Practitioner & Theoretical Perspectives

© *Journal of Trauma Studies in Education*
Volume 3, Issue 2 (2024), pp. 138-151
ISSN: 2162-3104 (Print), 2166-3750 (Online)
http://doi.org/10.70085/jtse.v3i2.5069

The Physiological and Psychological Impact of Race-Based Trauma: Implications for Counselor Education

Shaywanna Harris-Pierre
Texas State University

Michelle D. Ellis
Jacksonville University

Ashlei R. Petion
The College of New Jersey

ABSTRACT

The area of trauma has been well researched within counseling literature; however, discussions around race-based trauma have been proportionately minimal. Given the physiological, psychological, and behavioral impacts of race-based trauma it is imperative that counselors and counselor educators are equipped to broach and address client's experiences. Therefore, this article provides a review of race-based trauma literature and models. In addition, this article calls counseling professionals to action on exploring and addressing their own attitudes, beliefs, and biases, along with informing clinicians on how to advocate for people of color and translate their knowledge into their work.

Keywords: race, trauma, race-based trauma, counselors, broaching

Race-based traumatic stress is defined as the cumulative emotional and physiological response to racial incidents. This response can be to emotional injuries on the basis of race, racially motivated stressors, racial stressors that cause bodily harm or threatens one's life, or a severe racial stressor that causes fear, helplessness, or horror (Carter, 2006; Bryant-Davis, 2007; Pieterse, 2018). Further, racial battle fatigue (Smith, 2004) is defined as the intersection of the physiological, psychological, and behavioral reactions to race based stressors. That is, racial battle fatigue describes the

accumulated manifestation of the impact of race-based stressors. Thus, race-based traumatic stress, by definition, impacts not only the emotional wellbeing of those impacted by it, but physiological wellbeing as well.

As the brain interprets a threat within an individual, the fear response is activated. This response helps an individual to protect themselves from a perceived threat by either fighting it off, fleeing from it, or freezing. Freezing protects the individual by dimming or shutting off the ability to feel or take in stimuli. This is a protective mechanism as it keeps the body from being overwhelmed or flooded with negative stimuli. Chronic traumatic experiences can lead to instinctual reactions to stimuli that mimic the fear response within the body, even if the stimulus experienced is not a threat. This continued activation of the stress response within the body has numerous effects on the body physically due to stress hormones released which may include consistent tensing of muscles, and other manifestations of stress in the body (Van Der Kolk, 1994; Carter & Pieterse, 2020).

Moreover, researchers exploring intergenerational race-based trauma highlight the role of epigenetics in the transmission of historical trauma and its impact on health outcomes for marginalized groups over time (Conching et al, 2019). The collective experiencing of trauma by one generation has the potential to impact the expression of genes in subsequent generations. Intergenerational trauma research highlights a similar passing of trauma throughout generations from a social and emotional perspective. For example, parenting responses and approaches to child rearing may be passed down to children based on a generational experience of trauma (Lewis, 2019).

Considering the consistent and pervasive experiences of race-based stressors, and the potential impact of continuous activation of the stress response, it is imperative that counselors consider the physiological as well as the psychological impact of stress, specifically race-based stress, on clients. According to Hemmings and Evans (2018), in a sample of majority (77.4%) female and majority (69.8%) White, 70.8% of counselors reported having worked with a client who had experienced race-based trauma including, on average, at least 8 of the following: (a) covert acts of racism, (b) hate crimes, (c) institutional racism, (d) microaggressions, (e) outside-group racist comments, (f) overt acts of racism, (g) racial discrimination, (h) racial profiling, and (i) within-group racist comments (Hemmings & Evans, 2018). In the same group, more than half (67%) of counselors expressed not having received any training on how to identify race-based trauma. Moreover, the majority (80%) of counselors included in the study reported not having any training on ways to process through and work with race-based trauma with clients.

There are many models explaining the processes of racial trauma for people of color (Carter et al, 2020; Anderson & Stevenson, 2019; Nagata, et al, 2019; Chavez-Dueñas et al, 2019; Sibrava, et al, 2019) and suggestions for treatment in addressing race-based trauma. Therefore, it is imperative that counselors strive toward cultural competence and antiracism in our practice with our clients by learning more about these race-based trauma treatment models. The purpose of this conceptual article is to educate counseling clinicians as well as educators and supervisors on the impact of race-based trauma at the psychological and physiological levels. The present article assumes the reader has taken a multicultural course and/or has begun engaging in

their own interpersonal work prior as it relates to racial identity development, the deconstruction of white supremacist ideologies, and cross-cultural counseling as a prerequisite to their learning on the processing of race-based trauma. As such, this article will provide implications for clinicians, educators, and supervisors, calling counseling professionals to act on learning more about their own biases and how they can address them, advocate for people of color, and translate their new knowledge into their work with clients and students.

