. And what insights did they glean from their experiences during intersecting crises that might inform mental health care in Black communities?

Research Questions

This study explores the experiences of Black mental health clinicians providing services to predominantly Black clients during the intersection of the Black mental health crisis, the COVID-19 pandemic, and the racial traumas of 2020.

1. What were the experiences of Black mental health clinicians who serve Black communities during the intersecting, shared crises of the pre-existing Black mental health crisis, COVID-19, and racial trauma in the United States?
2. What changes and responses did these clinicians make, both professionally and personally, during these intersecting events?
3. What can we learn from the experiences and lessons-learned of these clinicians that can inform future mental health practice and outreach in Black communities?

Theoretical Frameworks

Shared Trauma

Mental health care providers are exposed to hearing about intense, horrible, and traumatic experiences. Exposure to others' trauma through the therapeutic process can sometimes cause mental health clinicians to experience their own level of trauma. The social isolation, anxiety, grief, and loss of COVID-19 was very distressing for many people, as were the racial tensions in America (Litam et al., 2021). For Black mental health clinicians, there has been trauma not only

from the professional side but firsthand, living through and experiencing the COVID-19 pandemic and witnessing—possibly experiencing—racial trauma (Liu & Modir, 2020). The intersection between the trauma being both personal and professional is called shared trauma (Tosone et al., 2012).

Shared trauma describes trauma mental health professionals experience directly, along with their clients. Shared trauma was first used in reference to the September 11 Terrorist Attacks. Tosone et al. (2012) stated,

> Shared trauma, also referred to as shared traumatic reality, is defined as the affective, behavioral, cognitive, spiritual, and multi-modal responses that clinicians experience because of dual exposure to the same collective trauma as their clients. The use of the term shared trauma, however, does not imply that the clinician's trauma response is identical to that of the client; clinicians and clients can be variably impacted by the same simultaneous event. (p. 233)

Research shows that shared trauma affects clinicians' personal and professional lives. After a traumatic event the boundaries were not clear between client and clinician; often, after the event occurred, therapy had to be done in a client's home, in a coffee shop, or wherever they could meet but not necessarily in their office (Boulanger, 2013). Also, a sense of vulnerability occurred because many clinicians had to self-disclose more with their clients about how they were doing during the traumatic event. Clients often asked their therapists how they were doing, handling recovery, and loss. Tosone et al. (2012) explain, "When the clinician and client are exposed to the same collective trauma (shared trauma), self-disclosure may be a moot point as the client is aware of the clinician's exposure to the community-based disaster" (p. 232). Many clinicians indicate that self-disclosure helps them connect more with their clients and their clients also feel more connected and vulnerable in some cases (Tosone et al., 2012).

Other research on shared trauma indicates that many clinicians feel a deeper level of empathy with their clients as they truly understand what their clients are going through. In

Boulanger (2013), a quote from a clinician who experienced Hurricane Katrina and had shared trauma with clients illustrates: “Even when we aren’t dealing with the storm, I understand what people have gone through in a different way, it’s not just empathy, there’s a new kind of understanding, recognition of what people are saying” (p. 30). Having gone through a traumatic event or situation in real-time with clients while simultaneously providing support for clients is the essence of shared trauma; mental health clinicians have to navigate both a therapeutic relationship and personal healing.

Black mental health clinicians who provide services to the African American community expose themselves to experiencing multiple crises and various traumas (Liu & Modir, 2020). Many clinicians had to navigate COVID-19-related changes on a personal and professional level. Mental health clinicians experienced the changes in demands for mental health support that came with COVID-19 and racial tensions in 2020. What can we learn from their experiences that may provide insight into improving mental health care, particularly by Black practitioners and for Black communities?

Critical Race Theory

Examining the Black mental health clinicians’ experiences requires understanding mental health in the community they primarily serve. Black mental health clinicians are educated in the profession to understand the cultural insights that cause barriers to seeking services and issues with access to treatment. Addressing Black mental health is a very complex issue due to race relations in the United States, systemic racism, oppression, poverty, health care, and the overall complexities of the state of Black America.

Critical race theory (CRT) provides a framework for examining racial inequities and power structures that maintain the disparities. The critical race theory movement is a scholarly

and activist movement seeking to transfer the relationship between race, racism, and power (Delgado & Stefancic, 2023). CRT has five main tenets: racial realism, interest convergence, the critique of liberalism, whiteness as ultimate property, and disregard for narratives of race/racism (Brown, 2008; Crenshaw et al., 1995; Delgado & Stefancic, 2023; Kolivoski et al., 2014). It is described in more detail in Chapter II, the review of the literature.

The African American community is a marginalized group with a rich history (and rich present story) as a people subjected to systems and structures of racism and oppression. When addressing mental illness in the African American community, the literature supports that many barriers are related to societal and systemic conditions. The lack of available and affordable healthcare, higher-than-average poverty rates, unavailability of healthcare practitioners familiar with the uniqueness of the African American experience, and the uncertainty that comes from issues related to interactions with police officers are barriers to mental health treatment and services. (Leis et al., 2011; Snowden, 1999).

CRT is a good framework for examining the Black community's barriers and stigma of mental health treatment services (Brown, 2008). It also allows space for Black mental health professionals to have a voice and to share their narrative as clinicians. In contrast with a typical Eurocentric focus, CRT allows for Black mental health professionals' narratives to be expressed as a valid and needed experience (Brown, 2008; Moodley et al., 2017).

CRT emphasizes the importance of people of color's lived experiences and provides a voice for the race narrative and stories. Kolivoski et al. (2014) stated, "The cornerstone of CRT is the assertion that racism, in the context of the usual way of conducting business in the United States, has become normalized and constantly perpetuated through social structures and institutions" (p. 270). CRT provides scholarship framework for understanding the relationship

between societal structures and experiences of mental health within Black communities. Much of the barriers and stigmas associated with mental health in the Black community can be recognized and analyzed through a critical race theory framework.

Significance of Study

The findings of this study will inform future practice to support clinicians and strengthen mental health care in Black communities. This exploration of Black mental health clinicians' professional and personal experiences will inform Black mental health professionals, clinical institutions, and instructors, as well as future mental health professionals. It will help give a voice to Black mental health clinicians' experience in a racially charged time and help provide scholarship for institutions to support their students of color. This study will also provide insight for instructors teaching clinical courses to students of color. Further support around the uniqueness of mental health cultural factors, race-based trauma, and shared trauma will hopefully attract more Black mental health clinicians to the field. An increase in Black mental health professionals will decrease barriers and increase access to culturally competent treatment services.

Furthermore, this research will provide more insights into shared trauma. Learning more about shared trauma as more mass and police shootings and other events continue to happen in the world will help to provide more support and educational resources to help with the professional development of clinicians. This research will provide insights on understanding navigating both professional and personal experiences to help future Black mental health clinicians.

My Positionality

I am a Black woman, married to a Black man, with four sons. I am a first-generation college graduate in pursuit of her doctorate degree. I come to this study as a Licensed Clinical Social Worker with an educational background and field training in mental health. I also have a private practice that has recently grown into a group practice; thus, I am the President and Clinical Director of a mental health practice. My practice provides individual, couples, and family psychotherapy to primarily African American men and women.

A frequent issue that emerges in my practice is resistance to addressing mental health issues. Clients in my practice have access to mental health services; however, they often hold a lot of misinformation about mental illness and treatment and are affected by the stigma around psychotherapy and medication. I also speak publicly and at community training for organizations and churches on this topic. Much of my training has been in mental health/mental illness in the African American community. Increasing mental health awareness, access, and utilization of services and decreasing stigma is not only what I do professionally, but it is passion work. In recent years, I presented a TEDx talk on "Changing Views on Mental Health in the Black Community." Since July 2018 I have held the office of Vice President of the Ohio Chapter of the National Association of Social Work (NASW). The NASW, Ohio provides advocacy, resources, guidance, and up-to-date information on social work issues and policies for the state. In addition to being a practitioner, mental health-related business owner, and mental health advocate, I am an educator.

I have been a lecturer at The Ohio State University (OSU) College of Social Work for nine years. A major benefit of this role is the firsthand insight into diversity and inclusion, the college community, and social work training initiatives. As a Black woman, I utilize many of my

resources and knowledge from OSU to assist in expanding mental health access, utilization of services, and resources in African American communities. Work being done in the Black community by a Black woman often helps with stigma reduction and access to care.

Like other clinicians, I lived the experience of supporting clients while also feeling the first-hand impact of COVID-19 and police violence against Black citizens and related protests. After more than a year of navigating these extraordinary conditions, I experienced a critical turning point: April 20, 2021, Ma'Khia Bryant, a 16-year-old Black girl, was fatally shot by police officer Nicholas Reardon in southeast Columbus, Ohio, where I live and practice. At the very same time that she was murdered, former police officer Derek Chauvin was found guilty on all charges in the murder of George Floyd. I watched the news that day as a Black woman, a wife and mother, a social worker, a therapist, and a college professor, and I felt at a complete loss. On April 20, 2021, this study began for me, as I had to navigate life both personally and professionally. I wanted to know how other clinicians had done so, as well. How did they adjust and adapt? What have we learned that would inform our wellbeing and that of our clients? What practices and lessons would support mental health care in the Black community in the future?

CHAPTER II: REVIEW OF THE LITERATURE

In 2019, COVID-19 created a shared stressful experience around the world while multiple police shootings piled onto the racial traumas of Black Americans already experiencing a crisis in mental health access (Reyes, 2020). Research on shared trauma experiences, such as during and after the September 11 attacks and Hurricane Katrina, explores how mental health clinicians process and navigate their own responses concurrently with their clients (Day et al., 2017). Research has long examined the effects of trauma on mental health clinicians as providers helping clients through a situation or event, but shared trauma navigates the professional and personal (Tosone et al., 2012). This literature review focuses on shared trauma to inform this study of the experiences of Black mental Health clinicians during the intersecting crises of the COVID-19 pandemic and its disproportionate impact on communities of color, race-based trauma in American society, and the mental health crisis in Black communities. Further, critical race theory (CRT) provides a framework for exploring Black clinicians' shared trauma with their clients (Williams et al., 2018). To contextualize how the literature on shared trauma applies to this study, I begin with a brief introduction to CRT.

Critical Race Theory

CRT was developed in the 1970s by lawyers, activists, and legal scholars when the civil rights area was slowing down. The activists and lawyers felt that new strategies and approaches were needed to address growing racism. Derrick Bell is one key founder of critical race theory. He was a professor at Harvard and New York University Law Schools. Derrick Bell was the author of many original texts (Delgado & Stefancic, 2023). Other instrumental figures in critical race theory are Alan Freeman, Kimberlé Crenshaw, Angela Harries, Cheryl Harris, Charles Lawrence, and Patricia Williams (Delgado & Stefancic, 2023).

CRT identifies how historical discriminatory practices contribute to continued social injustices (Aguirre, 2010; Burton et al., 2010; Kohli & Solórzano, 2012; W. A. Smith et al., 2011). Delgado and Stefancic (2023) stated the importance of understanding the effect of racism related to African Americans' and other oppressed minority groups' experiences in the context of societal institutions (Kohli & Solórzano, 2012). The purpose of CRT has evolved from its original legal perspective to address the effects of unjustly subjecting people of color to subordinate positions in multiple settings (Aguirre, 2010; Kohli & Solórzano, 2012; Rollock, 2012).

The critical nature of the theory focuses attention on moving researchers to disrupt current life (Bridwell, 2012; Gove et al., 2011; Milner, 2012). Institutions must evolve through critical theorists developing new lenses and frameworks previously left out of decision-making (Bridwell, 2012; Gove et al., 2011; Milner, 2012). Gove et al. (2011) suggested that critical investigations with the intent of advancing social justice movements are necessary to address sociopolitical issues.

CRT provides a framework for examining racial inequities and power structures that maintain the disparities. The critical race theory movement is a scholarly and activist movement seeking to transfer the relationship between race, racism, and power (Delgado & Stefancic, 2023). CRT provides a framework for examining racial inequities and power structures that maintain the disparities. The CRT movement is a scholarly and activist movement seeking to transform the relationship between race, racism, and power (Delgado & Stefancic, 2023).

Based on the literature (Brown, 2008; Crenshaw et al., 1995; Delgado & Stefancic, 2023; Kolivoski et al., 2014), there are five major components or tenets of CRT:

1. *Racial realism* reflects the concept that racism is ordinary and the overall ethos and beliefs of the culture in the majority promotes and perpetuates a notion of "color-blindness" and "meritocracy."
2. *Interest convergence* is the notion that whites will allow and support racial justice/progress to the extent that there is something positive in it for them or a "convergence" between the interests of whites and non-whites.
3. Race has been constructed socially, much to the detriment of people of color (*The critique of liberalism*).
4. The notion that whites have been recipients of civil rights legislation (*Whiteness as ultimate property*).
5. Disregard for narratives of *race/racism*) is the final tenet of critical race theory.

Storytelling and counter-storytelling are powerful, persuasive, and explanatory abilities to unlearn beliefs that are commonly believed to be true. CRT emphasizes the importance of the experiences of peoples of color and provides a voice for the race narrative and stories. Kolivoski et al. (2014) stated, "The cornerstone of CRT is the assertion that racism, in the context of the usual way of conducting business in the United States, has become normalized and constantly perpetuated through social structures and institutions" (p. 270). CRT provides a theoretical frame that connects scholarship with the structures that affect mental health in Black communities and Black mental health clinicians' experiences, including the shared racial trauma they may experience.

Trauma

Trauma is a physiological and psychological experience in which an individual experiences devastating fear for their life, figuratively or literally (van der Kolk, 2014). The

emotional experience of a person affected by trauma can vary, with fear being the most present (Amstadter & Vernon, 2008). Many types of events are traumatic. Some examples are illness or injury, child abuse, the murder of a loved one, intimate partner violence, physical assault, sexual assault, mass shootings, or anything else that could be considered dangerous and life-threatening (Amstadter & Vernon, 2008; Yeager & Roberts, 2003). The broad nature of trauma makes it difficult to define clearly because trauma can happen in one event, or it can be a lifelong situation (PTSD Alliance, n.d.). The subjective reality of trauma adds to the complexity of treating it (Weinberg & Gil, 2016). According to van der Kolk (2014), the effects of traumatic stress on the mind and body are extensive and lead to major changes in the brain. One of the most important changes in brain chemistry leads to the feeling of being "stuck" in the trauma; thus, the mental health provider must note that the client may continue to live their life as if the trauma is ongoing (van der Kolk, 2014).

The American Psychiatric Association (2022) defined post-traumatic stress disorder (PTSD) as a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event. People with PTSD have intense, disturbing thoughts and feelings related to their experience that last long after the traumatic event has ended. They may relive the event through flashbacks or nightmares, feel sadness, fear or anger, and detachment or estrangement from other people. People with PTSD may avoid situations or people that remind them of the traumatic event, and they may have strong negative reactions to something as ordinary as a loud noise or accidental touch (American Psychiatric Association, 2022). According to the American Psychiatric Association (2022), a person is diagnosed with PTSD when symptoms last for more than a month and cause significant distress or problems in the individual's daily functioning. Many individuals develop symptoms within three months of the trauma, but symptoms may

appear later and often persist for months and sometimes years. PTSD often occurs with other related conditions, such as depression, substance use, memory problems, and other physical and mental health problems (American Psychiatric Association, 2022).

