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Identifying and Treating Race-Based Trauma in Counseling

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This study investigated 106 counseling professionals' experiences with identifying and treating race-based trauma and the relationship between training and treatment. Competency was assessed with the Race-Based Trauma Survey for Counselors. Although most participants reported working with clients who had symptoms associated with race-based trauma, many had not received training in identifying and treating race-based trauma among individuals of color. This finding highlights the disparities between health care and the provision of related services. Recommendations for counseling professionals and researchers are included.

Keywords: race-based trauma, racism, discrimination, competency

Este estudio investigó las experiencias de 106 profesionales en consejería con la identificación y el tratamiento de traumas basados en la raza, así como la relación entre la capacitación y el tratamiento. La competencia se evaluó usando la Encuesta para Consejeros sobre Traumas Basados en la Raza. A pesar de que la mayoría de participantes informó que había trabajado con clientes que tenían síntomas asociados con traumas basados en la raza, muchos no habían recibido capacitación para identificar y tratar traumas basados en la raza en personas de color. Este hallazgo resalta las disparidades entre la atención sanitaria y la provisión de servicios relacionados. Se incluyen recomendaciones para profesionales en consejería e investigadores.

Palabras clave: trauma basado en la raza, racismo, discriminación, competencia

The U.S. population is rapidly changing because of immigration and differential fertility rates (Bobo & Fox, 2003). Approximately 32.6% of the U.S. population consists of ethnic minorities (U.S. Census Bureau, 2015). Researchers project this number to increase steadily, and between the years 2030 and 2050, individuals of color (IOCs) will be the numerical majority (Weinrich & Thomas, 2002). The U.S. Census Bureau (2015) supported this statement by citing that the majority–minority crossover will occur in 2044; for children, this crossover is projected to occur in the year 2020. These projected changes in racial demographics represent a shift unlike anything the United States has witnessed in the past. Despite these statistics indicating that the United States is becoming increasingly diverse and will become a plurality nation, it is a country that continues to struggle with respect for, and acceptance and inclusion of, its diverse population (Brondolo, Gallo, & Myers, 2009; Carter & Forsyth, 2009; Carter, Lau, Johnson, & Kirkinis, 2017;

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Ikuenobe, 2013; Klein, 2012; Ponds, 2013; Shams, 2015; Thompson & Carter, 2013; Tynes, Umana-Taylor, Rose, Lin, & Anderson, 2012; D. R. Williams, Neighbors, & Jackson, 2008).

Racism is involved in many aspects of daily living and is a common experience in the United States (Bonilla-Silva, 2014; Carter et al., 2013; DeLilly, 2012; Nadal, 2011; Nadal, Griffin, Wong, Hamit, & Rasmus, 2014; Nadal et al., 2011; Shams, 2015). Tynes et al. (2012) stated that there has never been a time in history where racial discrimination has been more critical. Racism can destroy self-confidence and identity, lead to internalization of discriminatory messages, prevent achievement of potential, and affect mental health due to the barriers in accessing and receiving mental health care (Anderson, 2013; Evans, Hemmings, Burkhalter, & Lacy, 2015; D. R. Williams et al., 2012; D. R. Williams & Williams-Morris, 2000). Researchers reported that the effects of racially motivated verbal and physical attacks on racial minorities have remained underdeveloped in research, reflecting the fact that this element of social disadvantage has not been adequately explored (Brondolo et al., 2009; Brown, 2008; Carter & Forsyth, 2009; Carter et al., 2013; Fernando, 2012; Garcia & Sharif, 2015; Thompson & Carter, 2013; Tynes et al., 2012).

Researchers have listed overt acts of racism that include harassment, verbal or physical attacks, threats to livelihood, social avoidance, exclusion, and discrimination (Brondolo et al., 2009; Bryant-Davis & Ocampo, 2005; Glaser & Kahn, 2005; Kang, 2000; Klein, 2012; Shavers & Shavers, 2006). With advancements in technology, Americans are able to readily learn of instances of injustice, racism, and domestic terrorism. The Federal Bureau of Investigations' (2014) hate crime statistics indicated that race was the cause of hate crimes in 48.5% of the reported cases. Public outrage has intensified as news reports, videos, and photos continue to surface that depict racially motivated acts. Several recent examples of racially motivated hate crime cases include the following victims: Freddie Gray (a 25-year-old male African American), the mass killings of nine African Americans by Dylann Roof, Bang Mai (a 16-year-old male Vietnamese American), Jordan Gruver (a 16-year-old male Panamanian–Native American), Trayvon Martin (a 17-year-old male African American), Andy Lopez (a 13-year-old Latino American), Ousmane Zongo (a 43-year-old male West African immigrant), Aiyana Stanley-Jones (a 7-year-old African American girl), Chen Tsu (an 18-year-old male Chinese immigrant), and Tamir Rice (a 12-year-old African American boy).

