AMERICAN PSYCHOLOGICAL ASSOCIATION
The Community for Psychologists in Independent Practice
Practice Innovations

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ISSN: 2377-8903
2022, Vol. 7, No. 3, 280–292
https://doi.org/10.1037/pri0000187

"Decolonizing Mental Health": Exploring Insights From Clinicians Trained in Kniffley Racial Trauma Therapy

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Exploring the experiences of clinicians trained in Kniffley Racial Trauma Therapy (KRTT), this study aimed to: (a) Understand clinicians' perceptions of competence with addressing race-based stress; and (b) Explore clinicians' perceptions of growth, skill development, and translation to practice, given their particular racial identity. A purposive sample (i.e., 15 clinicians) trained in KRTT participated in 1-hour-long virtual focus groups to discuss their training experience and potential influence on practice. Participants identified as White (60%), Black (26%), Hispanic (7%), and Asian (7%). Also, participants identified as female (86%), male (7%), and nonbinary (7%). Participants had an average of 6.5 years at their agency and 11 years working in their field overall. Focus groups were separated by participant race, were audio recorded, transcribed verbatim, and analyzed by two research team members using qualitative analytic software. Most commonly reported themes were included as main findings. Focus group data were organized into four categories with several themes within each category. Categories 1–3 include: Clinical Confidence with Race-Based Stress, Training Impact, and Posttraining Considerations. Within each category, some themes were consistent among both BIPOC (Black, Indigenous, and other people of color) clinicians and White clinicians. Finally, the fourth category, Suggestions for Training Improvement, offers clinicians' recommendations for improving the training, based on data from all clinicians. Findings shed light on the utility of KRTT and the need for further training for White clinicians focused on cultural humility, as well as self-care support for BIPOC clinicians.

Clinical Impact Statement
Mental health clinicians are not always equipped to address the race-based stress that BIPOC clients experience due to racism. Through evaluation of the Kniffley Racial Trauma Therapy training protocol, clinicians identified ways in which the intervention can enhance their work to better meet the needs of BIPOC clients.

Keywords: racial trauma, BIPOC clients, trauma training, clinical interventions

The ramifications of racism are experienced by Black, Indigenous, and other people of color (henceforth referred to as BIPOC) throughout the world on a daily basis. These discriminatory experiences can begin in utero, evidenced by disproportionate infant and maternal mortality rates (Collins & David, 2009; Owens & Fett, 2019). As children grow older, they are often forced to navigate an enclave of

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racism in schools, leading to widespread inequities, including disproportionate suspensions, expulsions, arrests, referrals to law enforcement, academic failure, drop-out, and juvenile justice involvement (Noltemeyer et al., 2015; U.S. Department of Education, 2018). By adulthood, the effects of racism are further compounded, leading to pervasively high incarceration rates, economic turmoil associated with poverty, a long list of health disparities, and shorter life expectancy (Alexander, 2012; Laurencin & Walker, 2020; Wildeman & Wang, 2017). The scope of racism extends well beyond these areas, impacting people in multifaceted ways, including physical, mental, emotional, and psychological manifestations of trauma.

Globally, racism is an enduring issue that has been exacerbated in dynamic ways by the COVID-19 pandemic and persistent police violence toward innocent Black men, women, transgender individuals, and children (Sherman et al., 2022). The COVID-19 pandemic has disproportionately affected BIPOC, due to elevated infection and death rates, and economic ramifications, including job, housing, and food insecurity (Benfer et al., 2021; Laborde et al., 2021; Laurencin & Walker, 2020). Movements around the world, including Black Lives Matter, have illuminated the enduring nature of racism, while offering hope to guide us through this tumultuous time (Jean, 2020). Positive change is already notable, as states, cities, and counties throughout the United States have declared racism as a public health crisis or state of emergency (American Public Health Association, 2021). This recognition is a crucial step toward fighting and ameliorating inequities and experiences of racism (Devakumar et al., 2020).

To further expose the depth of these challenges facing BIPOC, we encapsulate the experiences of racism within four primary levels: historical, structural, institutional, and individual. Historical-level racism may include slavery, Indigenous genocide, cultural assimilation, and the social construction of race (Kendi, 2016). Structural-level racism may include redlining, segregation, and unequal school funding (Harper, 2020; Washington, 2019; Winn, 2020). Institutional-level racism may include policies, norms, and hierarchies benefiting and conforming to ideologies of whiteness (Welch & Payne, 2018). Individual-level racism may include the manifestation of biases, prejudices, and stereotypes (Hall et al., 2015; Lewis & Diamond, 2015; Lynn & Dixson, 2013; Raible & Irizarry, 2010). The culmination and interaction of these levels leads to systemic or endemic-level racism and offer a glimpse into the vast undercurrent of racism that shapes inequities for BIPOC. Furthermore, it is unclear how these levels directly impact individuals and how BIPOC interpret or internalize these experiences across varied identities and realities (Pérez Huber & Solorzano, 2015; Rivera et al., 2010).