The incidence of PTSD in the United States population is substantial as the following facts illustrate:

- About 6 out of every 100 people (or 6% of the U.S. population) will have PTSD at some point in their lives. Many people who have PTSD will recover and no longer meet diagnostic criteria for PTSD after treatment. So, this number counts people who have PTSD at any point in their life, even if their symptoms go away.
- About 5 out of every 100 adults (or 5%) in the U.S. has PTSD in **any given year**. In 2020, about 13 million Americans had PTSD.
- Women are more likely to develop PTSD than men. About 8 of every 100 women (or 8%) and 4 of every 100 men (or 4%) will have PTSD at some point in their life. This is in part due to the types of traumatic events that women are more likely to experience—such as sexual assault—compared to men. (National Center for PTSD, U.S. Department of Veterans Affairs, 2023, paras. 13–15)

While a small percentage of individuals develop symptoms that meet the Diagnostic Statistical Manual's five diagnostic criteria (American Psychiatric Association, 2022), research shows that individuals are still deeply affected by the experience of a traumatic event even without the presence of a PTSD diagnosis (Kleber, 2019).

Vicarious Trauma and Secondary Trauma

Vicarious trauma and secondary trauma are both used to describe the effects on mental health clinicians and first responders of working with traumatized persons (Jenkins & Baird, 2002). The key difference between vicarious trauma and secondary trauma is the development of symptoms that results in cognitive representations (vicarious trauma) and the other more severe post-traumatic disorder symptoms (secondary trauma; Branson, 2019; Jenkins & Baird, 2002). Jenkins and Baird (2002) found that "secondary trauma and vicarious trauma are conceptualized as reactions to the emotional demands on therapist and social network members from exposure to

trauma survivors' terrifying, horrifying, and shocking images; strong chaotic affect, and intrusive traumatic memories" (p. 423). Branson (2019) stated,

> [Secondary trauma] results from professionals being psychologically overwhelmed by their desire to provide assistance and comfort to their observations of trauma and suffering. The presentation of secondary trauma is similar to post-traumatic stress disorder, such as avoidance, unwanted mental images, oversensitivity to trauma-related stimuli, and comprised daily functioning. (p. 3)

Pearlman and Saakvitne (1995) defined *vicarious trauma* as "the permanent transformation in the inner experience of the therapist that comes about as a result of empathetic engagement with client's trauma material" (p. 31). They indicated that the main symptoms of vicarious trauma are "disturbances in the therapist's cognitive frame of reference, identity, world view, and spirituality . . . affect tolerance, fundamental psychological needs, deeply held beliefs about self and others, interpersonal relationships, internal imagery, and psychical present in the world" (Pearlman & Saakvitne, 1995, p. 280).

Shared Trauma

Shared trauma occurs when the mental health providers and clients are both exposed to the same traumatic event, which may include any kind of collective trauma (Baum, 2010). According to Baum (2010), shared trauma is characterized by the following:

- A disaster or event that can cause collective trauma.
- The disaster or event having been recent.
- Both clients and clinicians having been in the community affected.
- Clinicians being exposed to the trauma through direct means as well as indirect means through their roles as a clinician and community member.

The concept of shared trauma came into wide use following the 9/11 terrorist attacks and later helped to describe clinicians' experiences in relation to such events as Hurricane Katrina and the Virginia Tech shootings (Day et al., 2017). Tosone et al. (2012) explained shared trauma

as occurring when mental health practitioners experience a primary trauma, such as a natural disaster, and secondary trauma based on their professional roles with affected populations. Shared trauma applies to mental health professionals who live and work in traumatized communities. For example, there were mental health workers responding to the 9/11 terrorist attack who lived in the New York metropolitan area (Tosone et al., 2012). Professionally, their work had focused on assisting survivors and families of survivors in mentally coping with the overwhelming tragedy. Simultaneously, the practitioners strived to cope with similar challenges in their private lives. Assumptions related to PTSD and secondary traumatic stress (STS) did not effectively capture this little-known population's struggles (Tosone et al., 2012).

Boulanger (2013) characterized shared trauma as a "fearful symmetry" (p. 33) because the clinicians go through the same thing as the clients; thus, they are responders but also both the victims and survivors. Shared trauma is exemplified through the shared intersection of stories told with stories lived. Boulanger (2013) studied the context of Hurricane Katrina and found what made it so devastating for mental health professionals and clients:

- that many clinicians, including psychiatrists, did not return to New Orleans after Katrina,
- that the highest rates of turnover came with community mental health providers, and
- how those departures from the field of mental health post-Katrina had a drastic impact on the ability of clinicians to meet the mental health needs of community members.

Boulanger (2013) provided four in-depth personal testimonies from clinicians who navigated their own trauma and attempted to meet the trauma needs of their communities. One therapist reported not feeling clinically trained/prepared for the level of trauma witnessed and

feeling unable to fall back on their typical treatment modalities. Instead, they felt they needed to practice trauma skills for which they had not been trained or provided previously. Another therapist discussed overcoming their own personal issues while being acutely aware of their own trauma, and their own family's and friends' trauma, including grief and loss (Boulanger, 2013). Dekel and Baum (2010) discussed negative consequences such as fear, grief, and loss in terms of personal and professional conflicts, such as loss of private space and management of one's own trauma response. They also described how social work professionals experienced trauma, especially as the strain on human resources and social services increased in demand with traumatic events.

Tosone et al. (2012) highlighted trauma narratives and the impact of shared trauma through case vignettes from mental health clinicians. The vignettes were from clinicians in New York City who dealt with trauma in the aftermath of 9/11, and in Sderot, Israel following years of war and the trauma of Quassam rockets. The vignettes are personal narratives documenting the experiences of clinicians who experienced shared trauma and the impact it has on them personally and professionally. The authors identified common themes that emerged from the narratives including an increase in clinical skills, compassion and connection with clients, personal self-care, disappointment in professional organizations and their responses to traumatic events, feeling unprepared, and personal vulnerability. Day et al. (2017) conducted interviews with clinicians who had dealt with the shootings at Virginia Tech. They identified themes indicating that clinicians who experienced shared trauma also experienced changes in their counseling practice. Boundaries of self-disclosure and vulnerability not only changed but also the boundaries around their time. Clinicians discussed a high demand for mental health services

which stretched them and resulted in taking on more clients than normal and seeing more clients in a day than normal (Day et al., 2017).

Boulanger (2013) discussed clinicians needing to be more open to self-disclosure; psychologists shift to doing sessions by phone; clinicians calling to check on their clients from another city or state; and clinicians operating from temporary spaces because their office and/or home were unavailable for use. Other topics included self-disclosures about how clinicians were affected and fared through the recovery from this storm. Many of the clinicians reported on their professional growth because their experiences transcended empathy into truly understanding and knowing the trauma that their clients went through. Therapeutic and clinical boundaries had to shift because the clinicians felt they had to self-disclose to help with the therapeutic relationship. Dekel and Baum (2010) discussed how positive consequences are associated with the care provided, such as experiences of further empathy and understanding with their clients.

Bell and Robinson (2013) provided strategies for treatment protocols that may be used by clinicians to minimize secondary or vicarious trauma by enhancing protective factors such as self-care, relationships, spirituality, and personal counseling. Bell and Robinson discussed the importance of therapists maintaining a space for their own healing; otherwise, they are more susceptible to vicarious trauma through a client's sharing of their stories. They emphasized the importance of the clinician having self-awareness, connection through community, and self-care to heal from the shared trauma. Dekel and Baum (2010) identified three levels of support (referred to as "circles of support") to help with healing—first, support from family; second, support from colleagues and professional organizations (supervisory); and third, societal, communal, and culture of support. Dekel and Baum concluded that social workers need to be

academically and organizationally prepared for shared traumatic reality events through training curriculum, practice protocols, and organizational policies around shared traumatic realities.

More recent research highlighted shared trauma as a new construct identified to explain when the professional must be personal. Other terms that are often synonymous with shared trauma or included in the research are secondary trauma and vicarious trauma. Day et al. (2017) helped understand the difference in vicarious trauma saying,

> Vicarious traumatization is a process of change, leading to distorted perceptions that are due to empathic engagement with clients who have survived trauma. These distorted perceptions can have a detrimental impact on mental health providers' professional and personal lives as they hear the explicit details of their clients' traumatic realities. (p. 270)

Countertransference, burnout, and compassion fatigue are terms that are also commonly associated with research on shared trauma, but the literature distinguishes the differences. Literature on shared trauma has discussed how it affects clinicians both positively and negatively and then provides lessons learned or strategies for treatment. Much of the literature reports how, before the traumatic event, therapeutic boundaries were clearer. Clients often asked their therapists how they were doing, handling recovery, loss, and other challenges. The clinicians often stated that their clients knew they were going through the same things, so they felt it was appropriate and therapeutically necessary to respond with some self-disclosure. Many of the clinicians discussed how self-disclosure helped them connect more with their clients and indicated that their clients felt more connected and vulnerable, in some cases. Overwhelmingly, clinicians discussed a deeper level of empathy; having a true understanding of what the client was going through. Clinicians also revealed how mental health needs increase after a shared traumatic event which does not always permit time for personal healing. Their schedules become a little more packed and some discussed how more debriefing and crisis intervention in group settings and/or workshops take over their normal day-to-day practice.

Researchers have started to explore the impact on mental health clinicians as many collective traumas surged during the COVID-19 pandemic (Haydon & Salvatore, 2022a, 2022b). Given that many people had traumatic experiences related to COVID-19 and the racial tensions surrounding violence directed at Black people in the United States, Black mental health clinicians serving Black clients were potentially doubly exposed to trauma, indirectly from their professional work and directly through their own personal, firsthand experiences—Black mental health clinicians likely experienced shared trauma on many levels.

Racial Trauma and Race-Based Trauma

In recent years in the United States has witnessed a national protest against racism, discrimination, and law enforcement practices targeting communities of color. Highly publicized incidents, such as the killings of George Floyd, Michael Brown, Ahmaud Arbery, Philando Castile, and Breonna Taylor, shined a national and global spotlight on the problem of police brutality and racism in America (Ater, 2020). These incidents, including killings and constant harassment of Black people by the police, exoneration of those involved in the killings of Black people, and persistent macro and microaggressions in public spaces, often lead to symptoms similar to those encountered in PTSD. Symptoms include increased and persistent anxiety, depression, erosion of one's self-esteem, isolation, triggers, flashbacks, fatigue, and persistent fear among Black individuals and Black communities (Winters, 2020).

Racial trauma, a form of distress based on race, is the overall psychological, emotional, and physical responses expressed by people of color because of psychological, emotional, and sometimes physical threats and injuries endured by the hand of oppressive systems (Comas-Díaz et al., 2019). Hemmings and Evans (2018) described race-based trauma or race-based traumatic stress as the emotional, psychological, and physical pain brought by the feeling of being

discriminated against. This reiterates that Black clinicians know and understand. Race-based traumatic stress is characterized by emotional and psychological injury, an inability to cope, severe stressors that threaten safety and wellbeing, or extreme racism experienced at the interpersonal or institutional level, causing fear and feelings of helplessness (Hemmings & Evans, 2018).

Forsyth and Carter (2012) examined the relationship between racial identity status attitudes and the specific strategies used by Black Americans to cope with racism, and mental health outcomes. The authors defined racial identity, explored racism and its impact, and provided general ideas on how Black Americans cope with racism. Carter et al. (2017) studied the relationship between racial identity status and a person's reactions to memorable racial encounters. They suggest that to understand the impact racial experiences have on people of color, it is important to consider whether there are any race-based traumatic stress symptoms. For example, Carter et al. (2017) posited that people evaluate the psychological and emotional impact associated with life events and racial incidents based on their racial identity status attitudes, which encompass how one makes sense of race-based encounters.

The terms "racial trauma" or "race-based traumatic stress" are used to indicate severe cases of racism-related stress (Hemmings & Evans, 2018; Truong & Museus, 2012). Truong and Museus (2012) also noted that racism-related stress and racial trauma stem from racialized interactions between people and their environment.

Researchers have proposed that stress associated with racial incidents can rise to the level of traumatic stress; thus, high rates of PTSD for people of color could be related to racism or racial discrimination (Williams et al., 2018). Comas-Díaz et al. (2019), as a part of a larger piece of research, reviewed literature pertaining to racial trauma and healing. The authors discussed the

direct and indirect racial trauma, or race-based stress, that African Americans have experienced and the psychological effects of these traumatic stressors.

Carter and Kirkinis (2021) studied differences in adults' responses to adverse, race-based events, to provide insights to a psychological response to race-based trauma such as the following:

- Race-based events were more memorable than other events for many of the participants.
- Higher emotion-related responses to these experiences are experienced as being more intense.
- Race-based stress may endure or possibly become more distressing especially as more experiences accumulate across a lifetime.

The literature on race-based trauma indicates that racism has the same psychological response as PTSD, thus, indicating that racial trauma is just as significant as other identified psychological traumas (Williams et al., 2018).

Not all racial events have to happen directly to the person to cause a traumatic response; they can be experienced vicariously (Lerias & Byrne, 2003). This helps explain the potential for shared and vicarious trauma among Black mental health clinicians during the intersecting crises of COVID-19—that disproportionately affected communities of color— racial violence, and existing issues around mental health access and stigma in Black communities.

Chapter Summary

This chapter explored multiple types of traumas and its effects on mental health clinicians. Race-based events are experienced as a trauma (Williams et al., 2018), and COVID-19 was traumatic for many (Choi et al., 2020). For both, research indicated adverse

psychological effects. The literature has shown the impact of shared trauma on clinicians. Even though there is growing literature on mental health clinicians and service professionals' experiences with shared trauma, the literature does not reflect how these experiences change with African American mental health professionals.

CRT provides a framework for the experiences of racism and lends scholarship to narratives of storytelling and oral traditions recounting experiences (Aguirre, 2000; Delgado & Stefancic, 2023). Graham et al. (2011) stated,

> CRT theory involves existential voice . . . Stories always refer to a particular context, place, and moment. The historical and cultural setting is critical to researchers' interpretation of facts, feelings, and understanding. Narrative is a medium in which intersectionality plays out in a complex manner without being watered down or only marginally taken up. Thus, narrative can be a forum in which to examine race, sex, class, national origin, and sexual orientation, and ways in which their combination play out in a range of situations. (p. 88)

CRT lends a voice to the insights of African American mental health clinicians.

CHAPTER III: METHODOLOGY

The purpose of this study was to explore the lived experiences of Black clinicians in delivering mental health care to primarily Black clients during the intersecting crises of the COVID-19 pandemic, the racial traumas related to extrajudicial violence and over-policing of Black Americans and other persons of color, and the mental health crisis of stigma and lack of access in Black communities. Black mental health clinicians were trying to navigate the intensified demands for their professional services because of multiple crises that occurred simultaneously while also navigating their direct, personal experiences of trauma, loss, and devastation in relation to them (Hemmings & Evans, 2018). The study explored how Black mental health clinicians fared, personally and professionally. How did they adapt their lives and practices? What did they find helpful to their clients and themselves? What insights did they gain? And what did they learn from it all that might benefit Black mental health practitioners serving Black communities? This study used a qualitative, interpretive phenomenological approach, inviting Black mental health clinicians to share their lived experiences in narrative interviews that explored the following research questions:

1. What were the experiences of Black mental health clinicians who serve Black communities during the intersecting, shared crises of the pre-existing Black mental health crisis, COVID-19, and racial trauma in the United States?
2. What changes and responses did these clinicians make, both professionally and personally, during these intersecting events?
3. What can we learn from the experiences and lessons learned by these clinicians that can inform future mental health practice and outreach in Black communities?

