Culturally Responsive Therapy
An Integrative Approach

10

I first began hearing the term *evidence-based practice* (EBP) when I was working part-time at a rural community mental health center, with seven 50-minute client sessions scheduled every day. I wrote my progress notes, reports, and made phone calls to obtain collateral information during the 10 minutes in between sessions and the half hour on either end of the workday. At the time, increasingly more approaches were being designated as EBP, and I remember thinking, "My clients would never go for a highly structured, manual-based therapy, and even if they did, how on earth can a therapist with a full caseload be expected to know all of the validated EBPs to pick the one that fits their particular client?"

At the time, I was mistakenly assuming that only empirically supported treatments (ESTs) supported by randomized controlled studies (RCTs) and administered according to a manual could be considered EBPs. RCTs and ESTs are the

http://dx.doi.org/10.1037/14801-010
Addressing Cultural Complexities in Practice: Assessment, Diagnosis, and Therapy, Third Edition, by P. A. Hays

standard for most researchers because they are designed to be replicated, and replication is strong evidence of their effectiveness (Laska, Gurman, & Wampold, 2014). Like other sources of evidence (e.g., case studies, expert opinion, cohort studies, case reports), RCTs and ESTs also have weaknesses, the biggest one being poor generalizability to clinical populations that are much more diverse and complex than most research populations.

Fortunately, since my initial introduction to EBPs, the American Psychological Association (APA) has officially defined EBP in a way that provides a useful road map for practitioners. EBP in psychology is now considered "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273). This definition allows for the inclusion of both RCTs and ESTs, if they are available, and acknowledges that even if they *are* available, they still need to be tailored to the particular client's individual preferences, characteristics, and culture. Emphasizing the importance of this tailoring process, the APA Presidential Task Force further noted that whereas "ESTs start with a treatment and ask whether it works for a certain disorder or problem under specific circumstances, . . . EBPP [evidence-based practice in psychology] starts with the patient and asks what research evidence (including relevant results from RCTs) will assist the psychologist in achieving the best outcome" (as cited in Laska et al., 2014, p. 2).

In general, research shows that cultural adaptations of psychotherapy have been effective with people of ethnic minority cultures. In a meta-analysis of 65 experimental and quasi-experimental studies, adapted therapies were moderately more effective than nonadapted therapies, and approaches with the greater number of adaptations were more effective than those with fewer adaptations. In addition, cultural adaptations specific to a particular ethnic group were several times more effective than general adaptations (T. B. Smith, Domenech Rodríguez, & Bernal, 2011). Another meta-analysis of 21 studies similarly found culturally adapted psychotherapy to be more effective than nonadapted psychotherapy (Benish, Quintana, & Wampold, 2011). And although a third meta-analysis did not find any difference between adapted and nonadapted therapies, sometimes adaptations did provide extra value and other times they did not (Huey, Tilley, Jones, & Smith, 2014).

Taken together, these studies suggest that adaptations are indeed helpful, with the most culturally responsive, ideal approach being therapies developed specifically for (and with) particular groups (e.g., see Bernal & Domenech Rodríguez, 2012). Because the majority of therapists are likely to work with clients of diverse cultures, one place to start

in learning about such adaptations involves widening one's repertoire of cultural adaptations that can be used with diverse people in diverse settings.

This chapter focuses on an integrative approach that is grounded in the home theory of cognitive behavior therapy (CBT). Other major psychotherapies also have addressed cultural considerations, including psychodynamic (Berzoff, Flanagan, & Hertz, 2011; Chin, 1994; Tummala-Narra, 2016), interpersonal (Budge, 2013), self-psychology (Hertzberg, 1990), existential (Vontress, Johnson, & Epp, 1999), family systems (Boyd-Franklin, 2003; McGoldrick, Giordano, & Garcia-Preto, 2005), and feminist therapies (Brown & Ballou, 1992; Comas-Díaz & Greene, 1994). CBT, however, is one of the most widely practiced approaches. A survey of more than 2,000 counselors, social workers, and psychologists found that 69% reported using CBT ("The Top 10," 2007), as did 89% of a poll of 470 practicing psychologists in the United States (Meyers, 2006). CBT is also practiced around the world; approximately 40 countries have national CBT associations (http://www.the-iacp.com), and CBT is the focus of large international conventions and organizations, such as the World Congress of Behavioural and Cognitive Therapies, and the International Association of Cognitive Psychotherapy. For this reason and others described in the following section, I will focus on an integrative approach I call *culturally responsive* CBT.

The Case for an Integrative Approach

Although the terms *eclectic* and *integrative* often are used interchangeably, researchers make a distinction. An *eclectic* approach is one that does not emphasize any single orientation over another, whereas an *integrative* approach allows "the process of therapy to be guided by a single overarching theoretical framework, while incorporating and adapting interventions from outside the 'home' intervention" (Petrik, Kazantzis, & Hofmann, 2013, p. 392). Currently, the 24-plus models of psychotherapy integration all are based in a home therapy of one particular orientation (Stricker, as cited in Wolfe, 2014).

Although a fair amount of controversy exists over whether the use of a single theoretical orientation versus an integrative approach is most effective (e.g., for opposing views, see Dimaggio & Lysaker, 2014, and Govrin, 2014), the APA Resolution on Psychotherapy Effectiveness states that "comparisons of different forms of psychotherapy most often result in relatively nonsignificant differences, and contextual

and relationship factors often mediate or moderate outcomes" (APA, 2013, p. 103). Research investigating common factors across different forms of psychotherapy confirms this conclusion. Specifically, studies show that approximately 40% of the variance in treatment outcome is due to factors outside the therapy, that is, to clients themselves or external influences. The next largest contributor is the therapeutic relationship, which accounts for 30% of the variance, and another 15% is due to client expectations. Only about 15% of this variance is due to the therapist's theoretical orientation and use of treatment-specific techniques (Norcross & Lambert, 2011).

Whatever theoretical orientation a therapist holds, the relationship is the most important factor within the therapist's direct influence. That is, a therapist may have a high level of expertise in a particular theoretical orientation, and the client may have high expectations and no interfering external influences, but if the therapist is unable to develop a good working relationship with the client, success is unlikely.

At the same time, all of these factors work synergistically to produce a successful outcome. Expertise in a particular theory tends to increase the self-confidence of the therapist (in part because theories provide guidelines for what to do, especially when you are stuck), and the therapist's self-confidence is subtly communicated to the client, which contributes to the client's confidence and expectations, which in turn contribute positively to the relationship.

Although I initially was trained almost exclusively in behavioral and cognitive behavioral approaches, I have found the integrative approach to be much more realistic for work with diverse people. CBT is my home theory because it provides me with an overarching theoretical conceptualization that is flexible enough to include ideas and approaches from other evidence-based practices, even those of psychodynamic therapy, which often is seen as an opposite approach.

To use this example of CBT and psychodynamic therapy, I consider them complementary. (Interestingly, CBT founders Aaron Beck and Albert Ellis originally were trained psychoanalytically.) Although CBT offers a wider array of strategies and tools for tailoring therapy to the particular client, and more measurable procedures for assessing progress, psychodynamic theories offer a richer set of ideas for exploring personal identity and relationship dynamics. In addition, I cannot imagine trying to work with a client without understanding their family of origin and childhood experiences—a domain that is often thought of as the realm of psychodynamic therapy. Along these lines, results of a recent survey suggested that cognitive behavioral therapists pay greater attention to the client's cultural context—for example, when exploring the environmental influences on dysfunctional thought patterns—but psychodynamic therapists are more likely to consider racial dynamics through an analysis of transference and countertransference (Tummala-Narra, Singer, Li, Esposito, & Ash, 2012).

Cognitive Behavior Therapy

People often assume that CBT is simply about teaching positive thinking, but it is more complex than this. Cognitive behavioral assessment focuses on the evaluation of five specific client-related domains—thoughts, emotions, behaviors, physical symptoms, and environment—and the interactions among these domains (Greenberger & Padesky, 1995). The therapeutic process of CBT involves problem solving, including making practical changes in the client's physical and social environments, increasing coping skills, making behavioral changes, building social support, and fostering cognitive restructuring. The goal of cognitive restructuring is not simply positive thinking, but rather more *realistic, helpful* thinking that enables clients to manage overwhelming emotions, replace self-defeating behaviors with helpful behaviors, and minimize or eliminate distressing physical symptoms.

Multicultural therapy (MCT) is well suited for integration with CBT in a number of ways (Hays, 2009). Although I use MCT as shorthand for the MCT literature, in practice, I see MCT as more of an orientation than a therapy per se. First, both emphasize the empowerment of clients—CBT through specific skill building and MCT through a focus on the client's cultural identity and strengths. Both acknowledge the need to adapt therapy to the particular needs and strengths of each client (versus one treatment modality for all). Both emphasize the role of the environment in shaping emotions, behaviors, thoughts, and physical symptoms (CBT from a behavioral perspective, and MCT from a cultural one). Both encourage the incorporation of a client's naturally occurring strengths and supports into therapy. And CBT focuses on conscious processes that can be easily articulated and assessed, which is helpful when language and cultural differences exist.

Note that CBT's usefulness with people of minority cultures and groups may be limited by the following factors: (a) an assumption of value neutrality when, in fact, values permeate all psychotherapies; (b) an individualistic orientation that places greater value and focus on the individual when this is not the client's orientation; and (c) a focus on the present to the neglect of the past. These limitations, however, can be minimized by a careful consideration and systematic integration of cultural influences.

Culturally Responsive CBT

Culturally responsive CBT (CR-CBT) builds on the steps outlined in previous chapters, specifically, the therapist's personal work; consideration of the client's culture; culturally responsive behaviors that establish a

warm, respectful relationship; and a systemic perspective. In addition, some steps specific to CBT can be taken to make the therapy more culturally responsive. The following examples are not comprehensive because what makes CBT culturally responsive will vary depending on the particular client and their cultural identity and context. But they will give you some examples to build upon.

CR-CBT CASE CONCEPTUALIZATION

CR-CBT, like CBT case conceptualization, can be thought of as a template that helps therapists understand their clients as deeply and fully as possible, including how their clients came to develop the problems that they hope to address in treatment; what maintains these problems; and the typical cognitive, behavioral, emotional, and physical reactions their patients have to life events. In collaboration with the client, this conceptualization becomes richer and more intricate over time, and it provides guidance at key decision points regarding the best course of action (Wenzel, 2013).

Toward the end of the initial assessment (as described in Chapter 7 of this volume), I provide an explanatory summary of the information the client has shared. The first part of this summary (provided directly to the client) includes my conceptualization of the client's situation based on three main factors: (a) the client's vulnerability to stress or the presenting problem based on childhood experiences, (b) stressors, and (c) strengths or supports. At this point, I also explain and collaboratively discuss the diagnosis and recommendations with the client. Once I've done this, I then move into an explanation of what the client can expect if they return for counseling sessions. This explanation represents, in lay language, how I conceptualize CBT. Because the phrase *cognitive behavior therapy* sounds so academic, and because it includes only the words *cognitive* and *behavior* but omits other words important to many clients, such as spiritual, family, and cultural, I rarely use the phrase in my rural practice with Native and non-Native people. I conceptualize and describe the therapy to clients as follows:

> I use an approach that divides problems and their solutions into two main categories. The first category are those that are more external to you, where the stress is caused by a person or situation outside of you, and/or there is some action you can take that will make the problem better or decrease the stress for you. These actions may involve changing something in your environment, or learning some information or a new skill that helps to decrease the stress you are experiencing, or learning new communication skills like assertiveness or conflict resolution skills. It might also involve increasing your social support or increasing your self-care. And with self-care, I'm not talking just about physical self-care like exercising and eating well, but also emotional [and spiritual—

if valued by the client] self-care. Anyway, with these kinds of problems, I help people figure out what can be done, come up with a plan, and then carry it out.

The second category of problems consists of those things that you can't change or for some reason decide not to. For example, if you have a chronic illness and you've done everything you can practically and medically to minimize your difficulties, there is still a lot of stress related to hospital visits, medication changes, the physical pain, and so on. Or you may have a supervisor who is very unfair, but you only have 9 months until you retire, so you decide you cannot quit. Even though these kinds of problems can't be changed directly, there is something you can do to feel better, and that is, change the way you're thinking about the situation. One thing we know in this field is that the way we think affects how we feel. So with this group of problems, I help people figure out what thoughts, images, or beliefs they may be repeating or holding onto that increase their feelings of stress, and help change them to more helpful, realistic ways of thinking. This doesn't mean just smearing happy talk over a bad situation, rather, it's about realistic self-talk, because whenever any of us is stressed, our thoughts skew toward the negative and we just don't see the positive. So this is about recognizing there's a problem, but also realistically recognizing that there are positive possibilities too. (For examples of this explanation in practice with different clients, see DVDs by Hays, 2012, 2015.)

CLARIFYING EXTERNAL VERSUS INTERNAL SOURCES OF STRESS

Think about this: Think of a problem in your life that brings you unwanted feelings, such as anger, anxiety, or hopelessness. What part, if any, of this problem is due to factors external to you or outside your control (e.g., someone else's behavior, a medical problem, an unreasonable workload)? What part, if any, does your *thinking* contribute to these unwanted feelings?

As my previous explanation suggests, a key step in CR-CBT involves defining which part of the client's stress is externally generated by the environment, including social and cultural influences as well as physical barriers, and which part is internally generated by the client's thoughts, beliefs, and images. These sources of stress often overlap, for example, when a person's self-defeating cognitions are creating distress that prevents them from taking action that would eliminate an environmental stressor. But whether or not stressors overlap, this distinction is helpful because it provides guidance regarding the most effective areas of intervention

If an emotional, physical, or behavioral stress response is primarily generated by the client's thinking, then cognitive interventions are often indicated. But if it's a genuinely stress-inducing environment, then action aimed at changing the environment (or the person's interactions

with it) is usually the place for attention. This latter point is especially important from a multicultural perspective because it calls attention to oppressive environmental influences. And recognition of oppressive environmental influences helps to prevent what I call *premature cognitive restructuring.*

Premature cognitive restructuring involves moving into thought-change strategies inappropriately or too quickly, that is, before exploring environmental influences that may be realistically causing distress. Trying to change a client's beliefs about an oppressive situation without first (or simultaneously) addressing the situation may be interpreted as blaming the individual, when the real problem is an abusive relationship or a racist, sexist, heterosexist, or disability-hostile environment.

Consider the case of an African American client who, in an initial assessment, tells a White therapist about an experience of racism from a coworker. If the therapist responds with questions aimed at eliciting alternative explanations for the coworker's behavior (e.g., "Could it be that your coworker meant something else by that statement? Are there any other explanations for your coworker's behavior?"), the client is likely to interpret the therapist's questioning as racist or naïve.

In such situations, Kelly (2006) advised always beginning with the validation of a client's report of experiences of racism. Although such an approach may seem obvious, remember that CBT emphasizes the exploration and challenging of beliefs that may be contributing to a person's distress. Validating a client's experience does not mean that therapists will never explore or question clients' reports of oppressive experiences; however, this exploration and challenging should not be attempted before a very strong trust is present. Once the client feels believed and validated, the therapist may then consider assessing the relevance of an incident to the client's presenting problem. Similarly, when working with people who have disabilities, therapists need to be careful not to minimize the impact of physical barriers and negative social attitudes, especially if the therapist does not have a disability (Mona, Romesser-Scehnet, Cameron, & Cardenas, 2006).

Also with transgender clients, therapists need to recognize the objective aspects of the dominant culture that create real obstacles, including housing discrimination, ostracism by family members, workplace discrimination, loss of custody of children, difficulty obtaining legal recognition of marriage, severe ridicule, and transgender identity-related violence (APA Presidential Task Force on Evidence-Based Practice, 2006; Erickson-Schroth, 2014). Attention later may be given to the ways in which these experiences shape the cognitions that work against a person's long-range goals (e.g., "I can't get a good job because I am transgender" or "They will never be able to accept the real me"), but

moving too quickly into changing such beliefs implies that the primary problem is the client's thinking rather than the dominant culture (Maguen, Shipherd, & Harris, 2005, pp. 486–487).

In their work with transgender clients, Austin and Craig (2015) illustrated the relationship between societal oppression and internalized beliefs, with a *transdiscrimination* inverted pyramid worksheet to illustrate the effects of discrimination on an individual's mental health. The top level of the inverted pyramid represents oppressive cultural beliefs and messages in the dominant culture. The second level down represents the institutional level of discrimination, including laws, government, businesses, media, religious, and other big institutions. The third level down is the interpersonal level, which represents how family, friends, and people in one's immediate environment treat the client and react to their identity. At the bottom tip of the inverted pyramid is the individual level, which consists of how individuals think and feel about themselves. This conceptualization helps clients to "move away from a view of themselves as 'disordered' or 'pathological' toward an affirming view of themselves as 'doing their best to cope with complex and often hostile environmental circumstances'" (Austin & Craig, 2015, p. 24).

In addition to exploring supportive as well as oppressive environmental influences related to culture, CR-CBT involves a consideration of cultural influences on the cognitive, emotional, behavioral, and physiological components of the client's problem. Culture clearly shapes cognitions in the form of values, beliefs, a person's interpretation of events, definitions of rationality, and views of what is adaptive versus maladaptive behavior (Dowd, 2003). Culture also affects the expression, reporting, and experience of emotions; for instance, studies show that people of Latin American identities tend to report high levels of positive affect, whereas East Asians tend not to (Diener, Oishi, & Lucas, 2003; Okazaki & Tanaka-Matsumi, 2006). And culture certainly accounts for differences in behavior, including the expression of physical and mental symptoms and illness. This includes not only the Cultural Concepts of Distress listed in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013), but all disorders (e.g., consider the way that European American cultural beliefs about women's bodies contribute to anorexia).

Developing a Treatment Plan

Once it's clear what parts of a person's stress are being caused by external factors versus internal (i.e., cognitive), it is easier to develop a treatment plan. As I'm developing the plan with a client, and considering

whether and when to focus on environmental, behavioral, or cognitive change, I usually ask the client for their opinion and go with their preference. With clients who prefer a more authoritative approach, Pan, Huey, and Hernandez (2011) noted that in their work with some Asian American clients, it works better for the therapist to say something like, "Let's have you try this."

ACTION INTERVENTIONS

I use the term *action interventions* to include strategies aimed at changing the environment (which shapes behavior) and strategies aimed at changing behavior (which interacts with the environment). Action interventions involve *physically* doing something (i.e., taking action), whereas *thought-change* (cognitive) *interventions* involve *mentally* doing something (i.e., changing the way one thinks about a situation).

For stress that primarily is generated by environmental factors or by one's behavior in interaction with the environment, interventions often will involve taking some sort of action, whether it is changing the environment or changing a behavior. I use the acronym CLASS to summarize these action interventions (see Exhibit 10.1). You may notice that these categories correspond to the types of change I included in my explanation of CBT to clients. Although some domains overlap, this is not a problem because the point of the acronym is simply to help generate and remember positive possibilities for environmental and behavioral change.

When taking action aimed at changing the environment or behavior, the adaptations that make an action culturally responsive will depend on the client's particular identity and context. When making such adaptations, it's important to look not only for oppressive cultural influences but also for the positive, healthy environmental influences within minority cultures that can be reinforced.

EXHIBIT 10.1

CLASS Actions That Counter Stress and Build Well-Being

- **C**reate a healthy environment;
- **L**earn a new skill or information;
- **A**ssertiveness, conflict resolution, and other communication skills;
- **S**ocial engagement and support; and
- **S**elf-care activities

Note. Adapted from *Creating Well-Being: Four Steps to a Happier, Healthier Life* (p. 125), by P. A. Hays, 2014, Washington, DC: American Psychological Association. Copyright 2014 by the American Psychological Association.

For example, when an intervention focuses on *creating a healthy environment*, an Asian Buddhist client may choose to set up an altar in her home to honor ancestors and provide a space for quiet contemplation. Or a person who recently has immigrated may play their culture's music, display culture-specific artwork, or find a grocery store that sells their preferred foods. (More ideas on culturally supportive environments can be found in the Environmental Supports list in Chapter 7 of this volume.) When a client is experiencing abuse or oppression in their environment, a culturally responsive approach may involve helping the client leave the situation, for example, in the case of a woman being abused by a partner. In the case of an individual being harassed or oppressed in a hostile workplace, creating a healthy environment may involve talking to a supervisor, filing a grievance, or taking some similar type of action.

When *learning a new skill*, consideration of culture with Orthodox Jewish clients, for example, would involve ensuring that when the client practices the new skill, they are not seen by neighbors who might infer that they are in therapy (even the suggestion of mental illness in one's family can affect a person's marriage prospects; Paradis, Cukor, & Friedman, 2006). If a client is learning a new skill to interact more effectively with dominant-culture members in a workplace, a culturally responsive approach makes it clear that dominant-culture social skills are not superior to the minority-culture skills. To emphasize this point in their work with American Indian clients, LaFromboise and Rowe (1983) explained the usefulness of *bicultural competence* (i.e., having skills in both cultures). They also chose situations targeted for change by consulting with tribal leaders, groups, and agencies, and they designed social skills trainings that paralleled American Indian traditions of role modeling, apprenticeship training, and group consensus.

When teaching *assertiveness, conflict resolution, and other communication skills*, a culturally responsive approach involves recognition of cultural norms regarding communication. For example, with Latino people, particular communication protocols are important for ensuring smooth, nonconfrontational interactions (*sympatía*) between people of different status (Comas-Díaz & Duncan, 1985). With regard to child–parent relationships, *respeto* (respect) is another strong value that, in traditionally oriented families, includes the concept of obedience to authority. In teaching assertiveness skills to the wife and son of a traditionally oriented Mexican American man who periodically exploded, Organista (2006) incorporated both concepts by suggesting the son and wife use phrases advised by Comas-Díaz and Duncan, including, "With all due respect papa . . . ," or ask "Would you permit me to express how I feel about that?" For the same reason, in a parenting program with Puerto Rican adolescents and their parents, facilitators emphasized to parents

that the adolescents' assertiveness was not an attempt to disrespect them (Saéz-Santiago, Bernal, Reyes-Rodríguez, & Bonilla-Silva, 2012). And in working with Chinese immigrant parents who objected to the idea of praising kids because praise was seen as sugarcoating and because "the more you praise them, the more you'll spoil them," one therapist simply changed the word *praise* to *encouragement* (Lau, 2012).

Regarding *social engagement and support*, reengagement with individuals or groups outside the therapy setting that have been a positive influence in the past is ideal because reinforcing a behavior that is supported by the client's culture is most likely to stick. For example, in my work with a young, recently separated African American Christian woman, I asked questions to help her think about who had been supportive of her in the past. In addition to her parents, with whom she and her children were living, she mentioned the church, although she had stopped attending months before. After exploring whether returning to the church would be helpful to her, she decided it would, and made attending the next Sunday her first homework step (Hays, 2012).

In some cases, a therapy or peer support group may be a helpful option. For example, Alcoholics Anonymous and Narcotics Anonymous are powerful sources of support for many people in recovery, as is Al-Anon for individuals living with someone who is abusing substances or in recovery. I'll talk more about group therapy in the next chapter on diverse interventions.

Finally, with regard to the CLASS action domains, a culturally responsive approach to finding and implementing *self-care activities* involves consideration of the client's resources, and ability to implement such activities in their own environment. For example, in working with single low-income women who have small children, even taking a hot bath in the evening can be challenging because it involves planning details such as whether or not to lock the bathroom door (if there's a bathtub or a lock), how to keep kids busy (e.g., plan a reward if they allow mom 30 minutes without interruption except for emergencies), and so on.

Because clients, especially caregivers for children and older adults, often have difficulty generating ideas for self-care, and because money can be an obstacle, I have a list of mostly free activities that prompts me to ask questions that help the client generate ideas. On rare occasions, I give the list to the client (see Exhibit 10.2). Because it is important that the activity be something the client genuinely enjoys or finds nurturing, a list or standardized inventory—unless it is culture specific—may not be helpful. For example, in working with an older Chinese American man, Lau and Kinoshita (2006) found that although the client chose activities from the Older Person's Pleasant Events Schedule (Gallagher & Thompson, 1981) and said he would do them, he did not follow through. But when he was helped to generate his own list, which

EXHIBIT 10.2

Self-Care Activities

taking a walk outside	attending a religious meeting/group
burning a scented candle	enjoying a favorite food
sitting with a warm blanket in your favorite chair	wearing fleece clothing
drinking herbal tea in your favorite cup	listening to your favorite music
reading the funnies	listening to an inspirational talk
snuggling with your partner	going out to eat
petting your dog or cat	creating, growing, or building something
painting your nails	talking with/calling a friend
laughing and playing with kids	planning a fun trip
watching a funny movie	planning something to look forward to
reading a good book	gardening
buying your favorite magazine	fishing
cooking a special dinner	joining a support group
arranging fresh cut flowers	attending counseling
taking time for morning devotions, prayer	getting a massage
meditating	watching/feeding birds
sitting outdoors	painting, drawing

Note. Adapted from *Creating Well-Being: Four Steps to a Happier, Healthier Life* (p. 181), by P. A. Hays, 2014, Washington, DC: American Psychological Association. Copyright 2014 by the American Psychological Association.

included tai chi, Chinese calligraphy, reading the Chinese newspaper, and visiting Chinatown, his homework compliance was 100% and his mood improved.

SETTING GOALS

It is important that therapists work collaboratively with clients to set goals and decide on interventions. Of course, there are exceptions, for example, when a client's cognitive abilities are too impaired; but even in these cases, collaboration with caregivers is essential. Such collaboration reinforces the idea that clients know more about their particular contexts and needs than a therapist ever can, especially a therapist who differs culturally from the client. It also means that there will be times when clients choose goals that do not fit with the therapist's expectations or preferences.

Take the case of a middle-class Greek American woman who came to therapy "for help in making my daughter behave." The mother had been separated from her husband for 10 years (they were never legally divorced), and she and their sole daughter lived together. The daughter was making good grades at the community college she was attending, but she wanted to do things that the mother did not like (e.g., go to

movies with friends at night, wear baggy pants). When the daughter tried to explain her desires and reason with her mother, the mother would interpret this as "talking back" and become furious and shout at her daughter.

The therapist realized that the mother's behavior was understandable in relation to some childrearing practices and views in Greek culture (e.g., the questioning of authority and disobedience being seen as disrespectful; Tsemberis & Orfanos, 1996). With further discussion, it became clear that the mother was unwilling to change her conceptualization of the problem or her own behavior, and the father (who was contacted by phone) would not become involved in what he perceived as a "mother–daughter problem."

The therapist's initial inclination was to help the daughter become more independent and eventually move out on her own. Neither the mother nor the daughter, however, was interested in this solution. Thus, the therapist worked with the daughter to help her find more effective ways to interact with her mother. Through therapy, the daughter came to realize that when she spent more time with her mother, her mother was more likely to let her go out or bring friends home. The two continued to have disagreements about clothes, but the conflicts over the daughter's socializing subsided, at least to a more acceptable level for the pair. In sum, by joining with the clients in pursuing their goals, the therapist was able to help them both.

At the same time, in some situations, behaviorally oriented goals may not be appropriate. For example, some American Indian people come to counseling primarily for support and want someone who will listen and provide encouragement, reassurance, practical suggestions, and caring but realistic feedback (Swinomish Tribal Community, 1991, p. 226). Similarly, with clients experiencing grief over the death of a loved one, the most helpful approach may be supportive counseling that provides a safe place to cry and reassurance that the experience of bereavement is a normal process. (For information on what constitutes normal bereavement in diverse minority cultures, see Irish, Lundquist, & Nelsen, 1993, and Shapiro, 1995.)

THOUGHT-CHANGE (COGNITIVE) INTERVENTIONS

The main task of cognitive interventions involves recognizing the cognitions and cognitive processes that may be contributing to a client's emotional distress, unwanted behaviors, or physical symptoms. The form of cognitive restructuring known as rational emotive behavior therapy (REBT) focuses on changing irrational thoughts to more rational ones, with the expectation that more rational thoughts help a person to feel better and engage in more constructive behaviors (Ellis, 1997). The

advantage of REBT is that it consists of a relatively simple model that is easy to explain and learn. One problem with REBT, however, is its reliance on the concept of rationality. Definitions of rationality are heavily influenced by a person's culture, and the dominant culture tends to perceive many minority group beliefs as strange and irrational. If the therapist does not know the client's culture well, he or she may jump to the conclusion that a client's belief is irrational, when in fact, it is normal in the client's culture.

The most well-researched form of CBT is known as cognitive therapy (A. T. Beck, Rush, Shaw, & Emery, 1979; J. Beck, 2011). Rather than challenge rationality, cognitive therapists generally prefer to question how functional or dysfunctional a belief is. Questions commonly used to do so include, "What is the evidence for this thought or belief?" and "Is there an alternative explanation?" Theoretically speaking, these questions challenge the validity rather than the utility of a client's belief. Other questions are used to challenge the utility.