THE PHYSIOLOGY OF TRAUMA

The brain is impacted by trauma and stress developmentally (Felitti et al., 1998). That is, as the brain develops, neurons build and strengthen connections and chronic stressors and trauma can impact how these neural pathways are established within the brain. These structures change as a result of consistent exposure to threats, thus changing brain physiology and potentially leading to long term and widespread bodily harm.

Specifically, when the brain interprets a threat, the stress response is activated, allowing the person to protect themselves by fighting the threat, fleeing from the threat, or freezing. If the stress response is activated consistently—that is, the neurons associated with the stress response are consistently activated and firing—these neurons build stronger connections, leading to the stress response becoming the inherent and instinctual response. Consequently, the stress response activates within the body as well, causing widespread changes such as muscle tension, slowing digestion, increased heart rate, and other changes. These widespread bodily changes that occur as a result of consistent activation of the stress response within the brain and body can be traced to the brain's connection to the body through the nervous systems.

The brain houses the central nervous system, consisting of neurons and connections within the brain and spinal cord. The Peripheral Nervous System connects the brain and body through the spinal cord to the various muscles and organs throughout the body and comprised of the Somatic Nervous system (also referred to as the voluntary nervous system, controlling voluntary actions in the body), and the Autonomic Nervous system (the system involved in automatic bodily functions). The autonomic nervous system (ANS) regulates physiological responses such as breathing, heart rate, and digestion. As the ANS evolved, the freeze/shut down response developed to ensure survival (Porges & Buczynski, 2011). Mobilization responses, popularly known as "fight or flight" evolved as well to ensure survival through confrontation or escape. The ANS is comprised of the Ventral Vagal Complex (VVC), the Dorsal Vagal Complex (DVC), and the Sympathetic Nervous system (SNS) (Kolacz, et al, 2019). Each of these systems work together to ensure survival when a threat is present, while also mediating the threat responses and regulating the body once a threat is passed. Specifically, the VVC inhibits the threat functions of the DVC and SNS and is also involved in the social engagement system. That is, the VVC is involved in perceiving danger or safety through sounds and others' facial expressions (Kolacz, et. al, 2019).

As the ANS is involved in subconscious bodily functions related to digestion, breathing, and heartrate, threats to safety trigger the ANS to restrict or engage bodily systems in response to perceived threats. As such, each of the ANS subsystems work together to tense muscles, reduce digestive functions, increase heartrate, or conduct other physiological adjustments necessary to survive the perceived threat (Kolacz et al, 2019). Based on an individual's prior experiences and how their brain has developed, some stressors may be perceived as life threatening, eliciting a physiological protective response, while other stressors may not. Each individual's ANS reactivity is dependent upon prior experiences and the "neuroception" of the nervous system and whether a threat is perceived or anticipated (Porges & Buczynski, 2011). Therefore, individuals whose brains have been rewired to instinctually perceive a threat due to past trauma, may be impacted by perceived threats on physiological (e.g., muscle tension), emotional (e.g., intrusive thoughts), and mental (e.g., flashbacks) levels.

HISTORICAL TRAUMA

While the psychological, physiological, and behavioral effects of race-based traumatic stress are described on an individual level, it is important to consider the long-term, interpersonal, and communal effects of race-based traumatic stress that may outlive the individual who experienced it first-hand. Historical trauma is a term that describes how complex and collective trauma that is experienced by a specific group of people with a shared identity persists over time and across many generations (Brave Heart & DeBruyn, 1998). Another key feature of historical trauma is that contemporary members of the group are affected by the trauma and may experience trauma-related symptoms even though they did not experience the trauma first-hand (Mohatt et al., 2014). This feature has been illuminated by examples such as the 'soul wound' (i.e., the cumulative effect of the systematic genocide of Native Americans) and 'Post Traumatic Slave Syndrome' (i.e., a play on the DSM PTSD diagnosis to describe the residual effects of slavery on present-day African Americans) (DeGruy, 2017; Duran et al., 1998). These examples provide glaring insights into what this amassed trauma feels like for individuals belonging to those groups, but much is to be explored about *how* these processes persist.