In addition to overt acts of racism, covert acts of racism, such as microaggressions, reflect the attitudes and beliefs about individuals of certain races (Sue et al., 2007). Microaggressions convey ambivalence, contempt, and/or disregard and promote defensive thinking (Ayalon & Gum, 2011; Carter et al., 2017; Franklin & Boyd-Franklin, 2000; Kogan, Yu, Allen, & Brody, 2015; Ponds, 2013; Sue, Capodilupo, & Holder, 2008). Microaggressions exist in cultural, individual, and institutional environments. Other examples of microaggressions that IOCs face on a continuous basis include racial vilification; racial profiling; institutional racism; discrimination; racial ambivalence; denial of racism; and

racist beliefs, behaviors, and attitudes (Evans et al., 2015; Landrine & Klonoff, 1996; Myers et al., 2015; Smolicz, 1999; Sue et al., 2007; Thompson & Carter, 2013; Utsey, 1999; Utsey & Ellison, 2000).

Advancements in technology have created a new platform for racism. Since Barack Obama was elected the first African American president, there has been a rise in hate activity, hate groups, and online hate sites (Tynes et al., 2012). Newer forms of hate crimes have emerged in the form of Internet hate sites, blogs, and social networks (Klein, 2012; Tynes et al., 2012). The Internet is a convenient means of transmitting hate because of its wide usage, anonymity, ease of distorting information, and the freedom it provides individuals to publish and propagate material they choose (Glaser & Kahn, 2005; Kang, 2000; Klein, 2012). Despite the continued existence of overt acts of racism, covert acts—whether intentional or unintentional—have become far more prevalent and remain pervasive in today's society (Dobbins & Skillings, 2000; Sue, 2010; Sue et al., 2007; Thompson & Carter, 2013).

As health care professionals, counselors strive to meet ethical guidelines mandating the provision of multiculturally competent care for their clients (American Counseling Association, 2014). A specific multicultural competency is working with IOCs who have experienced racism that results in race-based trauma (Carter, 2007). Researchers have used the term *race-based trauma* to describe the emotional, psychological, and physical reactions to personal experiences with harassment and discrimination that cause pain (Carter, 2007; Evans et al., 2015). To provide effective treatment, counselors must be educated and trained to acknowledge race-based trauma (Bryant-Davis & Ocampo, 2006; Carter, 2007; Carter & Sant-Barket, 2014; Sue & Sue, 2003). The purpose of this exploratory study was to examine counselors' professional experiences with identifying and addressing race-based trauma in their counseling populations. In addition, we investigated an emerging and underresearched category of multicultural competency: working with IOCs who have experienced race-based trauma.

health and mental health disparities for IOCs

Race is associated with many negative health outcomes for IOCs (Anderson, 2013; Ayalon & Gum, 2011; Benjamins & Whitman, 2014; Gee, Walsemann, & Brondolo, 2012; Hardy, 2013; Kogan et al., 2015; Nadal et al., 2014; Paradies, 2006; Schwartz & Meyer, 2010; D. R. Williams et al., 2012). IOCs experience direct and indirect health care disparities that include unequal access to social, educational, and material resources. They are also less likely to have health insurance, are more likely to experience racist attitudes and discrimination among providers, and are more likely to experience unequal access to quality health care (Adler & Rehkopf, 2008; Anderson, 2013; Benjamins & Whitman, 2014; Fernando, 2012; Garcia & Sharif, 2015; Klonoff, 2009; Smedley,

2012). Racial disparities also lead to chronic illnesses and higher mortality rates (Anderson, 2013; DeLilly, 2012; Garcia & Sharif, 2015; Klonoff, 2009; Smedley, 2012; D. R. Williams et al., 2012); these researchers found that racial minorities have higher rates of obesity, infant mortality, heart disease, stroke, cancer, diabetes, kidney disease, hypertension, liver cirrhosis, and homicide.