Although challenging the validity of the client's belief may be helpful in some situations, it is risky when the therapist and client differ culturally. Challenging the validity of core cultural beliefs is even riskier unless the client and family are open to this challenge. A safer approach is to avoid the question of rationality and validity altogether and focus instead on a collaborative exploration of the *helpfulness* (i.e., utility or usefulness) of a thought. The therapist may simply ask, "Is it helpful for you to say this to yourself or to hold on to this belief or image?" This question recognizes that ultimately, the client is the judge regarding the helpfulness of thoughts and behaviors (Kemp & Mallinckrodt, 1996). Functionality is obviously implied in the concept of helpfulness, but the term *helpfulness* sounds less academic.

Often cognitive restructuring will involve changing unhelpful thoughts and images specific to a particular situation. Consider the example of a 58-year-old bilingual man who began using a walker for mobility following a car accident that also led to the loss of his job. Cognitive restructuring involved countering the thoughts of "What am I gonna do? I know I'm never gonna get another job, I'll probably never work again, we'll have to move out of our house, we'll probably lose everything . . ." by changing them to "Okay, wait a minute, I'm still recovering, so I don't know for sure yet what kind of work I'll be able to do, but there are lots of different kinds of jobs, and remember that list the DVR (Department of Vocational Rehabilitation) guy showed me—there are jobs I could do even if I have to use a walker." Note that a middle-class therapist who thinks in terms of rationality versus irrationality might believe that this client is engaging in catastrophic thinking, but if the client does not have financial resources, such thoughts might be completely rational, even though they're not helpful.

Sometimes clients may benefit from more generic self-talk, that is, repetition of thoughts and images that are not necessarily specific to a particular dilemma. If a client has difficulty coming up with empowering self-talk, it can be useful to go back to the list of culturally related strengths and supports described in Chapter 7 of this volume. The list of personal strengths in Table 7.1 can be used as empowering self-statements; the list of interpersonal supports provides evidence that the client is valued by others; and, for spiritually oriented clients, the list of natural environmental supports may be a reminder that a higher power cares for them.

To use the same example, when this man was feeling discouraged, he used his list to remind himself of the following: "I have gifts that many people don't—I have a strong faith, I speak two languages, I'm a good storyteller, and I have experienced pain and disability that have made me strong [personal strengths]; I have a wife, children, and friends who love me, and a spiritual community that cares about me [interpersonal supports]; and I live in a safe place, I have a comfortable home, and, wherever I am, if I can go outdoors by some trees and listen to the birds and feel the sun on my face, I feel a sense of peace" [supportive environment].

When a client chooses to use their list of strengths and supports to develop more general, empowering self-talk, repetition of this self-talk often becomes a form of homework in which they read their list aloud to themselves on a daily basis. In such cases, using an idea adapted from Thich Nhat Hanh (1992), I explain that initially they may not notice any difference in how they feel, but to think of it like planting a seed in a flowerpot:

> After you plant the seed in the pot, you water it, then you walk away. Then the next day, you go back to it, look inside, and you see nothing but dirt. But you don't throw the pot out. You water it again, then you go away, and come back the next day, you look again and see nothing, but you water it again, and you keep doing this, until after a week or so, you start to see a tiny green sprout coming up. And that's how changing feelings with self-talk works—you may not notice anything right away, but if you keep at it, with time you'll start to feel a difference.

Culturally Responsive Adaptations

In addition to the practice of questioning the helpfulness of cognitions (which I consider the basic form of cognitive restructuring), over the years, I've collected a number of different ways to engage diverse clients

with this process. These variations include practices and exercises that work to a greater or lesser extent depending on the particular person and their context. They include compassion voice, looking for suffering, the most generous interpretation technique, wise elder, attitude of gratitude, growth opportunity, values compass, the use of metaphors and sayings, and cognitive restructuring adaptations for children—in particular, anxiety remote control, the magic three-step technique, and the worry hill.

COMPASSION VOICE

Compassion voice is based on Buddhist writings about compassion, and it involves replacing harsh judgmental cognitions with compassionate thoughts and images. I have found that spiritually oriented people often like this approach; one Christian woman I worked with called it her grace voice. In addition, some nonspiritually-oriented people also find it useful because it can be understood from a strictly cognitive perspective, too.

When a person is engaging in harsh critical, judgmental self-talk and holding onto such beliefs, I start by explaining the idea of judgmentalism and how it creates an emotion and a physical sensation of irritation that pushes people away:

> Of course we all have to make judgments, for example, about what is healthy to eat, what is helpful for our children, what is the kindest thing to do, and so on. But *judgmentalism* is different—it's not intended to help us or anyone else; rather, it involves a shaming, superiority component. If the judgmentalism is aimed at another person, the superiority message is "I know better than you, and I *am* better than you . . ." If the judgmentalism is aimed at ourselves, the message is "I'm so stupid, hopeless, unlovable, etc. . . ." When we go over and over these judgmental thoughts, they create irritability which in turn leads to disconnection from others. There's a saying, "The greatest source of human unhappiness is disconnection from one another" [His Holiness the Dalai Lama & Cutler, 1999]. This feeling of being disconnected or disliked, or irritated by others, is painful. Kindness and compassion feel much better than irritation and anger. And the feeling of compassion is incompatible with the feeling of irritation—that is, you can't feel them both at the same time. [Sometimes at this point, I ask the client to imagine holding a puppy, and ask them how this feels.]

I then talk with the client about this idea of judgmentalism in relation to their own critical self-talk, and their relationships. Often this involves an exploration of the origins of their critical voice, for example, from abusive critical parents, the dominant culture, or others. At some point, the work turns toward helping the client replace their critical, judgmental voice with a more compassionate one. As an example of this, I may tell the

story of a man I worked with who suffered from irritability and anger that was fueled by the harsh voice he had internalized from his father. After explaining the idea to him, he came in the next week and said,

> Pam, I saw a great example of what you were talking about—I had to ride for three hours with the moron who works as a driver for our company. He was a completely incompetent driver and I was really p.o.'d, but I just held it in because I was afraid I would explode but then afterwards, I went to our boss and told him he needed to fire the idiot. My boss said, "Oh, I'm glad you told me—must be Joe didn't get the training he needed. I'll talk to him and be sure he gets what he needs to be a better driver."

Although the client was not yet using compassion voice himself, he recognized it in his supervisor, and saw how it could decrease his anger.

Compassion voice is not a self-indulgent attitude. Rather, it is intended to counter unrealistically harsh self-talk. It involves talking to oneself as you would talk to a good friend or your child. So for example, if your friend or child does something wrong, you acknowledge that it's wrong, but you don't beat them into the ground about it. You talk with them in a way that shows you care about them and want to help them do better next time.

LOOKING FOR SUFFERING

A number of ways can help clients grow their compassion voice. When the problem is a critical view of someone else that is negatively affecting their relationship, one way is to ask questions that help the client recognize how the other person suffers. I call this the *looking for suffering* exercise, as it comes from the Buddhist idea that recognizing the suffering of another tends to increase compassion. When a client doesn't know the other person well enough to recognize this, a related strategy is to ask questions that help the client hypothesize difficulties in the other person's life, for example, "Is it possible that their spouse is leaving them for another person? Is it possible that they have a child that has a severe chronic illness? Is it possible that they struggle with their weight and don't feel good about themselves?"

MOST GENEROUS INTERPRETATION TECHNIQUE

A related approach is what I call the *most generous interpretation technique*. Here's how I explain this approach:

> When we say something hurtful to someone, we often give ourselves the benefit of the doubt, explaining our behavior with "Well, I was just really tired, and I hadn't eaten, and I still had all this work to do, so I snapped at her, but I didn't really mean it." In contrast, if someone says the same thing to us, we may say, "What a jerk." So with the most generous interpretation technique, you just tell yourself the most generous explanation

of the other person's behavior that helps you feel more compassionate, or at least less irritated by them, for example, "Maybe her dog died today. Or maybe she just tested positive for cancer. Or maybe her spouse just told her she doesn't love her."

Try this:

Step 1. Close your eyes (or look at the floor) and think about a problem in your life that seems unsolvable and creates feelings of stress in you.

Step 2. Now imagine yourself as 95 years old. Think about all the life experience and knowledge you have at 95. When you are able to imagine yourself as 95, go to the next step.

Step 3. Now with your eyes still closed, imagine what your 95-year-old self would say to your present-day self about this problem or situation.

WISE ELDER

The *wise elder* technique (adapted from Dolan, 1991) is helpful when a client has difficulty coming up with supportive thoughts in reaction to a stressor, particularly if the stressor is one without any clear solution. It involves asking the client to imagine themselves as much older, and then imagine the advice their older self would give them today. Almost always, the advice is encouraging, as in messages, such as "It'll get better; in 20 years this will seem minor; or whatever happens, it'll be okay, and you'll be okay." This message can then be used as a form of encouraging self-talk.

ATTITUDE OF GRATITUDE

Attitude of gratitude is an exercise derived from the work of positive psychology researcher Lyubomirsky (2007), who found that when people were asked to keep a list of things they were grateful for, over time, their mood improved. I've found this technique particularly helpful with couples. I introduce it by explaining the idea, and then depending on the couple, I may include the following self-disclosure piece:

> I decided I wanted to make gratitude a daily habit, and my husband agreed to do it with me. Over time, we shaped it into a game in which we each say five original things we are grateful for every day. The first person to remember the exercise that day, gets to go first, which is a little easier because the second person has to add five more original things to the first person's list. At first it was really hard, but over time it's gotten easier. And it has a nice effect on our relationship, because if one of us is being pretty negative, the other one can say, "Let's do attitude of gratitude," and it sort of shifts the mood. Also, we thank each other more for things we notice during the day.

If the couple wants to try this exercise, I suggest beginning with one thing each day that they are grateful for, in keeping with the "small-step" approach to homework (see the following section Culturally Responsive Homework). Sometimes this initial gratitude item will be for something their spouse did, but it doesn't have to be.

GROWTH OPPORTUNITY

Growth opportunity is a form of reframing, and it comes from the Buddhist view that obstacles are opportunities for growth. As a form of cognitive restructuring, it involves looking for a positive possibility in or aspect of a problem. For example, a major medical problem may lead a client to be more patient with the slowness of change because her own healing is so slow; to appreciate little things throughout the day that give her a positive feeling; and to feel more empathy toward others because she considers the possibility that a difficult person may be ill or have a non-visible disability.

VALUES COMPASS

This exercise involves helping people recognize what they value most in life, including in themselves and others, then using this value as a guide to make decisions and take action. It can be helpful when a person is frustrated with their own difficulty in making long-term change because it takes the focus off the negative experience of trying to change the behavior and puts it on the positive idea of human values. Judgmental self-talk is replaced by compassion voice with thoughts such as "Okay, I've tried my hardest, but for now, I need to accept myself as I am, including my weaknesses because everybody has weaknesses. I need to focus on my strengths, and live my life anyway." For example, if a client feels stuck after trying for years to fix a difficult work relationship, and he strongly values kindness, he might use as a guide in his interactions with others and himself the question, "What would a kind person do in this situation?" (This exercise is similar to the idea behind acceptance and commitment therapy developed by Stephen Hayes [e.g., Hayes & Smith, 2005].) Ideally, if the client is able to accept themselves in this way, they may experience a shift in the resistance that allows the behavior to come more easily.

METAPHORS AND SAYINGS

Metaphors and sayings can serve as powerfully supportive replacement thoughts for negative cognitions. In the development of treatment manuals for low-income ethnic minority populations at San Francisco General Hospital, Muñoz and Mendelson (2005) used culturally relevant images, metaphors, and stories to illustrate key concepts. For example, the phrase "*La gota de agua labra la piedra* [Drops of water can carve a rock]" was used to explain how thoughts can gradually change one's view of life into a more positive view that eliminates depression.

In their CBT work with Māori people, Bennett, Flett, and Babbage (2014) used metaphors and prayer relevant to the session at the opening

and closing, and integrated cultural sayings to facilitate cognitive shifts (e.g., "Turn your face to the sun and shadows will fall behind you"). In addition, upon the recommendation of a Māori advisory group, they developed a visual picture of the traditional Māori house (*whare*) to illustrate how thoughts affect feelings and behaviors. In this illustration, the foundation of the *whare* represents significant childhood experiences, the first floor represents core beliefs, the second floor represents intermediate assumptions and rules for living, and the roof represents coping strategies.

Culturally relevant metaphors and sayings can be found via an online search, or in some cases, clients may remember one they've heard and liked. Alcoholics Anonymous has many such sayings, for example, the Serenity Prayer ("Grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference"). For spiritually oriented individuals, I've shared the following metaphor (which I heard from a Navajo man) to help clients be gentler with themselves:

> It's said that we are all born with a cord attached to the Creator, and every time we do something hurtful to someone else or ourselves, the cord breaks. So then we have to repair the cord by tying a knot in it. And over a lifetime, as we make mistakes, and break the connection, then we repair it, the cord becomes shorter, and by the end of our life, we are much closer to the Creator.

Another helpful American Indian metaphor is that of *coyote thoughts.* The coyote is known as a trickster in many Indian Nations, and as Beau Washington (2012) explains,

> One coyote thought isn't much of a problem. [But] a pack of coyotes will take you down. If you don't chase the coyote thought away, it bring others. When we dwell on things the coyotes start to gather, creating bigger and bigger problems. . . . Knowing the names of the coyotes brings them out of the dark into the light. Recognizing them is our best chance of ending the darkness and pain they bring. (para. 8)

COGNITIVE RESTRUCTURING ADAPTATIONS FOR CHILDREN

Many adaptations of CBT are appropriate for children, even relatively young children. As with adults, the incorporation of culture-specific norms and values is important. For example, in teaching behavioral interventions to Mexican American parents, a culturally responsive therapist would need to consider that active ignoring of unwanted behavior, which operates on the principle of extinction, may not be accepted by some parents, and opportunities for *family* rewards for children's good

behavior are just as important as individual rewards because of the high value placed on family (Barker, Cook, & Borrego, 2010). The following are just a few examples of the ways in which CBT has been used with children, some of which have been used with children living in poverty or children of ethnic minority cultures.

Anxiety Remote Control

This approach is based on an anxiety management program for children at the Yale University Child Study Center, in which the idea of "changing your channel" via a mental remote control is used to help children learn how to change worries and scary feelings by changing their thoughts (E. R. Anderson, Smith, & Christophersen, 2011). The program emphasizes the involvement of parents as coaches to help children learn how to implement specific coping skills, and it is careful not to promote the avoidance of anxiety. (Obviously, it is intended for children whose families use modern-day technology such as remotes.)

For the first channel, the child is taught a breathing exercise called the leaky tire technique in which they learn to take a deep breath then exhale, making the continuous "s" sound until the breath is expelled, then take another deep breath to relax. A second channel uses visual imagery to imagine a fun and relaxing place, with parents coaching the child to pay attention to all of the senses in the imagery. The cheerleading or coaching channel consists of helpful self-talk, such as "I can do this, it'll be hard but I've done it before." For older kids, the facing my fears channel includes exposure activities.

Once they've learned to use these and other coping skills, children are asked to pretend they have a remote control on which each channel corresponds to a particular skill. They then learn to "change the channel" on worries by mentally going into their relaxation channel, visual imagery channel, coaching channel, humor channel, and so on.

One suggestion for making visual imagery exercises such as this more culturally responsive comes from La Roche, D'Angelo, Gualdron, and Leavell (2006) who found that because many Latino clients have an allocentric (i.e., social) orientation (versus a more individualistic focus among European Americans), it was helpful to ask individuals to imagine "sharing a moment with a person who makes you feel at peace" (versus the typical "imagine yourself alone in a beautiful place"). This suggestion may be helpful with children of Latino and other dominant and minority identities. Similarly, at an Alaska Native counseling center, clinicians liked the idea of using hardening clay with young kids to create pretend remote controls they could carry with them—an idea that could work with Native and non-Native children.

THE MAGIC THREE-STEP TECHNIQUE

This strategy is adapted from the work of Sommers-Flanagan and Sommers-Flanagan (2007), and it involves three steps. In the first step, *feel the feeling*, the child is helped to experience and express emotion in constructive ways. When I worked with a young, Christian 10-year-old I'll call B. J. who was angry at his mom's new boyfriend, this included stomping around outdoors (rather than indoors), using a mirror to make angry faces, and doing angry scribbles on paper.

The second step, *change the feeling*, involves teaching the child how to change a feeling by changing their thoughts or behavior. With B. J., after we did a couple of anger exercises, I asked him how he was feeling and he said, "mad." Then I asked, "Hey, have you ever heard of the magic three-step technique?" Of course he hadn't, and he wanted to know what it was. So I said, "Okay, let me ask you something. Can you tell me something funny that happened this week at school?" He thought briefly and then said "Johnny told the teacher 'Bite me.'" He knew this was "a bad thing" to say but thought it was hilarious. He started laughing so hard that he made me laugh (at the same time I was internally chastising myself for laughing at an inappropriate way to talk to a teacher). But in the middle of our laughter, I said, "Hey, how are you feeling right now?" He said, "happy!" I then pointed out how his mad feeling had changed when he changed what he was thinking about, and we talked a little about this.

The third step, *pass it on*, involves explaining that emotions are contagious, and that just as we can change our own emotions, we can positively affect the emotions of others. In this case, I asked B. J. questions to help him recognize how what he said and did affected his mother in hurtful ways. Then I said, "I bet you know how to make your mom happy." He went on to agree that, yes, he knew that he could make her smile by saying, "I love you" or giving her a hug, which led to the idea of practicing this. He also suggested that he could make his mother over-the-top happy if he cleaned the toilet bowl, which he had never done before, and he decided he would try this. The next week, his mother told me he hadn't cleaned the toilet bowl, but he did give her a hug and tell her he loved her.

THE WORRY HILL

The worry hill (Wagner, 2008) is a four-step approach to treating obsessive-compulsive disorder (OCD) in young children. When and only when the child expresses readiness to change, the program consists of the following four phases: stabilization, communication, persuasion, and collaboration. The communication phase uses the drawing of a bell shaped curve that illustrates how anxiety increases

with exposure to the feared situation until it peaks. Then, if the child persists in resisting anxiety-avoidance strategies, the anxiety begins to decline. Wagner (2008) explains it to the child and parents as follows:

> Learning how to stop OCD is like riding your bicycle up and down a hill. At first, facing your fears and not doing your rituals feels like riding up a big Worry Hill, because it's tough. You have to work hard to huff and puff up a hill, but if you keep going, you can get to the top. Once you get to the top, it is easy and fun to coast down the hill . . . [But] you can only coast down the hill if you first get to the top. Likewise, you can only get past your fears if you face them. You have to stick it out without doing your rituals until the bad feeling goes away. Then you'll see that your fears don't come true. But if you give into the rituals, it's like rolling backwards down the hill. (p. 64)

The exposure phase of the program involves development of a fear ladder (exposure hierarchy) of feared activities that are rated on a 10-point scale called the fearometer. It also uses the RIDE acronym to summarize the cognitive process: rename the thought, insist that *you* are in charge, defy OCD by doing the opposite, and enjoy your victory (for more on this approach, see Wagner, 2005).

In addition to this approach, Chorpita's (2007) book *Modular Cognitive-Behavioral Therapy for Childhood Anxiety Disorders* contains a detailed evidence-based protocol on how to use exposure with children with OCD and anxiety disorders, based on its effectiveness with culturally diverse families in Hawaii. With regard to American Indian and Alaska Native children in particular, the evidence-based practice of trauma-focused CBT has been used successfully in an adaptation known as *Honoring children, Mending the circle*, which incorporates CBT concepts that parallel traditional beliefs and practices (BigFoot & Schmidt, 2010). For example, to counter intrusive thoughts, during many traditional ceremonies and activities, traditional healers instruct participants to "leave bad thoughts at the door" or "come in with good thoughts" (BigFoot & Braden, 2007, p. 21; also see Indian Country Child Trauma Center at http://www.icctc.org).

Glickman (2009) has adapted CBT for children and adults with language and learning challenges, including deaf individuals. This approach is oriented around the acquisition and development of psychosocial skills, all of which are presented and taught using hundreds of specially developed pictures. And one final resource, the APA Public Interest Directorate's Office on Socioeconomic Status, together with the Office on Children, Youth, and Families, have produced a free resource for low-income parents and other caregivers aimed at bolstering resilience among children in poverty. This *Resilience Booster: Parent Tip Tool* outlines practical applications, such as developing family routines, talking about emotions, role modeling, and problem-solving strategies, and is available for free online (http://www.apa.org/topics/parenting/resilience-tip-tool.aspx).

Culturally Responsive Homework

Finally, CR-CBT involves weekly homework assignments with an emphasis on client direction. With children and teens, I use the word *practice* instead of homework, for obvious reasons. To facilitate the development of culturally responsive homework, at the end of each session, I ask clients, "Based on what we did or talked about today, what is the smallest possible step you could take that would feel like you are making progress?" (adapted from Dolan, 1991). For spiritually oriented people, I sometimes use the word healing instead of progress. Also, the word healing may be more appropriate with people who have chronic illnesses that will never completely disappear, because it has the connotation of personal and spiritual growth despite the illness. I explain that the step needs to be as small as possible because we want to build a feeling of success quickly, so that clients are more likely to take a next small step, which will lead to another step, and so on, and until after a few weeks, they will begin to see significant results.

Earlier, I mentioned the example of a Chinese client who did his homework only when it reflected his own personal and cultural interests. For this reason, and also because the likelihood of a client following through increases if it's their idea, I almost never suggest a specific homework. Rather, if the person cannot come up with something themselves, I ask questions to help them brainstorm. Most of the time, my role in developing homework involves simply helping the client to pare their chosen step down into an action step or a cognitive step that by their own report, they are 100% likely to do. (For additional suggestions on making CBT more culturally responsive with both adults and children, see Bernal & Domenech Rodríguez, 2012; and Hays & Iwamasa, 2006.)

The Case of Dee

Dee came to see me for help in controlling her anger following an altercation with one of her children's schoolteachers. She was a large European American woman—6 feet tall, 300 pounds—who spoke loudly and bluntly and had a few teeth missing. She lived with her two children, plus a neglected neighbor child she had taken in and a dog and two cats, in a three-bedroom trailer in an impoverished rural community in which alcoholism, drugs, guns, and sex offenders were common. She supported herself and the children on a small disability income supplemented with food stamps and occasional temporary "under the table"

jobs she was able to find. Every trip into town for medical appointments and groceries was an ordeal, because her car was old and frequently broke down. Dee admitted to screaming, swearing at, and even threatening teachers, store employees, and family members who she said gave her "a hard time." Dee, however, was also intelligent and insightful and had a wonderful sense of humor and a soft heart for kids.

I worked with Dee for several months, helping her to recognize that what she experienced as the "normal" difficulties of daily life (i.e., normal for her because she'd always had such problems) would be considered chaos by most people. I reassured her that anyone living in her situation would feel stressed and that she was not crazy for feeling angry, depressed, and overwhelmed. (See Lott & Bullock, 2001, and Nicolas & JeanBaptiste, 2001, regarding the shame, disrespect, insecurity, hopelessness, and repeated failures experienced by women living in poverty.)

Dee understood the cognitive behavioral case conceptualization. With help and frequent validation of the stressors she faced, she was able to distinguish between these environmental stressors and the ways in which she mentally exacerbated her feelings of anger, anxiety, and depression. The environmental, or externally oriented, portion of our work involved looking for ways to decrease Dee's overall stress level by making practical changes in her environment, including the addition of self-nurturing activities, keeping in mind the constraints that poverty placed on her options and looking for activities that cost nothing (Scarbrough, 2001; L. Smith, 2005). For example, the commonly chosen activity of taking a hot bath to relax was not an option for Dee, because her well water smelled and was discolored. She was eligible, however, for free aqua therapy at the community pool, which she found relaxing and provided the possibility of a clean shower afterward.

The internally oriented (cognitive) part of our work involved the normalization of Dee's feelings and some education regarding the differences between assertiveness and aggression. Dee learned to recognize a pattern in which denigrating and hopeless self-talk kept her from speaking up when she was frustrated until her feelings grew to such a level of anger that she would blow up, resulting in feelings of guilt and shame that reinforced the denigrating self-talk and further decreased her willingness to speak up. Through cognitive restructuring, she began to use more realistic, helpful, and empowering self-talk to manage her emotional reactions, with an emphasis on remembering long-term goals over the short-term satisfaction of venting and getting her way immediately.

After several weeks of this work, Dee came in excited to tell me about an incident she said she had handled exceptionally well. That week, her 13-year-old daughter had told her that a 21-year-old acquaintance said he would pay her $20 if she took off her shirt for him. (Her daughter did

not accept.) Dee was furious, but instead of taking her usual aggressive approach, she decided to practice her assertiveness skills. She told me,

> I remembered what we talked about, so I took three deep breaths and kept my cool. Then I marched over to the uncle's trailer where that boy was staying and knocked on the door, and when he came out, I got right up in his face. I looked him straight in the eye and said in a calm, low voice, "If you ever try anything like that again, you mother f—ing son of a b—, you're *mine*." I was so good; I didn't punch him or poke him in the chest with my finger, or even scream at him. I didn't even take a gun. I just walked away. And I got my point across—he looked really scared! You would've been so proud of me!

Needless to say, I had a little difficulty trying to decide on an appropriate response. I knew what most middle-class people would say she should have done: call the state troopers (she was out of city limits for police) and let them handle it. However, when I considered this from Dee's perspective, including her previous negative interactions with and lack of trust in the troopers as well as all of the other constraints of her social and physical environment, I could see how her particular adaptation of the skills we had discussed worked for her. Her long-range goals were to protect her daughter and permanently intimidate the guy, and she focused on these instead of doing what she felt like doing (i.e., killing him). Moreover, she did not take a gun with her, she did not physically touch him, and she did not make a specific threat of physical harm. She also added a strategy of telling everyone she met about the incident, which she said "might keep the guy in check, or maybe he'll get fed up and move out."

I tried to help Dee explore the possible ramifications of her actions. I still had some concerns for her safety and believed that she should have reported the incident to the troopers, at the least to have the incident on the young man's record, but at the same time, I did not want to dampen her sense of success. It took a lot of courage and effort to do what she did, so rather than suggest that she did something wrong, I shared my delight with her savvy resolution.

As therapists, we can teach clients specific coping skills, including new behaviors and a range of assertive responses, but clients must take into account the neighborhoods in which they live, community norms, and the reliability of community supports. And sometimes significant risks are associated with using these new behaviors. For example, Wood and Mallinckrodt (1990) emphasized the risks for members of minority groups in using dominant cultural behaviors in the example of an African American man waiting in a movie line when a White man cut in front of him. Although in some parts of the United States it would be considered appropriately assertive for the African American man to say, "Excuse me, I believe that the end of the line begins behind me," the authors made the point that in some areas of the country, such a

statement could place an African American man in physical danger (1990, p. 6). They advised therapists to help clients develop as wide a repertoire of responses as possible, but because the client is the best judge of what is right and safe, the client is the one who should decide what constitutes appropriately assertive behavior in any given situation. This approach also communicates the therapist's respect for the client's intelligence and decisions.

Conclusion

Culturally responsive therapy involves an integrative approach that begins with expertise in an evidence-based home therapy, and flexibly incorporates ideas and strategies from other sources. CR-CBT is one example of an integrative psychotherapy, which makes use of the CBT research base on EBPs and also emphasizes clinical expertise in using these practices. CR-CBT emphasizes the integration of cultural considerations because culture has been relatively neglected within the psychotherapy research literature and the field of CBT. This emphasis includes particular attention to oppressive environmental conditions that may be contributing to the client's distress.

Practice: Clarifying Your Approach

Write a brief, general description that explains your approach to therapy. Practice it with a friend who will give you feedback, and tweak it until you have a description that accurately represents what you do, and that your clients will understand.

KEY IDEAS

1. The American Psychological Association's definition of EBPP is *the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.*
2. An *integrative* approach to psychotherapy is guided by one overarching theoretical framework (i.e., home therapy) that also incorporates interventions from outside this home therapy.
3. A key step in culturally responsive cognitive behavior therapy (CR-CBT) involves defining which part of the client's stress is

externally generated by the environment, including social and cultural influences, and physical barriers, and which part is internally generated by the client's thoughts, beliefs, and images.