How scholars have studied and conceptualized the transmission of trauma has varied. Some scholars argue that historical trauma is a term more fit for more macro-level, community-oriented experiences, while terms like 'intergenerational trauma' and 'transgenerational trauma' are more descriptive of how processes are transmitted within families (Bar-On et al., 1998; Duran, 2006). Regardless of the term used to describe the transmission process, *something* is being transmitted, whether it be physiologically through epigenetics, socio-behaviorally through child-rearing and community care, or a combination of both. Epigenetics is the study of cellular variations caused by external, environmental factors that make changes in the phenotype of genetic expression (Krippner & Barrett, 2019). There is a plethora of empirical evidence explaining how the epigenetics of traumatized parents then affects offspring across generations, for individuals experiencing unique trauma as well as those who belong to specific groups that have been subjected to collective trauma

(Daud et al., 2005; Evans-Campbell, 2008; Karenian et al., 2011; Wexler et al., 2009). Each of these studies also explore the more socio-behavioral impacts of traumatic experiences and epigenetic modifications, highlighting how traumatized individuals perceive and navigate the world differently; their homes and interpersonal relationships not being exempt from this. As a result, the literature on historical and intergenerational trauma encompasses both epigenetic and interpersonal transmissions of trauma within families and communities and is becoming increasingly geared towards illuminating lived experiences and real-life examples of this phenomenon (Petion, et. al, 2022).

The effects of race-based traumatic stress persist throughout families and generations and have negative impacts on overall health and wellbeing for communities of color. DeGruy (2017) and Duran et al. (1998) have powerfully synthesized the race-based traumatic experiences of African Americans and Native Americans, respectively, in palatable and relatable terms that can easily be used to foster dialogue, connection, and healing within those communities. In like manner, Wilkins et al. (2013) illuminates the intergenerational transmission of trauma within African American families and communities by calling attention to 'residual effects of slavery'. Authors asserted that many practices that were upheld during slavery are still being used as survival and coping tactics today, even when immediate threats are no longer present. For example, enslaved children who developed through puberty into adult competencies were often taken away from their parents, triggering an incessant fear of loss. As a result, contemporary African American parents may have difficulty praising their children for reaching milestones or achievements, even when that same threat of loss due to developmental growth no longer exists. (However, it may exist in other forms; for example, young Black boys being perceived as adults, resulting in heightened discrimination from law enforcement and other serious threats to their wellbeing.) Another example is that of many African American parents viewing their primary function as preparing their children for the outside, oppressive world. As a result, they may subconsciously create a microcosm of society within their own homes, making home conditions oppressive as well. Being extremely criticizing, strict, and unpleasant to their children may be viewed as a 'necessary evil' in ensuring that they can survive outside the home while navigating an oppressive society. Parents may fear that if they do not engage in this maladaptive preparation, their children may succumb to oppressive forces. These are just two examples of many that demonstrate how the combination of physiological and socio-behavioral effects of race-based traumatic stress can manifest within families and across generations. Without awareness of these processes and cultural realities, professional counselors run the risk of misdiagnosis and potentially doing harm to their clients. The following are three extant models of working with racially marginalized clients to address the physiological and psychological impacts of race-based trauma.

RACE-BASED TRAUMATIC STRESS MODEL

Race is a social construct that differentiates groups of people based on social identifiers (Carter, 1995). Research has shown that people of color are impacted by institutional, individual, and cultural encounters with racism (Carter, 1995). These

encounters elicit the stress response within the body just as other chronic stressors and traumatic experiences (Carter, 1995; Carter et al, 2020; Smith et al, 2014). A traumatic racial encounter can activate a (a) psychological stress response (evoking anxiety, fear, shock, anger, defensiveness, etc.), (b) physiological stress response (increasing heart rate, blood pressure, gastric distress, tension, headaches, etc.), and (c) behavioral stress response (the coping skills one engages in as a result of being emotionally activated) (Carter & Pieterse, 2020; Smith, et al, 2014). The interaction of experiences of racism and the subsequent psychological, physiological, and behavioral responses is conceptualized as Racial Battle Fatigue (Smith, 2011).

Where PTSD and other conceptualizations of trauma focus on disorder and pathology, racial trauma may be better conceptualized through a lens of "injury" which removes blame or fault from the person experiencing the assaults and validates their encounter as something they cannot control (Carter et. al, 2020). Racial injuries may include: microaggressions, harassment, verbal or physical attacks, threats to livelihood, social avoidance, exclusion, and discrimination, among other experiences. Further, Carter (2006) conceptualizes these racial injuries and their subsequent impact through the lens of Race Based Traumatic Stress or Race Based Stress.

Carter's Race Based Traumatic Stress (RBTS) Model provides a conceptual framework to describe the emotional, physiological, cognitive, and behavioral impact of racial injuries and events. The context of potential RBTS occurs when an individual experiences a racial event that is (a) emotionally painful, (b) sudden, and (c) uncontrollable by the person (Carter, et. al, 2020). When individuals experience events that fall within these parameters, individuals may experience somatic manifestations such as headaches, behavioral symptoms like irritability or aggression, cognitive experiences like flashbacks or cognitive avoidance, or emotional symptoms like numbing. Of course, this list of symptoms is not exhaustive and each individual's experiences with racialized events will differ depending on the context of the event, the ability of the individual to reach out for support, and racial identity development.