The experiences of BIPOC are often shaped by the interaction of these levels of inequity, leading to elevated rates of traumatic stress, health complications, and community adversities, including decreased job opportunity, poverty, housing and food insecurity, violence, and environmental racism (Alegría et al., 2010; Lee & Matejkowski, 2012; Washington, 2019; Wildeman & Wang, 2017). Environmental racism reveals that BIPOC often experience a disproportionate exposure to toxins, lower quality drinking water, and food deserts (Alexander, 2012; Nocella et al., 2017; Washington, 2019). Elevated atmospheric toxicity is a product of racist redlining practices that shaped geographical boundaries of land defined as "uninhabitable"—often encapsulated around BIPOC communities—lowering housing values, stymies upward mobility, and increases the prevalence of waste facilities, refineries, and other poison-emitting plants (Nocella et al., 2017; Piketty, 2013; Washington, 2019). Environmental racism and redlining practices have led to innumerable health disparities for BIPOC, including asthma, cancer, HIV/AIDS, obesity, high blood pressure, and diabetes (Cohen et al., 2017; Devakumar et al., 2020; Freeman et al., 2017; Laurencin & Walker, 2020; Nocella et al., 2017; Washington, 2019). Collectively, these factors may produce intergenerational poverty, in addition to epigenetic variations, which entails the genetic transference of trauma (resultant of racism) passed from mother to child over multiple generations, leading to further health complications (Aroke et al., 2019; Washington, 2019). In fact, the mental health field is now recognizing this form of psychological distress as race-based trauma (also known as racism-based trauma or racial trauma), defined as the events of danger created by existing or perceived racial discrimination, which may include threats of harm and injury, humiliation and shaming, or witnessing racism-related harm to other BIPOC (Comas-Díaz et al., 2019).

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Responses From the Mental Health Field

The culmination of these factors leads to BIPOC having the highest burden of traumatic stress—inclusive of race-based trauma—impacting their long-term health and well-being; ultimately framing a need for mental health services (García & Sharif, 2015; Greater Louisville Project, 2015). However, several factors within the mental health field complicate mental health service utilization among BIPOC. For example, White clinicians often vary in whether or not—and how—they address race and experiences of racism (Hare, 2015). Lack of clinician attention to race/culture can be harmful for BIPOC due to ineffective clinician communication and minimized recognition of the social determinants of health (Butler & Shillingford-Butler, 2014; Pérez-Stable & El-Toukhy, 2018; Thompson et al., 2013). Fear also serves as a barrier during mental health service provision for both clinicians and clients. Clinicians may fear saying something offensive and may be hesitant to initiate discussions of race (Hare, 2015). For BIPOC, concern over double stigmatization has been noted, for example, with regard to mental health diagnosis and race (Alang, 2019). Additionally, racism also serves as a barrier to accessing, trusting, and utilizing mental health services (McGuire & Miranda, 2008; Nadal et al., 2014). The legacy of mistreatment, discrimination, and racism in the medical field and research industry has produced enduring effects and lingering skepticism, factors which are confounded by the predominance of White health professionals (Daley et al., 2021; Kendall, 2020; Kendi, 2016, 2019). BIPOC of lower socioeconomic status have higher levels of distrust toward health professionals and may view mental health services as an institutional barrier, at times feeling invisible to their mental health provider (Armstrong et al., 2007; Dowden et al., 2014). These realities are often confounded by clinician microaggressions—which entail unconsciously reinforced bias or prejudices toward BIPOC—such as pathologizing, demeaning, and stereotypical treatment based upon, but not limited to, a person's race, age, sex identity, and ability (Pérez Huber & Solorzano 2015; Rivera et al., 2010). Further, these experiences of marginalization may be duplicated by the interaction of multiple marginalized identities, including at the intersection of race and ability (Annamma, 2017; Crenshaw, 2017).