4. Premature cognitive restructuring involves moving into thought-change strategies inappropriately or too quickly, that is, before exploring environmental influences, such as racism, sexism, and other physical and social barriers that may be realistically causing distress.
5. Action interventions involve *physically* doing something (i.e., taking action), whereas *thought-change (cognitive) interventions* involve *mentally* doing something (changing the way one thinks about a situation).
6. CLASS summarizes action interventions, including ***c****reating a healthy environment*; ***l****earning a new skill*; ***a****ssertiveness, conflict resolution, and other communication skills*; ***s****ocial engagement and support; and* ***s****elf-care activities.*
7. Challenging the validity or rationality of a belief is risky, particularly if it is a core cultural belief; instead, a collaborative exploration of the *helpfulness* of a thought recognizes that, ultimately, the client is the judge regarding the helpfulness of thoughts and behaviors.
8. *Compassion voice* is a form of cognitive restructuring that involves replacing harsh judgmental cognitions with compassionate thoughts and images about oneself and others.
9. The development of culturally responsive homework can be facilitated by asking clients at the end of the session, "Based on what we did or talked about today, what is the smallest possible step you could take that would feel like you are making progress?"
10. As therapists, we can teach clients coping skills, including new behaviors and a range of assertive responses, but clients must take into account the neighborhoods in which they live, community norms, and the reliability of community supports; and sometimes significant risks are associated with using these new behaviors.

American Psychological Association

American Psychologist

0003-066X/19/$12.00

2019, Vol. 74, No. 1, 128–142
http://dx.doi.org/10.1037/amp0000296

Disarming Racial Microaggressions: Microintervention Strategies for Targets, White Allies, and Bystanders

Derald Wing Sue, Sarah Alsaidi, Michael N. Awad, Elizabeth Glaeser, Cassandra Z. Calle, and Narolyn Mendez
Teachers College, Columbia University

Given the immense harm inflicted on individuals and groups of color via prejudice and discrimination, it becomes imperative for our nation to begin the process of disrupting, dismantling, and disarming the constant onslaught of micro- and macroaggressions. For too long, acceptance, silence, passivity, and inaction have been the predominant, albeit ineffective, strategies for coping with microaggressions. Inaction does nothing but support and proliferate biased perpetrator behaviors which occur at individual, institutional and societal levels. This article introduces a new strategic framework developed for addressing microaggressions that moves beyond coping and survival to concrete action steps and dialogues that targets, allies, and bystanders can perform (microinterventions). A review of responses to racist acts, suggest that microaggression reactions/interventions may be primarily to (a) remain passive, retreat, or give up; (b) strike back or hurt the aggressor; (c) stop, diminish, deflect, or put an end to the harmful act; (d) educate the perpetrator; (e) validate and support the targets; (f) act as an ally; (g) seek social support; (h) enlist outside authority or institutional intervention; or (h) achieve any combination of these objectives. We organize these responses into four major strategic goals of microinterventions: (a) make the invisible visible, (b) disarm the microaggression, (c) educate the perpetrator, and (d) seek external reinforcement or support. The objectives and rationale for each goal are discussed, along with specific microintervention tactics to employ and examples of how they are executed.

Keywords: microinterventions, microaggressions, macroaggressions, metacommunication, race

> "We will have to repent in this generation not merely for the hateful words and actions of the bad people but for the appalling silence of the good people."
>
> —Dr. Martin Luther King Jr.

> "The world is a dangerous place to live, not because of the people who are evil, but because of the people who don't do anything about it."
>
> —Albert Einstein

These notable quotes echo the sentiment of many social justice advocates regarding the appalling worldwide silence and inaction of people in the face of injustice, hatred, and oppression directed toward socially marginalized group members (Freire, 1970; Potok, 2017; Tatum, 1997). In the United States, the omnipresence of racial bias and bigotry has led many to question the reasons for their persistence in light of widespread public condemnation. Social scientists have proposed a number of reasons for people's failure to act: (a) the invisibility of modern forms of bias, (b) trivializing an incident as innocuous, (c) diffusion of responsibility, (d) fear of repercussions or retaliation, and (e) the paralysis of not knowing what to do (Goodman, 2011; Kawakami, Dunn, Karmali, & Dovidio, 2009; Latané & Darley, 1968; Scully & Rowe, 2009; Shelton, Richeson, Salvtore, & Hill, 2006; Sue, 2003).

These reasons apply equally to targets of discrimination, White allies, and "innocent" bystanders (Scully & Rowe, 2009; Sue, 2015). In many cases, bias and discrimination go unchallenged because the behaviors and words are disguised in ways that provide cover for their expression and/or the belief that they are harmless and insignificant. Even when the biased intent and detrimental impact are

Editor's note. This article is part of a special issue, "Racial Trauma: Theory, Research, and Healing," published in the January 2019 issue of *American Psychologist*. Lillian Comas-Díaz, Gordon Nagayama Hall, and Helen A. Neville served as guest editors with Anne E. Kazak as advisory editor.

Authors' note. Derald Wing Sue, Sarah Alsaidi, Michael N. Awad, Elizabeth Glaeser, Cassandra Z. Calle, and Narolyn Mendez, Department of Counseling and Clinical Psychology, Teachers College, Columbia University.

Sarah Alsaidi and Michael N. Awad contributed equally to the article, and their names are listed in alphabetical order.

Correspondence concerning this article should be addressed to Derald Wing Sue, Department of Counseling and Clinical Psychology, Teachers College, Columbia University, Box 36, 525 West 120th Street, New York, NY 10027. E-mail: Dw2020@tc.columbia.edu

Derald Wing Sue

unmasked, the possible actions to be taken are unclear and filled with potential pitfalls. The reasons for inaction appear particularly pronounced and applicable to the expression of racial microaggressions (Sue et al., 2007), and racial *macro*aggressions, a concept to be introduced shortly (Huber & Solorzano, 2014).

The bombardment of racial micro/macroaggressions in the life experience of persons of color has been described as a chronic state of "racial battle fatigue" that taxes the resources of target groups (Smith, Hung, & Franklin, 2011). In the stress-coping literature, two forms of managing stress have been identified: emotion-focused coping and problem-focused coping (Lazarus & Folkman, 1984). The former is a strategy utilized by individuals to reduce or manage the intensity of the emotive distress (internal self-care) and tends to be more passive, whereas the latter is used to target the cause of the distress (external). Problem-focused strategies are more long term solutions that are proactive and directed to altering, or challenging the source of the stressor. Although there is considerable scholarly work on general models of stress-coping (Lazarus, 2000; Lazarus & Folkman, 1984), there is less research that take into consideration how people of color cope with prejudice and discrimination (Brondolo, Brady Ver Halen, Pencille, Beatty, & Contrada, 2009). Even when race-related stress and coping are discussed, it seldom explores questions about what people of color can do to disarm, challenge and change perpetrators or institutional systems that oppress target populations (Mellor, 2004). We anchor our proposed race-related coping strategies to the more active problem-focused strategies in navigating prejudice and discrimination, preserving well-being, and promoting equity.

Additionally, scholars have largely ignored the role that White allies and well-intentioned bystanders play in the struggle for equal rights (Scully & Rowe, 2009; Spanierman & Smith, 2017). Most research and training have attempted to identify how White Americans become allies, but there is an absence of work on the types of actions or intervention strategies that can be used to directly combat racism (Sue, 2017). In this article, we present a conceptual framework that (a) emphasize the harmful impact of race-related bias on persons of color (b) include a distinction between individual microaggressions that arise interpersonally and *macroaggressions* that arise on a systemic level, (c) acknowledge the central value of self-care in coping used by persons of color, (d) highlight the importance of disarming and neutralizing harmful microaggressions, (e) suggest intervention strategies that can be used by targets and antiracists, and (f) relate them to the goals of social justice.

The Harmful Impact of Microaggressions

Racial microaggressions are the everyday slights, insults, putdowns, invalidations, and offensive behaviors that people of color experience in daily interactions with generally well-intentioned White Americans who may be unaware that they have engaged in racially demeaning ways toward target groups (Sue et al., 2007). In addition to being communicated on an interpersonal level through verbal and nonverbal means, microaggressions may also be delivered environmentally through social media, educational curriculum, TV programs, mascots, monuments, and other offensive symbols. Scholars conclude that the totality of environmental microaggressions experienced by people of color can create a hostile and invalidating societal climate in employment, education, and health care (Clark, Spanierman, Reed, Soble, & Cabana, 2011; Neville, Yeung, Todd, Spanierman, & Reed, 2011; Solorzano, Ceja, & Yasso, 2000; Sue, 2010). Likewise, the current political climate (Potok, 2017) has been identified as a significant stressor for many Americans, especially to people of color because of its racially charged connotation (American Psychological Association [APA], 2017a, 2017b).

Many critics have downplayed the harmful impact of microaggressions, and have described them as trivial, negligible slights, insignificant offenses and as having inadequate empirical support (Campbell & Manning, 2014; Lilienfeld, 2017). Schacht (2008) believes microaggressions are no different from the everyday incivilities and rudeness in any human encounter. Thomas (2008) called microaggressions "macrononsense" that "hardly necessitate the handwringing reactions" by people of color. Lukianoff and Haidt (2015) asserted that we are teaching people of color to catastrophize and have no tolerance for being offended. In many respects, these assertions minimize the harmful impact of microaggressions and make an erroneous assump-

Sarah Alsaidi

tion that nonrace-based offenses are no different from race-based ones (Sue, 2010).

Sue (in press) has made a strong case that racial microaggressions are different from "everyday rudeness" in the following ways. They are (a) constant and continual in the lives of people of color, (b) cumulative in nature and represent a lifelong burden of stress, (c) continuous reminders of the target group's second-class status in society, and (d) symbolic of past governmental injustices directed toward people of color (enslavement of Black people, incarceration of Japanese Americans, and appropriating land from Native Americans). In one revealing study on Asian Americans, for example, Wang, Leu, and Shoda (2011) found that race-based microaggressions were much more harmful to the targets than nonraced-based insults because their lower social status in society was a constant reminder of their overall subjugation and persecution. They concluded that racial microaggressions differed significantly in quality and quantity from general nonrace-based incivilities.

In a major survey of over 3,300 respondents, the APA (2016) found that daily discrimination experienced by people of color had a profound impact on stress levels and contribute to poorer health. An astoundingly high number of African Americans (over 75%) reported *daily discrimination*; Asian Americans, Latina/o Americans, and Native Americans also all report significantly higher discriminatory experiences than their White counterparts. Among the reported discriminatory treatments were unjustified questioning by police and/or threats, receiving second-class health care treatment, unfair labor practices (being fired or not promoted when otherwise qualified), treated with disrespect, considered less intelligent, having teachers discourage them from further education, and unfriendly neighbors who made life difficult for them. According to microaggression theory, these individual forms of discriminatory behavior can be classified as microassaults, microinsults, and microinvalidations that vary on a continuum from being overt, intentional and explicit to subtle, unintentional, and implicit (Sue, 2010; Sue et al., 2007).

Being burdened with and contending with a lifetime of microaggressions have been found to increase stress in the lives of people of color (APA, 2016), deny or negate their racialized experiences (Neville, Awad, Brooks, Flores, & Bluemel, 2013), lower emotional well-being (Ong, Burrow, Fuller-Rowell, Ja, & Sue, 2013), increase depression and negative feelings (Nadal, Griffin, Wong, Hamit, & Rasmus, 2014), assail the mental health of recipients (Sue, Capodilupo, & Holder, 2008), create a hostile and invalidating campus and work climate (Purdie-Vaughns, Steele, Davies, Ditlmann, & Crosby, 2008; Solorzano et al., 2000), impede learning and problem solving (Salvatore & Shelton, 2007), impair employee performance (Hunter, 2011), and take a heavy toll on the physical well-being of targets (Clark, Anderson, Clark, & Williams, 1999).

The Harmful Impact of (Macro-)Aggressions

In addition to focusing on the detrimental impact of individual forms of microaggressions, some social justice advocates have indicated that institutional and cultural racism forms the foundations of prejudice and discrimination at the systemic levels (Jones, 1997; Tatum, 1997; Sue, 2010). Cultural racism has been identified as the individual and institutional expression of the superiority of one group's cultural heritage (arts, crafts, language, traditions, religion, physical appearance, etc.) over another group with the power to impose those standards (Jones, 1997). Its ultimate manifestation is ethnocentric monoculturalism (Sue & Sue, 2016), or in the case of the United States, an ideology of White supremacy that justifies policies, practices and structures which result in social arrangements of subordination for groups of color through power and White privilege. Huber and Solorzano (2014) used the term *macroaggression* to refer to the power of institutional and structural racism.

Considerable confusion surrounds the term (*micro-)aggression* regarding its usage, overtness, intentionality, and impact. It appears to be a misnomer when used to refer to people angrily shouting racial epithets, police officers unjustly profiling and shooting an African American suspect, or White parents not allowing their sons or daughters to date people of color. For many, these do not appear to be *micro-* but are instead *macroacts* of bias and discrimination. Microaggression theory, however, considers these acts as one of three forms of microaggressions (*microassaults*) that are conscious and deliberate (like old-fashioned racism) but occur

Michael N. Awad

on an interpersonal rather than a systemic level. This is not to deny that microaggressions cannot have major harmful impact such as the unwarranted shooting and killing of a Black male suspect (Sue, 2010). However, whether an act is subtle or blatant, deliberate or unintentional, or whether it has a shockingly harmful impact on targets are not criteria used to judge whether it is a micro- or a macroaggression. Chester Pierce (1969, 1970), credited with introducing the term *microaggression*, meant "micro" to refer to "everyday" rather than being lesser or insignificant.

We concur with Huber and Solorzano (2014) that the term *racial macroaggression* be reserved for systemic and institutional forms of racism that is manifested in the philosophy, programs, policies, practices and structures of governmental agencies, legal and judicial systems, health care organizations, educational institutions, and business and industry. Unlike microaggressions which have a more limited impact on an individual level, macroaggressions affect whole groups or classes of people because they are systemic in nature. The philosophy and belief in "manifest destiny," for example, justified unrestrained 19th century American expansion resulting in the forced removal of Native American from their lands, and provided a rationale for going to war with Mexico. There was a belief that God had decreed to Whites the right to expand and to impose their way of life on indigenous people who were described as heathens, uncivilized and primitive (Cortes, 2013; Sue, 2003). Like their individual counterparts, macroaggressions from a societal viewpoint can also be classified as macroassaults (Jim Crow laws), macroinsults (governmental policies aimed at civilizing American Indians), and macroinvalidations (forced assimilation and acculturation). In contemporary times, for example, the proposed building of the southern border wall, travel bans from Muslim-majority countries, and voting laws that limit early or weekend voting that disproportionally impacts people of color are examples of macroaggressions. In many respects, racial macroaggressions represent an overarching umbrella that validates, supports, and enforces the manifestation of individual acts of racial microaggressions.

The Need to Take Action: People of Color, White Allies, and Bystanders

Given the immense harm inflicted on individuals and groups of color via prejudice and discrimination, it becomes imperative for our nation to begin the process of disarming, disrupting, and dismantling the constant onslaught of micro- and macroaggressions. In this section, we describe the potential antiracist actions of three major groups—*targets, allies, and bystanders*—in their struggle against racism; we advocate the need for these constituents to take a proactive stance against the discriminatory actions of perpetrators. Through our review of the literature, we extract guiding principles that provide suggestions, strategies and interventions that disrupt, diminish, or terminate prejudice and discrimination at the individual level. Because of space limitations, however, we confine our discussion of microinterventions to primarily individual offenders. This is not to deny the importance of addressing macroaggressions, as there is a huge need for scholars and practitioners to develop antiracist microintervention strategies directed at biased institutional programs and practices and toward biased societal social policies as well.

Targets

Targets are people of color who are objects of racial prejudice and discrimination expressed through micro/macroaggressions. The experience of a microaggression can often feel isolating, painful and filled with threat (Sue, 2010). In the race-related stress-coping literature, the first rule of thumb for targets is to *take care of oneself* (Holder, Jackson, & Ponterotto, 2015; Mellor, 2004). In this respect, it is important to distinguish between the internal (survival and self-care goals of the target), and the external (confronting the source) objectives in dealing with bias and discrimination. It is often problematic to ask people of color to educate or confront perpetrators when the sting of prejudice and discrimination pains them. A number of coping or self-care strategies in the face of racism have been identified: social support (Shorter-Gooden, 2004), spirituality and religion (Holder et al., 2015), humor (Houshmand, Spanierman, & De Stefano, 2017), role shifting (Jones & Shorter-Gooden, 2003), armoring (Mellor, 2004), cognitive reinterpretation (Brondolo et al., 2009),

Elizabeth Glaeser

withdrawing for self-protection (Mellor, 2004), self-affirmations (Jones & Rolon-Dow, in press), and directly or indirectly confronting the racism (Obear, 2016). It is this last proactive response that we believe merits much more attention as it is one of the main explanations for inaction in the face of microaggressions.

Little has been done to offer people of color the tools and strategies needed to disarm, diminish, deflect, and challenge experiences of bias, prejudice, or aggression (Mellor, 2004). Although it is important not to negate the functional survival value of self-care for people of color, it represents a defensive or reactive strategy that does not eliminate the source of future acts of bias. The experiences of discrimination can be jarring and can cause a "freeze effect" (Goodman, 2011). Without knowing what to do or how to respond, targets often experience great anxiety, guilt, and self-disappointment. People of color often wish to confront the aggressor but their lack of action or paralysis leads to later rumination about the situation and to negative self-evaluations (Shelton et al., 2006; Sue et al., 2007). Additionally, individuals who do not stand up for themselves often experience feelings of helplessness and hopelessness. The result may be a fatalistic attitude and belief that racism is normative and must be accepted (Williams & Williams-Morris, 2000).

Rather than perpetuate a sense of resignation, it would be beneficial to (a) provide targets with a repertoire of interpersonal responses to racism, (b) arm them with the ability to defend themselves, (c) offer guiding principles and a rationale behind using external intervention strategies, and (d) decrease the negative impact on their mental health and well-being. Response strategies provide targets with the tools to be brave in the face of adversity and to feel dignified, leading to an increased sense of self-worth. They also provide targets with the ability to dispel racist attitudes of perpetrators through educational and action-oriented approaches, leading to a greater sense of self-efficacy. Unfortunately, not responding often leads to internalizing prevalent racist attitudes and negative beliefs about oneself (Speight, 2007).

White Allies

Allies are individuals who belong to dominant social groups (e.g., Whites, males, heterosexuals) and, through their support of nondominant groups (e.g., people of color, women, LGBTQ individuals), actively work toward the eradication of prejudicial practices they witness in both their personal and professional lives (Broido, 2000; Brown & Ostrove, 2013). Allies surpass individuals who simply refrain from engaging in overt sexist, racist, ethnocentrist, or heterosexist behaviors; but rather, because of their desire to bolster social justice and equity, to end the social disparities from which they reap unearned benefits, and to maintain accountability of their actions to marginalized group members, they are motivated to take action at the interpersonal and institutional levels by actively promoting the rights of the oppressed (Brown & Ostrove, 2013). Like targets, allyship development involves internal and painful self-reckoning, and a commitment to external action.

The internal component for potential White allies involves soul searching as to who they are as racial/cultural beings, acknowledging and overcoming their biases, confronting their motivations for engaging in antiracism work, and recognizing how their lives would be changed for the better in the absence of oppression (Edwards, 2006; Helms, 1996). As indicated by Helms' (1996), developing a nonracist White identity is a major step toward social justice work; allies are motivated by an intrinsic desire to advocate for equity rather than by White guilt or to seek glorification as a "White savior." Her theory of White racial identity development addresses this issue profoundly, and is central to our understanding of the difference between the development of a nonracist identity (interpersonal reconciliation with Whiteness) and an antiracist identity (taking external actions against racism). When individuals expect credit for being an ally, broadcast their self-righteousness to others, or do not accept criticism (especially from persons of color) thoughtfully, their work as an ally becomes questionable (Spanierman & Smith, 2017).

Scholars in the field of racism have been advocating for dialogue, openness, and social action for many years (Helms, 1996; Sue, 2015; Tatum, 1997). These works have often been the basis of colloquial strategies for breaking down racism and developing an "allied" identity for White people. It is a concerted movement from words toward

Cassandra Z. Calle

action, from privilege toward understanding one's positionality in oppression, and from identifying oppression to making a daily effort to resist that make allies distinct from bystanders, families, or friends (Brown, 2015; Reason & Broido, 2005). Allies possess affirmative attitudes on issues of diversity (Broido, 2000), consciously commit to disrupting cycles of injustice (Waters, 2010), and do not view their work as a means to a measurable end but a constant dismantlement of the individual and institutional beliefs, practices, and policies that have impeded the social growth and wellbeing of persons of color.

The shift from a nonracist identity to an action-oriented approach, however, assumes that activists have in their response repertoire the knowledge and skills to combat racism effectively. This may be a fallacious assumption as most educational and training programs often fall far short of teaching White allies the concrete and direct action strategies needed to influence perpetrators and social systems (Scully & Rowe, 2009; Sue, 2017).

Bystanders

Bystanders can be anyone who become aware of and/or witness unjust behavior or practices that are worthy of comment or action (Scully & Rowe, 2009). In many respects, the definitions of targets, allies, and bystanders may overlap, but research on White allyship suggests that allies are more likely to have an evolved awareness of themselves as racial/cultural beings, and to be more attuned to sociopolitical dynamics of race and racism (Broido, 2000; Helms, 1996). Although anyone can be a bystander, including targets (witnessing discrimination against a member of their group), we reserve this term for individuals who may possess only a superficially developed or a nebulous awareness of racially biased behaviors, and of institutional policies and practices that are not fair to a person of color or racial group. These individuals do not fall into the classes of targets or White allies but represent the largest plurality of people in society.

Most bystanders experience themselves as good, moral, and decent human beings who move about in an invisible veil of Whiteness (Sue & Sue, 2016), have minimal awareness of themselves as a racial/cultural being (Helms, 1996), and who possess limited experiences with people of color (Jones, 1997). Their naiveté about race and racism makes it very difficult for them to recognize bias or discrimination in others, and/or how institutional policies and practices advantage select groups and disadvantage groups of color. When they witness a discriminatory incident, for example, they may have difficulty labeling it as a racist act or they may excuse or rationalize away the behavior as due to reasons other than racism (Dovidio, Gaertner, Kawakami, & Hodson, 2002; Obear, 2016). Even when right or wrong behavior is recognized, inaction seems to be the norm rather than the exception.

Considerable scholarly work has attempted to explain the passivity of bystanders, even in the face of clear normative violations (Latané & Darley, 1968, 1970; Scully, 2005). Diffusion of responsibility, fear of retaliation, fear of losing friends, not wanting to get involved, and other anticipated negative consequences have all been proposed as inhibiting active bystander interventions. A number of social scientists, however, have begun to turn their attention to exploring conditions that would enhance or enable bystanders to intervene (Ashburn-Nardo, Morris, & Goodwin, 2008; Rowe, 2008; Scully, 2005). Four requirements for bystander action seem important: (a) the ability to recognize acceptable and unacceptable behaviors, (b) the positive benefits that accrue to the target, perpetrator, bystander, and organization through taking action, (c) providing a toolkit for active bystander interventions, and (d) the use of bystander training and rehearsal (Scully & Rowe, 2009).

Responding to Microaggressions

People of Color, White allies, and bystanders would all benefit from being cognizant of concrete strategies to disarm microaggressions. Although our focus is on interpersonal microaggressions, we propose a broader conceptual framework based on intervention strategies directed toward biased (a) individual perpetrator actions, (b) institutional programs, practices, and structures, and (c) social and community policies (see Figure 1). The choice and appropriateness of an action strategy may depend on which group is responding to racism, and whether the intervention strategy is directed toward a perpetrator, institution or societal pol-

Narolyn Mendez

icy. The antiracist techniques and strategies are not meant to be exhaustive, nor are they seen as universally applicable to all groups, populations, or institutional/societal structures, but rather are an attempt to list a few of the strategic goals and objectives that underlie antiracism interventions.

Microinterventions

We define microinterventions as the everyday words or deeds, whether intentional or unintentional, that communicates to targets of microaggressions (a) validation of their experiential reality, (b) value as a person, (c) affirmation of their racial or group identity, (d) support and encouragement, and (e) reassurance that they are not alone. The term *microaffirmation* has occasionally been used to refer to some of these behaviors (Jones & Rolon-Dow, in press), but microinterventions are much broader in scope. In many respects, they have two primary functions. First, they serve to enhance psychological well-being, and provide targets, allies, and bystanders with a sense of control and self-efficacy. Second, they provide a repertoire of responses that can be used to directly disarm or counteract the effects of microaggressions by challenging perpetrators. They are interpersonal tools that are intended to counteract, change or stop microaggressions by subtly or overtly confronting and educating the perpetrator.

Although some may perceive microinterventions to be small and insignificant actions that potentially trivialize the nature of racism, many scholars have suggested that the everyday interventions of allies and well-intentioned bystanders have a profound positive effect in creating an inclusive and welcoming environment, discouraging negative behavior, and reinforcing a norm that values respectful interactions (Aguilar, 2006; Houshmand et al., 2017; Jones & Rolon-Dow, in press; Mellor, 2004; Scully & Rowe, 2009). In other words, microinterventions can have a *macroimpact* by creating a societal climate in public forums, employment settings, and educational institutions that encourage the positive and discourage the negative (Scully & Rowe, 2009).

Microaggression interventions undertaken by individuals may vary in the degree of subtlety or directness. Unless adequately armed with strategies, microaggressions may occur so quickly that they are oftentimes over before a counteracting response can be made. A review of responses to racism, suggest that microaggression reactions/interventions may be primarily to (a) remain passive, retreat, or give up, (b) strike back or hurt the aggressor, (c) stop, diminish, deflect, or put an end to the harmful act, (d) educate the perpetrator, (e) validate and support the targets, (f) act as an ally, (g) seek social support, (h) enlist outside authority or institutional intervention, or (i) achieve any combination of these objectives (Aguilar, 2006; Brondolo et al., 2009; Houshmand et al., 2017; Joseph, & Kuo, 2009; Mellor, 2004; Obear, 2016).

Table 1 provides a listing of a few of the individual intervention strategies identified in our review of the literature. It has been a monumental undertaking to classify and organize the many tactics suggested by antiracist activists because they are often presented as simple *comebacks* without a clear explication of their rationale. We provide a conceptual framework of microinterventions divided into five categories: *strategic goals, objectives, rationale, tactics,* and *examples*. We elaborate on some of these to illustrate the principles for their inclusion, provide examples of microintervention tactics that can be taken, and discuss their potential desired outcome. It is important to note, however, that developing microinterventions is not only a science but also an art. Implementing or using the tactics can be manifested in many ways and is most influenced by creativity and life experiences (Sue, 2015). The strategic goals of microinterventions are to (a) make the "invisible" visible, (b) disarm the microaggression, (c) educate the offender about the metacommunications they send, and (d) seek external support when needed. It is important to note, however, that almost all the tactics outlined in Table 1 may overlap with one another, depending on the motives of the target, ally, or bystander. Oftentimes, the same tactic may be used either to disarm the microaggression or to educate the offender. In many cases, a microintervention tactic may operate from a combination of these goals.