RECAST MODEL

Andersen and Stevenson 2019 built upon the literature surrounding Race Based Traumatic Stress by adding racial socialization as an important factor to consider when conceptualizing the impact of racialized encounters. In the RECAST model, discriminatory racial encounters are appraised by an individual as threatening or non-threatening and managed accordingly. In situations where an individual perceives the event as a threat, both the individual's racial coping ability and racial self-efficacy impact the psychological, social, physiological, academic, and identity related outcomes associated with the event.

Racial socialization is considered to be a mediator of the impact of RBTS. That is, how an individual is socialized to navigate racialized encounters will either help or hinder their ability to adaptively cope with the racialized encounter. Further, racial socialization impacts racial coping self-efficacy. That is, individuals who receive impactful socialization to race may have a higher sense of efficacy in their ability to navigate racial encounters. The RECAST model provides counselors with a framework through which Race Based Traumatic Stress may be mitigated.

Specifically, the RECAST model somewhat mimics the stress response within the body. When a threat is perceived, the body appraises the threat and, based on one's foundation and ability to appraise and cope with the stimulus, physiologically prepares to react accordingly to the threat. This reaction within the brain and body mirrors the reaction described by the RECAST model in which the individual emotionally appraises a racialized encounter as a threat and, based on learned coping skills and self-efficacy, responds to the threat.

ETHNO-RACIAL TRUAMA (HEART MODEL)

Chaves-Dueñas and colleagues (2019) further expanded upon the idea of healing race-based trauma through a lens of liberation psychology and trauma informed care for clients, specifically Latinx clients. The Healing Ethno-Racial Trauma (HEART) model conceptualizes ethno-racial trauma as the intersection of marginalization on the basis of (a) nationalism (i.e., immigrant status), (b) ethnocentrism (e.g., Latinx ethnic identity), (c) racism (i.e., skin color/ phenotype), and (d) sexism/other marginalized identities.

Within the HEART model, healing of ethno-racial trauma occurs in four phases. First, in the establishment of sanctuary spaces to provide immediate relief from the impact of ethno-racial trauma. Second, in the acknowledgement, reprocessing, and coping with the symptoms of ethno-racial trauma. Third, in the connection of individuals to communities, families, and cultural survival strategies and traditions. And fourth, in liberation and resistance. These four phases all occur at the individual, family, and community level.

Each of the aforementioned phases has a connection to the physiological expression of trauma within the body. In establishing safe spaces and acknowledging and reprocessing trauma symptoms, it is imperative that clinicians create these spaces with emotional as well as physiological safety in mind. Further, connecting individuals to family, community, and cultural practices that heal can also provide that physiological safe space and release necessary for physiological re-regulation.

PSYCHOLOGICAL & PHYSIOLOGICAL IMPACT OF RACE BASED TRAUMA

When a person has an experience with racism—whether directly or by witnessing an event secondarily— the experience can elicit a stress response within the body. This stress response provides context to the physiological symptoms that may arise as a result of racial experiences. Continuous and severe stress responses in the body can lead to hyper or hypo arousal and can change overall brain physiology (Porges & Buczynski, 2011). Hyper-arousal is increased nervous system activation (tension, anxiety, fear), whereas hypo-arousal is decreased nervous system arousal (numbness, zoning out, etc).

In a review of research on the impact of racism or racial discrimination on behavioral, mental, and physical health outcomes in children and adolescents, Pachter and Coll (2009) found that racism has a significant impact on depression, anxiety, self-esteem, problem behaviors, cardiovascular disease, metabolic disease, and other

areas of behavioral, mental, and physiological health. Further, Priest and colleagues (2012) found similar results in a systematic review of studies examining the impact of racism and discrimination on children and adolescents. Mental health outcomes including depression and anxiety have been shown to be significantly related to experiences of racism and discrimination in children and adolescents. Moreover, children and adolescents who experience racism and discrimination report more negative general health, and less positive general health and wellbeing (Priest et al, 2012).