Table 3.1 relates these questions to the interview questions used in discussions with participants, the theoretical bases behind the questions and relevant sensitizing concepts.

Table 3.1

Study Research Questions in Relation to Interview Questions, Theoretical Framework and Sensitizing Concepts

Research Question	Interview Questions	Theoretical Framework	Sensitizing Concepts
What were the experiences of Black mental health clinicians who serve Black communities during the intersecting, shared crises of the pre-existing Black mental health crisis, COVID-19, and racial trauma in the United States.?	Tell me about your experiences (personally and professionally) after COVID-19 hit. How did racial tension and police shootings impact things for you?	• Trauma • Shared trauma • Racial trauma • CRT	• PTSD • Compassion Fatigue • Burn Out • Racism • Naturalization of Race
What changes and responses did these clinicians make, both professionally and personally, during these intersecting events?	What would you say has remained the same or has changed for you in your practice since the start of COVID-19 and the increase in racial tension?	• Shared trauma • CRT	• More Empathy • Changes in therapeutic boundaries • Increase self-disclosure
What can we learn from the experiences and lessons learned by these clinicians that can inform future mental health practice and outreach in Black communities?	What would you say you have learned that would help future mental health?	• Trauma • Racial trauma • Shared trauma • CRT	• Self- Care • Self-Awareness • Relational Connection

Research Philosophy and Approach

According to Fossey et al. (2002), qualitative methods are helpful for eliciting contextual data in quantitative research to gain an in-depth understanding of participants' experiences. They also observed,

> Qualitative research also lends itself to developing knowledge in poorly understood, or complex, areas of health care. These qualitative methods are especially appropriate for understanding individuals' and groups' subjective experiences of health and disease; social, cultural and political factors in health and disease; and interactions among participants and healthcare settings. (Fossey et al., 2002, p. 718)

The research questions and purpose of this research aligned appropriately with the rationale for conducting qualitative research. Qualitative designs are specific to certain philosophical assumptions (Goertz & Mahoney, 2012). Ontology deals with the nature of reality, and epistemology with the nature of how researchers know what they know; the research question reflects assumptions about these underlying research studies and the methods researchers choose (Kamal, 2019). Qualitative research typically reflects an interpretivist ontology and a constructivist epistemology, and researchers often take a semantic approach to identify a concept's intrinsic necessary defining attributes—qualitative researchers are concerned with meaning (Goertz & Mahoney, 2012).

This study was based on a constructivist or social constructivist worldview. Social constructivists believe,

> Individuals seek an understanding of the world in which they live and work. Individuals develop subjective meanings of their experiences—meanings directed towards certain objects or things. These meanings are varied and multiple, leading the researcher to look at the complexity of views rather than narrowing meaning into a few categories or ideas. The research goal is to rely as much as possible on the participants' views of the situation being studied. (Creswell & Creswell, 2017, p. 8)

Creswell and Creswell (2017) observed that social constructivism is often combined with interpretivism. This research aimed to rely on Black mental health clinicians that described their experiences and the impact, professionally and personally, during the multiple intersecting crises which affected mental health in Black communities.

A phenomenological approach was well suited to the aim of this study. Creswell and Creswell (2017) stated, "Phenomenological research is a design of inquiry in which the researcher describes the lived experience of the individuals about a phenomenon as described by participants" (p. 13). My research aligned with a phenomenological design because the goal was to understand the lived experiences of Black mental health clinicians. There was a uniqueness to

the Black mental health clinician's experience, which was evident in the number of professionals in the psychotherapy field. The American Psychiatric Association found "only 2% of the estimated 41,000 psychiatrists in the U.S. are Black, and just 4% of psychologists are Black. On college campuses, close to 61% of counseling center staff are White, and 13% are Black" (as cited in O'Malley, 2021, para. 2). This qualitative design allowed for a deeper understanding of Black mental health clinicians' experiences than quantitative research would provide.

Overview of Phenomenology

Phenomenology is a qualitative research method designed to investigate lived experiences in everyday life, the way people respond to phenomena, or the meanings that people assign to phenomena (Edward & Welch, 2011; Laverty, 2003; Randles, 2012). Randles (2012) stated that a phenomenological method occurs when one is "returning to the experience and prioritizing value" (p. 12) rather than relying on personal interpretations to determine meaning and shared experiences. Further, a phenomenon is about the crux of the experience and the essential substance based on a mutual understanding shared by multiple people (Randles, 2012). According to Neubauer et al. (2019), a phenomenon occurs when an event or experience has occurred to an individual and should be described by the person or persons who experienced the unique event. Phenomenology is one of the methods used for understanding experiences, allowing researchers to explore the lived experiences within everyday patterns of life (Edward & Welch, 2011). Phenomenology is grounded in the philosophy developed in the early 20th century by Edmund Husserl (Bloor & Wood, 2006). There are two philosophical schools of phenomenology: transcendental and hermeneutic (Bloor & Wood, 2006).

In transcendental phenomenology, the goal is for the researcher not to influence what is being observed but to keep separate their own subjectivity and to capture the descriptions given

by participants (Bloor & Wood, 2006; Neubauer et al., 2019). Husserl is credited as the most influential philosopher of transcendental or descriptive phenomenology (Bloor & Wood, 2006). In transcendental phenomenology, the researchers must suspend any theories or preconceived knowledge of the object of their study by "bracketing off" any previous knowledge or understanding of the phenomena (Neubauer et al., 2019). The researcher then considers each participant's descriptions of their individual experiences and then constructs a collective synthesis of the phenomenon's meanings and essences (Randles, 2012). As a result of my positionality, discussed in Chapter I, and as it relates to the methodology below, I was unable to separate my knowledge and experience from the participants. Attempting such personal separation from the study could impede the findings. According to Macbeth (2001), including the researcher's knowledge and experience strengthens the study's validity. Therefore, my study focused on an interpretive and hermeneutic phenomenology.

Interpretive phenomenology, also called hermeneutic phenomenology, was developed by Martin Heidegger on the premise of interpretation and acquired meaning (Bloor & Wood, 2006). Heidegger focused on what he termed *dasein*, "the situated meaning of a human world" (Laverty, 2003, p. 4). For Heidegger, consciousness is not separate from the world but arises from the construction of historically and socially lived experiences influenced by the culture an individual is raised in and how they come to understand their world (Laverty, 2003). Interpretive phenomenology examines participants' narratives to understand what they experience in their life (J. A. Smith & Nizza, 2022). Interpretive phenomenology recognizes that the researcher, like the participant, cannot rid themselves of their worldview but instead uses their knowledge and experience to inform the study (Neubauer et al., 2019). Peoples (2020) stated, "Interpretive phenomenology is best suited to research who aim to understand an experience and how people

with those experiences make sense of them" (p. 117). Interpretive phenomenology supports the research of understanding the lived experience of Black mental health clinicians during the shared trauma of COVID-19, racial trauma, amidst an existing mental health crisis in Black communities (Hemmings & Evans, 2018).

Research Design

This study was a qualitative, interpretive phenomenological study. The study entailed individual interviews of Black mental health clinicians who provided therapy for at least 50% of Black clientele before the advent of COVID-19. Participants were identified via snowball sampling and recruited using email and social media outreach to Black therapists or mental health clinicians of color.

Sampling Strategy

The sampling strategy used in this study was purposive sampling, also known as criterion-based sampling. Purposive sampling "is the deliberate choice of a participant due to the qualities the participant possesses" (Etikan et al., 2016, p. 2). The two types of purposive sampling I used were criterion and snowball. Criterion sampling means recruiting participants who meet specific pre-determined requirements (Parker et al., 2019). In this study, I was interested in the experiences of Black mental health therapists providing services to Black clients. According to Heppner and Heppner (2004), "Criterion-based sampling is used in a phenomenological study to select participants who meet the following criteria: (a) they experienced the phenomenon under study and (b) they can articulate their lived experiences" (p. 173).

Snowball sampling occurs when participants are selected from the recommendations of other prospective participants (Parker et al., 2019). I recruited initial participants through email

contacts and created social media inquiries via private social media groups that were specifically for mental health clinicians. Once a therapist had agreed to participate in the study, I asked that person to refer other clinicians to the study, employing snowball sampling.

Sample sizes for phenomenological studies can vary based on the research outcomes designated by the researcher (Starks & Brown Trinidad, 2007). For this study, I initially aimed to have at least 10 participants to meet an appropriate saturation level that reflects the ideas and beliefs of a diverse population, and that was the final number selected.

Informed Consent, Privacy, and Confidentiality

Once potential participants expressed interest in the study, I scheduled a meeting for an interview and sent them an informed consent form via email. When we meet for the interview, I went over the elements of informed consent and confirmed their consent to participate and be recorded. I reiterated to the participant the nature of the study, potential risks, and benefits of participation, and assurances of confidentiality. Then written informed consent was obtained, including permission to record the session.

After the interview, applying the snowball strategy, I asked participants if they knew another Black mental health therapist who might be interested in participating. Video conference interviews were video and audio recorded. Once transcriptions were complete and confirmed for accuracy and privacy with the participants, video recordings were destroyed with only password-protected audio recordings retained to help ensure the confidentiality of data and the privacy of participants.

Data Collection: Interviews

The design used narrative interviews to collect the data. Interviews were intended to capture the essence of the Black mental health clinicians' experiences during the intersecting crises. Interviews were generally between 60 and 75 minutes. Interviews began by my asking participants a few icebreaker and background items and then moved to open-ended questions in order to provide a clear agenda to explore the phenomena and to allow space for in-depth responses from the participants. An interview guide was used for continuity and consistency among participants. The interview guide also provided space making notes during the interview.

Background Items

In the first stage of the interview, I asked each participant about their professional background using specific demographic questions. Mental health professionals can vary in disciplines of training and practice specializations such as psychology, clinical social work, professional counselor, marriage, and family therapy. Therefore, I asked about their training and practice, such as the background of the participant's degree. Getting the participant's geographical location was relevant to how the therapists may have experienced local racial trauma. There were many police and racial events across the United States, and this information provides context for the participants' experience. The participants' setting was important to help understand the population of the clientele, such as a college that may have access to other resources, and the setting also helped understand possible pay structures, such as private insurance or public insurance.

Interview Guide

The following is a verbatim version of the guide I used during the research interviews.

Researcher Script:

Hi, my name is Chante Meadows, mental health therapist, and owner of a group practice located in Columbus, Ohio. Thank you for agreeing to participate in an interview for my doctoral research study on Black Mental Health Therapist Experiences and lessons during the mental health crisis, COVID-19, and racial events that occurred in the United States. This interview should take about 60 to 90 minutes. If at any time during this interview, you want to stop or if it becomes too difficult, please let me know. I am going to start by asking you some general questions such as name, licensure, where you practice, and things of that nature. Are you ready to begin?

Geographical Location:

- What state did you reside in from 2019-2021?
- What state provide mental health services during 2019 -2021?

Licensure/Mental Health Discipline:

- Social Work
- Professional Counselor
- Marriage and Family Therapist
- Psychology
- Other

Setting providing mental health services?

- Private Practice
- College or University
- Community Agency
- Private Agency

Narrative Interview Questions

- Tell me about your experiences, personally and professionally, after COVID-19 hit.
    - How did you handle the demands on you?
- How did racial tension and police shootings impact things for you?
    - What did you see in terms of clients' reactions—and how was that for you, going through those experiences at the same time?
- What would you say has remained the same or has changed for you in your practice since the start of COVID-19 and the increase in racial tension?
    - What changes have you made that help you? Your clients?

- What would you say you have learned that would help future mental health?
    - Any lessons from all of this for how we can better service Black communities?

Using video conferencing for interviews allowed access to more clinicians and ensured that all interviews were recorded for observation of behavior. Mental health during COVID-19 required many clinicians to move to an online format, so Black mental health clinicians were likely to be comfortable and familiar with this format. Long-term storage of the interview file was saved and password-protected on my personal computer and on at least one back up drive. Saving recordings to the researcher's private and secure computer was done to enhance participants' confidentiality.

Voice-to-text transcription software was used for initial transcription, then manually checked for accuracy, and corrected by me as the researcher. Once I de-identified the data in the transcripts for confidentiality, I asked participants to review the transcription of their interview to ensure accuracy and their approval of the content and their confidentiality.

Coding and Analysis

Data coding and analysis used a thematic coding approach. I followed Saldaña's (2009) guide to qualitative research coding. Saldaña (2009) stated that "a code in qualitative inquiry is most often a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attributes for a portion of language-based or visual data" (p. 3). Saldaña divided this approach to coding into first cycle and second cycle coding. First cycle is the initial codes given to the data and is coding for meaning. Second cycle is coding into categories. I coded the data from the transcriptions using first cycle coding to label meanings and second cycle coding to group the meaning labels into categories. Drawing on my theoretical

frameworks of CRT and trauma, I listened for how shared experiences of intersecting traumas show up in the lives of participants, both personally and professionally. Saldaña (2009) stated that "codifying is to arrange things in a systematic order, to make something part of a system or classification, to categorize" (p. 8). Once codes were clustered into categories, I analyzed these to identify patterns, connections, and themes in the participants' experiences that may relate to theories or represent other emergent findings. I used a combination of electronic coding software (Dedoose) and manual coding to identify connections as part of thematic analysis.

Since I was using narrative interviews, I also drew upon analytic approaches in narrative inquiry in tandem with the CRT framework of culture, race, and personal storytelling or narratives. Kim (2016) described narrative inquiry as using people's stories to understand the meanings they give their experiences. These understandings provide insight on broader human social phenomena. Particularly, I noted features of each participant's story of being a Black mental health clinician during the COVID-19 pandemic, heightened racial tensions and police killings, and the Black mental health crisis, including the elements of time, place, and relationships that are significant in their stories. Polkinghorne (1988) explained that studying the meanings of people's narratives expands our understandings of human experience because people project the meanings and impacts of events and human actions, as they have experienced them, in their stories and narrative accounts. Individual stories not only have narrative meaning, but collectively over time, they contribute to cultural collections that comprise fables, folklore, and histories reflecting values of the people.

Ensuring Quality

Trustworthiness in phenomenological studies is assessed by credibility, transferability, confirmability, and dependability to appraise and assess the research (Shenton, 2004). Mills and

Birks (2014) considered *credibility* to be the degree to which the data are accurate and aligned with the participants' meaning and plausibility. In this study, participants were asked to review the written transcript to ensure that it reflected their lived experience of the phenomena. The interview guide assisted with the consistency of interviews to ensure each participant was asked the same questions and given the same opportunities to share their perceptions. Participants' checks for accuracy assisted in validating the data and strengthening the credibility of the study.