Challenges to mental health service delivery are further illuminated by a lack of clinician training and resources to address trauma among BIPOC. To adequately address the depth of trauma associated with racist systems that affect BIPOC, it is crucial that the mental health field move toward training on interventions and practices that are antiracist (i.e., action-oriented practices focused on changing systems that have racist effects; Svetaz et al., 2020), equitable, and inclusive. Scholars suggest incorporating an array of education across the domains of race, privilege, and oppression to move clinical training beyond traditional, often Westernized, practices and sources of knowledge (Bracken et al., 2021). Even within our Western epistemology with the heavy reliance on evidence-based interventions, some concrete examples of decolonizing mental health training have been explicated in the literature, such as: (a) promoting critical reflection during training programs and engagement in literature that interrogates the status quo; (b) moving beyond the ideology of cultural competence to a more nuanced understanding of structural inequity and cultural humility; (c) exploration of forms of mental health care that prioritize communal or collective healing as well as alternative healing narratives; and (d) engagement with research that elevates the lived experiences of individuals along with acknowledgment of the hierarchy that has diminished the value of the voices of those with lived experience (Bracken et al., 2021). Moving toward a decolonized approach to clinical training might produce better equipped clinicians, as well as a shift in the forms of knowledge and evidence that are acknowledged to support the use of interventions. Traditionally, evidence-based practice has relied predominantly on knowledge derived from empirical research, given an assumption of objectivity (Rycroft-Malone et al., 2004). However, the inherently subjective social structure in which this research is produced inevitably has an impact on what becomes accepted as true evidence. Additionally, training often lacks more contextualized knowledge sources and interventions are often ill-equipped to recognize the extensive nature of racism and the dynamic lived experiences of BIPOC (Alang, 2019; Mensah et al., 2021). Therefore, we use a more inclusive definition of evidence-based practice in this paper, classifying client lived experience as a viable source of knowledge, thus making evidence-based interventions those that are supported by various intersecting forms of knowledge, rather than research knowledge alone.

Treating Racial Trauma

There are bodies of work that highlight modalities for addressing the racial needs of BIPOC

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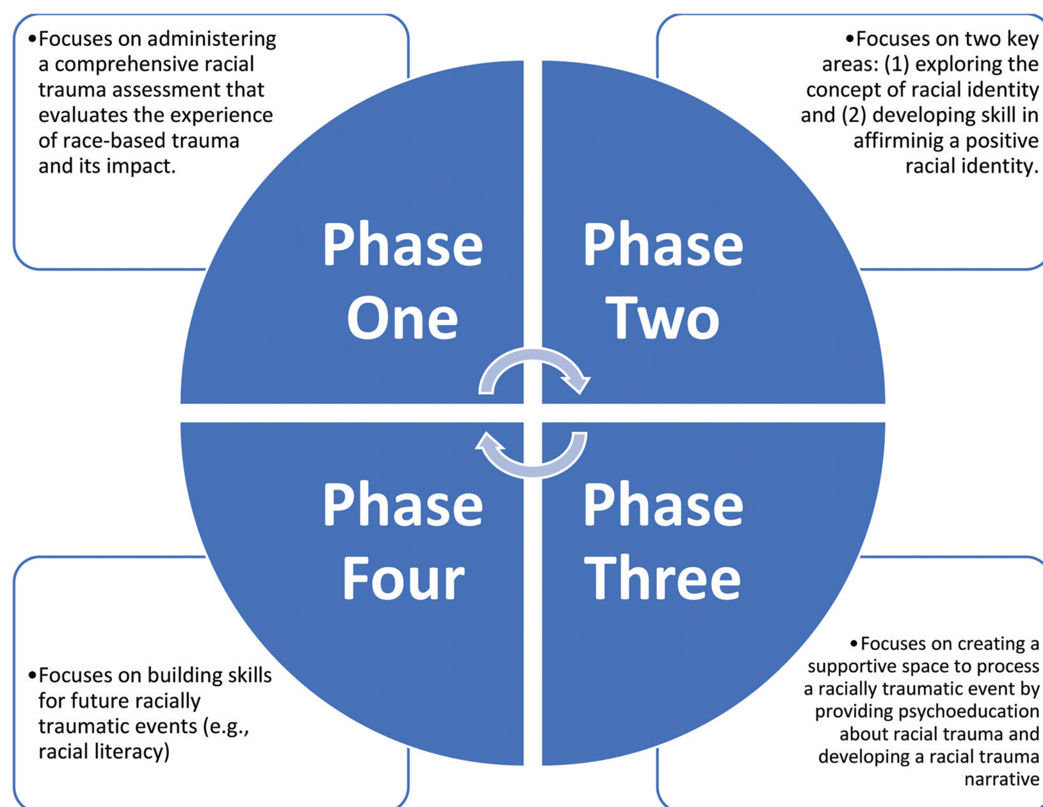
clients. For example, a few include the Historical Trauma and Unresolved Grief (HTUG) Intervention for American Indians (Heart et al., 2011), the Racial Encounter Coping Appraisal and Socialization Theory (ReCAST; Anderson & Stevenson, 2019), and the Healing Ethno-Racial Trauma (HEARTS) model (Chavez-Duenas et al., 2019). However, these modalities remain highly theoretical with less documented translation to practice, implementation manualization, or support for clinicians who seek to implement. Another intervention, Kniffley Racial Trauma Therapy (KRTT), was also developed, informed by evidence, to address race-based stress and trauma (Kniffley et al., 2022). KRTT is a 12-session race-related stress and trauma therapy model for BIPOC individuals, ages 13 and up, that focuses on racial identity development, processing experiences of racial trauma, and building skills for navigating future racially traumatic events (Kniffley et al., 2022). KRTT is rooted in African-centered and Liberation Psychology theory, has an emerging evidence base, and directs clinicians to foster racial trauma healing across four phases (see Figure 1) by engaging BIPOC individuals in activities such as a racial perception analysis, racial messaging family genograms, the construction of a racial trauma narrative, and the development of skills for racist interpersonal encounters such as microinterventions for microaggressions. The KRTT training program addresses three areas important to supporting BIPOC individuals who have experienced race-related stress and trauma: (a) content knowledge concerning the physiological, psychological, and relational impact of race-related stress and trauma, (b) the utilization of evidence-based assessment tools for racial identity development, quantifying discriminatory experiences, and determining the