Carter and colleagues have examined the impact of racial events on adults as well. Using the Race Based Traumatic Stress Syndrome Scale, Carter and Helms surveyed 262 individuals on their experiences with racial discrimination. The researchers found that participants of color experienced racial discrimination that could be separated into 10 categories (e.g., hostile work environment, physical or verbal assault, etc.), and that participants of color experienced 9 categories of lasting emotional effects (e.g., hypervigilance, intrusion, avoidance, low self-worth, etc.) from the racial discrimination they experience. Further, Carter and colleagues (2007) found that hostile and avoidant racial events may lead to more severe stress responses. In addition to these findings, literature highlights the importance of active race-based coping strategies (Mekawi et al., 2022). In fact, active race-based coping is associated with fewer mental health symptomology. In this way, active coping strategies with a race-based trauma informed model (e.g., Race-Based Traumatic Stress Model, RECAST Model, HEART Model) may serve as a buffer between racial discrimination and race-based trauma, even when accounting for one's trauma exposure timeframe (Mekawi et al., 2022). Therefore, it is imperative not only for counselors to understand the stress response within the body, but to also have a base knowledge of extant models that address the physiological as well as emotional impact of racial experiences and to understand that actively addressing and unpacking race-based trauma with a client is a primary intervention that greatly reduces risk of further mental illness and mental health concerns. The following is a fictional case example to illustrate how a counselor may integrate the aforementioned concepts and models into work with a client.

CASE ILLUSTRATION

Jai is a 28-year-old, Jamaican American cis-het woman. She seeks counseling from Ty, a 35-year-old, Black American, nonbinary counselor. Jai expressed that she has been considering therapy for a while, but her concerns have been exaggerated lately after the story of a Black person dying at the hands of a police officer has recently circulated the national news cycles. In their assessment, Ty explores Jai's presenting concerns which include increased feelings of anxiety at work, irritability within her relationships, and pervasive sadness.

Approaching this case from the Race Based Traumatic Stress Model, Ty would further assess the impact of the national news story and other racialized events in Jai's life. Ty's intent would be to identify racialized events Jai has experienced as (a) emotionally painful, (b) sudden, and (c) uncontrollable. Ty may also use Carter's Race Based Traumatic Syndrome Scale (Carter, et. al, 2013) to further explore the

impact of significant racial injuries Jai has experienced. Ty's focus would be on conceptualizing Jai's experiences from an emotional, psychological, behavioral, and physiological perspective. They may also provide Jai with psychoeducation (information specific to the clients presenting concerns) on how her experiences of anxiety, irritability, and sadness may each be connected to the physiological and psychological experiences associated with race based traumatic stress.

If Ty were to incorporate the RECAST model in their work with Jai, they might assess Jai's racial socialization and racial coping ability. Ty might provide psychoeducation on the physiological impact of racialized events in the body while contextualizing Jai's self-efficacy as it relates to navigating racial experiences. Ty and Jai's conversation may include discussions of how Jai makes meaning of the news story and messages she has received about how to navigate racial experiences. Ty and Jai may work together to increase Jai's racial self-efficacy while processing through the emotional and physiological impact of the events she is experiencing.

The HEART model may also be helpful in Ty's work with Jai. Ty might integrate Jai's Jamaican American identity into their conceptualization of how the racialized event has impacted Jai and the meaning she makes of it. Ty would assess Jai's identity development and the intersection of her identities. Ty may also create a sanctuary space for Jai, this may involve broaching race and ethnicity and opening the conversation for Jai to discuss her feelings about being in therapeutic relation with Ty and discussing racial matters. Ty may also explore the symptoms Jai expressed, allowing space for Jai to acknowledge, reprocess, and establish coping skills for the symptoms. Ty and Jai may also work together to establish a support system within Jai's community where Jai might be able to tap into cultural traditions and coping skills. Ty may also frame all of the work they do with Jai within the scope of liberation and resistance, empowering Jai to connect to her community.

As has been illustrated, counselors may integrate the models outlined in this article within the context of their work with clients. It is important for counselors to have an understanding of the nuanced impact of race-based experiences in order to tend to the nuanced manifestations of race-based experiences for clients.

IMPLICATIONS FOR COUNSELORS, COUNSELOR EDUCATORS, & SUPERVISORS

Counselors cohere several ethical codes and guidelines in their clinical work to provide the best care to clients (American Counseling Association [ACA] *Code of Ethics*, 2014; Ratts et al., 2016). A central element to adhering to the cultural needs of clients, especially racial minority clients, is the implementation of the Multicultural and Social Justice Counseling Competencies within one's clinical practice (MSJCC; Ratts et al., 2016). A foundational premise of the MSJCC is a basic understanding that cultural consideration is imperative when working with marginalized and/or unprivileged individuals within society. This is ever more prevalent among racial minorities who have experienced race-based trauma.