Strategic Goal: Make the "Invisible" Visible

It is oftentimes much easier to deal with a microaggression that is explicit and deliberate because there is no

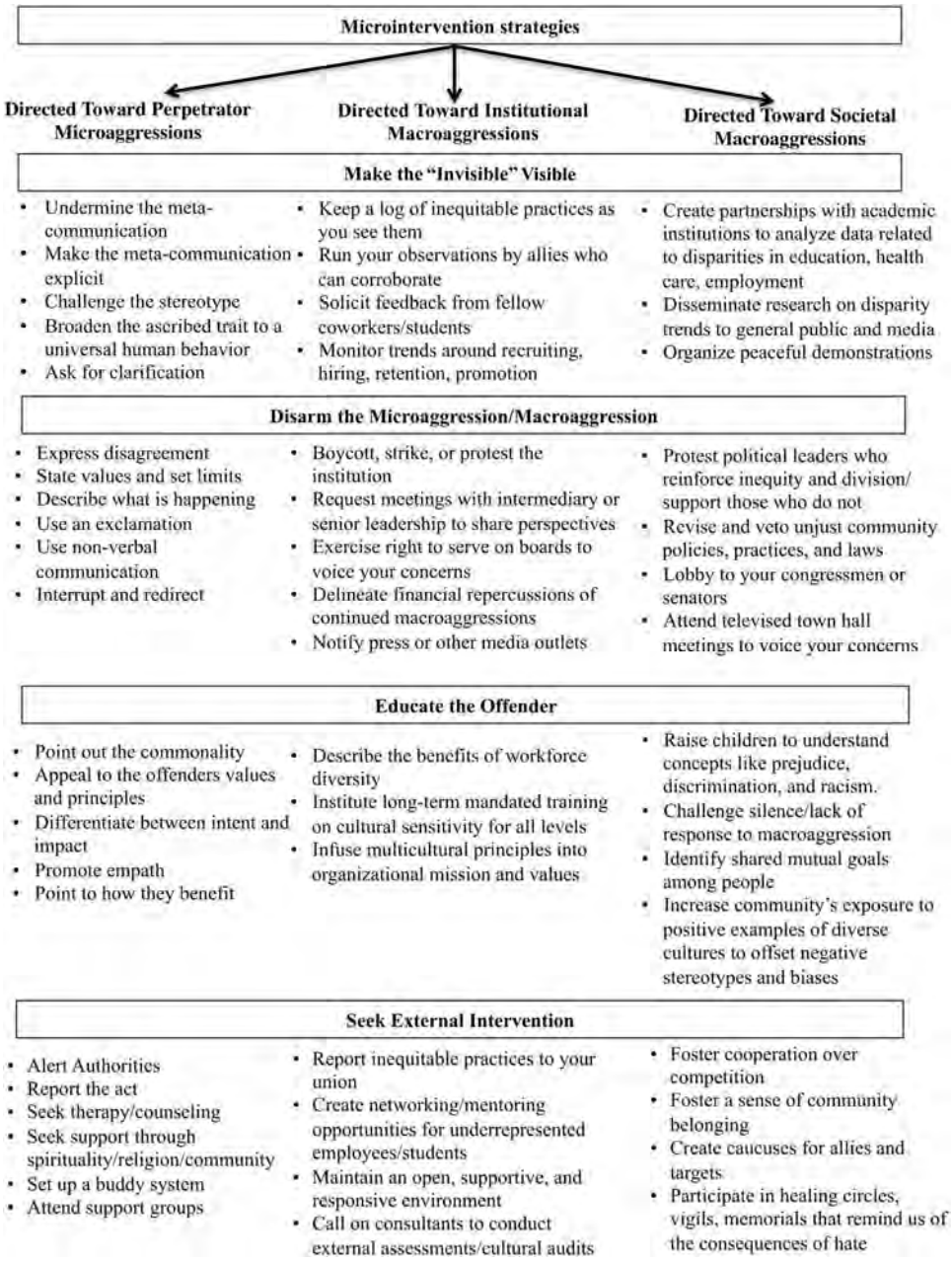

Figure 1. Microintervention strategies.

guesswork involved about the intent of the perpetrator (racial epithets or hate speech). Most microaggressions, however, contain both a conscious communication and hidden or metacommunication that is outside the level of perpetrator awareness (Nadal et al., 2014). Naiveté and innocence make it very difficult for offenders to change, if they perceive their actions as devoid of bias and prejudice (Jones, 1997). Microintervention tactics aimed at making the "invisible" visible can take many forms. Undermining or naming the metacommunication is an example of one of these tactics outlined in Table 1. For example, a White teacher says to a third-generation Asian American student, "You speak excellent English!" The metacommunication here may be "You are a perpetual alien in your own country. You are not a true American." In using a microintervention tactic, the student responds, "Thank you. I hope so. I was born here." This tactic may seem simplistic, but it does several things. It acknowledges the conscious compliment of the perpetrator, lowers defensiveness for the comeback to follow, subtly undermines the unspoken assumption of being a foreigner, and plants a *seed* of possible future awareness of

Table 1
Microintervention Strategies

Strategic goals	Objectives	Rationale	Tactics	Examples
Scenario: *African American male enters an elevator occupied by a White heterosexual couple. The woman appears anxious, moves to the other side of her partner, and clutches her purse tightly.* Metacommunication: *Black men are dangerous, potentially criminals, or up to no good.*				
Make the "invisible" visible	Bring the micro-/macroaggression to the forefront of the person's awareness	Allows targets, allies, and bystanders to verbally describe what is happening in a nonthreatening manner	Undermine the metacommunication	"Relax, I'm not dangerous."
	Strike back, defend yourself, or come to the defense of others	When allies or bystanders intervene, reassures targets they are not "crazy" and that their experiences are valid		"Don't worry, John is a good person."
	Indicate to the perpetrator that they have behaved or said something offensive to you or others	When those with power and privilege respond, has greater impact on perpetrator	Name and make the metacommunication explicit	"You assume I am dangerous because of the way I look."
	Force the perpetrator to consider the impact and meaning of what was said/done or, in the case of the bystander, what was not said/done		Challenge the stereotype	"I might be Black, but that does not make me dangerous."
			Broaden the ascribed trait	"Robberies and crimes are committed by people of all races and backgrounds."
			Ask for clarification	"Do you realize what you just did when I walked in?" "Do you feel afraid to be in this elevator with me?" "What was that all about? Are you afraid of him?"
Scenario: *Colleague makes the following statement about a new employee with a visible disability: "He only got the job because he's handicapped."* Metacommunication: *People with disabilities only receive opportunities through special accommodations rather than through their own capabilities or merit.*				
Disarm the microaggression	Instantly stop or deflect the microaggression	Provides targets, allies, and bystanders with a sense of control and self-efficacy to react to perpetrators in the here and now	Express disagreement	"I don't agree with what you just said."
	Force the perpetrator to immediately consider what they have just said or done	Preserves targets' well-being and prevents traumatization by or preoccupation with what transpired		"That's not how I view it."
	Communicate your disagreement or disapproval towards the perpetrator in the moment	Allows perpetrator to think before they speak or behave in future encounters with similar individuals	State values and set limits	"You know that respect and tolerance are important values in my life and, while I understand that you have a right to say what you want, I'm asking you to show a little more respect for me by not making offensive comments."

Table 1 (*continued*)

Strategic goals	Objectives	Rationale	Tactics	Examples
			Describe what is happening	"Every time I come over, I find myself becoming uncomfortable because you make statements that I find offensive and hurtful."
			Use an exclamation	"Ouch!" "Ahhh, C'mon!"
			Nonverbal communication	Shaking your head Looking down or away Covering your mouth with your hand
			Interrupt and redirect	"Whoa, let's not go there. Maybe we should focus on the task at hand."
			Remind them of the rules	"That behavior is against our code of conduct and could really get you in trouble."
	Scenario: *Student in a chemistry class makes the following comment about an Arab American student: "Maybe she should not be learning about making bombs and stuff."* Metacommunication: *All Arab Americans are potential terrorists.*			
Educate the offender	Engage in a one-on-one dialogue with the perpetrator to indicate how and why what they have said is offensive to you or others	Allows targets, allies, and bystanders the opportunity to express their experience while maintaining a relationship with the offender	Differentiate between intent and impact	"I know you didn't realize this but that comment you made was demeaning to Maryam because not all Arab Americans are a threat to national security."
	Facilitate a possibly more enlightening conversation and exploration of the perpetrator's biases	Lowers the defense of the perpetrator and helps them recognize the harmful impact	Appeal to the offender's values and principles	"I know you really care about representing everyone on campus and being a good student government leader but acting in this way really undermines your intentions to be inclusive."
	Encourage the perpetrator to explore the origins of their beliefs and attitudes towards targets	Perpetrator becomes keen to microaggressions committed by those within their social circle and educates others	Point out the commonality	"That is a negative stereotype of Arab Americans. Did you know Maryam also aspires to be a doctor just like you? You should talk to her; you actually have a lot in common."
			Promote empathy	"The majority of Arab Americans are completely against terroristic acts. How would you feel if someone assumed something about you because of your race?"
			Point out how they benefit	"I know you are studying clinical psychology. Learning about why those stereotypes are harmful is going to make you a better clinician."
Seek external reinforcement or support	Partake in regular self-care to maintain psychological and physical wellness	Mitigates impact of psychological and physiological harm associated with continuous exposure to microaggressions	Alert leadership	Ask to speak to a manager or someone who is in authority
	Check in with self and others to ensure optimal levels of functioning	Reminds targets, allies, and bystanders that they are not alone in the battle	Report	Report the incident in person or use anonymous online portals such as the Southern Poverty Law Center or use a hashtag on social media to make your experience go viral
	Send a message to perpetrators at large that bigoted behavior will not be tolerated or accepted	Ensures situations of discrimination or bias do not go unnoticed	Therapy/counseling	Seek out individual counseling with culturally competent providers for self-care and well-being

(*table continues*)

Table 1 (*continued*)

Strategic goals	Objectives	Rationale	Tactics	Examples
			Spirituality/religion/ community	Turn to your community leaders or members for support
			Buddy system	Choose a friend with whom you can always check in and process discriminatory experiences
			Support group	Join a support group such as "current events group" that meets weekly to process issues concerning minorities

false assumptions. With some modification, this type of response can also be made by White allies or bystanders who hear or see the transgression.

For targets, especially, there are other advantages to making the "invisible" visible. Disempowering the innuendo by "naming" it has been advocated by Paulo Freire (1970) in *Pedagogy of the Oppressed*. He concluded that the first step to liberation and empowerment is "naming" an oppressive event, condition or process so it no longer holds power over those that are marginalized. It demystifies, deconstructs and makes the "invisible" visible. Naming is (a) liberating and empowering because it provides a language for people of color to describe their experiences and (b) reassures them that they are not *crazy*. It further forces those with power and privilege to consider the roles they play in the perpetuation of oppression.

Likewise, White allies and bystanders cannot intervene when they are unable to recognize that a microaggression has occurred. The first rule of effective intervention is the quality of *perspicacity* or the ability to see beyond the obvious, to read between the lines, and to deconstruct conscious communications from metacommunications. Being able to decipher the double meanings of microaggressions is often a challenging task. Sternberg (2001) described perspicacity as a quality that goes beyond intellect but encompasses wisdom that allows for a person's clarity of vision, and penetrating discernment. Racial awareness training has been found to be effective in helping individuals recognize prejudicial and discriminatory actions, and to increase bystander intervention in the workplace (Scully & Rowe, 2009).

Strategic Goal: Disarm the Microaggression

A more direct means of dealing with microaggression is to disarm them by stopping or deflecting the comments or actions through expressing disagreement, challenging what was said or done, and/or pointing out its harmful impact. This more confrontive approach is usually taken because of the immediate injurious nature to targets and those who witness it. One technique advocated by Aguilar (2006) is to state loudly and emphatically, "Ouch!" This is a very simple tactic intended to (a) indicate to the perpetrator that they have said something offensive, (b) force the person to consider the impact and meaning of what they have said or done, and (c) facilitate a possible more enlightened conversation and exploration of his or her biases. Some examples are the following: "Those people all look alike" ("Ouch!"); "He only got the job because he's Black" ("Ouch!"); and "I'm putting you on the finance committee, because you people (Asian Americans) are good at that" ("Ouch!").

Another tactic found to be useful is to interrupt the communication and redirect it. During the course of a conversation when a microaggression, or a biased, and misinformed statement is made, simply interrupt it by directly or indirectly stopping the monologue, and communicating your disagreement or displeasure. This is very effective when a racist or sexist joke is being told. Examples of verbal microinterventions are these (Aguilar, 2006): "Whoa, let's not go there," "Danger, quicksand ahead!" and "I do not want to hear the punchline, or that type of talk." Nonverbal responses may include shaking your head (disapproval) and physically leaving the situation.

Strategic Goal: Educate the Perpetrator

Although microinterventions often create discomfort for perpetrators, most are not meant to be punitive, but rather educational (Sue, 2015). When microinterventions are used, the ultimate hope is to reach and educate the perpetrator by engaging them in a dialogue about what they have done that has proven offensive, what it says about their beliefs and values, and have them consider the worldview of marginalized group members (Goodman, 2011). We realize that education is a long-term process and brief encounters seldom allow an opportunity for deep discussions, nevertheless, over the long run, microinterventions plant seeds of possible change that may blossom in the future. This is especially true if they are exposed to frequent microinterventions by those around them, creating an atmosphere of inclusion and an environment that values diversity and differences (Purdie-Vaughns et al., 2008; Scully & Rowe, 2009). Many brief educational tactics can be taken by targets, allies, and bystanders to educate perpetrators. In Table 1, these include appealing to the offender's values and principles, pointing out the commonalities, increasing the

awareness of professional and societal benefits, and promoting empathy.

One of the most powerful educational tactics is to help microaggressors differentiate between good intent and harmful impact. When microaggressions are pointed out to perpetrators, a common reaction is defensiveness and shifting the focus from action to intention (Sue, 2015). Here, the person who may have engaged in behaviors or made a statement perceived as biased claims that "I did not intend it that way." In racial dialogues, shifting the topic to intent is tactically very effective because proving biased intent is virtually impossible. To overcome the blockage, it is often helpful to refocus the discussion on impact instead of intent. Some common statements may be the following: "I know you meant well, but that really hurts"; "I know you meant it as a joke, but it really offended Aisha (or me)"; "I know you want the Latinas on this team to succeed, but always putting them on hospitality committees will only prevent them from developing leadership skills"; I know you kid around a lot, but think how your words affect others"; and "I know you meant it to be funny, but that stereotype is no joke."

Strategic Goal: Seek External Reinforcement or Support

There are times in which individual efforts to respond to microaggressions may be contraindicated, and the most effective approach is to seek external support from others or from institutional authorities (Brondolo et al., 2009; Mellor, 2004). Targets, allies, and bystanders oftentimes put themselves at risk by confronting others about their microaggressions, and such efforts are often emotionally draining (Sue, 2017). Although the concept of racial battle fatigue is very applicable to targets, social justice advocates must also be prepared for the huge pushback likely to occur from others around them. Perpetrators may deny a target's experiential reality by claiming the person of color is *oversensitive*, *paranoid*, or *misreading the actions of others.* For allies and bystanders who choose to intervene, they may be accused as *White liberals*, or *troublemakers*, and consequently isolated or avoided by fellow White colleagues. A family member who objects to a racist joke told by an uncle, for example, may be admonished not to rock the boat for the sake of family harmony, or threatened to be disowned by the family. Antiracism work is exhausting and seeking support and help from others is an aspect of self-care.

Some important actions that can be taken are to find a support group, utilize community services, engage in a buddy system, or seek advice and counseling from understanding professionals. These external sources are meant to allow targets, allies, and bystanders to express their emotions in ways that are safe, to connect with others who validate and affirm their being, and to offer advice and suggestions. In many ways, these actions are meant to better prepare advocates for the challenges likely to be encountered, and to immunize them to the stresses of social justice work.

On another front, microinterventions often dictate seeking help from institutional authorities, especially when (a) a strong power differential exists between perpetrator and target, (b) the microaggression is blatant and immediately harmful (microassault), (c) it would be risky to respond personally, or (d) institutional changes must be implemented. A discriminatory act by a manager may best be handled by reporting to a higher authority or seeking an advocate with the same social/employment standing as the perpetrator within the company. Reporting racist graffiti and/or hate speech to university administrators, law enforcement agencies, and other community organizations are all possible microinterventions.

Context Matters

It would be erroneous and even dangerous for anyone to recommend microintervention strategies devoid of context and environmental considerations. Microaggressions do not occur in a vacuum and neither do antiracism strategies. White allies and bystanders who intervene after witnessing racial microaggressions may have a greater impact on the White perpetrator than targets who respond. Yet, it is also possible that a well-intentioned bystander might "make matters worse" by intruding on the privacy of the target (Scully & Rowe, 2009). It is important for all individuals engaging in microinterventions to operate with perspicacity and to understand the repercussions—both positive and negative. A few of these considerations are the following.

First, *pick your battles.* Although applicable to all three groups, this imperative seems more appropriate to people of color. Responding to frequent and endless microaggressions can be exhausting and energy depleting. For the purposes of self-preservation and safety, it is important to determine which offense or abuse is worthy of action and effort.

Second, *consider where and when you choose to address the offender.* Calling out someone on a hurtful comment or behavior in public may provoke defensiveness or cause an ugly backlash that does not end microaggressions but increases them. Determine the place (public or private), or time (immediate or later) to raise the issue with perpetrators.

Third, *adjust your response as the situation warrants.* If something was done out of ignorance, *educate* rather than just *confront.* A collaborative rather than an attacking tone lowers defensiveness and allows perpetrators to hear alternative views.

Fourth, *be aware of relationship factors and dynamics with perpetrators.* Interventions may vary depending on the relationship to the aggressor. Is the culprit a family member, friend, coworker, stranger or superior? Each relationship may

dictate a differential response. For a close family member, education may have a higher priority than for a stranger.

Last, *always consider the consequences of microinterventions, especially when a strong power differential exists between perpetrator and target.* Although positive results can ensue from a microintervention, there is always the potential for negative outcomes that place the target, White ally, or bystander at risk.

Discussion

In closing, we would like to suggest possible future directions in the study of microinterventions and provide a few general observations. First, although the existing stress-coping literature has identified valuable strategies in dealing with general stress, there is little research on microintervention coping strategies. It is imperative to identify new race-related response strategies, to determine their impact on microaggressive comments or actions, and to establish their effectiveness. It would also be valuable to determine the potency of microintervention training, and whether increasing the arsenal of antiracism strategies for targets have any positive effect on mental health, feelings of increased efficacy, and self-esteem. Likewise, does arming targets, allies, and bystanders with microinterventions increase the likelihood of challenging microaggressions? A reason often given for inaction in the face of bias is "not knowing" what to do. Additionally, "Do targets always want bystanders and allies to intervene?" Are there specific instances when interventions would be harmful to targets by reducing self-efficacy and autonomy, or actually increasing microaggressions? If so what are those situations and conditions? Further, what is the relationship of racial, cultural, and gender differences in responding to racist acts or statements? Do certain coping responses or specific microintervention strategies align better with some cultures or social identities? Lee, Soto, Swim, and Bernstein (2012) found that Asian Americans typically utilize indirect and more subtle approaches to maintain interpersonal harmony, whereas African Americans tend to confront racism more directly. To assume one is more functional than the other is to make an ethnocentric value judgment. It may be better to approach this issue by asking, "What role does race, culture, and ethnicity play in confronting discrimination, and what are the advantages and disadvantages that arise from their culture-specific use?" It is clear, that the concept of microinterventions is a complex issue, and future research is needed to clarify their manifestation, dynamics and impact.

Second, in the arena of education and training, identifying microintervention strategies and skills is not enough to produce actions on the part of well-intentioned individuals. It is clear that active interventions will only occur when other inertia and inhibitions are overcome, and when these skills are learned, practiced, and rehearsed. Some organizations in the business sector have begun "active bystander" training in confronting prejudiced responses (Aguilar, 2006; Ashburn-Nardo et al., 2008; Scully & Rowe, 2009). We believe such training would also benefit targets and White allies, and suggest similar microintervention training programs for psychology, education and other social service professions.

Third, this article has mainly addressed the microaggressions delivered on individual and interpersonal levels. Future research and work aimed at disarming macroaggressions at the institutional and societal levels are equally if not more important to develop. What can targets, allies, and bystanders do to impact macroaggressions that flow from the programs, procedures, practices, and structures of institutions and from societal social policies? We are currently working on delineating microintervention strategies at the institutional and societal levels shown on Figure 1.

Fourth, readers are probably aware that some of our examples and statements are not simply confined to racial microaggressions. Almost any marginalized group in our society can be subjected to microaggressions. Thus, many of our microintervention strategies may be equally applicable to gender, sexual orientation/identity, disability and other group-based micro/macroaggressions as well. We strongly encourage other scholars and practitioners to explore microintervention strategies that may not only share commonalities with other target populations, but also those unique to the group.

Last, it would be a monumental mistake to believe microinterventions alone would cure the omnipresent onslaught of microaggressions, and lead to the enlightenment of perpetrators. It is important to note that microaggressions are reflections of explicit and implicit biases and simply stopping prejudicial actions is not enough, unless serious internal self-reckoning occurs. Although microinterventions are short-term frontline actions that deal with the immediacy of racism expression, we believe they have major potential positive benefits for targets, White allies, bystanders, and ultimately our society.

References

Aguilar, L. C. (2006). *Ouch! That stereotype hurts: Communicating respectfully in a diverse world*. Orlando, FL: International Training and Development, LLC.

American Psychological Association (APA). (2016). *Stress in America: The impact of discrimination*. Washington, DC: Author.

American Psychological Association (APA). (2017a). *Stress in America: Coping with change, Part I*. Washington, DC: Author.

American Psychological Association (APA). (2017b). *Stress in America: Coping with change, Part II*. Washington, DC: Author.

Ashburn-Nardo, L., Morris, K. A., & Goodwin, S. A. (2008). The confronting prejudiced responses (CPR) model: Applying CPR in organizations. *Academy of Management Learning & Education, 7,* 332–342. http://dx.doi.org/10.5465/AMLE.2008.34251671

Broido, E. M. (2000). The development of social justice allies during college: A phenomenological investigation. *Journal of College Student Development, 41,* 3.

Brondolo, E., Brady Ver Halen, N., Pencille, M., Beatty, D., & Contrada, R. J. (2009). Coping with racism: A selective review of the literature and a theoretical and methodological critique. *Journal of Behavioral Medicine, 32,* 64–88. http://dx.doi.org/10.1007/s10865-008-9193-0

Brown, K. T. (2015). Perceiving allies from the perspective of nondominant group members: Comparisons to friends and activists. *Current Psychology, 34,* 713–722. http://dx.doi.org/10.1007/s12144-014-9284-8

Brown, K. T., & Ostrove, J. M. (2013). What does it mean to be an ally? The perception of allies from the perspective of people of color. *Journal of Applied Social Psychology, 43,* 2211–2222. http://dx.doi.org/10.1111/jasp.12172

Campbell, B., & Manning, J. (2014). Microaggressions and moral cultures. *Comparative Sociology, 13,* 692–726. http://dx.doi.org/10.1163/15691330-12341332

Clark, D. A., Spanierman, L. B., Reed, T. D., Soble, J. R., & Cabana, S. (2011). Documenting weblog expressions of racial microaggressions that target American Indians. *Journal of Diversity in Higher Education, 4,* 39–50. http://dx.doi.org/10.1037/a0021762

Clark, R., Anderson, N. B., Clark, V. R., & Williams, D. R. (1999). Racism as a stressor for African Americans: A biopsychosocial model. *American Psychologist, 54,* 805–816. http://dx.doi.org/10.1037/0003-066X.54.10.805

Cortes, C. (2013). *Multicultural America: A multimedia encyclopedia* (Vol. 1–4). Thousand Oaks, CA: Sage.

Dovidio, J. F., Gaertner, S. L., Kawakami, K., & Hodson, G. (2002). Why can't we just get along? Interpersonal biases and interracial distrust. *Cultural Diversity & Ethnic Minority Psychology, 8,* 88–102. http://dx.doi.org/10.1037/1099-9809.8.2.88

Edwards, K. E. (2006). Aspiring social justice ally identity development: A conceptual model. *NASPA Journal, 43,* 39–60.

Freire, P. (1970). *Pedagogy of the oppressed*. New York, NY: Continuum.

Goodman, D. (2011). *Promoting diversity and social justice: Educating people from privileged groups*. New York, NY: Routledge.

Helms, J. (1996). An update of Helm's White and people of color racial identity models. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 181–191). Thousand Oaks, CA: Sage.

Holder, A., Jackson, M. A., & Ponterotto, J. G. (2015). Racial microaggression experiences and coping strategies of Black women in corporate leadership. *Qualitative Psychology, 2,* 82–164. http://dx.doi.org/10.1037/qup0000024

Houshmand, S., Spanierman, L. B., & De Stefano, J. (2017). Racial microaggressions: A primer with implications for counseling practice. *International Journal for the Advancement of Counseling, 39,* 206–216. http://dx.doi.org/10.1007/s10447-017-9292-0

Huber, L. P., & Solorzano, D. G. (2014). Racial microaggressions as a tool for critical race research. *Race, Ethnicity and Education, 18,* 297–320. http://dx.doi.org/10.1080/13613324.2014.994173

Hunter, R. L. (2011). *An examination of workplace microaggressions and their effects on employee performance* (Master's Thesis). Available from ProQuest dissertations and theses database. (UMI No. 1503508)

Jones, C., & Shorter-Gooden, K. (2003). *Shifting:The double lives of Black women in America*. New York, NY: Harper Collins.

Jones, J. M. (1997). *Prejudice and racism*. Washington, DC: McGraw-Hill.

Jones, J. M., & Rolon-Dow, R. (in press). Multidimensional models of microaggressions and microaffirmations. In G. C. Torino, D. P. Rivera, C. M. Capodilupo, K. L. Nadal, & D. W. Sue (Eds.), *Microaggression theory: Influence and implications*. Hoboken, NJ: Wiley.

Joseph, J., & Kuo, B. C. H. (2009). Black Canadians' coping responses to racial discrimination. *The Journal of Black Psychology, 35,* 78–101. http://dx.doi.org/10.1177/0095798408323384

Kawakami, K., Dunn, E., Karmali, F., & Dovidio, J. F. (2009). Mispredicting affective and behavioral responses to racism. *Science, 323,* 276–278. http://dx.doi.org/10.1126/science.1164951

Latané, B., & Darley, J. M. (1968). Group inhibition of bystander intervention in emergencies. *Journal of Personality and Social Psychology, 10,* 215–221. http://dx.doi.org/10.1037/h0026570

Latané, B., & Darley, J. M. (1970). *The unresponsive bystander: Why doesn't he help?* New York, NY: Appleton-Century-Crofts.

Lazarus, R. S. (2000). Toward better research on stress and coping. *American Psychologist, 55,* 665–673. http://dx.doi.org/10.1037/0003-066X.55.6.665

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York, NY: Springer.

Lee, E. A., Soto, J. A., Swim, J. K., & Bernstein, M. J. (2012). Bitter reproach or sweet revenge: Cultural differences in response to racism. *Personality and Social Psychology Bulletin, 38,* 920–932. http://dx.doi.org/10.1177/0146167212440292

Lillienfeld, S. (2017). Microaggressions: Strong claims, inadequate evidence. *Psychological Science, 12,* 138–169.

Lukianoff, G., & Haidt, J. (2015, September). The coddling of the American mind. *The Atlantic*. Retrieved from https://www.theatlantic.com/magazine/archive/2015/09/the-coddling-of-the-american-mind/399356/

Mellor, D. (2004). Responses to racism: A taxonomy of coping styles used by Aboriginal Australians. *American Journal of Orthopsychiatry, 74,* 56–71. http://dx.doi.org/10.1037/0002-9432.74.1.56

Nadal, K. L., Griffin, K. E., Wong, Y., Hamit, S., & Rasmus, M. (2014). The impact of racial microaggressions on mental health: Counseling implications for clients of color. *Journal of Counseling and Development, 92,* 57–66. http://dx.doi.org/10.1002/j.1556-6676.2014.00130.x

Neville, H. A., Awad, G. H., Brooks, J. E., Flores, M. P., & Bluemel, J. (2013). Color-blind racial ideology: Theory, training, and measurement implications in psychology. *American Psychologist, 68,* 455–466. http://dx.doi.org/10.1037/a0033282

Neville, H. A., Yeung, J. G., Todd, N. R., Spanierman, L. B., & Reed, T. D. (2011). Color-Blind racial ideology and beliefs about a racialized university mascot. *Journal of Diversity in Higher Education, 4,* 236–249. http://dx.doi.org/10.1037/a0024334

Obear, K. (2016). *But I'm not racist! Tools for well-meaning Whites*. McClean, VA: The Difference Press.

Ong, A. D., Burrow, A. L., Fuller-Rowell, T. E., Ja, N. M., & Sue, D. W. (2013). Racial microaggressions and daily well-being among Asian Americans. *Journal of Counseling Psychology, 60,* 188–199. http://dx.doi.org/10.1037/a0031736

Pierce, C. (1969). Is bigotry the basis of the medical problem of the ghetto? In J. Norman (Ed.), *Medicine in the ghetto* (pp. 301–314). New York, NY: Meredith Corporation.

Pierce, C. (1970). Offensive mechanisms. In F. Barbour (Ed.), *In the Black seventies* (pp. 265–282). Boston, MA: Porter Sargent.

Potok, M. (2017). The Trump effect. *Intelligence Report, Spring,* 32–68. Retrieved from https://www.splcenter.org/fighting-hate/intelligence-report/2017/trump-effect

Purdie-Vaughns, V., Steele, C. M., Davies, P. G., Ditlmann, R., & Crosby, J. R. (2008). Social identity contingencies: How diversity cues signal threat or safety for African Americans in mainstream institutions. *Journal of Personality and Social Psychology, 94,* 615–630. http://dx.doi.org/10.1037/0022-3514.94.4.615

Reason, R. D., & Broido, E. M. (2005). Issues and strategies for social justice allies (and the student affairs professionals who hope to encourage them). *New Directions for Student Services, 2005,* 81–89. http://dx.doi.org/10.1002/ss.167

Rowe, M. (2008). Micro-affirmations and micro-inequities. *Journal of the International Ombudsman Association, 1,* 1–9.