Racism is a social determinant of health that works counter to the goals of health and mental health professionals (Garcia & Sharif, 2015). Numerous studies have documented negative health consequences for individuals who have experienced racism and discrimination (Carter & Forsyth, 2010; Carter & Reynolds, 2011; Clark, Anderson, Clark, & Williams, 1999; Pieterse, Todd, Neville, & Carter, 2012; Tynes et al., 2012; D. R. Williams et al., 2008; D. R. Williams & Williams-Morris, 2000). The research has resulted in empirical evidence documenting the psychiatric impact of discrimination, harassment, and perceived experiences of racism (Anderson, 2013; Carter & Forsyth, 2009). Racism can affect physical and mental health in the following ways: stress caused by reduced access to employment, housing, and education; increased exposure to risk factors; adverse cognitive–emotional processes; diminished participation in healthy behaviors and increased engagement in unhealthy behaviors; physical injury as a result of racially motivated violence; higher rates of raised blood pressure; increased psychological distress, depression, stress, negative self-esteem, and intrusive thoughts; and decreased quality of life (Anderson, 2013; Ayalon & Gum, 2011; Carter & Reynolds, 2011; Matthews, Hammond, Nuru-Jeter, Cole-Lewis, & Melvin, 2013; Nadal, 2011; Paradies, 2006; Paradies et al., 2015; Schwartz & Meyer, 2010; Tynes et al., 2012).

Researchers have reported that African Americans, Latina/o Americans, Asian Americans/Asians, American Indians/Alaskan Natives, multiracial individuals, and immigrants experience immediate distress when experiencing microaggressions, and the accumulation of these experiences has a detrimental effect on their well-being (Nadal et al., 2011, 2014; Rivera, Forquer, & Rangel, 2010; Sue, 2010; Sue et al., 2007; Sue, Nadal, et al., 2008). Depression, stress, isolation, psychological distress, suicidal ideation, and anxiety can result from perceived racism (Brown, 2008; Krieger, 2000; Nadal et al., 2014). Additional consequences of microaggressions include internalized devaluation, assaulted sense of self, internalized voicelessness, anger, decreased self-esteem, and rage (Fernando, 2012; Hardy, 2013; Ikuenobe, 2013; Landrine & Klonoff, 1996). More extreme reactions to racism result in maladaptive coping strategies, including suicide, displaced hostility or aggression, domestic violence, substance abuse, or sexual promiscuity (Krieger et al., 2010; Myers et al., 2015; Utsey & Payne, 2000). Pierce (1995) compared the effects of racism to that of terrorism because victims of both situations are consistently defensive and must adapt to face oppression, victimization, and domination, which could lead to psychological exhaustion.

In an effort to understand the relationship between racist incidents and emotional stress, Carter and Forsyth (2010) conducted a study that examined IOCs' experiences with racism and the stress these experiences caused. Participants included 324 Blacks, Latinos, Asians, Native Americans, and

biracial individuals. Of the total participants completing the survey, 91.4% (n = 296) reported they had experienced racial discrimination. Fifty-four percent of respondents who had experienced racial discrimination reported that the incident had a significant impact on them. Carter and Forsyth further explored the help-seeking behaviors of IOCs to address race-based stress and trauma. Fifty-seven percent of participants stated they sought help to cope with the discrimination they had experienced. The most frequent source of help was from a friend (41%), followed by a family member (28%), and, finally, a spouse or colleague (17% each). Under 10% of participants indicated that they sought help from a helping professional. Carter and Forsyth (2010) and other researchers (Helms & Cook, 1999; Sanders-Thompson, Bazile, & Akbar, 2004) hypothesized that IOCs may be hesitant to seek professional assistance because of a lack of awareness among helping professionals concerning racial issues.

race-based trauma

There is general agreement that experiences of racial and ethnic discrimination result in negative psychological outcomes (Carter, 2007; Myers et al., 2015; Paradies, 2006; D. R. Williams & Mohammed, 2009; D. R. Williams et al., 2008). Experiences of discrimination and racism that lead to race-related stress can result in race-based trauma (Carter, 2012; Carter & Reynolds, 2011; Evans et al., 2015). IOCs can experience significant stress caused by cultural, individual, and institutional experiences with racism. Chronic racism and discrimination can lead to a wide variety of psychological problems, including denigration of one's sociocultural in-groups, feelings of helplessness, numbing, paranoid-like guardedness, medical illnesses, anxiety, fear, and the development of posttraumatic stress disorder (Matthews et al., 2013; Myers et al., 2015; Paradies et al., 2015; Pieterse et al., 2012; Ponds, 2013; M. T. Williams et al., 2014). Garcia and Sharif (2015) stated that, to improve health outcomes among IOCs, those who work with minorities, including all health professionals, must address racism.