Having pulled from a socioecological perspective (Bronfenbrenner, 1979) that addresses both privileged and marginalized identity statues (e.g., Atkinson, Morten, & Sue, 1989; Helms, 1990; Jones and McEwen, 2000), the MSJCC's incorporate four

dimensions: (a) self-awareness, (b) client worldview, (c) the counseling relationship, and (d) counseling and advocacy interventions (Ratts et al., 2016). These pragmatic dimensions are designed to provide instruction on what and how to enhance one's multicultural competence. Thus, it is imperative counselors address the various aspects of competency development in order and through strategic and intentional goal setting. While aspirational, the MSJCC's provide counselors with a framework to use whilst attempting to conceptualize and implement treatment for clients from diverse racial, ethnic, and cultural backgrounds (Ratts et al., 2016).

Therefore, as counselors begin to address race-based trauma among their clients, it is imperative to first thoroughly reflect on one's own potential assumptions, biases, values, beliefs, and general ideas regarding various racial groups. In this way, the analysis of one's level of awareness and openness to learning more about experiences relating to race-based trauma may differentiate clinicians as physiologically safe or unsafe spaces to racially diverse clients. We also believe it is essential to mention that counselors should recognize that nuanced and varying beliefs can be held for one racial group and not another; thus, counselors should assess their attitudes and beliefs on racial groups individually. Counselors who do identify potentially harmful attitudes and beliefs through their reflections are encouraged to seek supervision, professional development, and potentially their own relationship with a licensed counselor to address these areas prior to exploring race-based trauma with racially diverse clients.

Although the aforementioned race-based trauma models are helpful in counselors clinical work among clients, this article does not present an exhaustive list of conceptual frameworks and/or therapeutic approaches to address race-based trauma among clients. In this way, systematically counter-storytelling hegemonic racial narratives (Quiros et al., 2020), the utilization of the transcultural Adlerian conceptualization and therapy (TACT) model (Lemberger et al., 2016), implementing a race-based stress and trauma intervention protocol within a group counseling (Carlson et al., 2018) and individual counseling (Williams et al., 2022) modalities are all viable approaches in addressing race-based trauma among racially diverse clients.

Thus, for counselors to better understand their client's worldview and to obtain an expansive understanding of race-based trauma, engaging in continued education units (CEUs) and real-life experiences with racially diverse individuals and communities will be important. Since race-based stressors and trauma present differently within and across racial groups, counselors should orient themselves not to make assumptions about the presentation of microaggressions, discrimination, or forms of overt and covert racism. Counselors would also benefit from CEUs and experiences to various racial groups and the intersections of racial groups. Increased exposure to racial groups will not guarantee counselors full cultural understanding of racial group dynamics, beliefs, and experiences; however, it will allow for increased opportunities for cultural understanding, empathy, and learning. This distinction is particularly important as it is imperative to both mitigate any potential harm to communities of color whilst attempting to educate and expose counselors-in-training to a diversity of clientele, which can be emphasized through counselor educators use of an anti-racist approach to concepts of self-care (Mitchell & Binkley, 2021). In this way, counselor educators can encourage self-care as students navigate their racial

identity (Mitchell & Binkley, 2021) along with learning concepts of race-based trauma.

Given the prevalence and need for counselors to understand race-based trauma in their work with clients, it is imperative that Counselor Educators and supervisors are aware, knowledgeable, and integrate race-based trauma training throughout their curriculum. Since trauma counseling is not one of the eight areas of curricular experience required by CACREP (CACREP, 2016), most counselor education programs fail to offer trauma focused courses. Thus, the field of counseling is called improve the spotlight and integration trauma counseling, especially race-based trauma counseling receives throughout program curricula. In this way, Counselor Educators are called to equip themselves with novel race-based trauma counseling focused literature and clinical approaches. Counselor Education programs, faculty, and supervisors must prepare for students experiencing re-traumatization, secondary traumatic stress, and vicarious trauma while engaging in learning on trauma focused topics (Gladden et al, 2022). Thus, providing trigger warnings, integrating self-care techniques (Mitchell & Binkley, 2021), and allowing time for students to process trauma related content within the classroom setting are ways to reduce the onset of the adverse effects of learning trauma content (Gladden et al, 2022). Lastly, given the activation of psychological, physiological, and behavioral stress responses race-based trauma can induce among clients (Carter & Pieterse, 2020), it is imperative counselors provide aid and engage in non-maleficence (American Counseling Association, 2014). For this reason, it is imperative that counselors are looking to utilize multicultural skills who may be experienced race-based trauma, they are able to engage in broaching with their clients. Broaching requires counselors to intentionally discuss racial, ethnic, and cultural (REC) concerns that may impact the client's presenting issues (Day-Vines, et al., 2007; Day-Vines, et al., 2020; Cardemil & Battle, 2003). Thus, practicing appropriate broaching as a foundational skill when working with clients experiencing race-based trauma is vital. To this end, counselors benefit from the operationalization of a multicultural framework in their work with marginalized clients experiencing race-based trauma.