Salvatore, J., & Shelton, J. N. (2007). Cognitive costs of exposure to racial prejudice. *Psychological Science, 18,* 810–815. http://dx.doi.org/10.1111/j.1467-9280.2007.01984.x

Schacht, T. E. (2008). A broader view of racial microaggression in psychotherapy. *American Psychologist, 63,* 273. http://dx.doi.org/10.1037/0003-066X.63.4.273

Scully, M. (2005). Bystander awareness: Skills for effective managers. In D. Ancona, T. Kochan, M. Scully, J. Van Maanen, & D. E. Westney (Eds.), *Managing for the future: Organizational behavior and processes* (Module 11, pp. 18–27). Cincinnati, OH: South Western College.

Scully, M., & Rowe, M. (2009). Bystander training within organizations. *Journal of the International Ombudsman Association, 2,* 1–9.

Shelton, J. N., Richeson, J. A., Salvtore, J., & Hill, D. M. (2006). Silence is not golden: The intrapersonal consequences of not confronting prejudice. In S. Levin & C. Van Laar (Eds.), *Stigma and group inequality: Social psychological perspectives*. Mahwah, NJ: Psychology Press.

Shorter-Gooden, K. (2004). Multiple resistance strategies: How African American women cope with racism and sexism. *The Journal of Black Psychology, 30,* 406–425. http://dx.doi.org/10.1177/0095798404266050

Smith, W. A., Hung, M., & Franklin, J. D. (2011). Racial battle fatigue and the miseducation of Black men: Microaggressions, societal problems and environmental stress. *The Journal of Negro Education, 80,* 63–82.

Solorzano, D., Ceja, M., & Yasso, T. (2000). Critical race theory, racial microaggressions, and campus racial climate: The experiences of African American college students. *The Journal of Negro Education, 69,* 60–73.

Spanierman, L., & Smith, L. (2017). Roles and responsibilities of White allies: Implications for research, teaching, and practice. *The Counseling Psychologist, 45,* 606–617. http://dx.doi.org/10.1177/0011000017717712

Speight, S. L. (2007). Internalized racism: One more piece of the puzzle. *The Counseling Psychologist, 35,* 126–134. http://dx.doi.org/10.1177/0011000006295119

Sternberg, R. J. (2001). *Wisdom, intelligence, and creativity synthesized*. New York, NY: Cambridge University Press.

Sue, D. W. (2003). *Overcoming our racism: The journey to liberation*. San Francisco, CA: Jossey-Bass. http://dx.doi.org/10.1002/9780787979690

Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender & sexual orientation*. Hoboken, NJ: Wiley.

Sue, D. W. (2015). *Race talk and the conspiracy of silence*. Hoboken, NJ: Wiley.

Sue, D. W. (2017). The challenges of becoming a White ally. *The Counseling Psychologist, 45,* 706–716. http://dx.doi.org/10.1177/0011000017719323

Sue, D. W. (in press). Microaggressions and student activism: Harmless impact and victimhood controversies. In G. C. Torino, D. P. Rivera, C. M. Capodilupo, K. L. Nadal, & D. W. Sue (Eds.), *Microaggression theory: Influence and implications*. Hoboken, NJ: Wiley.

Sue, D. W., Capodilupo, C. M., & Holder, A. M. B. (2008). Racial microaggressions in the life experience of Black Americans. *Professional Psychology, Research and Practice, 39,* 329–336. http://dx.doi.org/10.1037/0735-7028.39.3.329

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62,* 271–286. http://dx.doi.org/10.1037/0003-066X.62.4.271

Sue, D. W., & Sue, D. (2016). *Counseling the culturally diverse: Theory and practice*. Hoboken, NJ: Wiley.

Tatum, B. D. (1997). *Why are all the Black kids sitting together in the cafeteria?* New York, NY: Basic Books.

Thomas, K. R. (2008). Macrononsense in multiculturalism. *American Psychologist, 63,* 274–275. http://dx.doi.org/10.1037/0003-066X.63.4.274

Wang, J., Leu, J., & Shoda, Y. (2011). When the seemingly innocuous "stings": Racial microaggressions and their emotional consequences. *Personality and Social Psychology Bulletin, 37,* 1666–1678. http://dx.doi.org/10.1177/0146167211416130

Waters, A. (2010). Book review: *Injustice*. *Local Economy, 25,* 523–525. http://dx.doi.org/10.1080/02690942.2010.525995

Williams, D. R., & Williams-Morris, R. (2000). Racism and mental health: The African American experience. *Ethnicity & Health, 5,* 243–268. http://dx.doi.org/10.1080/713667453

Received September 21, 2017
Revision received December 11, 2017
Accepted December 28, 2017 ■

Available online at www.sciencedirect.com

ScienceDirect

Cognitive and Behavioral Practice xxx (2023) xxx–xxx

Cognitive and Behavioral Practice

www.elsevier.com/locate/cabp

An Evidence-Based Approach for Treating Stress and Trauma due to Racism

Monnica T. Williams, *University of Ottawa*
Samantha Holmes, *City University of New York, College of Staten Island*
Manzar Zare, *University of Ottawa*
Angela Haeny, *Yale School of Medicine*
Sonya Faber, *Bioville GmbH*

Racism can be stressful or even traumatizing. Psychological unwellness emerges out of the confluence of historical, cultural, and individual experiences, and resulting syndromes may or may not fit into a DSM-5 PTSD diagnostic framework. Although racial stress and trauma are common presentations in therapy, few therapists have the resources or training to treat these issues. Based on the empirical evidence to date, this article describes the essential components of treatment for racial stress and trauma from a cognitive-behavioral perspective, called the Healing Racial Trauma protocol. Each technique is described with reference to the literature supporting its use for racial stress and trauma, along with guidance for how therapists might implement the method with clients. Also provided is information about sequencing techniques for optimal outcomes. Critical therapist prerequisites for engaging in this work are also discussed, with an emphasis on an anti-racist, empathy-centered approach throughout.

Racial trauma has been described as a psychological injury caused by hate or fear of a person due to their race, ethnicity, or skin color (Carter, 2007; Comas-Díaz, 2016). It is cumulative in nature and eventually overwhelms a person's coping ability (Williams, Metzger, et al., 2018). It may manifest in a number of forms, including as a severe interpersonal stressor that threatens one's well-being or even one's life, or it may be an institutional stressor motivated by racism that causes severe ongoing distress (Reynolds, 2019). Racial trauma is linked with identity and can be experienced by people identifying as any race, people group, or ethnicity. Some experiences of racial trauma (e.g., physical assault in the context of a hate crime) would meet the DSM-5's definition of a trauma ("exposure to an actual or threatened death, serious injury, or sexual violence"; APA, 2013, p. 271). However, other manifestations of racial trauma (e.g., chronic exposure to racial microaggressions, vicarious trauma through graphic media coverage of police brutality) may not match the aforementioned criterion, despite being experienced as traumatic (Holmes et al., 2016). We, nonetheless, retain such experiences in our definition of racial trauma given previous research demonstrating that the prevalence and severity of PTSD symptoms do not vary as a function of whether the event met Criterion A (e.g., Anders et al., 2011; Lansing et al., 2017; Roberts et al., 2012), and such experiences are associated with PTSD symptoms above and beyond Criterion A events (e.g., Loo et al., 2001).

Racial stress refers to the psychological response to experiencing racism that can develop into a pathology called racial trauma. Racial stress and traumatization can reflect the severity and symptomatology of post-traumatic stress disorder (PTSD). Although PTSD, as described in the DSM-5, is caused by discrete events such as combat, sexual assault, or accidents, research indicates that experiences of racism can have similarly debilitating psychological effects on People of Color. As such, *racial trauma* can be defined as the cumulative experiences of racism throughout one's life that lead to severe mental and emotional injury (Williams, Osman, et al., 2021). Sufferers may display intrusion

Keywords: racism; PTSD; racial trauma; race-based trauma; discrimination

Please cite this article as: Williams, Holmes, Zare et al., An Evidence-Based Approach for Treating Stress and Trauma due to Racism, https://doi.org/10.1016/j.cbpra.2022.07.001

symptoms (e.g., recurrent nightmares, upsetting thoughts), avoidance behaviors, adverse changes in cognition and mood (e.g., distorted blame, embarrassment, isolation, dysphoria), as well as alterations in arousal and reactivity (e.g., self-destructive behaviors, hypervigilance, sleep issues; Williams, Metzger, et al., 2018). When untreated, racial stress may also lead to the development of other comorbid disorders, such as major depressive disorder, substance use disorders, social anxiety disorder, and even psychosis (Berger & Sarnyai, 2015; Gibbons et al., 2014; Williams, Printz, et al., 2018). It is estimated that 30% of People of Color may suffer from some degree of racial trauma, with many seeking help from mental health providers (Williams et al., in press). Research shows that racism is linked to a host of negative mental health conditions, but the connection between racial discrimination and PTSD symptoms appears to be the most robust (Williams, Haeny, & Holmes, 2021). Racial discrimination is the most common form of discrimination studied in relation to health outcomes, although all forms of discrimination can contribute to traumatization (e.g., Berger & Sarnyai, 2015; D. Williams et al., 2019). Racial stress and trauma are often compounded by community trauma, historical trauma, and cultural trauma.

To understand racial trauma, one must first have a clear understanding of racism. Racism can be defined as "a system of beliefs (racial prejudices), practices (racial discrimination), and policies (structural racism) based on race that operates to advantage those with historical power, White people in the United States of America (USA) and most other Western nations" (Haeny et al., 2021). Race, in the United States, is a social caste system that is constantly evolving, and is used to categorize people based on similar physical and social characteristics. Race is a social construct with no biological basis and is derived from White supremacy, an ideology that assumes the superiority of White people over People of Color (Haeny et al., 2021). This framework is based on the American racial paradigm. Still, it can be applied to other specific contexts where people are traumatized based on belonging to a specific people group (i.e., Serb-Croat, Tutsi-Hutu, Shiite-Suni conflicts). As such, although people with racial trauma are suffering psychologically, it is important to recognize that the source of the problem is not within the person, but rather is the product of a dysfunctional society.

White people can suffer from racial trauma as well. It should be noted, however, that because the impact of racial stress for White people is not augmented by their chronic and systemic racial oppression (as it is for People of Color), it may be less likely to be experienced as traumatic. Indeed, research shows that it is relatively rare for a White person to be traumatized due to persecution over their White identity (Carter et al., 2020), however, many White people can be subjected to racial stressors from other White people if they reject the rules of Whiteness as it exists in their societies (Malott et al., 2019). In racialized societies, the expectation is that White people will accept Whiteness as the unspoken standard to which all groups are compared, and this maintains the racial hierarchy whereby White people are treated as superior and People of Color are treated as inferior (Haeny et al., 2021). When White people in racialized societies attempt to stand up to racism, they are subject to persecution by other White people, which can result in traumatization. Although many of the techniques described herein can also be helpful for traumatized White allies, this paper will focus on using the Healing Racial Trauma protocol for People of Color.

Despite the fact that racial stress and trauma are relatively common, there are few evidence-based treatments available (Grau et al., 2021; Williams, Haeny, & Holmes, 2021; Williams, Osman, et al., 2021). Most counselors have seen clients with racial trauma, but few have received training in assessing or treating it (Hemmings & Evans, 2018). Although many experts in racial trauma have outlined what treatment might entail (e.g., Carlson et al., 2018; Chavez-Dueñas et al., 2019; Comas-Dias, 2016; Reynolds, 2019), there remains a need for a more detailed approach on how to help people suffering from racial stress and trauma. Further, no CBT treatments exist for racial stress and trauma that are grounded in the empirical literature.

Purpose of This Paper

The purpose of this paper is to provide guidelines for how therapists can help clients suffering from racial stress and trauma using a CBT framework. Notably, many interventions suggested in the literature focus on fostering resilience in People of Color. While we agree this is a worthwhile approach (and has been an essential conceptualization to combat notions of cultural deficiency), we argue that, in general, People of Color are already resilient enough. The issue is that no one can be continuously resilient in the face of ongoing abuse, and therefore treatment must also include components aimed at protecting the client from unnecessary racist acts and reducing racism in their lives. Despite that no manualized validated protocols are available, there is sufficient empirical support for multiple strategies to alleviate the stress or trauma associated with racist events, and as such it is our ethical obligation to offer this to clients who are suffering.

What follows is an intervention we have called the Healing Racial Trauma protocol to help clients who are struggling with racial stress and trauma. Accordingly, each section of this paper lists a technique within the intervention, provides research support surrounding the technique, and then offers guidance for therapists in making use of the technique. We also include a table of terms and definitions as Supplementary Materials to help orient readers to the terminology used here. However, anyone treating racial trauma should already be well-versed in current terminology, which is ever evolving.

Empirically Supported CBT Techniques for Racial Stress and Trauma

Assessment of Racial Stress and Trauma

Assessing a client's racial stress and trauma is an essential part of the treatment process. When people who have endured racism are able to tell their story in a supportive environment, it is the first step in taking agency and power over the harmful event. Therapists should be familiar with common racial stressors; in addition to commonly recognized sources of trauma, People of Color are often subjected to traumatic police search and assaults, incarceration, workplace discrimination and harassment, and hate crimes; refugees and immigrants may have been victimized by ethnic cleansing and persecution, torture, and migratory hazards (Williams, Printz, et al., 2018). It is important to explicitly ask about these experiences because clients may not volunteer all of the information out of shame or because some of the experiences are so familiar, they do not think of them as "traumas." Further, because so many People of Color are used to their experiences being dismissed or invalidated, they may fail to mention their racial stress and trauma entirely.

Scholars of color have developed multiple validated instruments to assist in the assessment of racial stress and trauma (for a comprehensive review, see Williams, Haeny, & Holmes, 2021). Some recommended instruments include the Racial Trauma Scale (RTS; Williams et al., in press) and the UConn Racial/Ethnic Stress & Trauma Survey (UnRESTS; Williams, Metzger, et al., 2018) clinical interview, designed to uncover various types of racism encountered by clients and assist in determining whether such experiences were collectively traumatizing. Clinicians may also make use of the cultural formulation interview (CFI; APA, 2013) to understand the client's experience in the context of their cultural definition of the problem, perceptions of causes, cultural factors affecting self-coping and help seeking. The CFI does not inquire about racism or oppression but can help provide a broader picture of the client's cultural context. The Race-Based Traumatic Stress Symptom Scale (RBTSSS) is available in self-report and interview formats and can help provide a good idea of key areas in need of intervention (Carter & Pieterse, 2020). Several of these measures are available in Spanish as well (Williams et al., 2017).

Besides using scales and specialized interviews to assess clients' racial stress and trauma experiences, clinicians can further evaluate what clients believe the incidents and the aftermath tell them about themselves. Taking a complete trauma history is necessary when assessing racial stress and trauma, as all traumas are cumulative, even those unrelated to racism. Clinicians should ask clients about prior attempts at healing, psychological and treatment history, and their explanatory models about the trauma.

Validation of Experiences and Support From Therapist

When clients are suffering from racial stress and trauma, validating their experience is essential. As a rule, clinicians should accept that all experiences of racism shared by a client are real and not imagined or exaggerated. Racism by nature is a system of social collusion that undermines the credibility and authority of those who experience it. This socially punishing response can make victims question their reality and pressure them into remaining silent and helpless in the face of ongoing abuse. For this reason, Socratic questioning around the veracity of experiences of racism should be avoided, as it will only compound a client's confusion and shame (e.g., Johnson et al., 2021). Indeed, the most important initial step on the journey of healing is ensuring that clients feel seen and heard.

Bryant-Davis and Ocampo (2006) note that survivors of racial trauma should acknowledge violations and identify them as a racist incidents. For some, this acknowledgment may be straightforward and easy; others, however, might need help working through denial, avoidance, and minimization. The therapist's response to disclosures of racism is critical to the healing process. Laszloffy and Hardy (2000) remind us that therapists must be capable of validating the role that racism plays in the life of the client, even in circumstances where they may question this perspective. The fact that it is possible to validate a perspective without necessarily agreeing with it deserves mention. That being said, in our experience, clients are often ashamed of having been victims of racism, and as such are much more likely to understate the impact of racism than the reverse. As noted by Carter and Pieterse (2020), "Guilt and shame may arise due to

self-blame and a sense of responsibility for the experience" (p. 36). Miller and colleagues (2018) underscore the importance of validation as a key general strategy for helping clients suffering the effects of racism. Validation includes a desire to acknowledge and explore racist experiences and racism-related stress, normalizing these experiences and reactions, recognizing a client's strengths, and validating the resilience and survival strategies used to navigate racism.

In many cases, clients have internalized so many negative thoughts about themselves and their group that they manifest psychopathology surrounding their idenity, which is a result of being immersed in an extremely toxic racialized social environment. To counteract the damaging negativity coming from all directions, an intense detoxifying experience may be necessary, which may involve repeated affirming and positive affirmations about the client and their ethnic group (e.g., Koch et al., 2020; Roberts, 2021; Williams, 2020).

Therapists can start to validate their clients' experiences of racism through body language that expresses empathy (e.g., being attentive, nodding thoughtfully, empathetic facial expressions). Support should be verbalized when the client discusses the reasons they sought treatment and the ways in which they have been harmed due to racism. Clinicians can provide responses such as, "I am so sorry you had to experience that" or "Nobody should ever have to put up with those behaviors." Therapists can underscore that racism is not the fault of the client by making statements like, "That wasn't right for them to make you feel responsible for their prejudice." This may be particularly challenging for therapists when the client describes being mistreated by people from the same racial group as the therapist. Therapists must take care not to become defensive or assume the client is including the therapist in this description.

Psychoeducation About the Nature of Racism and Its Connection to Poor Mental Health

Understanding the source, history, and nature of racism and how it functions is a prerequisite for addressing racism-related stress, since it can be difficult to make sense out of an experience if the core nature of the problem is not understood. Clients may not even have the language to describe their experiences (Reynolds, 2019). Clients will be best equipped to cope with racism when they understand how racism works in our society, although this will differ some based on the specific marginalized identities of the client and their intersectionalities. Clients may have embraced falsehoods, such as the Myth of Meritocracy, which posits that success is predicated on hard work alone (Kwate & Meyer, 2010; Madeira et al., 2019). As such, they may see their race-related struggles as personal failures, and others' dislike of them as being caused by personality flaws. Further, these experiences of racism have cumulative mental health sequelae that may reflect their reasons for coming to therapy.

Providing psychoeducation about a client's psychopathology is not unlike Foa and colleagues' (2007) empirically supported PTSD treatment protocol, Prolonged Exposure (PE), which dedicates time in an early session to reviewing common symptoms of traumatization that may be experienced by the client. In a review of the racial trauma literature, psychoeducation included educating clients that racism is a trauma and that clients may need treatment for PTSD symptoms due to racism, as well as education about the historical context of racism, the value of interracial connection, and antiracism strategies (Chapman-Hilliard & Adams-Bass, 2016; Miller et al., 2018).

Psychoeducation about racism early in the treatment process is important for building a strong foundation for healing. These concepts will be referenced and utilized repeatedly throughout the treatment process, and they give clients a language with which to describe and process their experiences (Reynolds, 2019). Psychoeducation should not be provided as a lecture, as therapists should try to make it as conversational as possible. A helpful start involves asking clients to share their understanding of racism and its impact. For example, the clinician might say, "Share with me the ways in which racism has impacted your life." This will help the clinician have a sense of the client's understanding of racism and its impact and identify gaps in knowledge they could share.

Furthermore, some time should be spent teaching clients that experiences of racism are a social problem that will make their lives more difficult in many ways and will bring about unmerited hate, even if they are doing everything "right." One common misconception is: "If you do the 'right thing' you won't be harmed by racism." People who hold this belief might be more likely to internalize or blame themselves for not doing the "right thing" when they experienced racism. It is important to help clients understand the insidiousness of racism so that they properly externalize these experiences as opposed to internalizing them. The reality is that even when we do the "right thing" we can still suffer from the effects of racism. This shifts the focus to doing the "right thing" by engaging in behaviors that are consistent with the client's values including after experiencing racism (this will be discussed further in the sections that follow).

Another approach for providing psychoeducation on racism to clients is to offer a reading list. If the client is interested in reading on racism, the therapist might select readings to do simultaneously outside of session and discuss them together in session. We recommend giving a weekly reading for homework, which should be tailored to the client's reading level and time available to engage in reading tasks. Some clients like dense, academic materials, whereas others might prefer a short popular press article or a podcast. Some clients might be more visual learners and may prefer to learn about racism through videos. This could include brief videoclips in session or providing a list of movies or documentaries.

Assess and Strengthen Coping Strategies Being Employed for Racism

Therapists should assess whether clients are using unhealthy strategies to cope, which may include misuse of substances, parasuicidal self-harm, suicidal ideation, dysfunctional eating, or other risk-taking behaviors, which should be discouraged (Bryant-Davis & Ocampo, 2006; Saban et al., 2021). It is important to note these behaviors may serve a purpose (e.g., short-term emotion regulation), and more beneficial approaches may not be available or readily apparent to sufferers (Jacob et al., 2022). Problem-focused strategies may increase distress in the short term but result in greater well-being in the long term. Although ameliorating acute distress may have a more immediate impact on the client's emotional state, behaviors that end ongoing racism rather than simply enduring it, constitute a more useful means of coping and contribute to reducing racism in the person's life overall (Jacob et al., 2022).

Some strategies are ambiguous regarding whether they are helpful, as approaches that prove useful for some may serve to increase stress and reduce functioning for others. Hence, taking an inventory of coping strategies and evaluating their effectiveness should occur early in the treatment process and be a collaborative endeavor between the therapist and client (Malott & Schaefle, 2015). Coping strategies need not be labeled "good" or "bad" but rather examined in terms of whether they are adaptive for a client in their specific context, in both the short and long term. Some strategies will be determined maladaptive, and as such, the therapist can help identify replacement strategies for the client. For ambiguous strategies, that is strategies that may be adaptive in some contexts and maladaptive in others, the therapist can conduct an ongoing assessment of the effect of said strategy before, during, and after responding to racism, and then make a determination as to whether adjustments are needed (Malott & Schaefle, 2015).

One strategy, that is often overlooked but should be assessed, is termed "John Henryism" (Hill & Hoggard, 2018). This is a harmful coping mechanism that is often used by People of Color, famously named after the fable of a Black man who worked himself to death competing against a steam engine. This coping style is found to be prevalent in those who believe that enough hard work will eventually lead to them being appreciated as equal to their White counterparts. Some research has identified this strategy as positive in the short term as it can promote hard work and avoid conflict. However, in the long term, it can cause or accelerate physical ailments (Jacob et al., 2022).

To start the conversation around coping mechanisms, therapists can say to a Client of Color, "If you're okay with it, I'd like to talk about how you respond when someone acts racist towards you or when you really feel the impact of being a Person of Color in society. What do you do after unpleasant things like this happen to you?" The clinician may want to give some examples to make it more tangible (crying, punching a wall, calling a friend, eating chocolate, etc.). The clinician can highlight that coping strategies range with regards to how adaptive or maladaptive they are. In the course of treatment, the therapist should encourage the use of coping strategies that they and the client collaboratively determine to be adaptive or "healthy" (next sections) with positive reinforcement while appreciating that change will be a process.

Self-Care

Self-care has been defined as activities performed by an individual for the purpose of promoting overall health and general well-being. It is also a skill that requires self-awareness of one's emotional, cognitive, physical and spiritual state. Self-care is critical for recovery from all manner of physical and emotional insults, and is required for sustained well-being (Hansson et al., 2005). Self-care is a broad term, but here we are specifically referring to self-focused behaviors strictly for personal well-being. These include fitness, relaxation, enjoyable personal pursuits, taking a personal day off work, shopping, hobbies, massage, individual psychotherapy, aromatherapy, travel for fun, listening to music, turning off the phone, and unplugging from stressful social media. Wyatt and Ampadu (2021) make a distinction between regular self-care and racial self-care, described as a tool for social justice and survival for marginalized communities, as the goal is to promote self-determination, self-preservation, and self-restoration in an environment of ongoing oppression. Both types of self-care are useful.

An exhaustive review of the coping literature reveals that People of Color often neglect self-care, and almost no Black people make use of it when overtaken by the stress of racism (Jacob et al., 2022). It could be that People of Color feel they cannot relax or pursue pleasurable activities lest they be judged in accordance with negative stereotypes. Further, the ability to make time for self-care is a privilege, given that racism contributes to limited time resources, especially among working-class People of Color who may have to choose between taking time for self, working to make ends meet, or caring for a loved one. With this in mind, it is imperative that clinicians acknowledge these competing demands and be creative on how self-care might be incorporated in everyday life in this context.

In many European countries, people experiencing workplace burnout routinely take a few weeks off to recuperate at a relaxing Alpine mineral hot spring spa. Indeed, German researchers have found that those undergoing a traditional "Kur" (recuperation at an all-inclusive hot spring) found long-term positive effects (reduction in pain and increase in well-being) of at least 1-year duration after the Kur (Leuchtgens et al., 1999). Likewise, the aromatherapy Japanese art of shirin-yoku, or walking through a natural evergreen or cedar forest, has been found to decrease stress-biomarkers, increase natural killer cells, and enhance the expression of anticancer proteins. These positive effects have been found to be due in part to aerosol phytoncides released from trees (Antonelli et al., 2019; Timko Olson et al., 2020).

Self-care first requires accurately assessing one's state of well-being, and those suffering from the trauma of racism should start building up a repertoire of self-care activities, such as resting, eating wholesome foods, exercising, engaging in spiritual practices, visiting nature, and pursuing fulfilling hobbies (Bryant-Davis & Ocampo, 2006). People from more collectivistic cultures may struggle with the idea of doing good things that appear to be just for themselves. Clients should be reminded that taking time for one's own personal wants and needs is essential for good physical and mental health, because when one is debilitated by racism, it makes it difficult to meet family obligations or be of service to others. Further, unapologetic acts of self-care can be framed as an act of empowerment in the face of racist social attitudes that may label such behaviors as selfish or indulgent when enjoyed by People of Color (e.g., Cromer, 2021). Audre Lorde acknowledges the power inherent in self-care in the face of oppression and writes, "Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare" (Nayak, 2020, p. 405).

For clients who have chaotic lives and stressful jobs, time alone may be particularly important. Therapists might say, "You need to allow yourself time to recover. During this period, you may want to limit exposure to racism. This may mean avoiding going into places where you know, or suspect people will mistreat you. This is an important step in prioritizing your wellness. You will not avoid these places or people forever, but for now, it may be helpful to allow your heart and mind to have some peace while you are recovering and healing." CBT strategies for helping clients to engage in self-care would include recognizing situations or people who might mistreat them, avoiding those situations when possible, and planfully preparing coping approaches for these situations when they are unavoidable. For clients with the means to do so, time away could be an excellent way to jump start self-care. For clients without means, as noted, even spending time in nature can facilitate healing.

Most clients we have seen with racial trauma are resistant to self-care, and carrying out these activities may require revisiting social notions of who is deserving of care and why. To help bring about change, therapists can work with clients to develop a self-care plan and even schedule days in the calendar when specific self-care activities will occur.

Self-Compassion

Self-compassion can be described as the ability to have compassion toward one's self despite feelings of inadequacy, failure, or suffering. Self-compassion has been described as having three dimensions: "self-kindness versus self-judgment, mindfulness versus over-identification, and common humanity versus isolation" (Neff, 2003) (mindfulness to be discussed in a later section). Increasing self-compassion can decrease feelings of guilt and shame following experiences of racism by promoting feelings of love and kindness toward the self and recognizing that others suffer in the same way as well.

Social connection appears to play a critical role in the utility of self-compassion. Liu and colleagues (2020) conducted a study of Asian American college students, where they found that when participants had *either* high levels of social connection *or* high levels of self-compassion (i.e., self-kindness, mindfulness), their experiences of racism were associated with greater depression symptom severity. However, when participants had *both* high levels of social connection and high levels of self-compassion (i.e., self-kindness, mindfulness), their experiences of racism were not associated with depression symptoms. The results of this study highlight the importance of not only cultivating components of self-compassion (i.e., self-kindness,

mindfulness) but also social connection as the combination is more likely to be protective against the deleterious impact of racial trauma.

Therapists should model and encourage self-kindness, which means being warm and loving rather than harsh or judgmental toward the self during times of difficulty. It is important to recognize that suffering and difficulties are part of a shared human experience rather than simply an isolated personal failure. Further, Litam (2020) recommends that clients with race-based trauma cultivate self-compassion by focusing on their immediate needs in the present without judgment. For example, a therapist might say, "I understand that you are frustrated with yourself for having to take a leave from work due to racial stress, but can you give yourself permission to feel unwell for a while? Everyone has times where they can't do all the things they would like due to illness, stress, or unexpected life events. How would it be to accept that you need a break, and for now that is ok?"