The concept of confirmability in qualitative research is described as the degree to which others can confirm the results (Shenton, 2004). According to Lincoln and Guba (1985), methods to establish confirmability include utilizing an audit trail and reflexivity. The data should reflect the experiences of the participants, not the presumptions or experiences of the researcher (Shenton, 2004). Reflexivity is the act of the researcher being aware of and systematically controlling biases, assumptions, and positions (Macbeth, 2001). In the research process, I routinely employed reflexivity, journaling, record-keeping, and note-taking.

The goal of qualitative research is not generalizability but transferability (Carminati, 2018). Transferability in qualitative research refers to how the study can be transferred or applied in other contexts, settings, and situations (Shenton, 2004). Transferability is possible through the researcher providing robust data description, including multiple participants, and reaching saturation of themes in the data (Carminati, 2018). In this research process, I provided a robust data description and reached saturation of themes in the data, suggesting the findings have transferability.

Dependability can be achieved through consistency and the in-depth description of procedures (Stenfors et al., 2020). Given (2016) suggested that carefully taking notes and constantly documenting can enhance dependability. As the researcher, I used journaling,

note-taking, and detailed record-keeping to capture the process and, thereby, improve dependability.

Positionality and Reflexivity

Positionality and reflexivity are vital to interpretive phenomenological studies. One's own biases, assumptions, and connections to the study should be identified early in the research process. Bourke (2014) reviewed the significance of positionality in its effects on qualitative research outcomes and interpretation. Grix (2019) described research from design to results as influenced by positionality.

Mortari (2015) stated that reflectivity is "a process whereby researchers place themselves and their practices under scrutiny, acknowledging the ethical dilemmas that permeate the research process" (p. 2). In qualitative studies, it is essential to report assumptions, positions, biases, and values to the reader because the researcher's perspective and position shape the study, so it is important to report to the reader assumptions, values, and biases. Researchers foster a reflective design through journal-keeping and reporting preconceptions and assumptions in the study. Mortari (2015) noted,

> The reflective practice is essential in research since it aims at raising a thoughtful eye on oneself, which allows the subject to gain self-awareness. To be reflective researchers means to become conscious of what already structures the mental life and to analyze how these underlying cognitive artifacts mold the process of inquiry. (p. 2)

As the researcher conducting this study and a Black mental health clinician working with Black clients, it was vital for me to be aware of my own interpretations, biases, and attitudes. I believe that it is impossible for me to disregard my own knowledge and experience in this investigation; therefore, I chose to utilize the approach of interpretive phenomenology. Throughout this study, I regularly engaged in reflexivity and intentional reflective practices

whereby I examined and recorded my own responses to conceptions of the targeted phenomena and collected data.

Ethical Considerations and Procedures

Ethical considerations that needed to be addressed were the potential for psychological harm to participants and issues related to confidentiality, consent, privacy, integrity, and responsible management of data collected. I took measures to minimize these risks in the present qualitative research. The IRB process at Antioch University was followed to ensure the design of the study includes the appropriate steps for minimizing risks to participants. All participants knew in advance about the ethical considerations and steps taken to mitigate risks and to ensure trustworthiness of the research and researcher. Participation was voluntary, and every participant was informed about the study's objectives, the data collection process, and the data management process. Each participant read and signed the informed consent prior to providing any individual data for this study. Participants also chose a pseudonym during the recruitment process to protect the privacy of their data. Participants were made aware in advance they could stop participating at any time.

Risks are inherent to a qualitative study. In a qualitative research study of this nature, experiencing psychological upset is possible given the various types of topics between client and clinician that participants might recall. Many individuals, including mental health clinicians, lost family members and friends during the COVID-19 pandemic, and this could have resulted in psychological harm in recalling this time. Additionally, the racialized events surrounding policing, which saturated TV and social media on an ongoing basis, could have induced mental health clinicians to experience personal and/or secondary trauma. As part of informed consent, I provided contact information for support resources in case of emotional upset. The previous

sections regarding the recruitment of participants, data collection, and analyses addressed the multiple actions I took to address the issue of confidentiality from end-to-end throughout the research design. The need to support an appropriate comfort level was important to participants.

Data management was one area that became a concern of ethics due to increased electronic communications, including data gathering, analysis, and storage. Participants were asked to provide their choice of e-mail for correspondence. Pseudonyms were for data management and in all reports of this research. Names of participants were removed from transcripts and stored separately, along with informed consent forms, in password protected files to ensure that no participant data could be linked with the person who provided it.

Chapter Summary

In Chapter III, I described the underlying ontology, epistemology, and methodological approach for this study. I provided my rationale for qualitative methods, specifically a phenomenological methodology. I also described my methods for collecting and analyzing data, which adequately allowed me to explore these experiences. This research was aimed at exploring the lived experiences of Black mental health clinicians during the intersecting mental health crisis, COVID-19 pandemic, and racial trauma with the use of interpretative phenomenology.

CHAPTER IV: RESULTS

The purpose of this study is to explore the experiences of Black mental health clinicians providing mental health psychotherapy during the COVID-19 pandemic, highly publicized extrajudicial violence, and over-policing, amidst a pre-existing mental health crisis. This chapter presents the study's findings using an interpretative phenomenological methodology grounded in critical race theory and trauma frameworks. In this chapter, I provide detailed information on the setting and participants, data collection and analysis procedures, and the research results.

Research Questions

This study explored the experiences of Black mental health clinicians providing services to predominantly Black clients during the intersection of the Black mental health crisis, the COVID-19 pandemic, and the racial traumas of 2020.

1. What were the experiences of Black mental health clinicians who serve Black communities during the intersecting, shared crises of the pre-existing Black mental health crisis, COVID-19, and racial trauma in the United States?
2. What changes and responses did these clinicians make, both professionally and personally, during these intersecting events?
3. What can we learn from the experiences and lessons-learned of these clinicians that can inform future mental health practice and outreach in Black communities?

Participant Demographics

Pseudonyms are an important part of the research process. Lahman et al. (2015) discussed how the traditional research process the researcher provides the participants' names such as Subject X or Participant 1. Lahman et al. argued how this conventional process is very Eurocentric, so I had each participant choose their pseudonym. This process aligns with critical

race theory and allows each participant to choose something cultural and personally significant. Table 4.1 shows the pseudonyms and other key demographics of each participant.

Table 4.1

Participant Demographics

Pseudonym	Sex	Licensure	Years in Mental Health Field	Geographical Location	Setting
Airicka	F	Professional Counselor	21	Midwest	Private practice
Amanda	F	Professional Counselor	12	Southeast	Private agency
Artistine	F	Social Work	12	Midwest	Private Practice
Lorraine	F	Clinical Psychologist	20	Midwest	Hospital and private practice
Maurice	M	Clinical Psychologist	14	Midwest	Private practice
Mr. Stinky	M	Professional Counselor	5	Midwest	Community
“Participant”	F	Social Work	8	Northeast	Private practice
PhenomenalAF	F	Clinical Psychologist	8	Southeast	Hospital and private practice
Sasha K	F	Social Work	20	Midwest	Private practice
The Helper	M	Clinical Psychologist	5	Midwest	University

The potential participant population included all mental health clinicians who self-identified as Black or African American and are licensed mental health professionals. All the participants self-reported having a caseload of at least 50% Black or African American prior to the COVID-19 pandemic.

Four participants were clinical psychologists, three were professional counselors, and three were clinical social workers. Seventy percent of the participants are in the Midwest, however, not all are in the same state. Midwest states include Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin. Participants varied considerably in age and years of experience. Below are brief introductions of each participant to serve as context and help the reader understand each mental health clinician and their experience.

Airicka has been working in the field of mental health for over 21 years, and working with people unofficially longer, for almost 40 years. Airicka is a Licensed Professional Counselor in the Midwest. She works in a private practice setting with her partner.

Amanda is a licensed professional counselor in the Southeast. She is currently transitioning to her own private practice, but during 2020 she was working at a mental health agency. Amanda has been in the mental health field for 12 years. Amanda was scheduled to get married with a wedding planned but had to get married in the courthouse because of the pandemic.

Artistine is a Licensed Clinical Social Worker practicing in the Midwest. She has been in the mental health field for 12 years. Artistine is a psychotherapist and the owner of a group practice and is currently pursuing her PhD.

Lorraine has been a Licensed Clinical Psychologist for 20 years and practices in the Midwest. Lorraine is the owner of a private practice now, but during the time of the COVID-19 pandemic, she was working in a hospital outpatient setting full-time and in private practice part-time. She transitioned into full-time private practice in part because of the racial culture of

the United States and in her workplace. Also, the hospital setting during the height of the COVID-19 pandemic was intense.

Maurice is a Licensed Clinical Psychologist who moved from one Midwest state to another Midwest state during the pandemic. At the start of the pandemic Maurice was a group practice owner and a full-time clinician but has since let the group practice go and only works as a psychologist, much in part do the changes the pandemic and the move. Maurice has been practicing in the mental health field for 14 years.

Mr. Stinky has been working in the mental health field for almost five years. He has a chemical dependency license and is a Licensed Professional Counselor. Mr. Stinky works in a community agency that specializes in the LGBTQ+ community located in the Midwest.

"Participant" is a Licensed Clinical Social Worker and has her PhD in Social Work. She has been in the mental health field for eight years. Participant's private practice is in the Northeast and only provides services to Black women.

Phenomenal AF is a clinical psychologist practicing in two Southeast states. Phenomenal AF works full-time in an outpatient hospital setting and practices part-time in her own private practice virtually. Her private practice is in a different state than the hospital. She has been in the mental health field for 8 years.

Sasha K has been in the mental health field for almost 20 years and is a Licensed Clinical Social Worker. She owns her private practice and is slowly transitioning into a group practice owner as a result of business growth. Sasha K is in the Midwest.

The Helper is a Licensed Clinical Psychologist in the Midwest. At the start of the pandemic The Helper was in one city and moved to a new city right as COVID-19 pandemic

began, working in a University Counseling Center. The Helper's wife had a baby during the pandemic. He has been a mental health clinician for five years.

Selection Criteria

Participants had to identify as Black or African American, served 50% or more Black clients prior to COVID-19, and be a licensed mental health therapist/counselor. According to Heppner and Heppner (2004), "criterion-based sampling is used in a phenomenological study to select participants who meet the following criteria: (a) they experienced the phenomenon under study and (b) they can articulate their lived experiences" (p. 173). Snowball sampling occurs when participants recommend other prospective participants (Parker et al., 2019). For recruitment, I connected with participants through my professional networks. As a Black licensed mental health therapist, I belong to various professional networks of similarly identified professionals. I participate in social media groups such as Clinicians of Color in Private Practice, a private Facebook group with 20,800 group members, and Black Therapists Rock, a private Facebook group with 30,000 group members. These are two of the established professional networks I utilized by sharing announcements of the study to recruit participants (Appendix A). I also reached out to my existing relationships with other mental health clinicians via email requests to assist with recruiting participants (Appendix B). Professional and personal acquaintances shared the social media posts and emails to help reach more Black mental health clinicians. Some of the participants were individuals with whom I have only professional acquaintanceship, such as minimal prior professional interactions at professional meetings, and people unknown to me previously but who are also members of the private social media groups for similar professionals. Keeping the relationships at this level was meant to help avoid role conflicts and conflicts of interest.

This study involved participants in individual 60-to-75-minute narrative interviews held on the video conference platform, Zoom. In the first stage of the interview, I asked each participant about their professional background using specific demographic questions. Mental health professionals can vary in disciplines of training and specialty in practice (psychology, clinical social work, professional counselor, marriage, and family therapy, etc.); therefore, the researcher asked about their training and practice, such as the background of the participant's degree. Getting the participant's geographical location was relevant to how the therapists may have experienced local racial events.

Participants also varied based on the workplace setting. For example, those working in agencies or healthcare systems often did not feel as supported around racial issues and had much more intense responses. Those participants who worked in settings such as healthcare or in the community spoke about how there was an expectation to work as a normal and experienced very little acknowledgment of the killing or racial tension. Other workplace issues varied based on whether the participant was a group practice owner, in solo private practice, or a manager. Those who had leadership roles responded not only to the impact of the crises as clinicians but also as a leader which impacted their responses.

Data Collection

All participants received an email invitation to participate along with an attached informed consent form. The email asked each participant to provide two or three dates and times that they would be available for the interview. Once I received the signed informed consent, I sent the participant a response email with the teleconference (Zoom) link calendar invitation at one of the times listed in their availability.

Interviews took place between April 11, 2023, and May 5, 2023. Using the IRB-approved interview guide, I conducted in-depth interviews with 10 mental health clinicians to understand their experiences and the lessons they learned regarding these intersecting traumas. I asked semi-structured interview questions of all participants, with variations or additional questions for clarity included based on individual responses. The interview guide is presented in Chapter III.

After the first two interviews it became evident that, because 2020—the year when several of the traumas I asked about had occurred—was three years before data collection for this study, some clinicians had to take some time to think about what their experiences were like. Thus, I had to start with a few questions to prompt memories. Member-checking was performed at the end of every session to ensure accuracy. Follow-up interviews were not required.

All interviews were recorded via Zoom video conferencing software and Otter ai transcription software. Otter ai did not always pick up the audio well thus Zoom and Otter ai transcripts were used in combination. I downloaded the Zoom audio and imported it into Otter ai for transcription of the interviews. I cleaned up the transcripts in Otter ai by ensuring the correct speaker was recognized and cleaned up miswording and mis-transcription of the participant's data. I was able to listen and clean up the audio prior to downloading the transcript into a Microsoft Word document. All data documents were saved under the participant's chosen pseudonym. All digital files related to the study are stored in a password-protected device. Researcher notes are stored in a locked file cabinet in a locked office.

Data Analysis

After completing the interview and transcription process, I manually coded and organized the data using computer-assisted data analysis software, Dedoose. Saldaña (2009) stated that "a

code in qualitative inquiry is most often a word or short phrase that symbolically assigns summative, salient, essence-capturing, and/or evocative attributes for a portion of language-based or visual data" (p. 3). I followed Saldaña's guide to qualitative research coding. Saldaña divided coding into two cycles: First cycle and second cycle. Saldaña further stated that "codifying is to arrange things in a systematic order, to make something part of a system or classification, to categorize" (p. 8). I coded the data from the transcriptions using the first cycle coding to label meanings and the second cycle coding to group the meaning labels into categories. In drawing on my theoretical frameworks of CRT and various trauma models discussed in Chapter II, the "Review of the Literature," I intentionally listened for how shared experiences of intersecting traumas showed up in the lives of participants, both personally and professionally. I used a combination of Dedoose and manual coding to help with identifying connections in thematic analysis.