method

We chose an exploratory survey research design to provide greater understanding of counselors' experiences with race-based trauma, including training to identify and treat race-based trauma, and to look for gaps in identifying and treating race-based trauma in counseling. Exploratory research designs are the most appropriate and useful methods for projects that address a subject about which there are high levels of uncertainty and ignorance, and when the problem is not very well understood (i.e., very little existing research on the subject matter; van Wyk, n.d.). Researchers use exploratory research to inquire about a topic, to gather information, and to share that information with readers. This method has no formal structure, is flexible in nature, and is used to identify environmental obstacles in which problems reside (Brizee, 2010).

A great need exists for literature about the trauma experienced as a result of racial discrimination and harassment (Bryant-Davis, 2007; Carter, 2012; Evans et al., 2015; Forsyth & Carter, 2014; Pieterse et al., 2012). The small amount of research available provides limited information for counselors who wish to treat and identify race-based trauma. We developed the Race-Based Trauma Survey for Counselors to explore counselors' experiences with race-based trauma after careful review of literature on the subject (see Anderson, 2013; Bobo & Fox, 2003; Bonilla-Silva, 1997, 2014; Bryant-Davis & Ocampo, 2005, 2006; Carter, 2007; Carter & Forsyth, 2009; Carter et al., 2013; Carter & Reynolds, 2011; Carter & Sant-Barket, 2014; Corlett, 2005; Dunbar, 2001; Essed, 1991; J. D. Ford, 2008; Gaertner & Dovidio, 2006; Hardy, 2013; Helms & Cook, 1999; Loo et al., 2001; Manges, Saenz, & Murga, 2015; Sanchez-Hucles, 1999, 2008; Utsey, 1999; M. T. Williams, 2013).

We used the Delphi model for item selection, creation, and revision. The Delphi model helps researchers utilize feedback from experts to ensure that the instrument reflects trends in the counseling profession. A group of counselors, professors, and counseling doctoral students examine each of the survey questions, make recommendations regarding content and clarity, and also make recommendations regarding item inclusion and omission. The reliability and validity are further addressed by conducting a pilot study. For the present study, we made adjustments to the survey based on the outcomes of both the Delphi model and pilot study. We did not conduct possible relations to other measures because of a lack of like instruments.

We used the Race-Based Trauma Survey for Counselors to examine professional counselors' experiences with identifying and treating race-based trauma when working with racially diverse clients. The research questions for this study were as follows:

Research Question 1: To what extent do counselors report addressing issues of race-based trauma in counseling sessions?

Research Question 2: What factors do counselors identify that contribute to race-based trauma?

Research Question 3: To what extent have counselors received training to identify race-based trauma?

Research Question 4: To what extent have counselors received training to treat race-based trauma?

The findings of this study could lead to (a) an increase in awareness of race-based trauma among counselors, (b) an increase in counselors' dedication to provide effective therapeutic practices through continued education and training, (c) an increase in training opportunities focused on counseling IOCs who have experienced race-based trauma, (d) inclusion in the limited research on race-based trauma that could lead to future studies and publications, and (e) new racially sensitive and appropriate assessment measures and treatment strategies for counselors.

PARTICIPANTS

A total of 106 respondents consented to participate in this study and completed the survey. The majority of participants, 82 (77.4%), were women, 22 (20.8%) were men, and two (1.9%) identified as transgender. (Percentages may not total 100 because of rounding.) Participants' ages were as follows: 45 (42%) participants were 25–35 years, 17 (16%) were 36–45 years, 22 (20.8%) were 46–55 years, 15 (14.2%) were 56–65 years, and seven (6.6%) were 66–75 years. Most participants, 74 (69.8%), identified as White, 16 (15.1%) as African American, seven (6.6%) as biracial, four (3.8%) as Latina/o, two (1.9%) as Asian American/Asian, one (0.9%) as Pacific Islander, and two (1.9%) preferred not to say. For highest level of education, 62 (58.5%) participants had a master's degrees in counseling, four (3.8%) had an EdS degree, 14 (13.2%) were PhD students, and 26 (24.5%) had PhD/EdD degrees. Ninety-six (90.6%) participants were mental health counselors and 10 (9.4%) were school counselors. The majority of participants, 88 (83.0%), reported licensure and 18 (17%) reported certification. Finally, 39 (36.8%) participants reported 1–5 years of practice, 20 (18.9%) reported 6–10 years, nine (8.5%) reported 11–15 years and 16–20 years, eight (7.5%) reported 21–25 years, five (4.7%) reported 26–30 years, and four (3.8%) reported over 30 years (the remaining 12 met inclusion criteria but were employed in areas other than clinical/school practice).