External Social Support

One of the most successful and healthy coping mechanisms to combat the stress of racism is social support (e.g., Noh & Kaspar, 2003; Wright & Wachs, 2019). Family, friends, dating partners, coworkers, neighbors, and anyone who offers care and support for an individual are considered part of the social support network (Evans et al., 2016). Research has demonstrated that social support is protective against mental health concerns, generally (Turner & Brown, 2010), and posttraumatic stress, specifically (Bryant-Davis et al., 2011, 2015). Further, social support may be particularly important for People of Color. Due to a long and enduring history of institutional racism and medical racism, and the resulting cultural mistrust, People of Color may be less likely to utilize formal mental health care and may prefer relying on their own social support networks, which may also be consistent with collectivist values (Sue, Alsaidi, et al., 2019; Williams, Duque, et al., 2018). When people share their experiences of racism with those who have had similar experiences, they may feel a sense of kinship and understanding (Evans et al., 2016). Discussing experiences with trusted others also provides an opportunity for emotional processing and an opportunity for reexamining maladaptive cognitions (e.g., internalized racism, hopeless outlook).

Evans and colleagues (2016) suggest that in the case of racial trauma, therapists should first acknowledge the severity of the racism in the Western world, and then, help clients find social resources that address racial discrimination. In keeping with this, they suggest meeting with the client in a comfortable community-based setting, inviting supporting persons to the counseling session as needed, and promoting dialogue with the client's cultural community. Likewise, Miller and colleagues (2018) advise therapists to help clients build meaningful ties within their family, racial and ethnic community, ethnic churches and religion, as well as to identify and connect with members of other racial groups, including White allies.

Another strategy to incorporate social support in the treatment of racial trauma is "within-group sanctuary" proposed by Watts-Jones (2002). That is because the shared experience of a within-group environment tends to limit the exacerbation of shame and reduces the possibility of defensiveness, both of which are more likely in the presence of those who have benefited from racism. In an environment comprising people from the same ethnoracial group, experiences such as racial microaggressions are less likely. However, even in spaces that provide within-group sanctuary with regards to race and ethnic group, there is potential for discrimination based on other marginalized identities (e.g., gender, sexual orientation, religion; Quaye et al., 2019), so this must also be considered.

For those with racial trauma, it is crucial to increase social support by purposefully connecting clients with members of their social network who are reliably supportive. For example, clients can reach out to someone important with whom they have lost touch (e.g., an old friend) or increase time with nurturing family members. Purposefully connecting with others within one's own group can provide social support for survivors of racial trauma in the sense that the individual's experiences with racism may be best validated by others who experience the same thing, rather than people who might not have a thorough understanding of these experiences (e.g., Carlson et al., 2018; Watts-Jones, 2002). Therapists can support clients in creating an interpersonal inventory for quick reference. Other options that can be cultivated include affinity groups like meetups, Equity, Diversity and Inclusion Committees at work or school, antiracism groups, healing circles, and/or friends and family members who understand racism (but not those who are overly critical).

Mindfulness to Connect With Emotions

The concept of mindfulness originated from Buddhist traditions, although all religions have some form of contemplative practice. In psychological contexts, mindfulness has been used to help clients learn to pay attention to the present moment by nonjudgmentally noting their surroundings, physical sensations, and thoughts without becoming involved in them. Specifically, mindfulness entails being aware of

thoughts and feelings while refraining from ruminating about personal struggles (Sobczak & West, 2013). Sobczak and West observe that mindfulness allows clients to build a feeling of acceptance, which allows them to notice their interior sensations without ignoring, manipulating, or avoiding them. As such, clients who practice mindfulness and acceptance are less likely to participate in avoidance behaviors and more likely to engage in actions that help them to live a more meaningful, improved, and valued life. This is especially crucial for those who are experiencing racism, as emotionally distracting from experiences of racism is associated with greater depression severity (Noh & Kaspar, 2003).

Mindfulness can be a positive strategy because it presents a mechanism for accepting the negative emotions elicited by racist events, thereby reducing experiential avoidance (Graham et al., 2013; Zapolski et al., 2019). Many people struggling with racial trauma have difficulty acknowledging their feelings about these experiences and how they are impacted. But mindfulness can be potentially unhelpful if it results in acceptance of repetitive mistreatment that, in turn, facilitates continued victimization due to racism. As such, therapists must take care in their use of mindfulness with clients to ensure that it is being judiciously employed in the service of the client's well-being. DeLapp and DeLapp (2021) provide a framework for addressing repressed emotions around experiences of racism. They suggest therapists explore this by saying things like, "I notice that when we start discussing events that cause racial stress, you say that the event 'wasn't a big deal.' I wonder why you say this?" When the client responds, the therapist can follow up with, "What does it feel like when these things happen? What are you feeling in your body right now as we talk about the security guard following you in the store?" This approach acknowledges the behavioral patterns and invites the client's awareness of these patterns while facilitating processing.

There are many ways in which mindfulness can be practiced, including through guided meditation (e.g., Hwang & Chan, 2019). Dr. Candace Nicole developed a Black Lives Matter guided meditation that includes mindfulness, affirmation, and loving-kindness (Hill, 2017). She developed two versions: (1) a Black Lives Matter Meditation for Healing from Racial Trauma, which is shown to be beneficial in reducing race-based stress reactions among Black people (Hargons et al., 2021), and (2) the Ally+ Accomplice Meditation for cultivating an anti-racist mindset. Both meditations are just under 20 minutes long and include affirmations specific for those seeking healing from racial trauma or cultivating an antiracist mindset. These meditations can be played in session or offered as an additional resource to clients outside of the therapy room as needed.

Psychoeducation Surrounding Colorism to Combat Internalized Racism: *Not* Born That Way

Every racialized society has a myth to justify the unjust treatment and discrimination endured by racialized groups. Psychological harm is caused when people believe these untruths, contributing to racial traumatization. Often these myths have been internalized in childhood and may be accepted by both racially dominant and minoritized individuals.

One of the more pernicious myths about race is that meaningful genetic or biological differences between races exist, and that visible inequality is a natural product of human biological variation (Donovan et al., 2019). The myth goes on to assert that there is a genetic colorist racial hierarchy in which darker-skinned people are less intelligent, moral, and/or valuable (Cerdeña et al., 2020; Evans, 2018; Hogarth, 2019). These racial fallacies are presented as facts and even legitimized in medical journals, which bolster society's beliefs about biological White supremacy (Hogarth, 2019. Disparate healthcare profoundly affects life outcomes and success indicators for racialized people (Belak et al., 2018; Kwate & Meyer, 2010). The well-documented false belief by medical professionals that there are real (i.e., genetic) differences between races (e.g., Black people feel less pain than White people) leads to disparities in treatment, including the reduction in empathy from White clinicians to under-administration of pain medication to racialized patients (Cerdeña et al., 2020; Hoffman et al., 2016).

Examples of how this "innate inferiority" myth manifests can also be found in situations concerning education, promotion, and leadership when darker-skinned people are assumed to have lower "innate" ability or fewer higher-level skills. Microaggressions, such as tracking African American children into lower-level math classes, or saying "you are a credit to your race, so articulate," also feed on the "biological races" myth. In this framing, saying to a Black physics professor or neurosurgeon, "Wow, I've never met anyone like you at this level," can be an insult, not a compliment (Williams, 2020).

Research shows that people with darker skin experience more racism, and this has been termed by Landor and McNeil Smith (2019) as "skin-tone trauma." For healing to occur, it is necessary to expose untruths about color (Donovan et al., 2019; Hogarth, 2019). Debunking these myths will also help answer questions

People of Color may have about why POC seem to lag in societal success and health indicators. If true information is not provided to young POC, they will find the incorrect, societally imposed racist answer for themselves, assuming that the disparity is due to some biological or innate factor linked with skin shade (Márquez-Magaña et al., 2013). This myth also underlies the attitude by some that attempting to achieve racial equality is fruitless, because it assumes that disparities are innate and racial hierarchies are inevitable. They may think improving the situation will only be accomplished by handouts, since these disadvantaged groups are not capable of competing. As such, these biological myths may underpin a large swath of racist and supremacist thinking and saviorism.

According to a recent *New York Times* article, there is a growing sense that the avoidance of directly explaining how race is not a genetic category within high-school biology curricula is backfiring, because it leaves youth to rely on societal myths to explain social disparity (Harmon, 2019). More alarmingly, at least three randomized controlled trials (RCTs) show a cause–effect relationship between how race is taught in the U. S. biology curriculum and the development of racial biases (Donovan et al., 2019). Therefore, providing clients with evidence of race-based discrimination that specifically explains disparities in success indicators is critical (Cerdeña, et al., 2020; Donovan et al., 2019; Kwate & Meyer 2010; Lewis & Teasdell, 2021). Straightforward counterfactual examples can be provided—e.g., demonstrating tendency of darker-hued African and Caribbean children to *over*achieve in the U.S., or showing how increases in environmental pollution and lead poisoning disproportionately harm Black children (Griffith et al., 2011). Such facts can help clients process that the differences in success that they are witnessing are not because they were born that way (Schwarz et al., 2016).

The quality of the psychoeducation will be key for this intervention (Donovan et al., 2019; Márquez-Magaña et al., 2013). Americans are used to thinking about races of humans as they would breeds of dogs, as something tangible, familiar, and scientific, when it is in reality unscientific and bigoted (Norton et al., 2019). Part of the confusion around genes and race stems from the conflation of the understanding that genes define heritable traits such as height, blood type, and skin color, and then mashing this together with assumptions about how related individuals may be based on skin hue. This is as sensible as assuming, for example, that individuals must be biologically related because they are the same height or that skunks and pandas may be highly related because both have black and white fur.

Therapists can provide general scientific literature to clients, such as *National Geographic*'s special issue "There's No Such Thing as Race—It's a Made-up Category" (Kolbert, 2018), which can be helpful for certain clients. It can be important to explain to the client how the concept of "race" is inconsistent with population genetics and that humans cannot be categorized neatly into biologically distinct subcategories (Cerdeña et al., 2020). Some may have a hard time believing this as myth, as it is so firmly embedded in individuals at all educational levels up to and including university professors (Donovan et al., 2019). However, common sense can also be helpful as it may be easier to explain that in America it does not make much sense that a White mother and her Black child can be highly related, sharing 50% of their genes, but be called different "races'' based on skin hue. People categorized as "Black" in America on average have 25% European ancestry but can have up to 90% European ancestry (Bryc et al., 2015). This illogical custom was originally implemented so that White slave owners could legally own and sell their darker-hued children (i.e., "one drop rule"; Lujan & DiCarlo, 2021).

Cognitive Restructuring and Defusion From Internalized Racism

One of the many ways racism may impact mental health is through internalized racial oppression (Banks et al., 2021). Internalized racism is described as a negative view of the self, based on the perceived inferiority of one's own ethnic group or race, which can cause shame and self-blame in People of Color (Bryant-Davis & Ocampo, 2006). It is important that individuals suffering from internalized racism understand that their negative thoughts and feelings are a product of context (i.e., racism) and not an accurate description of the self. This is possible by helping clients to see internalized cognitions in the context of racism, defusing from these ideas, and using cognitive restructuring to critically question and edit these negative thoughts (Banks et al., 2021; Ching, 2021). Although it might be assumed that internalized racism is associated with low self-esteem and self-hate, it is important to note that given the insidiousness of racism, even People of Color with a strong racial/ethnic identity who might not experience self-hate or low self-esteem are subject to internalizing negative messages about their racial group, and it can be especially hard for these clients when they realize the ways in which they experience internalized racism and may unintentionally contribute to maintaining White dominance.

Banks and colleagues (2021) examined the effectiveness of an ACT-based intervention to help Black

women heal from racial oppression. This included thinking about new ways of interacting with thoughts and feelings caused by internalized racial oppression. More specifically, the intervention included a focus on cognitive defusion, a strategy that helps clients recognize that their thought is not more than a thought; put more distance between themselves and the thought, and then, take value-based action regardless of the messages racism sends them about who they are or what they can do. As such, therapists must look for opportunities to address shame, self-blame, and internalized racism (Bryant-Davis & Ocampo, 2006). Clients may speak critically about themselves and/or their racial group, either with humor or with venom. Therapists must recognize such comments as self-defeating responses to trauma, even when delivered in a humorous manner.

Cognitive restructuring is a core component of one of the first-line treatments for PTSD, Cognitive Processing Therapy (CPT; Resick et al., 2016), where therapists work with clients to identify "stuck points," evaluate the existing evidence for the stuck points, and generate more balanced and adaptive beliefs. To assist clients in their cognitive restructuring of internalized racism, therapists can help them make sense of their experiences by placing them in their appropriate sociohistorical context. It is critical that therapists do not reinforce clients' cognitive distortions surrounding the incorrectly perceived low value of their ethnoracial group. Also, therapists should not remain silent in the face of a clients' shame or self-blame. They should rather identify client comments that degrade their racial or ethnic group and discuss these in a nonshaming manner together with the client. The fundamental objective of CBT with clients who suffer from internalized racism is to help them become more aware of, confront, and alter their negative thoughts and beliefs about themselves and their ethnic group (Steele, 2020).

Modification of dysfunctional core beliefs can begin once clients have learned to recognize negative automatic thoughts and their accompanying emotional, behavioral, or physiological consequences. Clinicians can help clients externalize the impact of racial stressors by explaining discrimination-related events as the perpetrators' own prejudice and biases, and thereby minimizing internalization of negative race-based messages (Guerin, 2005; Miller et al., 2018). Take, for example, a Black college student who has developed core beliefs reflecting White supremacist ideology and blames herself for not being smart or capable, because she keeps failing school tests. To deal with the client's internalized racism, the therapist should help externalize the oppression by questioning the client's beliefs and critically changing them—that is, helping the client to see that the problem is separate from themself. So, the first step would be increasing the client's awareness about their automatic thoughts based on their internalized race-based core belief in different life situations (e.g., school, work)—for example, how the client thinks that she is not smart enough to finish school, because Black people are not as smart as White people. Next, the therapist can ask the client to keep a journal of their thoughts to help identify and challenge recurring patterns. After identifying the pattern of automatic thoughts, the therapist should work with the client to review the evidence to see if those thoughts/beliefs are supported, or if there are alternate explanations for the beliefs (e.g., failing tests because of test anxiety or stereotype threat, rather than not being smart). Helping clients discover new and more functional race-related beliefs would be the final stage in this approach (Steele, 2020).

Ethnic and Racial Identity Development/ Identity Affirming Practices

Ethnic identity development is a multifaceted construct that describes how people develop a sense of belonging to their culture. Traditions, customs, and attitudes about one's heritage are important facets of ethnic identity. Individuals progress through different stages as they learn to identify with their culture, whereby they come to understand their culture's customs and values, and ultimately identify with their ethnic group (Roberts et al., 1999). This can be a challenging process for People of Color and White people alike, and it starts in early childhood. Having strong, positive feelings about one's ethnoracial group is considered a protective factor against the stresses of racism for People of Color (Williams, Duque, et al., 2018). As such, strengthening clients' ethnoracial identities is considered an important way to help combat negative cognitions about one's group and self-worth.

Malott and Schaefle (2015) suggest that therapists view their clients' identities as a rich source of positive attributes and strengths in the midst of the stresses caused by racism. Further, Metzger et al. (2021) have emphasized the importance of integrating racial socialization into trauma-focused CBT for African American youth. They explain that it is crucial to transmit culture, attitudes, and values to adolescents (i.e., racial socialization) in order to prepare them to cope with the oppression they will face as a racialized person in Western society.

As such, therapists need to thoughtfully implement strategies to strengthen ethnoracial identity in clients to help improve their overall psychological well-being (e.g., Umaña-Taylor & Douglass, 2017; Umaña-Taylor

et al., 2018). CBT interventions might include discussions of what the client likes about their ethnic group, learning more about their history and the achievements of others from their group, explicit rejection of stereotypes, and increased involvement in traditional cultural activities to build a greater sense of ethnic and racial pride. To be an effective source of cultural support and healing for clients, therapists can set aside a few moments to think about each client of color individually. Reflect on what they have shared about their culture. Consider cultural sources of strength for them and identify admirable facets of their culture. Note several specific things that are applicable to the client and find opportunities to share these during sessions (Williams, 2020).

If therapists cannot think of anything clients have shared about their culture, find reasons to get curious and ask more about their heritage, family, and community during sessions. Ask clients to share with you what gives them pride in their ethnic group. Questions from the Cultural Formulation Interview (APA, 2013) might be used, including those assessing important aspects of their cultural identity. Identify role models and other sources of support who also identify as a member of their ethnic group. Ethnic identity measures such as the Multigroup Ethnic Identity Measure (MEIM-12; Roberts et al., 1999) might be used to assess the strength of ethnic identity. Items on which the client scores lower might be targets for strengthening. For example, if a client scores low on "I am active in organizations or social groups that include mostly members of my own ethnic group," the goal might be to brainstorm ideas for getting involved in social groups of people from their ethnic identity. Finally, it is important that clinicians communicate they value their clients and the ways they are different.

Recounting Traumatic Racism–Related Experiences (Exposure to Trauma Memories)

Clients suffering from racial trauma may avoid thinking or talking about the experience because it feels emotionally overwhelming (Bryant-Davis & Ocampo, 2006). However, recounting memories of traumatic experiences has been shown to have beneficial effects on traumatic stress, as it leads to habituation (i.e., decrease in anxiety without the need of harmful safety and avoidance strategies), disconfirmatory learning (i.e., opportunities to find evidence against maladaptive trauma-related beliefs), and opportunities to process those experiences and find meaning (next sections).

Bryant-Davis and Ocampo (2006) highlight the importance of clients regaining control of the past by being able to recollect the trauma without feeling helpless. Recounting the trauma can be conceptualized as storytelling, and Chioneso and colleagues (2020) note that storytelling facilitates an understanding of human behavior and also functions as a tool for resisting oppression, and even promoting spiritual communion. Imaginal exposure is a type of storytelling that involves vivid revisiting of the traumatic event in the client's imagination in the presence of the therapist (Foa et al., 2007). Williams and colleagues (2014) explain that a mechanism through which imaginal exposure helps clients to recover from racial trauma is in changing inaccurate cognitive patterns and anxieties related to trauma that are maintained through avoidance behaviors. Recounting traumatic racism-related experiences in a safe and supportive environment empowers clients by providing them with a greater sense of control over their response to trauma memories and ultimately a reduction in symptoms.

Prolonged exposure (PE) is one of the first-line treatments for PTSD, and therapists can use culturally relevant adaptations that include race-related trauma themes unique to the clients' racial experience (Williams et al., 2014). These adaptations include asking explicitly about race-related issues throughout the treatments, and then bringing those distressing aspects to the center of treatment during imaginal exposures. In imaginal exposures, the therapist acts as a guide for the client's recollection and recounting of the events. More specifically, the therapist asks the client to provide a comprehensive verbal description of their traumatic incident in the first-person present tense from beginning to conclusion, assessing their anxiety throughout. With repeated recounting, their subjective levels of distress can be expected to decrease over time.

Carlson and colleagues (2018) designed and implemented a group-based intervention to address racial trauma among veterans. The authors found that veterans sharing their traumatic encounters with each other allowed them to meaningfully recount uncomfortable memories that were previously avoided, which, in turn, led to new perspectives, less distress, and a healthier mental and emotional processing of those traumas. Not only did the veterans share their own experiences, they listened to others' experiences and provided mutual support by sharing common struggles.

Writing can be used as an alternative way of recounting traumatic experiences (e.g., Gerger et al., 2021; Hirai et al., 2012; Tavakoli et al., 2009). Therapists should ask clients to write freely about their deepest thoughts and feelings concerning the traumatic race-related incident they encountered. It is recommended that clients continue writing about the same experience for at least 3 days. They should bring the written account to therapy and read it aloud to the therapist.

The therapist and client should process what the client wrote (see next section) as research demonstrates expressive writing with therapist feedback is more effective in decreasing PTSD symptoms than independent expressive writing (Gerger et al., 2021). After discussing it, the therapist should take the written account and ask the client to prepare a new version of the story for homework, without referencing the previous version. The client should repeat this process until recounting the event no longer causes distress. Clients who have a great deal of distress may do better to start with writing facts only about their trauma and adding emotions to their stories later (Hirai et al., 2012).

Processing Racist Experiences

Processing experiences of racism is an important next step in resolving racial trauma and learning to cope with racial stressors (Comas-Díaz, 2016). Although revisiting the memories of upsetting events will help in reducing the distress caused by the recollections (previous section), processing is helpful for bringing new perspectives and insights into these events. Processing can take many forms, from formal discussion of different facets of the event with a therapist to creating art or music from the experience.

Williams et al. (2014) suggest that strong emotions connected with experiencing discrimination and racism can lead to skewed perceptions of society and the world in general. Thus, it would be critical to establish that the client's experience should not be extended to all social circumstances. Accordingly, therapists should work through distorted cognitions by assisting the client in distinguishing between genuine social restrictions and distorted views created as a result of the trauma. In a similar vein, Mosley and colleagues (2021) argue that processing enables trauma survivors to understand racism on a systemic level, develop their intersectional awareness, and strengthen their capacity for coping with and confronting it (to be discussed in the following sections). Relatedly, Ching (2021) warns that failing to process the traumatic racist experience may lead to the misconception that the problem was not rooted in racism, but rather in personal inadequacies. Accordingly, assisting clients in discovering an external (instead of internal) attribution for their traumatic racist experience should help with processing by allowing them to learn to develop greater pride (instead of shame) in their racial identity.

Jernigan et al. (2015) suggest that it is vital that people suffering from racial trauma engage in activities that allow for processing emotions externally. Activities such as painting, sketching, singing, or dancing allow clients to express their emotions through body movement and expression. Drama therapy has been explored as a tool to help clients process their racist experience. In the form of applied performance research, Williams-Witherspoon (2020) developed a performance piece—*From Safe to Brave*—to address the trauma of racism on college campuses. The authors note that "giving voice" to the participants' truth helped them process their emotions. Notably, the positive effects of movement-based creative expressions on mental health have been well-established (Stuckey & Nobel, 2010).

Another potentially helpful approach is called photovoice (Wang & Burris, 1997), where members of marginalized communities can use photographs of people, places, and events to construct narratives about experiences of adversity (e.g., racism; Williams, Byrd, et al., 2020). In addition to therapeutic effects inherent in sharing one's story, photovoice is also focused on sharing narratives with others to facilitate critical consciousness-raising and impact policy, and thus could be a potentially important strategy in addressing racial trauma (e.g., Tessitore, 2021). See Williams, Byrd, et al. (2020) for details on how to use this technique in counseling to address experiences of racism.

Processing should occur after recounting the traumatic experience by the client to help clients understand their traumatic experience from a more functional vantage point. An important approach would be to inquire openly about their thoughts and feelings and how these fit into their racial identity in the context of their trauma. For example, by asking "Did you believe you were accused of stealing because you were Black?" the therapist may encourage the client to express themselves more openly about how they felt about their Blackness when they were confronted with the traumatic event. Next, to alleviate the suffering associated with memory, the therapist can broaden the context, allowing the client to have a more objective and helpful perspective on what happened. Socratic questioning can be used to point out cognitive distortions and false beliefs about the traumatic event, such as being inadequate. Williams and colleagues (2014) advise therapists to point out individual strengths during processing questions; for example, "It was very brave to press forth in a workplace where so much racism was present. What does this say about you?" (p. 113). Ching (2021) advises clinicians to help clients process their traumatic experience by communicating racism and its impact in a nonpaternalistic way, through open-ended questioning and compassionate, nonjudgmental listening, while maintaining a position of curiosity and humility.

Skills Building in Confronting Racism (Which Includes in-Vivo Exposure)

When confronted with racism, both targets and observers must decide whether to speak up or remain silent. This decision is influenced by many factors, including potential risks (e.g., losing a job), whether basic needs are met (e.g., too sick, tired, or hungry to effectively stand up at the moment), or emotional state (e.g., an initial response might be shock and paralysis). To decrease the impact of experiencing racism, clients will need to build skills in responding to these events. Strong personal agency can promote healing in the face of racism. People feel more empowered when they have greater control over how they respond to racist incidents.

Nonetheless, this critical aspect of healing and growth is glaringly absent from most clinical conversations on the issue of racism. It is not uncommon for racism to be considered an immutable and unchangeable reality, where perpetrators are given free rein to cause harm. Miller and colleagues (2018) found little to no representation of this topic in their content analysis of the counseling psychology literature on practice recommendations for addressing racism. It seems as if there is an unspoken expectation that People of Color may recover from the impact of racism only if they "stay in their place" and maintain the comfort of perpetrators. Unfortunately, some scholars advocate that People of Color should passively accept racism and give offenders "the benefit of the doubt" (Haidt, 2017). Yet, common sense tells us that the only way to overcome victimization is to resist being victimized. While this is not always possible, it often is. Nonetheless, traumatized clients will typically have lost their ability to confront racism effectively, even when it entails little or no personal risk. They will need to be taught (or retaught) how to do this and be encouraged to do so.

As such, treatment for racial trauma must include working with clients to make changes to things within their sphere of control (Laszloffy & Hardy, 2000). Clinicians should speak with clients about the different ways they might respond to racism. Clinicians can help clients process these experiences and situations, both in which they feel good about their response in the moment and situations in which they wish they responded differently. The first step in this process is to provide psychoeducation about small actions clients can take to counter microaggressions.

Imagery rescripting can be one good way to prepare clients for confronting racisms (e.g., Arntz et al., 2013). Rescripting allows clients to confront their distressing memories while simultaneously learning to think about such encounters in different ways. Rescripting provides alternate endings for upsetting experiences, and these can help clients imagine responding differently the next time they encounter a similar event. The next step would be to help clients develop courage and skill to confront racism through behavioral rehearsal using role-plays (e.g., Litam, 2020; Williams, 2020).

It is essential to respect a client's fear or hesitancy to confront racism, especially when the therapist has a nonstigmatized identity. When clients have racial trauma, it will almost always feel unsafe to confront someone about their racism, even in small and safe ways. Usually, the traumatization will have resulted in some level of avoidance from feared people and situations, which can be counterproductive (Han et al., 2015). The client must learn to take calculated risks to increasingly venture outside of their comfort zone, whenever possible, and expose themselves to these situations. This process is similar to *in vivo* exposure, a core component of PE for PTSD (Foa et al., 2007). Strategies such as behavioral rehearsal can help People of Color start to build the skills required to confront racism in the moment. Litam (2020) borrows the phrase "microinterventions" from Sue and colleagues (2019) to explain various approaches that can be practiced. Educating the offender or calling out a racist joke as "not funny" are examples of microinterventions.

Further, some means of addressing racism in the moment will be better received by offenders than others. The client should understand that the goal is not to "stop people from being racist" or "educate other people," although we can certainly hope for these outcomes. The more central goal is to facilitate clients being their authentic selves in the moment and tolerating any discomfort, which cannot occur unless they are empowered to use their voice in a manner that is fitting to their personality and values.

In a case study of an Asian American client who was distressed about ongoing microaggressions from his friends, Ching (2021) reports that speaking up against microaggressions was framed as value-driven, autonomous exposures that he could try, and for which he subsequently reported success. For example, he pointed out his roommates' racially insensitive comments about peaceful Black Lives Matter protests in their town, which made them apologize. This sparked a deep conversation about racism in America, which ultimately brought them closer together.

Sue et al. (2019) provide an overview of how to address microaggressions through microinterventions, providing some insightful examples of the technique. However, these interventions are not appropriate for all people in all situations, and some interventions would only be safe for allies and not racialized people at all (e.g., elevator microintervention; Williams,

2020). There is some important nuance in choosing how to respond to everyday racism. The type of response should vary based on the relationship between the client and the perpetrator, which dictates the level of vulnerability appropriate for the situation (see Table 1; Williams, 2020).

Clients can keep a log or journal of their regular encounters with microaggressions and other forms of racism and discuss these during therapy. They should process with the therapist what worked, what did not, and what they might do differently next time. They should also be encouraged to lean on their social support system to process these experiences as they arise.

Posttraumatic Growth and Meaning Making

Meaning systems inform people's understanding of themselves and their lives, direct their personal goals, and contribute to well-being and life satisfaction (Park & Kennedy, 2017). Posttraumatic growth refers to positive life changes individuals experience after a traumatic event and is one key objective in treating racial trauma (Comas-Diaz, 2016). This is accomplished through modifications to meaning systems that allow people to adapt their understanding of the world to accommodate their traumatic experience. Clinicians working to help clients recover from racial trauma will want to facilitate this meaning-making process (Comas-Diaz, 2016). As the client starts to feel less distress and more mastery in terms of managing racism, this is the time to introduce the concept of posttraumatic growth and engage in discussions around the meaning of their experiences (e.g., Hernández & Harris, 2022).