Findings

The findings are themes that are based on participants experiences, responses, and lessons learned during the intersecting crises. The experiences, responses, and lessons are also looked at from participants' personal and professional perspectives. Research Question 1 (RQ1) probes the experiences of the intersecting crises and Research Question 2 (RQ2) is about the adaptations or responses Black clinicians made to the experiences. And Research Question 3 (RQ3) asks about lessons learned from the experiences and adaptations of the clinicians. The key themes in the interviews with these clinicians were as follows:

- Themes (RQ1): Experiences and RQ2: Responses:
  - Anxiety and Fear
  - Connection to Family and Friends

- Transition to Telehealth
- Anger
- Increase in Demand for Services
- Increase in Demand for Black Clinicians
- Self-Care

- RQ3: Lessons Learned

  Personal Lessons

  - Self-Care
  - Own Therapy

  Professional Lessons

  - Need for Training in Trauma-Informed Care
  - Need for Training in Race-Based Care
  - Need for knowledge related to Business Content and Processes

The previous chapters provided the background and literature context surrounding COVID-19 and racial tension in the United States. The themes are broken down into how Black mental health clinicians responded to COVID-19 and racial tension both personally and professionally. Table 4.2 compares the key themes from personal and professional perspective with the intersecting crisis with racial tension and COVID-19.

Table 4.2

Key Themes of Interviews With Clinicians

CRISIS	PERSONAL	PROFESSIONAL	BOTH
COVID-19	Connection to family; anxiety and fear	Transition to Telehealth	
Racial Tension	Anger	Increase in demand for Black clinicians	
Both		Increase in services provided	Self-Care

Thematic Outcomes

Shared trauma is the intersection between the trauma being both personal and professional (Tosone et al., 2012). Participants answered the questions about their personal experiences with COVID-19 and racial tension and their professional experiences with COVID-19 and racial trauma. The thematic outcomes are separated into personal and professional experiences with COVID-19 and trauma. The thematic outcomes from lessons learned from the intersecting crisis are derived from the experience and responses.

Personal Experiences and Responses

The two subsequent sections describe the participants' experiences and responses to each of the main crises. The first section deals with personal experiences to COVID-19 and to racial tensions. The second describes professional responses.

Table 4.3 summarizes personal responses to COVID-19 and racial tensions.

Table 4.3

Personal Experiences and Responses Related to Research Questions

	Themes	Experiences RQ1	Adaptations RQ2	Lessons RQ3
COVID-19	*Anxiety*	Reaction to COVID-19	Own Personal Therapy	Clinicians should be in their own therapy (a requirement)
	Connection to Family	COVID Isolation/stay at home	Creative Family and Friend Time	
	Self-Care	Reaction to policies of COVID/ World Shut Down	Physical activity/hobbies	Self-care is a vital part of personal and professional work and should be required in academic programs.
RACIAL TENSION	*Anger*	Overpublicized killing of Black community	Activism	

Personal Experiences of and Responses to COVID-19

Anxiety and Fear. Anxiety and fear were one of the top themes among Black mental health clinicians. Among many mental health clinicians, there was a consistent reaction when feeling overwhelmed and having a fear of the unknown. As Lorraine reflected on COVID-19 and how she personally felt during that time she stated:

> Probably like everybody else, just really, just baffled by the whole thing. Like, where did it come from, how it was hitting people, the fact that we just really didn't know anything, right just came out of nowhere, people weren't dying, and you started seeing all this stuff in the media. Just awful, boring, it was just awful traumatic images of doctors, you know, suited up in all of this protected where and, again, being in healthcare, I wasn't in a hospital, but I was still outpatient. It was difficult, challenging, and scary. Because we just really didn't know—and there's a lot we still actually don't know.

Due to the overwhelming anxiety and fear that the clinicians were struggling with personally, many of the clinicians discussed resuming and starting their own therapy. Many participants discussed how they were grappling with all the COVID-19 pandemic effects, managing a family, being a mental health clinician, managing their feelings around politics, and racial upheaval. Overwhelmingly, all the participants discussed how being in their own mental health therapy was a fundamental aspect in managing their fear and anxiety. Mental health therapy became a necessity of implementation for handling everything. Lorraine spoke about being grateful she already had a therapist prior to the pandemic:

> I have my own therapist. That was something I was really intentional about; I was seeing her before the pandemic. So, it was just kind of natural obviously to kind of keep that going. But that has been essential for my mental health and grounding.

In addition, some of the therapists also spoke about being a therapist to other therapists. Amanda discussed how a change in her caseload was around providing services to other clinicians. Amanda shared, "all of this made me shift to seeing therapists, as well. So, I have a high caseload of therapists on my caseload. So, providing that space for other therapists' mental health is important."

Self-Care. Every clinician mentioned and stressed self-care, but especially how people got through the world shutting down. There was so much anxiety around not knowing about the COVID-19 virus, but there were many feelings of uncertainty around the world shutting down. The number one way every participant spoke of their experience and reaction to the world shutting down came with positive cognitions around needing to take care of themselves. Sasha K discusses how she was isolated as a single person when the world shut down:

> I had to be very intentional about how I was taking care of myself because, there was a long period of time where I'm trying to take care of myself, within four small walls, I live in a one-bedroom apartment. It's like every day taking my temperature, my emotional, mental, physical, and spiritual temperature. Every day, I had to check in with myself, I

> had to be very intentional about how I was taking care of myself physically, mentally, emotionally, and spiritually.

Physical activity and hobbies became one of the most significant changes the participants implemented in their lives as a way of self-care. Many participants discussed how being quarantined in the house was challenging; thus, getting out and being active was a habit that they either picked up for the first time or increased. Some changes also included physical activity to help with weight loss and mental health self-care. Some participants spoke of how mental health therapy is much more sedentary work. They wanted to be intentional about getting active for their self-care. Some clinicians spoke about creating home gyms; others mentioned getting out and being one with nature. Mr. Stinky explained:

> I like hiking, right. I really am outdoorsy, so I just did a Four-Miler. I run 5Ks, I hike, I cycle, like, I'm active. I am 100% super appreciative that I had those as tools before the pandemic because, right hand to God, I know that's what got me through the pandemic. Still being able to go outside and commune with nature was vital for me. . . . So, I would go to the trails or go get on the kayak. I needed it, that was the saving grace.

Another participant discussed how she used physical activity and hobbies for self-care:

> I started making maps of hiking and I took up the practice of sort-making t-shirts. That's why I made that "I am not okay t-shirt." I went out and bought a Cricut and all that kind of stuff. I had to find healthy, safe ways to manage what I was feeling.

Connection to Family. In addition to self-care and self-love being significant parts of the clinicians' COVID-19 reaction and experience, the theme of needing connections with others, specifically close family and friends was prominent. Many participants spoke of the isolation and stay-at-home orders as an experience of grief and loss. Many participants said they knew what it was like to need that connection with their family and friends in order not to feel isolated and at a complete loss. Sasha K has discussed being single and how it was very important for her:

> I had to be very intentional about staying connected to people. Going into COVID, I was okay with being single. I was single, independent, I felt like I was in a good place, I was okay with being single, when COVID hit, even in the beginning, I was like, "Okay, I got this," like, I don't mind being alone, you know, I enjoy my own company. But as the

> months went on, it became harder and harder because I was single, and I was living by myself.

Despite the problematic nature of being isolated and away from friends and family, for many participants, this became an intentional time for families to grow closer. Maurice spoke about creating a hangout space in his garage for him and his family. They would have family game nights and eat dinner together, which is something before COVID-19 they seemed to need. Participants discussed how COVID-19 created an opportunity for families to spend time together and find creative ways to do it. "Participant" shared:

> We made it a ritual weekend, my family, my mom, and my sister. I went to my mom's house every single Sunday for family dinners. That was our only way to socialize. So, all of us have to work from home. We all, you know, had to be very safe. Wearing mask and, I think, very early on, some of us will probably be putting on gloves, the little plastic gloves, and the way to get out of the house. We look forward to going to Sunday dinner. Every single weekend we went to my mom's and we go, we march ourselves back in and you know kind of hibernate that Sunday night to Saturday, again Sunday, we were out again to my mom's house to the grocery store and back home. That was a piece of self-care. Because it also became a piece of sanity. When I got to see somebody—that did it for me.

Personal Experiences of and Responses to Racial Tension

Anger. Many of the clinicians felt a sense of anger that is still present today. Participants discussed how racism has always been present in the United States, but the highly publicized killings were getting to be too much. Participants shared stories of being frustrated and angry because it felt like there was something going on every day. There was also a sense of anger because it felt like the leadership of the United States and the leadership of communities, such as mayors, governors, and even churches and pastors were not doing enough. Many of the participants discussed this sense of "enough is enough." Maurice shared:

> I think that being a father, certainly a father of a young Black son, there was a powerlessness and an anger that, I don't know, that I had experienced at that level before. Like borderline rage, like really feeling like I'm at the place where someone will catch me on the wrong day, which was, which was and is so outside of my character.

Because of this great sense of anger and frustration, many of the participants discussed how it made them feel like they needed to do something. Many felt that this was not something they could just sit and watch senseless killings on television and social media. It was time for them also to get involved, which was new for some of the participants and not so new for others. Maurice further shared,

> There was some level of activism that I got involved in for the first time. And, so, figuring out what was going on in the city, figuring out how to physically show up, figuring out how to financially show up. I think that it caused me to be plugged in, in a way that I hadn't before. Because I mean, really, I think that so many of us got to where enough is enough, it really is, okay, what do we do now? But I also think it caused me to start kind of looking at things through a different lens.

Professional Experiences and Responses

Table 4.4 summarizes the professional experiences and responses to COVID-19 and to racial tension.

Table 4.4

Professional Experiences and Responses Related to Research Questions

	Themes	Experiences RQ1	Adaptations RQ2	Lessons RQ3
COVID-19	*Transition to Telehealth*	Required to work from home	Working from home/transition to home to a workspace	It would be helpful to know more about the business side of mental health. The business of how to transition things.
	Increase in Services	Increase in caseload size/ Increase in type of work	Seeking treatment modality Structural business changes for growth	Trauma classes should be taught more treatment modalities around.
RACIAL TENSION	*Increase in Demand for Black Clinicians*	Decrease in stigma/ Black clients coming to therapy for the first time	Development of specializations and niche	Academic classes offered on Race-based trauma and how to treat race-based trauma

Professional Experiences of and Responses to COVID-19

Transition to Telehealth. When the world shut down and everyone was required to work from home, every participant stated that was an experience in itself. For some participants prior to COVID-19, they already had a few online clients for various reasons. No participant spoke about having a fully functional online mental health therapy practice, though, prior to COVID-19. So no matter what, it was an experience moving an entire business or practice online. Sasha K expressed her experience with the transition to telehealth:

> Oh, my goodness. I mean, I've never practiced virtual, telephone, or telehealth. I've never practiced teletherapy until COVID. I hit it and I mean, it was literally one week, we're in the office. And the next week, I got to figure out how to see 40 clients, virtually. So that's which was insane. And I have never, pre-COVID, I just did not feel like I could have the same rapport with clients virtually, which is why I've never entertained. Being forced to see clients virtually. It was an adjustment. I am much more comfortable with it now.

Some participants own group practices, so they discussed not only having to transition themselves but also having to transition their business. It was not only the shift of being required to work at home but also the shift of working from home. Participants shared how they had to transition their living space to accommodate working at home on telehealth. Maurice explained what the process was like for him:

> So literally, in 24 hours, I had to shift my practice to an online practice. I'm literally out at 9:00 in the morning buying computers, because my admin didn't have a computer. And obviously, I didn't want her using our personal computer for company stuff. So just trying to make that shift was one of those things where I think it was everyone's experience of COVID is coming at you 90 miles an hour, it is literally uprooting everything that is happening in your life, and you have absolutely no control. And so you're flying by the seat of your pants. And as the practice owner, you have to act as if you have some level of control because they're looking to you. But while I'm at home, I'm freaking out. Because I don't know, if our clients are going to return. I don't know: is this going to be two minutes or two weeks?

Airicka provided her experience with the transition, which was initially very difficult:

> The business transition was challenging because we started cutting back on the number of clients we saw because my husband had COVID. I was still seeing clients until the Governor did the mandated shutdown of everything. And, so, I stopped seeing clients in person and did the whole home office thing—was not easy. The number of clients decreased significantly; I had a caseload averaging about 25 clients a week. And I went down to as low as five clients a week at the beginning of everything because people were used to coming in here and they were used to talking to me. There's a certain energy that comes when you actually are sitting with someone in person versus the whole, telehealth video virtual thing, or over the telephone, so, and then individuals themselves were struggling with their own experiences with the COVID, not to mention the whole George Floyd thing that was going on.

Increase in Services Provided. When the world shut down, everyone was forced to work from home, and mental health transitioned to telehealth, there was a big increase in demand

for services. Many participants talked not only about more clients coming to therapy but doing speaking engagements, sitting on panels, and providing mental health training. The participants stated that the COVID-19 pandemic was hard, but the added racial upheaval was causing many people to seek services. Not only were clients coming to therapy to discuss their anxiety, fear, anger, and frustration, but they were trying to process what was happening with all the over-policing and killings. Many of the clients were angry and needed a place to put it. In addition, companies were requesting mental health professionals to come and talk about social justice and mental health.

Many of the participants discussed how busy 2020 was for them professionally. Phenomenal AF shared her increase in services as related to panel speaking. She said:

> I saw an uptick in folks wanting to come in particularly agencies requesting panel speakers—requesting that I serve as a panel of virtual panelists, whether we were talking about surviving COVID, self-care on the world has shut down now; How do I survive the pandemic? Everything was pandemic and survival and self-care and stress management during that particular time.

Artistine spoke of her growth in terms of having to hire more staff, stating,

> It was like a big period of growth. Because everybody was in the house, and all the stuff about being in the house and mental health. All that stuff was becoming very, very trendy. And everything that was being talked about, so everybody wanted therapy. So, we grew so that we could serve more people. I ended up hiring eight people that year. It was a lot.

Many of the clinicians were able to meet the demands of the increase in services but were not always feeling well prepared. Many clinicians said that the layers of trauma with COVID and racial tension caused them to seek additional training. Participants reported that they had to go seek additional training and/or information to help provide quality care to clients. Some participants reported that they were reading books, articles, watching online videos on trauma, treating race-based trauma, and more. Other participants sought formal training and certifications by attending online courses. Amanda said:

> I had more adults than kids so an increase interest in trauma. So, that was always interesting for me, but I really dug into trainings like EMDR trainings and anything that was about, like you said, collective trauma. Collective trauma and responding to incidents like what we experienced during the pandemic, and all of the racial injustice is, so kind of, figuring out how I could be supportive for corporations and other entities.

Increase in Demand for Black Clinicians. Not only was there an increase in demand for mental health clinicians to provide therapy, activism, and speaking but there was a particular increase in demand for Black mental health clinicians. Maurice shared that for the first time, he has been having Black males reach out for services. Phenomenal AF and "Participant" discussed how Black churches were also reaching out trying to find faith-based, Black clinicians to provide mental health services to their congregation. Because of the racism, racial tension, and mistrust of the systems of the Black community were not only seeking therapy for the first time and requesting to see a Black therapist. Many participants stated that they once were 50 or 60% Black caseloads shifted to almost 80 to 90% Black clientele. Sasha K shared her experience stating,

> I believe that more African Americans sought counseling during the pandemic, which is wonderful. The bad downside is that here they was not ready for that. White mental health professionals and administrators don't like to hear this, but Black people want to see Black people. So, we didn't have enough African American therapist in here to see all the Black people who wanted counseling.