CONCLUSION

The impact of race-based trauma is far reaching and devasting for marginalized clients. The psychological, physiological, and behavioral impact of persistent race-based stressors and ultimately trauma calls for the counseling profession's attention. While models to address race-based trauma can be found within literature (Andersen & Stevenson 2019; Carter, 1995; Chaves-Dueñas et al., 2019), pragmatic illustrations of race-based trauma model implementation with clients have been a missing element. For counselors to be multiculturally competent and prevent harm to marginalized clients, counselors have a duty to understand race-based trauma and explore the ways race-based trauma responses may impact the disposition of racially diverse clients.

AUTHOR POSITIONALITY STATEMENT

The authors are three Black American Tenure Track Counselor Educators in CACREP accredited counseling programs. The authors have not only researched and published in the areas of multicultural competence, race-based trauma, and culturally competent counselor education, but they have integrated the themes explored in this article into their counseling courses and provided workshops and trainings in the area of race-based trauma to fellow counselor educators, community clinicians, and counselors in training.

REFERENCES

American Counseling Association. (2014). American Counseling Association code of ethics. *Alexandria, VA: Author*.

Atkinson, D. R., Morten, G., & Sue, D. W. (1989). A minority identity development model. *Counseling American minorities*, 35-52.

Bar-On, D., Eland, J., Kleber, R. J., Krell, R., Moore, Y., Sagi, A., Soriano, E., Suedfeld, P., van der Velden, P. G., & van IJzendoorn, M. H. (1998). Multigenerational Perspectives on Coping with the Holocaust Experience: An Attachment Perspective for Understanding the Developmental Sequelae of Trauma across Generations. *International Journal of Behavioral Development*, *22*(2), 315–338. https://doi.org/10.1080/016502598384397

Brave Heart, M. Y. H., & DeBruyn, L. M. (1998). The American Indian Holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research*, *8*(2), 60–82. https://doi.org/10.5820/aian.0802.1998.60

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard university press.

Cardemil, E. V., & Battle, C. L. (2003). Guess who's coming to therapy? Getting comfortable with conversations about race and ethnicity in psychotherapy. *Professional Psychology: Research and Practice*, *34*(3), 278.

Carlson, M., Endlsey, 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. https://psycnet.apa.org/doi/10.1037/vio0000221

Council for Accreditation of Counseling and Related Educational Programs. (2016). 2016 CACREP Standards. Retrieved from http://www.cacrep.org/wp-content/uploads/2012/10/2016-CACREPStandards.pdf

Daud, A., Skoglund, E., & Rydelius, P. A. (2005). Children in families of torture victims: Transgenerational transmission of parents' traumatic experiences to their children: Children in families of torture victims. *International Journal of Social Welfare*, *14*(1), 23–32. https://doi.org/10.1111/j.1468-2397.2005.00336.x

Day-Vines, N. L., Wood, S., Grothaus, T., Craigen, L., Holman, A., Dotson-Blake, K., & Douglass, M. (2007). Broaching the subjects of race, ethnicity, and culture during the counseling process. Journal of Counseling & Development, 85, 401–409. https://doi:10.1002/j.1556-6678.2007.tb00608.x

Day-Vines, N. L., Cluxton-Keller, F., Agorsor, C., Gubara, S., & Otabil, N. A. A. (2020). The multidimensional model of broaching behavior. *Journal of Counseling & Development, 98*(1), 107-118.

DeGruy, J. (2017). *Post Traumatic Slave Syndrome: America's legacy of enduring injury and healing*. Joy DeGruy Publications.

Duran, E. (2006). *Healing the soul wound: Counseling with American Indians and other native peoples*. Teachers College Press.

Duran, E., Duran, B., Heart, M. Y. H. B., & Horse-Davis, S. Y. (1998). Healing the American Indian Soul Wound. In Y. Danieli (Ed.), *International Handbook of Multigenerational Legacies of Trauma* (pp. 341–354). Springer US. https://doi.org/10.1007/978-1-4757-5567-1_22

Evans-Campbell, T. (2008). Historical trauma in American Indian/Native Alaska communities: A multilevel framework for exploring impacts on individuals, families, and communities. *Journal of Interpersonal Violence*, *23*(3), 316–338. https://doi.org/10.1177/0886260507312290

Gladden, J., Weller, B. E., Hernandez, A., & Hopkins, A. (2022). Teaching trauma content in higher education: a systematic literature review. *Trauma, Violence, & Abuse*, 15248380221129575. https://doi.org/10.1177/15248380221129575

Helms, J. E. (1990). *Black and White racial identity: Theory, research, and practice*. Greenwood Press.