PROCEDURE

The study was approved by the university's institutional review board. Data were collected via an online survey that was announced on counseling electronic mailing lists that included a link to the survey. Individuals interested in participating in the study could visit the survey link and consent to participate. We chose electronic mailing lists based on the desired sample of professional counselors and counselor educators from the Alabama Counseling Association, American Counseling Association, Association for Humanistic Counseling, American College Counseling Association, American Mental Health Counseling Association, and the Counselor Education and Supervision Network (CESNET-L). After the surveys were screened for inclusionary criteria (over age 19, identified as a practicing counselor), data were analyzed using SPSS software.

INSTRUMENT

Demographic information. A brief questionnaire collected information on participants' age, gender, highest level of education, professional discipline, professional licensure/certification, race/ethnicity, and years of practice. After participants completed the demographic questionnaire, the following explanation of race-based trauma was provided: "Race-based trauma is defined as emotional, psychological, and physical reactions to personal experiences with

harassment and discrimination that cause pain" (Carter, 2007; Evans et al., 2015). Experiences with race-based trauma can affect one's self-concept, identity development, and ability to cope. In extreme cases, the term *race-based traumatic stress* is used. Race-based traumatic stress is characterized by

> a) an emotional injury that is motivated by hate or fear of a person or group of people as a result of their race; b) a racially motivated stressor that overwhelms a person's capacity to cope; c) a racially motivated, interpersonal severe stressor that causes bodily harm or threatens one's life integrity; or d) a severe interpersonal or institutional stressor motivated by racism that causes fear, helplessness or horror. (Bryant-Davis, 2007, p. 135)

Race-based trauma may present in the counseling relationship, and practitioners may demonstrate a range of responses to this information.

Race-based trauma survey. We developed questions for the Race-Based Trauma Survey for Counselors based on a literature review of multicultural competencies, race and racism, health disparities in health and mental health care among IOCs, race-based stress and trauma, and the associated implications for counselors. The Race-Based Trauma Survey for Counselors consisted of 20 questions that were rated on a Likert scale or were multiple choice, multiple response, or open ended. Questions 1–6 pertained to professional discipline, professional licenses and certifications, typical population, type of counseling and work environment, and years of experience. Additional questions in this study asked participants to identify factors they believe contributed to the development of race-based trauma, their experiences with training to identify and treat race-based trauma, the existence of professional policy for race-based trauma that includes treatment recommendations, the rate participants reported counseling clients who had experiences with race-based trauma, and perceived competency in identifying and treating race-based trauma.

RELIABILITIES

The means, standard deviations, and reliability scores for competency from the Race-Based Trauma Survey for Counselors were examined. The competency measure included the following four items: "I have been prepared to identify race-based trauma," "I have been prepared to treat race-based trauma," "I am comfortable addressing race-based trauma in session," and "I feel competent addressing issues related to race-based trauma in session." Internal consistency analysis using Cronbach's alpha determined reliability coefficients that reflect consistency within these survey questions and the level at which the survey questions measure for intended outcomes. The competency measure appeared to have good internal consistency (α = .897), with a mean of 3.42 and standard deviation of 0.69. This indicates all items correlated with the total scale, with an average of .78 and a range of .70–.83. Reliability coefficients for the four competency items were .80 ("I have been prepared to identify race-based trauma"), .83 ("I have been prepared to treat race-based trauma"), .70 ("I am comfortable addressing

race-based trauma in session"), and .77 ("I feel competent addressing issues related to race-based trauma in session"). Because each item contributed to the reliability of the scale, each was retained with the remaining items in calculating the competency score.

results

Research Question 1 examined the extent that counselors had worked with clients who reported experiences with race-based trauma. All 106 participants answered this question. Seventy-five (70.8%) participants reported that they had worked with clients who reported experiences with race-based trauma, and 31 (29.2%) participants reported they had not.