With the increase in demand for Black mental health clinicians and the change of caseload demographics, many of the participants discussed how they began to develop specializations and niches. Phenomenal AF discussed how she basically has a caseload of 95% Black and the other 5% are LGBTQ+. Amanda described how because of her caseload initially being a lot of kids and adolescents she shifted to more adults during the pandemic. Amanda stated it was difficult to provide telehealth services to kids. The increase in demand for Black mental health clinicians forced some of the participants to narrow or niche their clientele. Airicka discussed these changes in her practice:

> So, I don't see men at all. Now, anymore. As a result of COVID changes, I would see men, and my husband was working with men because we're both in the same office. We saw couples together. So, I don't work with men or couples at all anymore. I find that working with women specifically, especially now, because I focus on women's issues that maybe some women and female clinicians may not consider. I am an older woman, let's talk about menopause, you know, how are you dealing with that whole transition? And, you know, how's that impacting your relationship? And what can you do to still feel good about who you are as a woman, even though you're going through that change? It is different now.

Lessons Learned

Many of the strategies in which the participants handled and coped with the stressors of the COVID-19 pandemic and racial tension are also lessons learned for the participants. Even though COVID-19 was overwhelming, racial tension was infuriating, and the increase in demand for Black mental health clinicians was increasing, the participants reported experiences of resilience and positivity. Many of the participants spoke about faith or spirituality in some capacity, as a means of getting through this difficult time.

COVID-19 infection rates and death tolls were being posted on social media and television in ways to keep the public informed. The police shootings were so heavily televised and on social media all the time, many clinicians discussed *turning off all social media and all television*. Amanda told of how she often did not know what was happening until a client came into the session to inform her. Many clinicians shared that activism was new, but not watching any television and getting off social media was also new. Participants felt it was a new change not being connected but very necessary. Artistine said:

> I literally . . . I just ended up deciding, like, I'm not going actually watch the videos anymore. Because, during that time, everything was just being replayed so heavily on TV or online. And so, I had to just kind of get to a point where I was like, "Okay, I'm not going to watch this." The stuff where Breanna Taylor . . . like all that stuff was like happening around the same time. Nope, I cut it all off.

Research Question 3 focused on lessons learned during the intersecting crises. The participants provided lessons learned both personally and professional as related to COVID-19

and racial tension experiences. Table 4.5 shows the key lessons learned in relation to this study's Research Question 3.

Table 4.5

Lessons Learned in Relation to Research Question 3

THEMES	LESSONS LEARNED	INTERSECTING CRISIS
Self-Care	Self-care should be taught and required in academic programs.	COVID-19
Connection to Family	Being connected to family and friends vital to getting through shutdown.	COVID-19
Anxiety & Fear	Clinicians should be in their own therapy (a requirement).	COVID-19
Transition to Telehealth	It would be helpful to know more about the business side of mental health. The business of how to transition structures and systems.	COVID-19
Increase in Services	Trauma classes should be taught more treatment modalities around.	Racial Tension & COVID-19
Own Therapy	Necessary to find a place to process own feelings and emotion	Racial Tension & COVID-19
Increase in Demand of Black Clients	More classes offering training on race-based trauma and how to treat race issues (race-based trauma).	Racial Tension
Anger	Cutting off social media and TV	COVID-19 Racial Tension

Lessons: Personal

Self-Care. All participants discussed the various ways that they were able to get through these intersecting crises. Self-care was not only what the participants stated that they needed for themselves to get through this time, but self-care is very much what participants stated that they strongly recommended that future and current mental health clinicians make a habit of implementing in their life. Mr. Stinky and other participants feel it should be required in colleges and universities. Mr. Stinky stated:

> For all the stuff we teach about working with people, we sure as hell don't talk about how we do self-care for ourselves. That should be a whole lesson. Like, I feel like it gets talked about, but it should be a class that should be a requirement. Or it should be or should be woven into programs in such a way that it's like, oh, wow, we were doing this this entire time. And I didn't realize we were doing it.

Own Therapy. Every participant discussed that resuming or starting their own therapy was a vital way they were able to manage the traumas of COVID and racial tensions. The participants spoke about it as being such a fundamental part of surviving the intersecting crisis that it was inherent that it was a lesson learned. All the participants doing their own therapy needs to be something we do a better job of enforcing for future clinicians. Airicka asserted:

> Get your own counselor. Don't think that just because you've got the training, you can physician, heal thyself. Get your own counselor and engaged in self-care. Because loving your neighbor as yourself, even as a clinician means if you're going to help somebody else, you got to realize that sometimes you need a helping hand to, and to help clinicians understand it's okay to say I'm struggling, and I need some help.

Lessons: Professional

Need for Training in Trauma-Informed Care. When asked about lessons learned and what would be future Black mental health clinicians should know, Artistine said:

> They need to ramp up trauma training. Because I think that is, one of the bigger issues is that clinicians are coming out of school and they have a skill set of like CBT and solution focus, which there's nothing wrong with those but we know that specifically COVID, racial unrest, and other social justice issues that have happened. We know that these things are ongoing. Right. I do think that there needs to be a shift and what that focus is

> you need to make sure that students are, you know, fully aware, and can also conduct themselves in a manner that they're recognizing their power and privilege in working with populations that are impacted by this and specifically marginalized populations.

Need for Training in Race-Based Care. Based on the over-policing, political climate, racism, race-based trauma, the decrease in stigma around getting mental health care for the Black community, and the increase in demand for Black mental health clinicians, many participants discussed needing additional training for future and current clinicians and/or academic courses in race-based classes. "Participant" stated:

> We just need race-based clinical classes. So, for me, the race would be Black, right? African American, Caribbean, Afro Caribbean, like whatever it is, because there are nuances of being Black in America, that are not taught in university. And, so, you do get out here. And you think, you know, as a new college, you know. And you don't (know) necessarily; school is not teaching that. And some of this stuff like for me, my school didn't teach it. I took classes upon classes I studied under Dr. DeGruy about PTSD and racial trauma. I had to because I can't say that I treat Black women and not study Black women, and racial trauma and intersectionality and social and economic areas and concerns that that that really weigh on us. I just think that universities could definitely have a different slate of classes . . . One class that I believe every Black clinician out here, I don't care what degree it is, I believe post-traumatic slave syndrome should be taught to everybody. By the way, racial dynamics and how to deal with being aware, and then how to meet those that have to deal with this day to day.

This was a lesson learned as many participants, even those who identify as African American or Black, still feel they wished they had more training while in school. Race-based treatment models are what some of the clinicians stated they researched as their Black clientele grew.

Need for Knowledge in Business Content and Processes. Many of the participants, especially the private practice owners, discussed wishing they had prior knowledge of business structures and systems. Participants discussed their transition to telehealth and what it was like to provide services online and shift their business structure to online. This transition that COVID-19 presented created one of the biggest lessons that participants discussed. Even some of the non-business owners discussed wanting to know about pay structures, insurance, and policies

that influence business decisions. Many participants suggested that moving forward, clinical programs add more content around the business. Sasha K discussed how she began to do her own will and estate planning because of COVID. Maurice stated,

> I think that for clinicians, in particular, I think some coursework in business is something that even for folks who are not going to go on and own their own business, I just think understanding how to be about your business, clinically. And from that perspective, I got PPP money, and just other things that really [helped] to stay afloat that, other clinicians that I was in touch with were behind the eight ball on.

Mr. Stinky, who does not work in private practice but in the community, also discussed business content being an important lesson and thing that is needed in the future. He said:

> We all get taught how to do the clinical work, but we don't talk about the business of doing the work. And I feel like that also is beneficial to us in the long run. And, thank god I've worked in the field before I actually became a therapist, because if you can't understand . . . You can't just tell me what to do. I feel like when you don't understand the business, you don't understand why people are telling you to move or what you're doing or why you are doing it.

Chapter Summary

African American mental health clinicians providing services to predominantly Black clientele during intersecting crises shared personal and professional experiences. While shared trauma was a backdrop of the study, very few participants expressed the collective experience or mentioned the intersection of both the personal and professional. When questions were asked about the intersecting crises, many participants answered the question very compartmentalized in that they responded to their COVID-19 experience and their racial tension experience.

Personal experiences reflected how the participants personally experienced COVID-19 and how they personally experienced racial tension. Every story was unique based on life factors, but there were similarities in the participants' experiences as clinicians and how they handled the intersecting crises. All the participants had a reaction to COVID-19, being overwhelmed and very anxious because of the level of uncertainty. There tended to be a connection between the

lessons learned and what the participants did to cope personally and/or professionally with getting through this time. Self-care, by far, resonated with the participants and their emphasis is that self-care needs to be more than just something clinicians say but it is essential to practice purposefully. Many participants experienced racial tension as infuriating and articulated their frustration in watching racism continue to go unaddressed. This was impacting the Black mental health clinicians as a clinician experiencing an increase in demand for services and as Black people experiencing race-based trauma.

The participants' responses varied based on certain factors and demographics. For example, did the participant have COVID-19 personally, or did someone in their household contract COVID-19? Or did they lose a family member or friend to COVID-19? These factors appeared to impact the responses of the participants. For example, Maurice spoke vividly about contracting COVID-19 and navigating to keep his family safe, and isolating himself in a house where he really did not feel well. Maurice also spoke about how once he returned back to work; he continued to have extreme exhaustion and would have to take naps frequently and sometime between counseling sessions. Responses vary depending on whether the participant was single, married, had children, and the age of the participant. The research did not inquire about participants' ages but the risk and implications of COVID were higher for older age groups and for those with pre-existing health conditions. Sasha K spoke a lot about how her being single drastically impacted her experiences. And, Airicka, who was likely the oldest participant interviewed, discussed a decrease in clinical hours while other participants discussed having an increase. The decrease was likely due to her having a hard transition to telehealth, not being a person experienced with technology, and being slower to make than transition to telehealth. In addition, her husband stopped seeing clients all together during is stint with COVID-19 and

Airicka cared for him safely during this time. Additionally, with Airicka being an older clinician, her implications on contracting COVID-19 were different from the younger clinicians. It is worth noting that the responses to the interview questions were impacted by various life factors varies factors including age, being married or single, contracting COVID-19, workplace setting, and being more than a clinician.

In this chapter, I reviewed the demographics of the participants, data collection strategies, data analysis process, and the results of the 10 in-depth interviews of Black mental health clinicians. Chapter V, "Discussion and Conclusion," provides interpretations of the findings, implications of the study, limitations, and recommendations.

CHAPTER V: DISCUSSION AND CONCLUSION

On April 20, 2021, Ma'Khia Bryant was fatally shot by police in Columbus, Ohio at about the same time that former police officer Derek Chauvin was found guilty of all charges in the murder of George Floyd in Minneapolis. I remember that day in April 2021 because that is the day that I changed the course of my dissertation research. It was my "enough is enough" moment.

Before the pandemic, the Black community already had a high need for mental health treatment services, but it only worsened with never-ending racial tension and COVID-19 (Rajkumar, 2020). As professionals, many Black mental health clinicians had to navigate the increased and complex demands for services because of these multiple traumas while navigating their personal feelings, trauma, and losses. This study aimed to explore the experiences of Black mental health clinicians as to what did Black mental health clinicians experience personally and professionally. What did they learn that helped clients and themselves? And what insights did they gather from their experiences during intersecting crises that might inform mental health care in Black communities? In this chapter, I discuss the findings in light of the guiding theoretical frameworks of the study, critical race theory and trauma models, the limitations of the study, directions for future research, and implications for policy and practice, before concluding.

Table 5.1 illustrates how the themes relate to the theoretical framework of critical race theory, race-based trauma, and shared trauma. Chapter II, "Review of the Literature," provided a description of these frameworks. Different findings are linked to the different frameworks. This chapter provides an interpretation of the finds as linked to the different frameworks.

Table 5.1

Relationship of Themes to the Theoretical Framework and the Research Questions

Themes	Theoretical Framework	Experiences RQ1	Adaptions RQ2	Lessons RQ3
Self-Care	Trauma Race-based Trauma CRT	Reaction to policies of COVID/ World shut down	Physical Activity / Hobbies	Self-care should be taught and required in academic programs.
Connection to Family	Shared Trauma critical race theory	COVID Isolation/ Stay At Home	Creative Family and Friend Time	Being connected to family and friends is vital to getting through the shutdown.
Anxiety & Fear	Race-Based Trauma critical race theory	Reaction to COVID-19	Own Personal Therapy	Clinicians should be in their own therapy (a requirement).
Transition to Telehealth	Shared Trauma	Required to work from home	Working from home/transition to home to a workspace	Helpful to know more about the business side of mental health. The business of how to transition structures and systems.
Increase in Demand for Services	Shared Trauma	Increase in caseload size/ Increase in type of work	Seeking treatment modality Structural business changes for growth	Trauma classes should be taught more treatment modalities around.
Increase in Demand of Black Clients	Race-based Trauma critical race theory	Decrease in stigma/ Black clients coming to therapy for the first time	Development of Specializations and niche	More classes offering on Race-based trauma and how to treat race issues (race-based trauma).
Anger	Trauma Race-based Trauma critical race theory	Overpublicized killing of Black Community	Cutting off social media and TV	Cutting off social media and TV

Discussion of the Findings

Critical Race Theory

A key theoretical framework used to understand the experiences of Black mental health clinicians was critical race theory (CRT). Because the mental health clinicians I interviewed work in healthcare systems, I selected CRT as a theoretical lens as it explores the effect of racism within institutional settings (Aguirre, 2010). CRT supports not only the exploration of mental healthcare and the healthcare system but access and utilization of services of the Black community. The participants all identified as Black or African American, thus lending a Black voice to scholarship and clinical practice. CRT emphasizes the importance of the experiences of people of color and provides a voice for the race narrative and stories. Kolivoski et al. (2014) stated that "the cornerstone of CRT is the assertion that racism, in the context of the usual way of conducting business in the United States, has become normalized people constantly perpetuated through social structures and institutions" (p. 270). CRT was linked to the study findings in particular ways addressed below.

Connection to Family and Friends

Inequalities in healthcare and health disparities were already prevalent in the Black community, and COVID-19 added to this. COVID-19 affected the Black community at significantly higher rates than other communities. With the highly contagious nature of COVID-19, working from home, quarantining, and social isolation because of the stay-at-home order, the participants found that connection to family and friends was required for mental and emotional wellness. The connection to their village or community was necessary for their health.

Anxiety

COVID-19, in the beginning, came with many unknown factors in the beginning, such as where did it come from, how do you contract the virus, will I contract the virus, if I contract it, will I die, and so much more. Not only was there unknown with COVID-19, but there was constant media coverage daily reporting the number of people contracting the Coronavirus and the number reporting how many died daily, and these numbers were exponential in the Black community. The Black community and Black mental health clinicians were just as nervous, anxious, and scared as the general community. The coronavirus came with a lot of anxiety and fear, especially in the Black community.

Anger

The participants felt anger and frustration about the continued racism against the Black community in the United States. Racism resulting in violence and killing of members of the Black community, such as Trayvon Martin or Ahmaud Arbery. Participants were angry about the continued systematic racism that was not protecting the Black community but killing the Black community. Police murders, such as those of Sandra Bland or Breonna Taylor, were becoming overwhelmingly infuriating. Anger was an emotion consistently experienced by the participants surrounding the racial crisis in the United States.