Of the strategies proposed by Evans and colleagues (2016) for fostering posttraumatic growth, one includes celebrating both racial and gender identity through meaning-making activities. This can include learning how others from the same racial/ethnic group made sense of the racism they endured and how they achieved, despite obstacles. Others might prefer to learn how those who came before them created change to make the path easier for those who came after them. Chioneso et al. (2020) further note that storytelling and resistance can help with meaning making by reducing disempowering thought patterns, combatting inertia, and raising awareness of systemic inequities that harm racialized communities. The solution to racial trauma is not to find ways to integrate oppressed groups into oppressive systems; rather, healing approaches should empower oppressed groups to transform oppressive systems.

Trauma can also injure a person's sense of spirituality. With respect to meaning making after a trauma, Allen et al. (2017) note that "spiritual resources and interventions that are congruent with the clients' beliefs should be utilized when this can help clients cope, heal, and grow." Religious rituals can be used to enact destroying the traumatized life and nurture an experience of a renewed and more meaningful life in a way that symbolizes an inner transformation.

When clients are able to find meaning in stressful situations through creating more positive situational and global meanings, they generally have a better adjustment to stressful events (Park & Kennedy, 2017). The therapist should not hold specific expecta-

Table 1
Responding to Microaggressions

Perpetrator	Type of Response
Close friend or caring family member	The client should share how the racist act made them feel and why. They are appealing to the quality of the relationship to help bring about mutual understanding and positive change.
Coworker or acquaintance	Gently educate the person about stereotypes and racism. Although others may not show appreciation for being educated in the moment, over time and with repeated messaging, they may come to understand how they commit racist acts, and this awareness will allow them to more easily make nonviolent choices in the future. But more importantly, it empowers the client to take action against racism in a way that is positive, prosocial, and maintains personal integrity.
Stranger	Be assertive and correct the person; reject any controlling aspects of the encounter. Racism ultimately is a power-play, and clients should reclaim their agency and publicly resist.
Powerful person in a dangerous situation	Do not respond to the act of racism. Remove one's self from the situation as quickly as possible and then make a report to the authorities. Clients should not expect their report to result in any particular outcome given that the structures in place are designed to protect and maintain racism, but the point is to practice being agentic. Even an anonymous report would be better than none at all in situations where it would be unsafe to reveal one's identity.

tions of meaning making for the client but rather anticipate that each client will heal at their own pace and in a myriad of different ways (Courtois, 2017). Clinicians can support posttraumatic growth through creating a climate of openness, promoting self-efficacy, and strengthening self-esteem. Clients will learn to appraise their posttraumatic stress as caused by the racism and normalize their reaction to the traumatic event, which will support the development of resiliency. Given that trauma silences the voices of anyone who speaks out against it, healing involves retelling the trauma story in a way that focuses on healing, growth, and empowerment. Comas-Diaz (2016) notes that storytelling is culturally congruent with many clients of color. It is an effective way to recall and honor people's cultural memory and to facilitate identity reconstruction. As clients share their story of racial trauma with others, it promotes self-healing and group healing, collective empowerment, and racial solidarity.

In terms of meaning making, the therapist should introduce the idea that painful experiences are often quite terrible when we are going through them but can ultimately lead to growth and make us stronger and more empathetic toward others who suffer. Experiences of racism may similarly lead the client to acquiring useful and valuable knowledge. Reflecting on these experiences of racism may be an opportunity to promote healing by focusing on what was learned. Therapists might say, "What would you say you have learned from these difficult experiences of racism you've shared with me over the past eight weeks?" Even if no identifiable benefits emerged from the trauma experience, the survival and recovery of the client is a victory worth celebrating. The story has a happy ending because the client learned how to survive, heal, and thrive in a society where the odds were stacked against them. Meaningful works of art, music, or poetry that have emerged from the journey can be positive reminders of growth and triumph.

Social Action and Activism

Engaging critically against racism entails using racial justice strategies for activism (Mosley et al., 2021). Making a meaningful contribution to antiracist and projustice causes around issues of structural racism can be a healing act of agency and self-affirmation (e.g., Carlson et al., 2018; Hope et al., 2018). For example, Bryant-Davis and Ocampo (2006) advance resistance strategies as the final step in the treatment of racial trauma, which may include advocating for antiracist policies, distributing and/or signing petitions, voting, teaching people about racism, and, where necessary, bringing charges against perpetrators. They note that if the client has been subjected to an institutionalized racist occurrence, such as portrayals in the media or a prejudiced school curriculum, they may feel especially helpless to effect change. Therapists can help clients investigate what they might do to make an impact on a systemic level. Similarly, Comas-Díaz (2016) asserts that the final phase of race-informed treatment is social action. She notes that the goals of social action are collective agency, social change, and racial equality, which can be reached through various methods such as advocacy, activism, and solidarity. Chioneso and colleagues (2020) emphasize how public storytelling can lead to community healing and resistance and affect racism at personal, interpersonal, and organizational levels.

An important part of therapy is helping the client develop self-efficacy in engaging in antiracist efforts or social justice movements in ways that align with their values. Clinicians can help clients identify ways to respond to racism through social action, though it is important to emphasize that there is no single or "right" way to engage in efforts to create change. The clinician may ask the client whether there are ways in which they already engage in social action. If the client is not currently active but would like to engage, the clinician might ask what sorts of social actions are most appealing to them. Clinicians may also help the client find ways to be involved through discussing their strengths or resources. For example, maybe a client does not prefer to protest, but would be interested in creating advertisements for demonstrations. Perhaps a client does not have as many time resources but has money to donate to certain organizations. The clinician might also assess whether the client has an end goal and, if so, to specify that goal. For example, the client may share the desire to eliminate microaggressions in their place of work. With this in mind, the clinician can work with the client to develop SMART goals to help them identify reasonable action steps toward achieving this goal, where SMART goals are those that are specific, measurable, attainable, result-oriented, and time-bound (O'Neill, 2000).

The therapist must consider the various forms of activism and resistance that would be most beneficial and meaningful to the client. Community activism may address the root causes of racism, which can be therapeutic and satisfying, producing long-term benefits for both the individual and society as a whole (e.g., Carlson et al., 2018). Structural racism, which manifests itself in the form of discrimination in housing, work, and education, is a primary source of the community burden of racism and therefore proper targets for reform, as their resolution can lead to a wider alleviation of racism. Activities that directly address the community burden of racism can be therapeutic in

ways that raise up both the individual and the community and thereby generate a positive feedback loop and make the community more resilient against racist threats. Additionally, community involvement that is thoughtful and well-targeted increases sources of social support. It is important to keep in mind that activism comes in many forms and may or may not involve formal protests or a Black Lives Matter event. Communal activities such as a community garden, after-school tutoring, elimination of neighborhood pollution, cataloging businesses owned by People of Color, classes on homeownership, or organizing a workshop addressing racism in schools are just a few examples of these types of pursuits (Jacob et al., 2022).

Some clients will be seeking treatment due to racial trauma that was precipitated by social activism. In these cases, it will be important to troubleshoot what specifically led to the traumatization, and what needs to change to enable them to resume these activities in a way that will not be traumatizing. It might simply be a matter of reducing the amount of time spent, or it could be that different types of activism are a better fit for the client's temperament.

Discussion

Table 2 provides an overview of the phases of treatment using the techniques described herein, along with the goal and method. The treatment approach can be conceptualized as three phases: Part 1 for stabilization is called "Stop the Bleeding," where the client is highly distressed with a focus on support; Part 2, "Healing," focuses on cognitive restructuring, exposure, and reevaluation; and Part 3 is "Empowerment," where the client starts to combat racism in their daily lives for sustained wellness. This model bears some similarities to the three-stage approach proposed by Herman (2015) (Safety; Remembrance-Mourning; Reconnection) and builds on the Racial Trauma Recovery approach by Comas-Diaz (2016) and Chavez-Dueñas et al. (2019). Approaches in the peer-reviewed literature tend to be relatively brief, and case examples can be helpful. We recommend additional reading for therapists who may be unfamiliar with any of the techniques described (see Ching, 2021; Halstead et al., 2021; Williams et al., 2014; Williams, 2020, for more case examples of techniques).

Although the techniques are listed in roughly the order they should be used, certain techniques will be utilized throughout and some may need repeating or periodic revisiting, depending on the client's progress and life circumstances. Additionally, it is important to appreciate that the effects of oppression may have destabilized the client's life across many domains, making regular meetings challenging (Bhambhani & Gallo, 2021), and, as such, therapists should be as flexible as possible (e.g., evening appointment times, phone/email support as needed, etc.).

Table 3 notes where each technique may be used in the intervention, along with the empirical support for readers who would like more information. The Expert Support items are all specifically about engaging with racism and/or racial trauma. In terms of empirical support for techniques, 9 studies are specifically about racial trauma (Anderson et al., 2018; Banks et al., 2021; Carlson et al., 2018; Conway-Phillips et al., 2020; Halstead et al., 2021; Hargons et al., 2021; Mosley et al., 2021; Saban et al, 2021; Williams et al., 2014), 6 studies are about racial stress or other racism-related pathologies (Ching, 2021; Heard-Garris et al., 2021; Hwang & Chan, 2019; Malott et al., 2010; Steele, 2020; Tavakoli et al., 2009), 1 study is focused on an intervention for refugee trauma (Tessitore, 2021), and 11 studies examine correlates of racism or oppression in general (Adkins-Jackson et al., 2019; Barclay & Skarlicki, 2009; Degife et al., 2021; Donovan et al., 2019; Graham et al., 2013; Koch et al., 2020; Márquez-Magaña et al., 2013; Noh & Kaspar, 2003; Umaña-Taylor et al., 2018; Williams, Kanter, Peña, Ching., & Oshin, 2020; Zapolski et al, 2019).

Therapist Qualities

In this article, we have discussed the key techniques for treating racial stress and trauma that comprise the Healing Racial Trauma protocol, but this protocol alone is not enough to make one an effective therapist for traumatized clients (Carter & Pieterse, 2020; Spann, 2022). Treating racial stress and trauma requires a culturally humble and empathetic clinician, which is by no means assumed. Therapists enter the world with their own ethno-cultural lens and racial biases. If not specifically trained to do this work, there is the risk that they may further harm the client (e.g., Williams, 2020). In the U.S., 80% of therapists are White and many graduated before therapists were required to undergo multicultural training in their programs, and some are graduating without such training currently (Benuto et al., 2019). Therefore, before starting, the therapist should do their own work to ensure that their biases are assessed. Malott and Schaefle (2015) emphasize that any interventions for racial trauma must sit on a firm foundation of counselor multicultural and racial competencies, and conceptual frameworks must recognize racism's role in the etiology of client issues.

Table 2
Healing Racial Trauma Treatment Protocol

Phase	Goal	Techniques
Assessment	Understand the scope of the client's racial stress and trauma	Use of validated scales and clinical interview to assess racial stress/trauma
Part 1: Stabilization – "Stop the Bleeding"		
1. Making Sense of Racism	Reduce shame by helping client understand racism is caused by society and is not the client's fault	Provide psychoeducation about racism and resulting harms
2. Coping & Self-Care	Increase functional strategies and decrease dysfunctional ones	Assess coping and self-care strategies, and discuss these with client
3. Cultivating a Support Network	Reduce stress and provide resources for when racial stress occurs	Identify existing social supports and find ways to create more
Part 2: Healing		
4. Dismantling Internalized Racism	Reduce shame, increase feelings of belongingness	Cognitive defusion and restructuring, cultural exploration/appreciation
5. Understanding Race & Whiteness	Increase feelings of control by better predicting racism in environment	Psychoeducation about race, including the invisibility of Whiteness
6. Exposure & Processing of Experiences of Racism *(repeat as needed)*	Habituation through exposure, new thinking about event, reducing distress, shame and guilt	Conversations about distressing events, expressive writing, Socratic questioning, artistic expression
7. Learning Strategies to Combat Racism	Skill building to respond to racism in various situations, increase confidence to act	Journaling racist events to discuss in session, review of possible responses, role play
Part 3: Empowerment		
8. Practicing Combatting Racism in Everyday Life *(repeat as needed)*	Increase feelings of agency toward racism, reduce feelings of helplessness and victimization	Responding to racism in daily life, graduated exposure, make predictions and processing outcomes, skill building
9. Posttraumatic Growth and Meaning Making	Recognize and reinforce success	Consolidating events into a cohesive and meaningful narrative
10. Social Action, Activism, and Healing Outside Therapy	Ongoing meaning-making of prior trauma, promote change in one's environment, feel agentic	Evaluation of values, exposure to challenging situations, attempting racial justice goals
11. Good-Byes – Moving On	Relapse prevention	Synthesize course of treatment and mastery of techniques

Treating racial trauma should only be done by clinicians who have a good understanding of the traumatizing impact of racism. They should have the following competencies:

- A good understanding of microaggressions and racism (Williams, 2020)
- The ability to identify/diagnose racial trauma (Williams, Printz, et al., 2018)
- The ability to initiate a nondefensive repair of any microaggressions or cultural insensitivities committed in session (Williams, 2020)
- Have done their own personal antiracism and allyship work (e.g., Williams, Sharif, et al., 2021)
- Willingness to discuss racism and cultural issues, even when it evokes discomfort (Calloway & Creed, 2021; DeLapp & DeLapp, 2021; Malott & Schaefle, 2015)
- The ability to learn about a client's culture from the client and other sources
- Appreciation of individualistic versus collectivistic cultural worldviews (Sue, Sue, et al., 2019)
- An understanding of their own cultural development (bias, blind spots, areas for growth) and how that can affect the therapeutic relationship (Miller et al., 2015)
- An understanding of models of racial identity development and how this might impact the therapeutic alliance (Graham-LoPresti et al., 2019)

Koch et al. (2020) examined affirming experiences reported by culturally diverse graduate students. Those who were deemed to be affirming were described as validating, nonjudgmental, interested, genuine, receptive, mindful, and self-aware, with an affirmative communication style. Such individuals were not afraid to

Table 3
Support for Protocol Techniques as Applied to Racial Stress and Trauma

Racial Trauma Technique	Session	Expert Support	Empirical Support
Validation of Experiences/ Support and Affirmation	1 (also 2–6)	Bryant-Davis & Ocampo, 2006; Miller et al., 2018; Roberts, 2021	Koch et al., 2020
Psychoeducation About the Nature of Racism and Connection to Mental Health	1, 5, 6	Miller et al., 2018; Reynolds, 2019	Carlson et al., 2018; Conway-Phillips et al., 2020; Williams, Kanter et al., 2020
Assess and Strengthen Coping Strategies	2	Bryant-Davis & Ocampo, 2006; Jacob et al., 2022; Malott & Schaefle, 2015	Anderson et al., 2018; Conway-Phillips et al., 2020; Saban et al, 2021
Self-Care	2	Bryant-Davis & Ocampo, 2006; Jacob et al., 2022; Nayak, 2020; Wyatt & Ampadu, 2021	Adkins-Jackson et al., 2019; Quaye et al., 2019
Self-Compassion	2	Litam, 2020; Watson-Singleton et al., 2021	Hwang & Chan, 2019; Liu et al., 2020
External Social Support	3	Evans et al., 2016; Miller et al., 2018; Watts-Jones, 2002	Liu et al., 2020; Noh & Kaspar, 2003; Saban et al., 2021
Mindfulness	2, 4, 8	Sobczak & West, 2013	Graham et al., 2013; Zapolski et al, 2019
Psychoeducation About Colorism for Internalized Racism	4	Landor & McNeil Smith, 2019	Degife et al., 2021; Donovan et al., 2019; Márquez-Magaña et al., 2013
Cognitive Restructuring and Defusion from Internalized Racism	4, 5 (also 1)	Bryant-Davis & Ocampo, 2006; Roberts, 2021; Williams, 2020	Banks et al., 2021; Hargons et al., 2021; Steele, 2020
Ethnic and Racial Identity Development and Affirmation	5	Chavez-Dueñas et al., 2019; Malott & Schaefle, 2015; Metzger et al., 2021	Malott et al., 2010; Umaña-Taylor et al., 2018
Recounting Racism-Related Traumatic Experiences	6, 7	Bryant-Davis & Ocampo, 2006; Comas-Díaz, 2016; Evans et al., 2016	Carlson et al., 2018; Halstead et al., 2021; Williams et al., 2014
Processing Racist Experiences	6 (also 3–5)	Ching, 2021; Comas-Díaz, 2016; Williams, Byrd, et al., 2020	Anderson et al., 2018; Barclay & Skarlicki, 2009; Williams et al., 2014
Skills Building in Confronting Racism	7, 8	Sue et al., 2019; Thurber & DiAngelo, 2018; Laszloffy & Hardy, 2000; Litam, 2020; Williams, 2020	Ching, 2021; Tavakoli et al., 2009
Posttraumatic Growth and Meaning Making	9	Chioneso et al., 2020; Comas-Díaz, 2016; Evans et al., 2016; Hernández & Harris, 2022; Williams, Byrd, et al., 2020	Tessitore, 2021
Social Action and Activism	10	Bryant-Davis & Ocampo, 2006; Chioneso et al., 2020; Comas-Díaz, 2016; Hope et al., 2018; Miller et al., 2018	Carlson et al., 2018; Heard-Garris et al., 2021; Mosley et al., 2021

Note. This table provides a list of each of the techniques discussed, along with supporting literature. The second column lists which session the technique will be used, based on the treatment protocol as outlined in Table 2. The third column provides sources that advocate the use of the method for treating racial stress and trauma in the scientific literature. The last column contains sources that provide empirical support for the technique, and these can be helpful in providing more details about how to implement the technique in clinical practice. In some cases, the technique was examined in isolation and in other cases it was part of a more comprehensive treatment approach. This is not an exhaustive list and there are many additional sources that speak to the merits of these techniques for trauma from other sorts of discrimination and in general.

acknowledge culture, were willing to grow and learn, and advocated for others who were marginalized. Therapists working with racialized clients should embody these qualities.

In addition, therapists must be able to do the things they are asking clients to do themselves. Much of the work clients will do, beyond processing their traumas, is learning a new way of approaching racism. For exam-

ple, this includes calling out microaggressions when they occur. Therapists should ask themselves if they have ever done this themselves. If not, they need to make a concerted effort to increase not only their awareness, but also their courage (Williams et al., 2022).

Same Versus Mixed-Race Dyads

Given the benefits of working with someone from the same ethnic group, matching may seem like the best way to promote mutual understanding. Most clients feel more comfortable discussing their difficulties with someone of the same ethnic and racial background, and they may provide information about their symptoms more accurately when matched. They may feel their counseling experience is more effective when they are with someone who has a native understanding of their culture. Ethnic matching has been shown to strengthen the therapeutic alliance and improve retention (Cabral & Smith, 2011).

However, ethnic matching is not always possible, due partly to systemic barriers in higher education, which have resulted in relatively low numbers of non-White mental health clinicians (Stewart et al., 2017). Further, a client may prefer someone who is not a part of their own ethnic group for any number of reasons. For example, they may have struggles related to not adhering to their cultural group's norms, and so may worry about judgment from someone from their same community. Additionally, unmatched dyads provide an opportunity to grow surrounding awareness, connection, and cross-cultural understanding in both the client and therapist (Miller et al., 2015).

Limitations and Future Directions

Although we have identified techniques for treating racial stress and trauma with evidence of empirical support, no RCT has been conducted to validate the approach as a whole. Future work in this area could investigate the efficacy of this combination of techniques by comparing this approach to treatment as usual (e.g., evidence-based trauma treatment not tailored to treat racial trauma). This would inform whether this new approach for treating racial trauma is associated with improved outcomes over existing trauma treatments. Further, although we emphasize the importance of engaging in antiracism training before a clinician can safely implement this treatment protocol for racial trauma, it is unclear specifically how much antiracism work is needed to deem a clinician ready to effectively implement this protocol, and so consultation is recommended (Calloway & Creed, 2021). Future research is needed to investigate specifically which components of antiracism training are essential competencies associated with the safe implementation of treatment for racial trauma (e.g., Curtis et al., 2019).

Conclusion

Racism is a widespread problem that continues to evolve and shift with the times. Although the ultimate goal must be to eliminate racism, the reality is that this will take time and people need support now managing the stress and trauma associated with racism. This is the first protocol for a racial trauma treatment utilizing a CBT framework, which fills an important gap in the literature. However, more work is needed to empirically test and disseminate this protocol widely. To effectively achieve these goals, substantial resources are needed. Specifically, resources are needed to: (1) fund clinical trials and studies aiming to understand the mechanisms of action to further refine the protocol; (2) develop protocol materials and make them easily accessible to clinicians; and (3) train clinicians to implement the protocol with high fidelity. Providing a racial trauma treatment protocol utilizing evidence-based cognitive-behavioral strategies is a necessary way to support healing while we continue the fight to end racism.

Supplementary data to this article can be found online at https://doi.org/10.1016/j.cbpra.2022.07.001.

References

Adkins-Jackson, P. B., Turner-Musa, J., & Chester, C. (2019). The path to better health for black women: predicting self-care and exploring its mediating effects on stress and health. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing, 56*, 1–8. https://doi.org/10.1177/0046958019870968. 0046958019870968.

Allen, G. E. K., Richards, P. S., & Lea, T. (2017). Spiritually oriented psychotherapy for trauma and meaning making among ethnically diverse individuals in the United States. In E. M. Altmaier (Ed.), *Reconstructing meaning after trauma: Theory, research, and practice* (pp. 83–100). Elsevier/Academic Press.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596.

Anderson, R. E., McKenny, M., Mitchell, A., Koku, L., & Stevenson, H. C. (2018). EMBRacing racial stress and trauma: Preliminary feasibility and coping responses of a racial socialization intervention. *Journal of Black Psychology, 44*(1), 25–46. https://doi.org/10.1177/0095798417732930.

Anders, S. L., Frazier, P. A., & Frankfurt, S. B. (2011). Variations in criterion A and PTSD rates in a community sample of women. *Journal of Anxiety Disorders, 25*(2), 176–184. https://doi.org/10.1016/j.janxdis.2010.08.018.

Antonelli, M., Barbieri, G., & Donelli, D. (2019). Effects of forest bathing (shinrin-yoku) on levels of cortisol as a stress biomarker: A systematic review and meta-analysis. *International Journal of Biometeorology, 63*(8), 1117–1134. https://doi.org/10.1007/s00484-019-01717-x.

Arntz, A., Sofi, D., & van Breukelen, G. (2013). Imagery rescripting as treatment for complicated PTSD in refugees: A multiple baseline case series study. *Behaviour Research and Therapy, 51*(6), 274–283. https://doi.org/10.1016/j.brat.2013.02.009.

Banks, K. H., Goswami, S., Goodwin, D., Petty, J., Bell, V., & Musa, I. (2021). Interrupting internalized racial oppression: A community based ACT intervention. *Journal of Contextual Behavioral Science, 20*, 89–93. https://doi.org/10.1016/j.jcbs.2021.02.006.

Barclay, L. J., & Skarlicki, D. P. (2009). Healing the wounds of organizational injustice: Examining the benefits of expressive writing. *Journal of Applied Psychology, 94*(2), 511–523. https://doi.org/10.1037/a0013451.

Belak, A., Madarasova Geckova, A., van Dijk, J. P., & Reijneveld, S. A. (2018). Why don't segregated Roma do more for their health? An explanatory framework from an ethnographic study in Slovakia. *International Journal of Public Health, 63*(9), 1123–1131. https://doi.org/10.1007/s00038-018-1134-2.

Benuto, L., Singer, J., Newlands, R. T., & Casas, J. B. (2019). Training culturally competent psychologists: Where are we and where do we need to go? *Training and Education in Professional Psychology, 13*(1), 56–63. https://doi.org/10.1037/tep0000214.

Berger, M., & Sarnyai, Z. (2015). 'More than skin deep': Stress neurobiology and mental health consequences of racial discrimination. *Stress: The International Journal on the Biology of Stress, 18*(1), 1–10. https://doi.org/10.3109/10253890.2014.989204.

Bhambhani, Y., & Gallo, L. (2021). Developing and adapting a mindfulness-based group intervention for racially and economically marginalized patients in the Bronx. *Cognitive and Behavioral Practice.* https://doi.org/10.1016/j.cbpra.2021.04.010. Advance online.

Bryant-Davis, T., & Ocampo, C. (2006). A therapeutic approach to the treatment of racist-incident-based trauma. *Journal of Emotional Abuse, 6*(4), 1–22. https://doi.org/10.1300/J135v06n04_01.

Bryant-Davis, T., Ullman, S., Tsong, Y., Anderson, G., Counts, P., Tillman, S., Bhang, C., & Gray, A. (2015). Healing pathways: Longitudinal effects of religious coping and social support on PTSD symptoms in African American sexual assault survivors. *Journal of Trauma & Dissociation, 16*(1), 114–128. https://doi.org/10.1080/15299732.2014.969468.

Bryant-Davis, T., Ullman, S. E., Tsong, Y., & Gobin, R. (2011). Surviving the storm: The role of social support and religious coping in sexual assault recovery of African American women. *Violence Against Women, 17*(12), 1601–1618. https://doi.org/10.1177/1077801211436138.

Bryc, K., Durand, E. Y., Macpherson, J. M., Reich, D., & Mountain, J. L. (2015). The genetic ancestry of African Americans, Latinos, and European Americans across the United States. *American Journal of Human Genetics, 96*(1), 37–53. https://doi.org/10.1016/j.ajhg.2014.11.010.

Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology, 58*(4), 537–554. https://doi.org/10.1037/a0025266.

Calloway, A., & Creed, T. A. (2021). Enhancing CBT Consultation With Multicultural Counseling Principles. *Cognitive and Behavioral Practice.* https://doi.org/10.1016/j.cbpra.2021.05.007.

Carlson, M. D., Endsley, M., Motley, D., Shawahin, L. N., & Williams, M. T. (2018). Addressing the impact of racism on veterans of color: A race-based stress and trauma intervention. *Psychology of Violence, 8*(6), 748–762. https://doi.org/10.1037/vio0000221.

Carter, R. T. (2007). Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress. *The Counseling Psychologist, 35*(1), 13–105. https://doi.org/10.1177/0011000006292033.

Carter, R., & Pieterse, A. (2020). *Measuring the Effects of Racism: Guidelines for the Assessment and Treatment of Race-Based Traumatic Stress Injury.* Columbia University Press.

Carter, R. T., Roberson, K., & Johnson, V. E. (2020). Race-based stress in white adults: Exploring the role of white racial identity status attitudes and type of racial events. *Journal of Multicultural Counseling and Development, 48*, 95–107. https://doi.org/10.1002/jmcd.12168.

Cerdeña, J. P., Plaisime, M. V., & Tsai, J. (2020). From race-based to race-conscious medicine: How anti-racist uprisings call us to act. *The Lancet, 396*(10257), 1125–1128. https://doi.org/10.1016/s0140-6736(20)32076-6.

Chapman-Hilliard, C., & Adams-Bass, V. (2016). A conceptual framework for utilizing Black history knowledge as a path to psychological liberation for Black youth. *Journal of Black Psychology, 42*(6), 479–507. https://doi.org/10.1177/0095798415597840.

Chavez-Dueñas, N. Y., Adames, H. Y., Perez-Chavez, J. G., & Salas, S. P. (2019). Healing ethno-racial trauma in Latinx immigrant communities: Cultivating hope, resistance, and action. *The American Psychologist, 74*(1), 49–62. https://doi.org/10.1037/amp0000289.

Ching, T. H. W. (2021). Culturally attuned behavior therapy for anxiety and depression in Asian Americans: Addressing racial microaggressions and deconstructing the model minority myth. *Cognitive and Behavioral Practice.* https://doi.org/10.1016/j.cbpra.2021.04.006. Advance online publication.

Chioneso, N. A., Hunter, C. D., Gobin, R. L., McNeil Smith, S., Mendenhall, R., & Neville, H. A. (2020). Community healing and resistance through storytelling: A framework to address racial trauma in Africana communities. *Journal of Black Psychology, 46*(2–3), 95–121. https://doi.org/10.1177/0095798420929468.

Comas-Díaz, L. (2016). Racial trauma recovery: A race-informed therapeutic approach to racial wounds. In Alvarez, A.N. (Ed); Liang, C. T. H. (Ed); Neville, H. A. (Ed.), *The cost of racism for people of color: Contextualizing experiences of discrimination. Cultural, racial, and ethnic psychology book series* (pp. 249–272). American Psychological Association.

Conway-Phillips, R., Dagadu, H., Motley, D., Shawahin, L., Janusek, L. W., Klonowski, S., & Saban, K. L. (2020). Qualitative evidence for Resilience, Stress, and Ethnicity (RiSE): A program to address race-based stress among Black women at risk for cardiovascular disease. *Complementary Therapies in Medicine, 48*, 102277. https://doi.org/10.1016/j.ctim.2019.102277.