Research Question 2 examined which factor(s) counselors identified that contribute to the development of race-based trauma. Participants selected *all that apply* from nine possible contributing factors, as well as a 10th category of *other* with the option to list additional factors. These factors included covert acts of racism, hate crimes, institutional racism, microaggressions, outside-group racist comments, overt acts of racism, racial discrimination, racial profiling, and within-group racist comments. The majority of participants (n = 71, 67%) selected between eight and 10 factors. Table 1 outlines the factors that contribute to the development of race-based trauma according to participants' responses. The data indicate that the responses were evenly distributed among the nine factors.

Regarding the extent counselors had received training to identify and treat race-based trauma, 35 (33.0%) participants reported receiving training to identify race-based trauma, whereas 71 (67.0%) reported they had not. Among the 35 participants who reported they had received training to identify race-based trauma, most reported two to four types of training that included continuing education and integration into course work and supervision. Of the 106 participants, 20 (18.9%) reported they had received training to treat race-based trauma and 86 (81.1%) reported they had not. Among the

TABLE 1

Factors Contributing to Race-Based Trauma

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

20 participants who reported they had received training to treat race-based trauma, most reported one type of training that included continuing education.

In consideration of these findings, we examined the relationship between the criterion variable competency score and the three predictor variables: (a) training to identify race-based trauma, (b) training to treat race-based trauma, and (c) professional policy. A bivariate correlation indicated a significant relationship among five of six total correlations at $p < .001$. There was a significant correlation between the competency score and training to identify race-based trauma ($r = –.50$, $p < .001$), training to treat race-based trauma ($r = –.45$, $p < .001$), and professional policy ($r = –.36$, $p < .001$). There was also a significant correlation between training to identify race-based trauma and training to treat race-based trauma ($r = .57$, $p < .001$) and training to identify race-based trauma and professional policy ($r = .42$, $p < .001$). These findings reflect that there was a decreased perception of competency among those participants who had training to identify race-based trauma and those who had training to treat race-based trauma. Table 2 outlines the correlations among the study variables.

The competency score questions were answered on a 7-point Likert scale ranging from 1 = *strongly agree* to 7 = *strongly disagree*. The overall competency score was calculated by summing all scores on the 7-point Likert scale for each of the four questions and dividing by the total number of participants ($N = 103$). The overall mean was 3.42 and the standard deviation was 0.69, indicating that participants somewhat agreed to overall self-reported competency. These results indicate that, on average, participants agreed they felt comfortable addressing race-based trauma in session, somewhat agreed they had been prepared to identify race-based trauma and felt comfortable addressing race-based trauma in session, and were neutral about being prepared to treat race-based trauma.

Using a multiple linear regression analysis, we evaluated the relationship between the criterion variable competency score and the predictor variables training to identify race-based trauma, training to treat race-based trauma, and the existence of professional policy on race-based trauma that includes treatment recommendations. The predictor variables were entered in a multiple linear regression model predicting perceived competency. The regression

TABLE 2

Correlations Among Study Variables

Variable	1	2	3	4
1. Competency score	—			
2. Training to identify race-based trauma	–.50*	—		
3. Training to treat race-based trauma	–.45*	.57*	—	
4. Professional policy	–.36*	.42*	.20	—

*$p < .001$.

analysis indicates that the model was significant, $F(3, 99) = 16.09$, $p < .001$. The linear combination of measures was significantly related to competency, with an adjusted $R^2 = .31$. The model R^2 of .31 indicates that the model explains approximately 31% of the variance observed in the competency score. The predictor variables were significant at the $p < .05$ level: training to identify race-based trauma ($B = -.79$ $p = .014$), training to treat race-based trauma ($B = -.91$, $p = .011$), and professional policy on race-based trauma ($B = -.82$, $p = .031$). These findings support that training to identify race-based trauma, training to treat race-based trauma, and the existence of professional policy had a negative relationship with self-reported competency; however, other factors that have not been identified exist.