Self-care

Racial tension was overwhelming, frustrating, and a lot for many participants to hear about and process regularly as mental health clinicians. In addition, to race-based trauma, clinicians experienced anxiety and fear of COVID-19. With the combination of these crises, the participants found that self-care practices were vital to their overall health and wellness. It was vital for the participants to find ways to take care of their own mental, emotional, and physical

health. Many participants discussed how they lost weight, changed eating habits, became more physical, and started or resumed their mental health therapy. Self-care was important to maintain their own health and wellness.

Increase in Demand for Black Clinicians

During this racially charged time, the participants noted that the increase in demand for Black clinicians became important to the Black community because mental health stigma was decreasing, and more of the Black community wanted to see a Black clinician. The participants noted that the clients wanted a space to speak openly about Black issues and feel seen and heard. Lorraine embodied critical race theory as it relates to Black mental health clinicians in the following statement:

> I think we need to be in a community, I think we need to understand what was happening in the community, what the community needs are, and let the community guide what we do. You know, that whole let me come in and help out like, we already know that's not appropriate. But I think, coming from this place of, you know, you talk about, like, I think a lot of there's a movement towards, you know, for in a Black community, having organizations that are Black-led leading the charges and the things that are needing to be done. That is, I think, super important because, generally, now, there may be some exceptions. But those organizations that are Black-led, and that are in the community and base, and really know and understand what's happening, and have the structures to be able to support and kind of bring and collaborate with other providers organizations to move agendas forward. I think that really is essential. So I think, being present, being actively involved, advocacy, policy, those things. And we have to really be looking at policies that are affecting our communities, we have to be looking at politicians who are in our communities, and what they are doing and what they're not doing and holding people accountable because we know some of these people are not doing right.

Black mental health, COVID-19, and racial tension all intersected at the same time in the United States, and individually as well as collectively, these crises are social justice events that demanded attention. The COVID-19 rate for predominantly Black counties in the United States is three times higher than for predominantly White counties, and the death rate is six times higher (Reyes, 2020; Yancy, 2020). Gove et al. (2011) suggested that CRT is the critical investigation needed in advancing social justice movements that are necessary to address

sociopolitical issues. The racial upheaval during this time with the over-policing and killing of the Black community started a social justice movement. “Participant” shared their story of driving to Washington, D.C. to participate in the racial justice march of March 2020. CRT provides a framework for examining racial inequities and power structures that maintain the disparities. The critical race theory movement is a scholarly and activist movement seeking to transform the relationship between race, racism, and power (Delgado & Stefancic, 2023).

One of the five tenets of CRT is that *racial realism* reflects the concept that racism is ordinary and the overall ethos and beliefs of the culture in the majority promote and perpetuate a notion of “color-blindness” and “meritocracy.” The highly publicized killing of members of the Black community by police and the high infection rate of COVID-19 in the Black community shed light on the oppression, systematic racism, social disparities, and health inequalities the Black community was facing. It became harder for anyone to ignore. Many participants discussed the need to turn off all news media and social media because it was too much trauma—racial trauma, vicarious trauma, and shared trauma. Most participants stated, “Enough is enough,” and they had to get involved and could not sit idly by watching the racial injustice endured by the Black community. “Participant” shared they went to the march in Washington D.C. and Maurice spoke of how he became involved with activism work for the first time.

Anxiety, fear, and anger findings were related to psychological experiences that participants reported due to race-based trauma and COVID-19, findings that also link to critical race theory. Many of the participants discussed the increase in services and the increase in demand for Black mental health clinicians. Some participants talked about how their clients did not want to explain certain cultural aspects or wanted to speak freely about the racial trauma they have experienced. Thus, many clients sought Black mental health clinicians. Sasha K stated,

"Black people want to see Black people," referring to from whom the Black community is seeking mental health treatment. But this also holds true for Black mental health professionals to have their own psychological reactions and feel safe and comfortable to share.

Another of the five tenets of CRT is *storytelling and counter-storytelling*. These are based on a powerful, persuasive, and explanatory ability to unlearn beliefs that are commonly believed to be true (Brown, 2008; Crenshaw et al., 1995; Delgado & Stefancic, 2023; Kolivoski et al., 2014). Many participants told of the importance of self-care and connection to their family and friends, which is connected CRT tenets. In a time when everyone was being strongly encouraged to distance themselves and isolate socially, many of the Black mental health clinician participants found that to be counterintuitive to their needs. The participants discussed the need to be connected.

Attending to one's own therapy or being physically active often came up as means of self-care. Connection to others, one's own therapy, physical activity, and self-care are not always activities in which the African American community honors and actively participates. Some of this is explored in the Black mental health section and attributed to some of the Black mental health stigmas in Chapter I. During this intersecting of crises, many participants were a part of the counter-storytelling for themselves and their clients. Counter-storytelling is about magnifying the stories and experiences of underrepresented communities. The Black mental health psychotherapist shared stories of their experience with increasing the caseload or the services they provided as the Black community participated in decreasing stigma and attended therapy. For many Black clients, it was their first time speaking with a mental health clinician.

Racial Trauma and Race-Based Trauma

Hemmings and Evans (2018) described race-based trauma or race-based traumatic stress as the emotional, psychological, and physical pain brought by being discriminated against. Race-based traumatic stress is characterized by emotional and psychological injury, an inability to cope, severe stressors that threaten safety and wellbeing, or extreme racism experienced at the interpersonal or institutional level, causing fear and feelings of helplessness. Participants discussed feeling tired of feeling helpless and knew they needed to get involved. Maurice, "Participant," Lorraine, and other participants discussed how, based on the racial tension and incidents occurring, they became more involved; they joined marches and became activists.

The research on race-based trauma indicates that those who have experienced race-based trauma or racial trauma experience depression, anxiety, anger, fear, panic, and other physiological symptoms associated with PTSD (Hemmings & Evans, 2018). The literature on racial trauma also discusses people who have vicarious trauma by watching negative race-based events, such as police brutality. Racial events do not have to happen directly to the person for them to have a traumatic response. This information is vital to helping understand the shared and vicarious trauma of a Black mental health clinician.

One main theme of racial tension is the feeling of being angry. Many of the clinicians who participated in this study discussed how they felt angry. They discussed not being surprised by racism but upset over the policing and the killings. They also spoke about fear and anxiety for loved ones, especially their children, during these racially tense times. Several participants discussed having to turn off the television and social media during this time because it was too much to take in and be present for their clients. Some described this as "race-based trauma" and vicarious trauma because even though they were not on social media or watching television, their

clients would come into session and tell them what had happened or inform them of the latest killing. Amanda and Artistine shared stories of being very intentional to try not to know but, serving Black clients, knowing was unavoidable.

Shared Trauma

Tosone et al. (2012) stated:

> Shared trauma, also referred to as shared traumatic reality, is defined as the affective, behavioral, cognitive, spiritual, and multi-modal responses that clinicians experience as a result of dual exposure to the same collective trauma as their clients. The use of the term shared trauma, however, does not imply that the clinician's trauma response is identical to that of the client; the same simultaneous event can variably impact clinicians and clients. (p. 233)

Shared trauma explains the intersection of the COVID-19 pandemic and the racial tension during pre-existing Black mental health crisis.

Black mental health clinicians had to transition to telehealth during these intersecting crises. This transition to telehealth also creates a space in which invited clients into clinicians' homes and vice versa. Clinicians had to navigate completing mental health sessions on electronic devices. The transition to telehealth changed the therapeutic boundaries for many Black mental health participants. Transitioning mental health services to telehealth also increased the ability to serve clients. Many of the participants discussed how their services increased once they transitioned to telehealth.

Much of the literature on shared trauma reported that therapeutic boundaries are clearer before a traumatic event (Day et al., 2017). The literature on shared trauma indicates that, in the context of a more widely shared traumatic event, clinicians feel a sense of vulnerability because many clinicians self-disclose more with their clients about how they are doing during the traumatic event. During the intersecting crises of COVID-19 and racial trauma in the United States, clients often asked their therapists how they were handling recovery, loss, etc. The stay-

at-home orders were put in place to keep people safe from the highly contagious virus that was killing many. And, as Black mental health clinicians, the participants were aware that COVID-19 was affecting and killing the Black community at higher rates than non-Black communities. The participants experienced the same fear and anxiety as many of the clients they were treating. There was so much uncertainty during this time. If a clinician had COVID-19, or a family member contracted COVID-19, that information was being shared, inviting clients into the participant's personal life. Tosone et al. (2012) explained, "The symptomatology of shared trauma and compassion fatigue are synonymous, but shared trauma symptoms are attributed to the dual nature of the exposure" (p. 233). The participants in this study discussed how they had anxiety and fear that they had to navigate themselves during this time. The participants discussed that attending their own therapy was vital to getting through this time. They need a place to discuss their worries around COVID-19.

The literature on shared trauma also revealed that mental health needs increase after a shared traumatic event which does not always permit time for personal healing for clinicians (Day et al., 2017). The literature indicates that clinician schedules become a little more packed (Day et al., 2017). Some clinicians in this study discussed how they must do more debriefing and crisis intervention work in group settings or workshops, which moves them out of their usual roles. Phenomenal AF, The Helper, and "Participant," as well as Artistine and Sasha K, specifically shared stories of how service demands increased during this time, whether it was finding and hiring more staff, expanding business operations in their practice, making more money because of the demand, or sitting on education and awareness panels to help others understand the COVID-19 impact on the Black community.

Key strategies and techniques for treatment for clinicians in the shared trauma literature are overwhelming and include self-awareness, self-care, and relational connections. Much of the literature supports that in shared traumas clinicians feel isolated and alone, so family, friends, colleagues, and organizational support become crucial to healing (Dekel & Baum, 2010). Many clinicians in this study indicated feeling a need for connectedness and to find a space to do their own therapeutic work.

The literature suggests that, during shared trauma, clinicians need to spend more time on self-care after sessions; some even find they need to take some clinical time off to heal (Boulanger, 2013). This supports what the clinicians in this study shared regarding how they coped, handled, and managed during this time. The predominant themes from the participants in this study about what they did to get through this time were self-care and connecting with family or friends. Many participants shared stories of the importance of self-care as part of how they got through this time, such as engaging in physical activity and hobbies. The Helper discussed how he had to stay connected to nature, so he hiked often. Staying connected to friends and family was vital for many of the participants. “Participant” shared how she gathered with her mom and sister every weekend because she needed those connections. The family would intentionally isolate and take extra safety precautions during the week in order to safely be together during the weekend. These experiences of Black mental health clinicians reflect and support the literature on how clinicians effectively manage shared trauma.

Limitations

There are several limitations to this study. Ten in-depth interviews were conducted and analyzed, demonstrated saturation, and provided enough data to address the research questions. The sample size aligns with an interpretive phenomenological study. However, a sample size of

10 participants may not be enough for future researchers to address transferability comfortably. It is possible that the perspectives and experiences of some Black clinicians are not represented in this study. Participants had to identify as Black or African American, which provided constraints of transferability to other demographics, such as Caribbean or Haitian. Different demographic categories of people who identify as Black may not necessarily have been born in the United States. However, they were raised in the United States, and these criteria could hamper transferability.

The absence of some types of mental health clinicians in the study sample is also a limitation. There are some psychiatric nurse practitioners and psychiatrists who provide mental health psychotherapy but are not included in this study. Psychiatric nurse practitioners and psychiatrists often solely prescribe medication; however, this study did not include the participation of those psychiatric clinicians who may also provide psychotherapy. This study also did not have any marriage and family therapists participate; these are mental health clinicians who provide solely mental health psychotherapy. Thus, the absence of marriage family therapists in this study means that the study does not capture the perspectives and experiences of all the types of licensed professional Black mental health clinicians.

A predominantly Midwest sample, in terms of geographic location, is also a limitation of this study. The study was conducted by video conference over Zoom and could reach a participant anywhere in the United States; however, no participants were from the western part of the United States.

Another limitation of this study is the concern of multiple traumatic experiences being intertwined for the participants. The interview questions were asked about the three co-occurring, intersecting traumas of the Black mental health crises, heightened racial tensions in the United

States and the COVID-19 pandemic; however, the clinician participants could and did differentiate among these crises in reflecting on their experiences. The participants were able to speak of each event separately, and they were rarely mentioned as intersecting or overlapping crises. Maurice did note that "it is too much to think of them all together." The participants mainly delineated their experiences and adaptations to each of these situations.

The time between the events and the collection of data for this study is another concern. Three years had passed since the COVID-19 pandemic hit the United States and when the interviews for this research took place. Memories were not fresh, and the information likely had unintentionally altered. Several participants said, "It seems so long ago, and yet it wasn't." Some of the participants said, "Let me think back." Participants were able to recall details and visceral responses: some clinicians would start speaking and say things like, "it is coming back to me now." The participants could remember specific police killings by name of the victim; some said there had been "too many" and it was too long ago to remember details. The amount of time elapsing between 2020 and 2023 raises questions about accuracy of participants' memory, recall of the impact of events on their experiences, and the adaptations of that time reflected in the participants' responses. On the other hand, the distance from the events means that many of the clinicians had been able to process them and could look back on them with greater clarity and objectivity to identify the key issues and adaptations for them in retrospect.

Potential biases are always a concern in any kind of research. Researcher bias is among them. In this qualitative interpretive phenomenological study, the researcher is critical to the research process. It is important to remember that the researcher has their level of biases and positionality, which I addressed in previous chapters. I am a Black woman, a licensed clinical social worker, mental health therapist, and an owner of a group practice of Black mental health

clinicians. Understanding my positionality and the content and context of the study, I used extensive memoing to facilitate reflexivity. I took great care to document and memo the procedures used and to separate my own memories, thoughts, and reactions from those of participants to reduce researcher bias.

Directions for Future Research

One recommendation for future research is to sample more and different clinicians to obtain more representation from all geographic locations and more diverse backgrounds. Expanding the geographic areas to have clinicians from the West Coast of the United States could provide additional insights. Also, including in a study the growing the number of clinicians who identify as Black but are non-U.S. born although raised in the United States, would increase the range of voices from different ethnicities and be an area for future research.

This study's participants were licensed mental health professionals but did not include psychiatric nurse practitioners or psychiatrists. Most psychiatric nurse practitioners and psychiatrists prescribe psychotropic medication to manage mental health symptoms; however, some prescribing clinicians also do psychotherapy. An area of future research would add those that prescribe psychotropic medication to the study to examine if there are any differences or similarities. Would adding these clinicians to the study change or impact the findings?

A very heartfelt experience was shared by Mr. Stinky regarding his LGBTQ+ clients who had lived through the AIDS pandemic. He stated that his clients equated the trauma of COVID-19 with the anxiety, fear, social distancing, and isolation of the AIDS pandemic. He said that many of his clients were triggered by how the media was covering the COVID-19 pandemic. Future research could explore COVID-19 from an intersecting identity perspective. How did the Black gay or queer mental health clinician experience these crises? Mental health clinicians

have intersecting identities beyond race, and this research did not explore the clinician's identity, and there is room for future research in this area.