Courtois, C. A. (2017). Meaning making and trauma recovery. In E. M. Altmaier (Ed.), *Reconstructing meaning after trauma: Theory, research, and practice* (pp. 187–192). Elsevier/Academic Press.

Cromer, F. B. (2021). Transformative radical self-care by women in African and Pan-African spiritual traditions: Divine power of joy, lemonade self-care, self-love holiday. *Journal of Women, Politics & Policy, 42*(1), 4–22. https://doi.org/10.1080/1554477X.2021.1870092.

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *International Journal for Equity in Health, 18*(1), 174. https://doi.org/10.1186/s12939-019-1082-3.

Degife, E., Ijeli, C., Muhammad, M. I., Nobles, A., & Reisman, A. (2021). Educational intervention against biological racism. *The Clinical Teacher, 18*(5), 542–546. https://doi.org/10.1111/tct.13403.

DeLapp, C. L., & DeLapp, R. C. T. (2021). Talking racial stress: Clinician recommendations for exploring racial stress with BIPOC patients. *the Behavior Therapist, 44*(2), 75–79.

Donovan, B. M., Semmens, R., Keck, P., Brimhall, E., Busch, K. C., Weindling, M., Duncan, A., Stuhlsatz, M., Bracey, Z. B., Bloom, M., Kowalski, S., & Salazar, B. (2019). Toward a more humane genetics education: Learning about the social and quantitative complexities of human genetic variation research could reduce racial bias in adolescent and adult populations. *Science Education, 103*(3), 529–560. https://doi.org/10.1002/sce.21506.

Evans, A. M., Hemmings, C., Burkhalter, C., & Lacy, V. (2016). Responding to race related trauma: Counseling and research recommendations to promote post-traumatic growth when counseling African American males. *The Journal of Counselor Preparation and Supervision, 8*(1). https://doi.org/10.7729/81.1085.

Evans, G. (2018). The unwelcome revival of 'race science.' *The Guardian*. https://www.theguardian.com/news/2018/mar/02/the-unwelcome-revival-of-race-science.

Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2007). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences: Therapist guide*. Oxford University Press.

Gerger, H., Werner, C., Gaab, J., & Cuijpers, P. (2021). Comparative efficacy and acceptability of expressive writing treatments compared with psychotherapy, other writing treatments, and waiting list control for adult trauma survivors: A systematic review and network meta-analysis. *Psychological Medicine*, 1–13. https://doi.org/10.1017/S0033291721000143.

Gibbons, F. X., Kingsbury, J. H., Weng, C. Y., Gerrard, M., Cutrona, C., Wills, T. A., & Stock, M. (2014). Effects of perceived racial discrimination on health status and health behavior: A differential mediation hypothesis. *Health Psychology, 33*(1), 11–19. https://doi.org/10.1037/a0033857.

Graham, J. R., West, L. M., & Roemer, L. (2013). The experience of racism and anxiety symptoms in an African-American sample: Moderating effects of trait mindfulness. *Mindfulness, 4*(4), 332–341. https://doi.org/10.1007/s12671-012-0152-z.

Graham-LoPresti, J., Williams, M. T., & Rosen, D. C. (2019). Culturally responsive assessment and diagnosis for clients of color. In M. T. Williams, D. C. Rosen, & J. W. Kanter (Eds.), *Eliminating race-based mental health disparities: Promoting equity and culturally responsive care across settings* (pp. 169–185). New Harbinger Books.

Grau, P., Kusch, M. M., Williams, M. T., Loyo, K. M., Zhang, X., Warner, R. C., & Wetterneck, C. (2021). A review of the inclusion of ethnoracial groups in empirically-supported posttraumatic stress disorder treatment research. *Psychological Trauma: Theory, Research, Practice, and Policy, 14*(1), 55–65. https://doi.org/10.1037/tra0001108.

Griffith, D. M., Johnson, J. L., Zhang, R., Neighbors, H. W., & Jackson, J. S. (2011). Ethnicity, nativity, and the health of American Blacks. *Journal of Health Care for the Poor and Underserved, 22*(1), 142–156. https://doi.org/10.1353/hpu.2011.0011.

Guerin, B. (2005). Combating everyday racial discrimination without assuming "racists" or "racism": New intervention ideas from a contextual analysis. *Behavior and Social Issues, 14*, 46–70. https://doi.org/10.5210/bsi.v14i1.120.

Haeny, A., Holmes, S., & Williams, M. T. (2021). The need for shared nomenclature on racism and related terminology. *Perspectives on Psychological Science, 16*(5), 886–892. https://doi.org/10.1177/17456916211000760.

Haidt, J. (2017). The unwisest idea on campus: Commentary on Lilienfeld. *Perspectives on Psychological Science, 12*(1), 176–177.

Halstead, M., Reed, S., Krause, R., & Williams, M. T. (2021). Ketamine-assisted psychotherapy for PTSD related to experiences of racial discrimination. *Clinical Case Studies, 20*(4), 310–330. https://doi.org/10.1177/1534650121990894.

Han, C. S., Ayala, G., Paul, J. P., Boylan, R., Gregorich, S. E., & Choi, K. H. (2015). Stress and coping with racism and their role in sexual risk for HIV among African American, Asian/Pacific Islander, and Latino men who have sex with men. *Archives of Sexual Behavior, 44*(2), 411–420. https://doi.org/10.1007/s10508-014-0331-1.

Hansson, A., Hilleras, P., & Forsell, Y. (2005). What kind of self-care strategies do people report using and is there an association with well-Being? *Social Indicators Research, 73*(1), 133–139. https://doi.org/10.1007/s11205-004-0995-3.

Hargons, C., Malone, N. J., Montique, C. S., Dogan, J., Stuck, J., Meiller, C., ... Stevens-Watkins, D. (2021). Race-based stress reactions and recovery: Pilot testing a racial trauma meditation. *Journal of Black Psychology*. https://doi.org/10.1177/00957984211034281.

Harmon, A. (2019). Can biology class reduce racism? *The New York Times*. https://www.nytimes.com/2019/12/07/us/race-biology-genetics.html.

Heard-Garris, N., Ekwueme, P. O., Gilpin, S., Sacotte, K. A., Perez-Cardona, L., Wong, M., & Cohen, A. (2021). Adolescents' experiences, emotions, and coping strategies associated with exposure to media-based vicarious racism. *JAMA Network Open, 4*(6), e2113522.

Hemmings, C., & Evans, A. (2018). Identifying and treating race-based trauma in counseling. *Journal of Multicultural Counseling and Development, 46*(1), 20–39. https://doi.org/10.1002/jmcd.12090.

Herman, J. L. (2015). *Trauma and recovery: The aftermath of violence–from domestic abuse to political terror*. Basic Books.

Hernández, E., & Harris, D. M. (2022). Racial trauma: Implications for student development. *New Directions for Student Services, 2022*(177), 95–103.

Hill, L. K., & Hoggard, L. S. (2018). Active coping moderates associations among race-related stress, rumination, and depressive symptoms in emerging adult African American women. *Development and Psychopathology, 30*(5), 1817–1835.

Hill, Z. (2017). This BLM meditation can help people cope with the tiring cycle of oppression for when current events take a toll on your mental health. *Huffington Post*. https://www.huffpost.com/entry/this-blm-meditation-can-help-people-cope-with-the-tiring-cycle-of-oppression_n_59089aade4b0bb2d0871e5ac.

Hirai, M., Skidmore, S. T., Clum, G. A., & Dolma, S. (2012). An investigation of the efficacy of online expressive writing for trauma-related psychological distress in Hispanic individuals. *Behavior Therapy, 43*(4), 812–824. https://doi.org/10.1016/j.beth.2012.04.006.

Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences of the United States of America, 113*(16), 4296–4301. https://doi.org/10.1073/pnas.1516047113.

Hogarth, R. A. (2019). The myth of innate racial differences between White and Black people's bodies: Lessons from the 1793 Yellow Fever Epidemic in Philadelphia, Pennsylvania. *American Journal of Public Health, 109*(10), 1339–1341. https://doi.org/10.2105/AJPH.2019.305245.

Holmes, S. C., Facemire, V. C., & DaFonseca, A. M. (2016). Expanding Criterion A for posttraumatic stress disorder: Considering the deleterious impact of oppression.

Traumatology, 22(4), 314–321. https://doi.org/10.1037/trm0000104.

Hope, E. C., Velez, G., Offidani-Bertrand, C., Keels, M., & Durkee, M. I. (2018). Political activism and mental health among Black and Latinx college students. *Cultural Diversity & Ethnic Minority Psychology, 24*(1), 26–39. https://doi.org/10.1037/cdp0000144.

Hwang, W., & Chan, C. (2019). Compassionate meditation to heal from race-related stress: A pilot study with Asian Americans. *American Journal of Orthopsychiatry, 89*(4), 482–492. https://doi.org/10.1037/ort0000372.

Jacob, G., Faber, S. C., Faber, N., Bartlett, A., Ouimet, A., & Williams, M. T. (2022). A systematic review of Black People coping with racism: Approaches, analysis, and empowerment. *Perspectives on Psychological Science*. https://doi.org/10.1177/17456916221100509. Advance online.

Jernigan, M. M., Green, C. E., Pérez-Gualdrón, L., Liu, M., Henze, K. T., Chen, C., & Helms, J. E. (2015). #racialtraumaisreal. *Alumni Advisory Group Institution for the study and promotion of race and culture*. https://www.bc.edu/content/dam/files/schools/lsoe_sites/isprc/pdf/racialtraumaisreal.pdf.

Johnson, V., Nadal, K., Sissoko, D., & King, R. (2021). "It's not in your head": Gaslighting, 'splaining, victim blaming, and other harmful reactions to microaggressions. *Perspectives on Psychological Science, 16*(5), 1024–1036. https://doi.org/10.1177/17456916211011963.

Koch, J. M., Knutson, D., Loche, L., Loche, R. W., III, Lee, H. S., & Federici, D. J. (2020). A qualitative inquiry of microaffirmation experiences among culturally diverse graduate students. *Current Psychology*, 1–13. https://doi.org/10.1007/s12144-020-00811-3.

Kolbert, E. (2018). Skin Deep: What is race, exactly? Science tells us there is no genetic or scientific basis for it. Instead it's largely a made-up label, used to define and separate us. *National Geographic, 233*(4), 28 https://www.nationalgeographic.com/magazine/article/race-genetics-science-africa.

Kwate, N. O., & Meyer, I. H. (2010). The myth of meritocracy and African American health. *American Journal of Public Health, 100*(10), 1831–1834. https://doi.org/10.2105/AJPH.2009.186445.

Landor, A. M., & McNeil Smith, S. (2019). Skin-tone trauma: Historical and contemporary influences on the health and interpersonal outcomes of African Americans. *Perspectives on Psychological Science, 14*(5), 797–815. https://doi.org/10.1177/1745691619851781.

Lansing, A. E., Plante, W. Y., & Beck, A. N. (2017). Assessing stress-related treatment needs among girls at risk for poor functional outcomes: The impact of cumulative adversity, criterion traumas, and non-criterion events. *Journal of Anxiety Disorders, 48*, 36–44. https://doi.org/10.1016/j.janxdis.2016.09.007.

Laszloffy, T. A., & Hardy, K. V. (2000). Uncommon strategies for a common problem: Addressing racism in family therapy. *Family Process, 39*(1), 35–50. https://doi.org/10.1111/j.1545-5300.2000.39106.x.

Leuchtgens, H., Albus, T., Uhlemann, C., Volger, E., Pelka, R. B., & Resch, K. L. (1999). Auswirkungen der Kneipp-Kur, einer standardisierten Komplextherapie, auf schmerz, Lebensqualität und medikamentenverbrauch: Kohortenstudie mit 1-jahres-follow-up [Effects of Kneippism, a standardized complex therapy, on pain, quality of life and use of medicines: Cohort study with a one-year follow-up]. *Forschende Komplementarmedizin, 6*(4), 206–211. https://doi.org/10.1159/000021249.

Lewis, E., & Teasdell, A. (2021). Health, wellness, and history: Enhancing self-perceptions for black students through revolutionary approaches to education. *Black History Bulletin, 84*(2), 24–26. https://doi.org/10.1353/bhb.2021.0007.

Litam, S. D. A. (2020). "Take your Kung-Flu back to Wuhan": Counseling Asians, Asian Americans, and Pacific Islanders with Race-Based Trauma Related to COVID-19. *Professional Counselor, 10*(2), 144–156.

Liu, S., Li, C.-I., Wang, C., Wei, M., & Ko, S. (2020). Self-compassion and social connectedness buffering racial discrimination on depression among Asian Americans. *Mindfulness, 11*(3), 672–682. https://doi.org/10.1007/s12671-019-01275-8.

Loo, C. M., Fairbank, J. A., Scurfield, R. M., Ruch, L. O., King, D. W., Adams, L. J., & Chemtob, C. M. (2001). Measuring exposure to racism: Development and validation of a Race-Related Stressor Scale (RRSS) for Asian American Vietnam veterans. *Psychological Assessment, 13*, 503–520. https://doi.org/10.1037/1040-3590.13.4.503.

Lujan, H. L., & DiCarlo, S. E. (2021). The racist "one drop rule" influencing science: It is time to stop teaching "race corrections" in medicine. *Advances in Physiology Education, 45*(3), 644–650. https://doi.org/10.1152/advan.00063.2021.

Madeira, A. F., Costa-Lopes, R., Dovidio, J. F., Freitas, G., & Mascarenhas, M. F. (2019). Primes and consequences: A systematic review of meritocracy in intergroup relations. *Frontiers in Psychology, 10*, 2007. https://doi.org/10.3389/fpsyg.2019.02007.

Malott, K. M., Paone, T. R., Humphreys, K., & Martinez, T. (2010). Use of group counseling to address ethnic identity development: Application with adolescents of Mexican descent. *Professional School Counseling, 13*, 257–267.

Malott, K. M., & Schaefle, S. (2015). Addressing clients' experiences of racism: A model for clinical practice. *Journal of Counseling and Development, 93*(3), 361–369. https://doi.org/10.1002/jcad.12034.

Malott, K. M., Schaefle, S., Paone, T. R., Cates, J., & Haizlip, B. (2019). Challenges and coping mechanisms of whites committed to antiracism. *Journal of Counseling and Development, 97*(1), 86–97. https://doi.org/10.1002/jcad.12238.

Márquez-Magaña, L., Samayoa, C., & Umanzor, C. (2013). Debunking 'race' and asserting social determinants as primary causes of cancer health disparities: Outcomes of a science education activity for teens. *Journal of Cancer Education, 28*(2), 314–318. https://doi.org/10.1007/s13187-013-0474-0.

Metzger, I. W., Anderson, R. E., Are, F., & Ritchwood, T. (2021). Healing interpersonal and racial trauma: Integrating racial socialization into trauma-focused cognitive behavioral therapy for African American youth. *Child Maltreatment, 26*(1), 17–27.

Miller, M. J., Keum, B. T., Thai, C. J., Lu, Y., Truong, N. N., Huh, G. A., ... Ahn, L. H. (2018). Practice recommendations for addressing racism: A content analysis of the counseling psychology literature. *Journal of Counseling Psychology, 65*(6), 669–680. https://doi.org/10.1037/cou0000306.

Miller, A., Williams, M. T., Wetterneck, C. T., Kanter, J., & Tsai, M. (2015). Using functional analytic psychotherapy to improve awareness and connection in racially diverse client-therapist dyads. *the Behavior Therapist, 38*(6), 150–156.

Mosley, D. V., Hargons, C. N., Meiller, C., Angyal, B., Wheeler, P., Davis, C., & Stevens-Watkins, D. (2021). Critical consciousness of anti-Black racism: A practical model to prevent and resist racial trauma. *Journal of Counseling Psychology, 68*(1), 1–16. https://doi.org/10.1037/cou0000430.

Nayak, S. (2020). For women of colour in social work: Black feminist self-care practice based on Audre Lorde's radical pioneering principles. *Critical and Radical Social Work, 8*(3), 405–421.

Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. *Self and Identity, 2*(3), 223–250. https://doi.org/10.1080/15298860309027.

Noh, S., & Kaspar, V. (2003). Perceived discrimination and depression: Moderating effects of coping, acculturation, and ethnic support. *American Journal of Public Health (1971), 93*(2), 232–238. https://doi.org/10.2105/AJPH.93.2.232.

Norton, H. L., Quillen, E. E., Bigham, A. W., Pearson, L. N., & Dunsworth, H. (2019). Human races are not like dog breeds: refuting a racist analogy. *Evolution: Education and Outreach, 12*(1), 1–20. https://doi.org/10.1186/s12052-019-0109-y.

O'Neill, J. (2000). SMART goals, SMART schools. *Educational Leadership, 57*(5), 46–50.

Park, C., & Kennedy, M. C. (2017). Meaning violation and restoration following trauma: Conceptual overview and clinical implications. In E. M. Altmaier (Ed.), *Reconstructing meaning after trauma: Theory, research, and practice* (pp. 17–27). Elsevier/Academic Press.

Quaye, S., Karikari, S. N., Allen, C. R., Okello, W., & Carter, K. D. (2019). Strategies for practicing self-care from racial battle fatigue. *JCSCORE, 5*(2), 94–131. https://doi.org/10.15763/issn.2642-2387.2019.5.2.94-131.

Resick, P. A., Monson, C. M., & Chard, K. M. (2016). *Cognitive processing therapy for PTSD: A comprehensive manual*. Guilford Publications.

Reynolds, J. E. (2019). Addressing racial trauma in therapy with ethnic-minority clients. In J. Lebow, A. L. Chambers, & D. C. Breunlin (Eds.), *Encyclopedia of couple and family therapy* (pp. 32–33). Springer.

Roberts, A. L., Dohrenwend, B. P., Aiello, A. E., Wright, R. J., Maercker, A., Galea, S., & Koenen, K. C. (2012). The stressor criterion for posttraumatic stress disorder: Does it matter? *Journal of Clinical Psychiatry, 73*(2), e264–e270. https://doi.org/10.4088/JCP.11m07054.

Roberts, H. (2021). Use microaffirmations and call out microaggressions to help others. *Nature*. https://doi.org/10.1038/d41586-021-01498-7.

Roberts, R. E., Phinney, J. S., Masse, L. C., Chen, Y. R., Roberts, C. R., & Romero, A. (1999). The structure of ethnic identity of young adolescents from diverse ethnocultural groups. *Journal of Early Adolescence, 19*, 301–322.

Saban, K. L., Motley, D., Shawahin, L., Mathews, H. L., Tell, D., De La Pena, P., & Janusek, L. W. (2021). Preliminary evidence for a race-based stress reduction intervention for Black women at risk for cardiovascular disease. *Complementary Therapies in Medicine, 58*, 102710.

Schwarz, N., Newman, E., & Leach, W. (2016). Making the truth stick & the myths fade: Lessons from cognitive psychology. *Behavioral Science & Policy, 2*(1), 85–95.

Sobczak, L. R., & West, L. M. (2013). Clinical considerations in using mindfulness- and acceptance-based approaches with diverse populations: Addressing challenges in service delivery in diverse community settings. *Cognitive and Behavioral Practice, 20*(1), 13–22. https://doi.org/10.1016/j.cbpra.2011.08.005.

Spann, D. (2022). Ethical considerations for psychologists addressing racial trauma experienced by Black Americans. *Ethics & Behavior, 32*(2), 99–109.

Steele, J. M. (2020). A CBT approach to internalized racism among African Americans. *International Journal for the Advancement of Counselling, 42*(3), 217–233. https://doi.org/10.1007/s10447-020-09402-0.

Stewart, C. E., Lee, S. Y., Hogstrom, A., & Williams, M. (2017). Diversify and conquer: A call to promote minority representation in clinical psychology. *the Behavior Therapist, 40*(3), 74–79.

Stuckey, H. L., & Nobel, J. (2010). The connection between art, healing, and public health: A review of current literature. *American Journal of Public Health, 100*(2), 254–263. https://doi.org/10.2105/AJPH.2008.156497.

Sue, D. W., Alsaidi, S., Awad, M. N., Glaeser, E., Calle, C. Z., & Mendez, N. (2019). Disarming racial microaggressions: Microintervention strategies for targets, White allies, and bystanders. *The American Psychologist, 74*(1), 128–142. https://doi.org/10.1037/amp0000296.

Sue, D. W., Sue, D., Neville, H. A., & Smith, L. (2019). Multicultural counseling and therapy (MCT). In *Counseling the culturally diverse: Theory and practice*, pp. 26–45). John Wiley & Sons.

Tavakoli, S., Lumley, M. A., Hijazi, A. M., Slavin-Spenny, O. M., & Parris, G. P. (2009). Effects of assertiveness training and expressive writing on acculturative stress in international students: A randomized trial. *Journal of Counseling Psychology, 56*(4), 590–596.

Tessitore, F. (2021). The Asylum Seekers Photographic Interview (ASPI): Evaluation of a new method to increase Nigerian asylum seekers' narrative meaning-making after trauma. *Psychological Trauma: Theory, Research, Practice, and Policy, 14*(1), 66–79. https://doi.org/10.1037/tra0000913.

Thurber, A., & DiAngelo, R. (2018). Microaggressions: Intervening in three acts. *Journal of Ethnic & Cultural Diversity in Social Work, 27*(1), 17–27. https://doi.org/10.1080/15313204.2017.1417941.

Timko Olson, E. R., Hansen, M. M., & Vermeesch, A. (2020). Mindfulness and Shinrin-Yoku: Potential for physiological and psychological interventions during uncertain times. *International Journal of Environmental Research and Public Health, 17*(24), 9340. https://doi.org/10.3390/ijerph17249340.

Turner, R. J., & Brown, R. L. (2010). Social support and mental health. In T. L. Scheid & T. N. Brown (Eds.), *A handbook for the study of mental health: Social contexts, theories, and systems* (2nd ed., pp. 200–212). Cambridge University Press.

Umaña-Taylor, A. J., & Douglass, S. (2017). Developing an ethnic-racial identity intervention from a developmental perspective: Process, content, and implementation of the identity project. In *Handbook on positive development of minority children and youth* (pp. 437–453). Cham: Springer.

Umaña-Taylor, A. J., Douglass, S., Updegraff, K. A., & Marsiglia, F. F. (2018). A small-scale randomized efficacy trial of the Identity Project: Promoting adolescents' ethnic–racial identity exploration and resolution. *Child Development, 89*(3), 862–870. https://doi.org/10.1111/cdev.12755.

Wang, C., & Burris, M. A. (1997). Photovoice: Concept, methodology, and use for participatory needs assessment. *Health Education & Behavior, 24*(3), 369–387.

Watts-Jones, D. (2002). Healing internalized racism: The role of a within-group sanctuary among people of African descent. *Family Process, 41*(4), 591–601. https://doi.org/10.1111/j.1545-5300.2002.00591.x.

Watson-Singleton Womack, V. Y., Holder-Dixon, A. R., & Black, A. R. (2021). Racism's (un)worthiness trap: The mediating roles of self-compassion and self-coldness in the link between racism and distress in African Americans. *Cultural Diversity & Ethnic Minority Psychology*. https://doi.org/10.1037/cdp0000398. Advance online publication.

Williams, D. R., Lawrence, J. A., & Davis, B. A. (2019). Racism and health: Evidence and needed research. *Annual Review of Public Health, 40*, 105–125. https://doi.org/10.1146/annurev-publhealth-040218-043750.

Williams, J. M., Byrd, J., Smith, C. D., & Dean, A. (2020). Photovoice as an innovative approach to group work with black youth in school settings. *The Journal for Specialists in Group Work, 45*(3), 213–225. https://doi.org/10.1080/01933922.2020.1789794.

Williams, M. T. (2020). *Managing microaggressions: Addressing everyday racism in therapeutic spaces*. Oxford University Press. ISBN: 9780190875237

Williams, M. T., Duque, G., Chapman, L. K., Wetterneck, C. T., & DeLapp, R. C. T. (2018). Ethnic identity and regional differences in mental health in a national sample of African American young adults. *Journal of Racial and Ethnic Health Disparities, 5*(2), 312–321. https://doi.org/10.1007/s40615-017-0372-y.

Williams, M. T., Faber, S. C., Nepton, A., & Ching, T. (2022). Racial justice allyship requires civil courage: Behavioral prescription for moral growth and change. *American Psychologist*. https://doi.org/10.1037/amp0000940. Adavnce online.

Williams, M. T., Haeny, A., & Holmes, S. (2021). Posttraumatic stress disorder and racial trauma. *PTSD Research Quarterly, 32*(1), 1–9.

Williams, M. T., Kanter, J. W., Peña, A., Ching., T. W. C., & Oshin, L. (2020). Reducing microaggressions and promoting interracial connection: The Racial Harmony Workshop. *Journal of Contextual and Behavioral Science, 16*, 153–161. https://doi.org/10.1016/j.jcbs.2020.04.008.

Williams, M. T., Malcoun, E., Sawyer, B., Davis, D. M., Bahojb-Nouri, L. V., & Leavell Bruce, S. (2014). Cultural adaptations of prolonged exposure therapy for treatment and prevention of posttraumatic stress disorder in African Americans. *Behavioral Sciences, 4*(2), 102–124. https://doi.org/10.3390/bs4020102.

Williams, M. T., Metzger, I., Leins, C., & DeLapp, C. (2018). Assessing racial trauma within a DSM-5 framework: The UConn Racial/Ethnic Stress & Trauma Survey. *Practice Innovations, 3*(4), 242–260. https://doi.org/10.1037/pri0000076.

Williams, M. T., Mier-Chairez, J., & Pena, A. (2017). Tools for treating obsessive compulsive disorder among Latinos. In L. T. Benuto (Ed.), *Toolkit for Counseling Spanish-Speaking Clients* (pp. 71–95). Springer. https://doi.org/10.1007/978-3-319-64880-4_7.

Williams, M., Osman, M., Gran-Ruaz, S., & Lopez, J. (2021). Intersections of racism and PTSD: Assessment and treatment of racial stress and trauma. *Current Treatment Options in Psychiatry, 8*, 167–185. https://doi.org/10.1007/s40501-021-00250-2.

Williams, M. T., Osman, M., Gallo, J., Printz, D., Gran-Ruaz, S., Strauss, D., Lester, L., George, J., Edelman, J., & Litman, L. (in press). A clinical scale for the assessment of racial trauma. *Practice Innovations*. https://doi.org/10.1037/pri0000178.

Williams, M. T., Printz, D., Ching, T., & Wetterneck, C. T. (2018). Assessing PTSD in ethnic and racial minorities: Trauma and racial trauma. *Directions in Psychiatry, 38*(3), 179–196.

Williams, M. T., Sharif, N., Strauss, D., Gran-Ruaz, S., & Bartlett, A. (2021). Unicorns, leprechauns, and White allies: Exploring the space between intent and action. *The Behavior Therapist, 44*(6), 272–281.

Williams-Witherspoon, K. L. (2020). Performing race: Using performance to heal the trauma of race and racism on college campuses. *Storytelling, Self, Society, 16*(1), 33–60. https://doi.org/10.13110/storselfsoci.16.1.0033.

Wright, M. F., & Wachs, S. (2019). Does social support moderate the relationship between racial discrimination and aggression among Latinx adolescents? A longitudinal study. *Journal of Adolescence, 73*(1), 85–94. https://doi.org/10.1016/j.adolescence.2019.04.001.

Wyatt, J. P., & Ampadu, G. G. (2021). Reclaiming self-care: Self-care as a social justice tool for black wellness. *Community Mental Health Journal*, 1–9. https://doi.org/10.1007/s10597-021-00884-9.

Zapolski, T., Faidley, M. T., & Beutlich, M. (2019). The experience of racism on behavioral health outcomes: The moderating impact of mindfulness. *Mindfulness, 10*(1), 168–178. https://doi.org/10.1007/s12671-018-0963-7.

The authors would like to acknowledge Joseph La Torre and Sophia Gran-Ruaz for their help on this protocol and related manual.

This research was undertaken, in part, thanks to funding from the Canada Research Chairs Program, Canadian Institutes of Health Research (CIHR) grant number 950-232127 (M. Williams) and from the National Institutes of Health R25DA035163, K23AA028515, L30DA049246 (A. Haeny).

The authors have no competing interests to declare.

Address correspondence to Monnica T. Williams, Ph.D., University of Ottawa, School of Psychology, 136 Jean-Jacques Lussier, Vanier Hall, Ottawa, Ontario K1N 6N5, Canada. e-mail: Monnica.Williams@uOttawa.ca.

Received: January 9, 2022
Accepted: July 19, 2022
Available online xxxx