discussion

Researchers have indicated that an important aspect of providing multiculturally competent care includes the awareness of race, racism, and discrimination and how these may contribute to, or be the source of, the problems IOCs experience (Carter, 1995, 2001, 2003; Dunbar, 2001; Evans et al., 2015; Helms & Cook, 1999; Sue, 2001). Researchers have also found that, often, these topics are not broached in the counseling relationship because of counselors' unease; fear of saying the wrong thing and offending the client; lack of specific multicultural training that focuses on race, discrimination, and racism; or lack of understanding of the importance these issues have in the lives of IOCs (Carter & Forsyth, 2010; Helms & Cook, 1999; Sanders-Thompson et al., 2004; J. Williams & Keating, 2005). The limited amount of research, literature, assessments, treatment guidelines, and training opportunities make it challenging for counselors to treat IOCs who experience race-based trauma (Carter, 2007, 2012; Carter & Forsyth, 2010; Carter & Reynolds, 2011; Kressin, Raymond, & Manze, 2008). This prompts the general question: What experiences with race-based trauma do counselors report?

The majority of participants ($n = 75$, 70.8%) reported that they had worked with clients who had experiences with race-based trauma, and 31 (29.2%) indicated they had not. This finding supports research that indicates racism continues to be a profound and damaging problem and is involved in many aspects of daily living among IOCs in the United States (Carter, 1995; Carter et al., 2013). The finding also supports research that racism, racial classification, racial categories, and inequality continue to have negative effects for some IOCs (Carter, 2007; Carter & Forsyth, 2009; Landrine & Klonoff; 1996; Smedley, 2012). In addition, this finding supports research that reports the prevalence of race-based trauma resulting from experiences with discrimination and racism among IOCs (Bryant-Davis & Ocampo, 2005; Carter, 2007; Carter & Forsyth, 2009; Carter et al., 2013; Loo et al., 2001).

The majority of participants ($n = 71$, 67%) selected between eight and 10 factors that contribute to the development of race-based trauma, including covert acts of racism, hate crimes, institutional racism, microaggressions,

outside-group racist comments, overt acts of racism, racial discrimination, racial profiling, and within-group racist comments. This finding supports previous research that identifies both overt and covert factors that can have a negative psychological impact or lead to the development of race-based trauma or stress among IOCs. For example, researchers have listed overt acts of racism that included harassment, verbal or physical attacks, threats to livelihood, social avoidance, and exclusion (Brondolo et al., 2009; Bryant-Davis & Ocampo, 2005). Other researchers have listed examples of microaggressions that IOCs experience on a continuous basis, including racial vilification; racial profiling; institutional racism; discrimination; racial ambivalence; denial of racism; and racist beliefs, behaviors, and attitudes (Evans et al., 2015; Landrine & Klonoff, 1996; Sue et al., 2007; Utsey, 1999; Utsey & Ellison, 2000).

Furthermore, 71 (66.9%) participants indicated they had not received training to identify race-based trauma, and 86 (81.1%) participants indicated they had not received training to treat race-based trauma. In addition, 93 (87.7%) participants indicated their professional practice did not have a professional policy on race-based trauma that includes treatment recommendations. The low percentage of counselors who reported training to identify and treat race-based trauma is consistent with research indicating a paucity of training opportunities (Carter, 2007, 2012; Carter & Forsyth, 2010; Carter & Reynolds, 2011; Hardy, 2013; Kressin et al., 2008). In addition to the low reported rates of training, the low percentage of counselors who reported having a professional policy on race-based trauma that includes treatment recommendations supports research indicating a need for training beyond academia, additional racism-related research, and the development of testing measures for assessment and modalities for treating the effects of racism, race-based stress, and race-based trauma so that policies can be developed (Brondolo et al., 2009; Brown, 2008; Carter & Reynolds, 2011; C. L. Ford, 2010; Jones et al., 2008; Krieger, 2003; Kumagai & Lypson, 2009; Tabloada, 2011; Thomas, Quinn, Butler, Fryer, & Garza, 2011; D. R. Williams & Mohammed, 2009).

A significant finding of the study was that although the majority (n = 75, 71%) of participants reported working with clients who had experiences with race-based trauma, many participants also reported not having received training to identify race-based trauma or to treat race-based trauma, and no professional policy on race-based trauma that includes treatment recommendations. Furthermore, the predictor variables training to identify race-based trauma, training to treat race-based trauma, and the existence of professional policy on race-based trauma that includes treatment recommendations were negatively correlated to reported competencies. This negative correlation is remarkable due to the frequent recommendation that counselors seek training to increase their multicultural competency, as well as the recommendation that in order to effectively treat race-based trauma, counselors must first be educated and trained to acknowledge it (Bryant-Davis & Ocampo, 2006; Carter, 2007; Sue & Sue, 2003). Researchers have also stated that counselors are ethically responsible for using multiculturally sensitive and appropriate

assessments and interventions; however, many counselors may find it difficult to access models to identify and treat race-based trauma, and most models that exist fail to include strategies to manage the interpersonal and emotional harm caused by racism (Brondolo, Brady, Pencille, Beatty, & Contrada, 2012). The negative correlation could also indicate participants may have known they needed additional training.