This study examined the intersecting crises of the COVID-19 pandemic, heightened racial tensions in the United States and the Black mental health crisis; however, each could be read individually from the Black mental health clinicians' perspective. COVID-19 research continues to develop as the virus mutates and the world has learned to live with the virus. There could be further research into the Black mental health experience during COVID-19, and even more specifically, the grief and loss as experienced from clinicians' viewpoints. In examining race-based trauma, future research that can explore the political climate of the United States to the research on race-based trauma. Politics also play a role in healthcare and healthcare benefits which impact mental health clinicians. Much of the political climate in the United States has contributed to race-based trauma, but that aspect was not explored in this study and would be an aspect to explore in the future.

Telehealth has allowed for an increase in access to care. Telehealth prevented clients from having to travel to a clinician's office. Telehealth allowed clients to expand their search for the desired mental health clinician. An area for future research is how telehealth has impacted Black mental health access, stigma, and how telehealth has affected Black mental health clinicians. Telehealth has influenced mental health policies and procedures and the utilization and access to care.

Implications for Policy and Practice

One overall implication of this study is that representation matters. The increase in demand for Black mental health clinicians in this study indicates that representation matters. There is a growing demand for Black mental health clinicians, and we need their presence to

meet the needs of the Black community. Recruiting and retaining Black mental health clinicians is necessary to meet the workforce needs to provide mental health services. Having Black mental health clinicians' presence and voice matters in the mental health field to provide racially-informed care. Black mental health clinicians provide insights into race-based trauma as members of marginalized groups, and they provide insights into shared trauma as it intersects with race. To meet the need of the growing demand from the Black community and to influence both policy and practice, more Black mental health professionals are needed. The results of this study have significant implications for both policy and clinical practice.

Implications for Policy

The findings indicate that universities and clinical academic programs must add additional course content around trauma and racially informed care. Many of the participants told of taking training or certification programs on trauma treatment modalities because they did not feel they were adequately prepared for the level of trauma they were treating. Many participants spoke of taking a course in multicultural care or cultural competency that focused on a different population every week. The findings suggest universities and academic clinical programs must offer more comprehensive racially informed care and trauma courses. Some participants stated that there should be courses not only provided in Black mental health but Asian mental health and Latinx mental health and adequate race-based treatment for the community.

The World Health Organization (2001a) suggested that "stigma, discrimination, and neglect prevent care and treatment from reaching people affected with mental illness" (para. 2). Mental health stigma has been a big barrier to access and utilization of care for the Black community. Sickel et al. (2014) stated that there are,

> many literature reviews documenting the relationships between mental health stigma and self-perception, employment and housing, interpersonal relationships, physical and

> mental health and mental health treatment seeking collectively indicate that mental health stigma is part of a complex network of relationships. (p. 208)

The Black mental health crisis, racial tension, and COVID-19 are examples of the complexities that contribute to mental health stigma in the Black community, however, during these intersecting crises we saw mental health stigma decrease and demand for services rise.

During COVID-19 employers and insurance companies covered copays and deductibles for better access to therapy. The systematic change of insurance coverage also contributed to the increase in services and decrease in mental health stigma in the Black community. In addition to insurance coverage changes telehealth allowed for healthcare to provide services via phone and computer devices. This change to telehealth that was forced by COVID-19 opened the doors of healthcare access, and especially mental healthcare access. For mental health care clients had access to clinicians not only in the city or state, but the whole United States. This allowed for people who would not or could not normally access mental health services to have access to treatment and services. More specifically, if there was not a Black mental health clinician in your city or town, you could find one in your state or the United States and receive racially informed care from a Black mental health clinician. These implications suggest that removing healthcare barriers and systematic changes around such factors as insurance and telehealth will decrease stigma and increase access to mental health treatment and services. By removing these barriers to mental health care not only is stigma reduced but access and utilization of services and treatment increase, not only in a marginalized population but for all who are seeking services. Increasing access and utilization of services allows for hurt people to get the help the clinical help they need to heal. Hurt people hurt people, and by healing one person at a time we can heal households and communities. Removing systemic and structural barriers increases access and utilization of services which in turn could prevent more traumatic events from continuing to occur in this

country. We need more healthcare policy changes to continue to aid in the mental health care of the Black community.

The shared trauma and vicarious trauma research indicate that hearing the stories and experiences of their clients impacts clinicians. Day et al. (2017) stated:

> Vicarious traumatization is a process of change, leading to distorted perceptions that are due to empathic engagement with clients who have survived trauma. These distorted perceptions can have a detrimental impact on mental health providers' professional and personal lives as they hear the explicit details of their clients' traumatic realities. (p. 270)

Countertransference, burnout, and compassion fatigue are terms that are also commonly associated with research around shared trauma and vicarious trauma. The goal is not to cause additional trauma to the clinician and not contribute to anything that will cause clinicians, especially Black clinicians, to leave the field. It is essential that educational institutions and clinical training programs facilitate processes that help Black mental health clinicians feel supported. The support starts with educational institutions providing adequate training on racially informed care and trauma informed care to assist Black mental health professionals feel prepared for work in the Black community. Academic institutions would also benefit from adding shared trauma to the types of traumas about which clinicians are taught. This will aid in decreasing burnout among clinicians. The world continues to report increased violence and mass shootings, and clinicians would benefit from more crisis and trauma training. The clinicians are also members of their communities and would benefit from understanding and treating trauma from a shared trauma perspective.

There is a growing demand for Black mental health clinicians; within the existing underrepresentation of Black clinicians in the mental health field, we already have a workforce shortage issue. The lack of trauma-informed and racially-informed care trained Black clinicians will only exacerbate the shortage of clinicians to provide quality mental health care to Black

clients. Preventing burnout and compassion fatigue is vital to mental health clinicians, but especially among Black mental health clinicians experiencing shared trauma and racial trauma. Burnout, compassion fatigue, and vicarious trauma lead to leaving the mental health care field, which contributes to workforce strain issues. More Black mental health clinicians need to be added to the field to support the growing demand, and we cannot afford to lose any. Making a concerted effort to recruit, train, and retain Black mental health clinicians, as well as providing role models for youth to see this as a potential career path, are needed.

Implications for Practice

Prior research on mental health clinicians' experiences with various forms of trauma included little attention to the experiences of Black mental health clinicians. The current study's findings indicate that race is a factor, but not the only component, in their experiences of trauma shared with their clients. This study contributes to existing research by adding Black narratives regarding Black mental health conditions. The Black mental health clinicians' voice provides counter-narratives to those in the existing literature and offers different perspectives to future Black clinicians. Representation matters and having the Black mental health clinician in the experiences and lessons in the literature helps other clinicians feel represented and seen in scholarship. This study may validate other Black mental health clinicians' experiences with race-based trauma, the COVID-19 pandemic, and Black mental health. It is essential to bring the Black mental health clinician experiences to the forefront as more of the Black community seeks mental health services.

The findings suggest that not only is there an increase in demand, but specifically an increase in demand for Black mental health psychotherapists. The implication of critical race theory and the increase in demand of Black mental health clinicians by adding the narratives,

experiences, and lessons for Black mental health clinicians may help with recruitment of more Black clinicians. Attracting Black clinicians to the field and to the academics of mental health are clearly needed.

Self-care became vital to all the participants in surviving the intersection of these crises. Many participants reported that self-care was not something other than something focused on in their academic program. The findings help in understanding how vital it is for clinicians to participate in self-care. Taking care of self is an essential part of being a clinician. It is hard to do trauma work without the tools and techniques to care for oneself. The participants often made commented, in essence, “You have to have somewhere to put it.” All the stories and trauma-filled sessions can be heavy, and one must have a place as a clinician to put that, so it does not weigh them down or burn them out. There is literature that discusses burnout and compassion fatigue of mental health clinicians. Self-care must become something more than mental health clinicians teach their clients; it has to become a vital part of their regular practice as mental health clinicians. Self-care is important in preventing burnout and important to retaining mental health clinicians.

Academic programs and supervisors need more emphasis on the importance of the implementation of self-care. Some cultures are not taught to prioritize self-care, thus academic institutions and clinical supervisors need to implement and mandate self-care action plans in the training of mental health professionals. Providing racially-informed supervision and academic training requires recognizing the barriers and stigma some cultures have surrounding self-care and helping clinicians overcome those barriers. Clinicians need tangible and practical techniques that they learn to implement for themselves as soon as their clinical training and career begin.

We must incorporate self-care into our academic curriculum to train mental health clinicians to integrate it into their lives to help retain and support mental health clinicians.

Conclusion

This study explored the experiences of African American mental health professionals navigating the intersecting crises of COVID-19, racial tensions, and the Black mental health crisis. I asked them about both personal and professional experiences as they dealt with the devastation of the COVID-19 pandemic and the shared race-based trauma that affected their own and their clients' mental health. I also explored with the clinicians in this study what they learned from navigating this time of shared trauma that might help improve mental health practices for clinicians and clients and better serve Black communities.

This study of these intersecting crises is a phenomenon for Black mental health clinicians. This study is about experiences and lessons learned from the perspective of a Black mental health therapist. Adding the voices of Black mental health clinicians to the story was important because we are all more than therapists. Many participants are not only in the human services business but also partners, parents, and leaders in their communities. This study was intended to explore how the whole person who serves as a mental health therapist, part of a marginalized group, experienced this phenomenon of these three crises intersecting.

Despite anger towards the social injustices and systematic racism and the fear and anxiety caused by COVID-19, the participants showed resiliency. The narratives and experiences of the participants showed an incredible amount of resilience during these intersecting crises. The adversity and challenges were present in the participants' narratives. Still, the resilience shined as the participants thrived during a preexisting Black mental health crisis, intense racial tension,

and the COVID-19 pandemic. The participants shared the importance of not only showing up and being present for the clients but also showing up and taking care of oneself in the process.

The themes *increase in demand for services*, *connection to others*, and *self-care* were themes that were salient among all the participants. It is important for future and current Black mental health clinicians to have good training on trauma in its various forms, the training is necessary to handle the increase in demands of treatment and services. It also important that Black mental health clinicians have a support system. They need to have their community or village to handle some of the challenges that come personally and professionally with this role. And lastly, and likely most importantly, Black mental health clinicians need to engage in regular practice of self-care. Self-care from a holistic wellness perspective includes such activities as staying connected with family and friends, engaging in physical activity and hobbies, taking care of their physical health, and attending therapy for themselves.

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Appendix A: Interview Guide

Date / Time: _____

Researcher Script: Hi, my name is Chante Meadows, mental health therapist, and owner of a group practice located in Columbus, Ohio. Thank you for agreeing to participate in an interview for my doctoral research study on Black Mental Health Therapist Experiences and lessons during the mental health crisis, COVID-19, and racial events that occurred in the US. This interview should take about 60 to 90 minutes. If at any time during this interview, you want to stop or if it becomes too difficult, please let me know. I am going to start by asking you some general questions such as name, licensure, where you practice, and things of that nature. Are you ready to begin?

First, to maintain your confidentiality as a participant in this research study, I would like to ask you to choose a fictitious name. Please choose something you think suits you. What name would you like me to use in referring to you in the study?

Interviewee Pseudonym _____

Great, thank you. Next, a bit of background information:

Geographical Location

- What state were you living in between 2019 and 2021?
- And where–in what state–did you provide mental health services during 2019 to 2021?

Licensure / Mental health Discipline

- Social Work
- Professional Counselor
- Marriage and Family Therapist
- Psychology
- Other

Setting providing mental health services?

- Private Practice
- College or University
- Community Agency
- Private Agency

Altogether, how many years have you been practicing as a *licensed* mental health clinician?

_____

Narrative Interview Questions:

- Tell me about your experiences (personally and professionally) after COVID-19 hit.
    - Possible follow up: How did you handle the demands on you?
- How did racial tension and police shootings impact things for you?
    - Possible follow up: What did you see in terms of clients' reactions—and how was that for you, going through those experiences at the same time?
- What would you say has remained the same or has changed for you in your practice since the start of COVID-19 and the increase in racial tension?
    - Possible follow up: What changes have you made that help you? Your clients?
- What would you say you have learned that would help future mental health?
    - Possible follow up: Any lessons from all of this for how we can better service Black communities?

NOTES:

Appendix B: Recruitment Announcement

BLACK THERAPISTS NEEDED FOR RESEARCH STUDY

Do you want to share your experiences as a Black Therapist?

I'm conducting a dissertation research study to explore the experiences of Black clinicians in delivering mental health care during the COVID-19 pandemic with its accompanying mental health crises and the documented and highly-publicized emergence of racial crises tied to extrajudicial violence and over-policing.

Participating in the study involves taking part in a confidential 60 to 75-minute one-to-one interview with me via Zoom.

Particularly, I am seeking to interview:

- clinicians who identify as Black/African-American,
- who are licensed mental health therapists/counselors (social worker, counselor, psychologist, marriage & family therapist), and
- who, prior to COVID-19, serve 50% or more Black clients.

If you think you might be willing to contribute to this research, please contact Chanté Meadows, Ph.D.c. by:

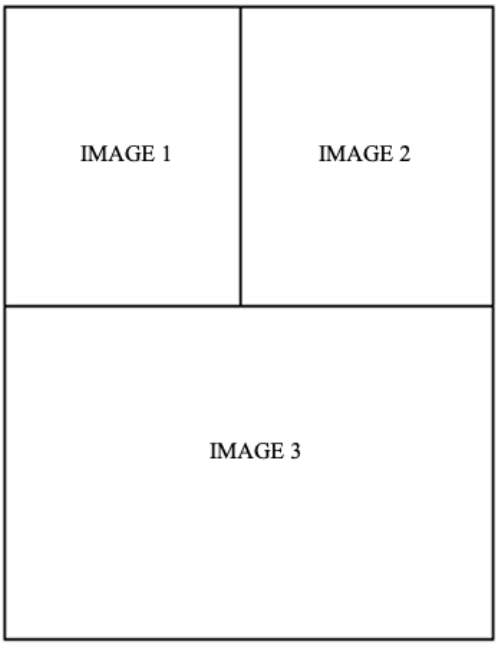
sending a Direct Message to Chante Meadows or

putting your email in the comment section below, or

emailing [Author's email]

This study was reviewed by the Antioch University Institutional Review Board for the protection of Human Subjects (Dr. Lisa Kreeger, Chair, [EMAIL]).

Appendix C: Recruitment Flyer



PARTICIPANTS NEEDED

Do you want to share your experience as a Black Therapist?

Purpose: I'm conducting a dissertation research study to explore the experiences of Black clinicians in delivering mental health care during the COVID-19 pandemic with its accompanying mental health crises and the documented and highly publicized emergence of racial crises tied to extrajudicial violence and over-policing.

Study Procedures: Participating in the study means taking part in a confidential 60 to 75 minutes one-to-one interview with me via Zoom

Who Can Participate:

- ❖Clinicians who identify as Black / African American
- ❖Licensed mental health therapists / counselors (*social worker, counselor, psychologist, marriage & family therapists)*
- ❖Prior to COVID-19, served 50% or more Black clients.

If you think you might be willing to contribute to this research, please contact Chanté Meadows, PhD c. by:

- Sending a Direst Message to Chanté Meadows, or
- Putting your email in the comment section below, or
- emailing [email address]

This study was approved by the Antioch University Independent Review Board for the protection of Human Subjects (Dr. Lisa Kreeger, Chair [email])