Jones, S. R., & McEwen, M. K. (2000). A conceptual model of multiple dimensions of identity. *Journal of college student development*, *41*(4), 405-414.

Karenian, H., Livaditis, M., Karenian, S., Zafiriadis, K., Bochtsou, V., & Xenitidis, K. (2011). Collective trauma transmission and traumatic reactions among descendants of Armenian refugees. *International Journal of Social Psychiatry*, *57*(4), 327–337. https://doi.org/10.1177/0020764009354840

Krippner, S., & Barrett, D. (2019). Transgenerational trauma: The role of epigenetics. *The Journal of Mind and Behavior*, *40*(1), 53–62.

Lemberger, M. E., Trott, A., & Lemberger-Truelove, T. (2016). Using the Transcultural Adlerian Conceptualization and Therapy (TACT) model to depict the influence of race-based trauma. *The Journal of Individual Psychology*, *72*(3), 186-199. http://doi.org/10.1353/jip.2016.0016

Mekawi, Y., Carter, S., Packard, G., Wallace, S., Michopoulos, V., & Powers, A. (2022). When (passive) acceptance hurts: Race-based coping moderates the association between racial discrimination and mental health outcomes among Black Americans. *Psychological trauma: theory, research, practice, and policy*, *14*(1), 38. https://psycnet.apa.org/doi/10.1037/tra0001077

Mitchell, M. D. & Binkley, E. (2021). Self-care: An ethical imperative for anti-racist counselor training. *Teaching and Supervision in Counseling*, *3*(2), 38-52.

Mohatt, N. V., Thompson, A. B., Thai, N. D., & Tebes, J. K. (2014). Historical trauma as public narrative: A conceptual review of how history impacts present-day health. *Social Science & Medicine*, *106*, 128–136. https://doi.org/10.1016/j.socscimed.2014.01.043

Petion, A. R., Chang, C. Y., Brown-Thompson, C., Mitchell, M. D., Grinnage, D., & Huffstead, M. (2022). "Battling something bigger than me": A phenomenological investigation of generational trauma in African American

women. *Journal of Counseling & Development*, 1-15. https://doi.org/10.1002/jcad.12454

Quiros, L., Varghese, R., & Vanidestine, T. (2020). Disrupting the single story: Challenging dominant trauma narratives through a critical race lens. *Traumatology*, *26*(2), 160. https://psycnet.apa.org/doi/10.1037/trm0000223

Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development*, *44*(1), 28-48. https://doi.org/10.1002/jmcd.12035

Wexler, L. M., DiFluvio, G., & Burke, T. K. (2009). Resilience and marginalized youth: Making a case for personal and collective meaning-making as part of resilience research in public health. *Social Science & Medicine*, *69*(4), 565–570. https://doi.org/10.1016/j.socscimed.2009.06.022

Wilkins, E. J., Whiting, J. B., Watson, M. F., Russon, J. M., & Moncrief, A. M. (2013). Residual Effects of Slavery: What Clinicians Need to Know. *Contemporary Family Therapy*, *35*(1), 14–28. https://doi.org/10.1007/s10591-012-9219-1

Williams, M. T., Holmes, S., Zare, M., Haeny, A., & Faber, S. (2022). An evidence-based approach for treating stress and trauma due to racism. *Cognitive and Behavioral Practice*. https://doi.org/10.1016/j.cbpra.2022.07.001

SHAYWANNA HARRIS-PIERRE, PhD, LPC, is an Associate Professor at Texas State University. She teaches primarily marriage and family therapy courses in the Department of Counseling, Educational Leadership, Adult Education, and School Psychology. Her research interests include developmental trauma, race-based trauma, and somatic approaches in counseling. Email: s_h454@txstate.edu

MICHELLE D. (MITCHELL) ELLIS, PhD, LPC, LMHC-QS, NCC is an Assistant Professor at Jacksonville University. She primarily teaches clinical mental health counseling courses in the counseling department within the Brooks Rehabilitation College of Healthcare Sciences. Her research interests involve multicultural issues in counseling, trauma informed care, and the strong black woman schema. Email: mmitche40@ju.edu

ASHLEI R. PETION, PhD, LPC, NCC, is a Visiting Assistant Professor at The College of New Jersey. She primarily teaches in the clinical mental health counseling program in the College of Psychology. Her research interests involve generational trauma and healing in Black families and communities as well as bridging the gap between research and counseling practice. Email: apetion@nova.edu.