Although research has found that racism causes negative psychiatric and emotional consequences, mental health assessments and guidelines tend to exclude racism, resulting in a lack of understanding concerning the ensuing mental health effects (Brondolo et al., 2009; Carter & Forsyth, 2009; Carter et al., 2013). The negative correlation between reported competencies and training to identify race-based trauma, training to treat race-based trauma, and professional policy support these researchers' findings on the need for additional research on racism, racial discrimination, and race-based trauma, as well as effective training and treatment models.

LIMITATIONS

There are several limitations to this study. Initially, we developed the Race-Based Trauma Survey for Counselors because of the lack of an existing measure. Since the current study is the first to collect data with this instrument, information concerning its validity is insufficient. We addressed the validity of the instrument by using the Delphi model and conducting a pilot study. However, disseminating the study to larger audiences will allow for additional validity analysis. Furthermore, the exploratory design of the study did not include all competencies regarding race-based trauma. Because participants self-reported competencies, and because of the subjective nature of responses, a possibility exists for bias and social desirability influences. Graham, McDaniel, Douglas, and Snell (2002) reported that social desirability may result in inflated correlations among variables.

IMPLICATIONS FOR COUNSELING PROFESSIONALS AND RECOMMENDATIONS FOR FUTURE RESEARCH

With the continual growth of racial and ethnic minority populations in the United States and the prevalence of mental health disparities for IOCs, the implications of this study are critical for counselor educators, supervisors, counselors, and researchers. The results of this study contribute to the existing research that indicates IOCs are experiencing discrimination, harassment, and racism that could result in negative psychological outcomes, including race-based trauma (Carter et al., 2017; J. D. Ford, 2008; Pieterse, Howitt, & Naidoo, 2011; Pieterse et al., 2012). Researchers emphasize that counselors must take action to provide multiculturally competent care to IOCs who have experienced race-based trauma. These actions include confronting racism; including race-conscious curricula; incorporating models, theories, and methodologies; including training beyond academia; and supporting

additional racism-related research. Researchers also recommend developing testing measures for assessment, as well as modalities for treating the effects of racism, race-based stress, and race-based trauma (Brondolo et al., 2009; Brown, 2008; Carter & Reynolds, 2011; C. L. Ford, 2010; Jones et al., 2008; Krieger, 2003; Kumagai & Lypson, 2009; Tabloada, 2011; Thomas et al., 2011; D. R. Williams & Mohammed, 2009). Although counselors have acknowledged that race-based trauma exists and that it is being discussed in session, it is important that the profession identifies effective methods to intervene on individual and systemic levels.

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

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

Because the present study is one of the first of its kind, several future research recommendations are apparent following an examination of the study's findings and limitations. Future research to examine the extent to which clients seek treatment to specifically address race-based trauma is needed, because most participants reported working with IOCs who had experienced race-based trauma. Similarly, future research is needed on the topics of race, discrimination, racism, and race-based trauma.

Additional research recommendations include examining the assessment and treatment strategies used by counselors when working with IOCs who have experienced race-based trauma, as well as how counselors become aware of these methods. In this study, a limited number of participants indicated they had been trained to identify race-based trauma, and fewer reported they had been trained to treat race-based trauma. Research that further examines the types and content of training for identifying and treating race-based trauma is needed. Similarly, research on the development of trainings, assessments, and treatment strategies is greatly needed. Such research would prove beneficial for counselor educators, supervisors, counselors, and clients.

We also recommend that future research include an examination of client satisfaction among IOCs who have discussed issues of race-based trauma in session with professional counselors. A study of this kind would provide valuable information for counselors regarding the reasons for

satisfaction/dissatisfaction, information pertaining to what these clients have found or would find beneficial, and additional information concerning the clients' perceptions about the counselors' effectiveness. Finally, we recommend that future research include studies to examine ways to incorporate discussions of discrimination, harassment, and racism that lead to race-based trauma into classrooms, supervisory experiences, workshops, and counseling sessions.

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