Figure 1

Phases of KRTT Intervention



Note. KRTT = Kniffley Racial Trauma Therapy. See the online article for the color version of this figure.

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physical and emotional impact of racially stressful events, and (c) applying cultural relevant therapeutic techniques rooted in racial identity exploration/development, racial trauma processing, and skill development (see Kniffley et al., 2022).

Present Study

More work is needed to bolster clinician preparedness for addressing race/racism in the ongoing treatment of trauma. The research literature continues to expand regarding race-based/racism-based stress and trauma among BIPOC. Still, there continues to be a lack of manualized treatment models and clinical training to address such experiences with BIPOC clients. This study aims to fill this gap in the literature through the evaluation of the KRTT training program. By exploring the qualitative experiences of clinicians who completed the KRTT training, this study aimed to: (a) Understand clinicians' perceptions of competence with addressing race-based stress; and (b) Explore clinicians' perceptions of growth, skill development, and translation to practice, given their particular racial identity.

Method

Participants

Participants included a purposive sample (i.e., 15 clinicians) who completed the KRTT training and participated in focus groups to further discuss their training experience and how that has influenced their practice. Participants identified as White (60%), Black (26%), Hispanic (7%), and Asian (7%). Also, participants identified as female (86%), male (7%), and nonbinary (7%). The average age of clinicians was 38 years old with an average of 6.5 years working at their respective agency, an average of 11 years working in their field overall, and all participants holding a master's-level degree.

Procedure

This study was conducted as part of a city-wide initiative to address and reduce structural and community violence in a midsize southern city. From 2020 to 2021, as part of the effort to develop a trauma resilient community, 118 local mental health clinicians completed the KRTT training and clinical consultation. The clinician trainees were provided with virtual access to the training through a web link from the training creator. This web-based, asynchronous, and self-paced training was available to trainees for completion from September 2020 to November 2020. Given that the study aimed to assess the training components, separate from the clinical consultation process, participants were invited to participate in this study after training completion and before the start of consultation—15 clinicians responded to participate and focus groups were held in February 2021 (i.e., approximately 2 months after the end of the training period). The research team obtained approval from the University of Louisville Institutional Review Board and informed consents were obtained electronically via passive consent prior to trainee participants completing an online demographic survey. All 15 participants completed the passive consent and survey.

After survey completion, interviews were scheduled to collect data via 1-hour focus group sessions that were separated by participant race (i.e., clinicians who identified as BIPOC interviewed together and clinicians who identified as White interviewed together in a separate group). Interviews were conducted via web conferencing, facilitated by one White female member of the research team (for the White clinician group) and one Black female research team member (for the BIPOC clinician group). This approach was taken to encourage clinicians to speak transparently about race without concerns about the impressions of their coworkers or fear of saying something offensive (Hare, 2015). Interviews were recorded and audio from recordings was transcribed verbatim and analyzed by members of the research team.

Analyses

Focus group transcriptions were analyzed by two members of the research team to develop a working codebook. Afterward, transcripts were uploaded into Dedoose 9.17 qualitative analytic software (Dedoose, 2021) to be coded and recoded for themes. To safeguard qualitative rigor, audit trails with memos related to analytic decisions and reflections were maintained (Padgett, 2016). Additionally, the use of a code-recode procedure allowed for increased dependability of qualitative findings. Themes that were most commonly reported were included as main findings. Regarding the researchers' positionality, coding and interpretation of the focus group data was conducted by one Black,

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female, social work researcher and one White, male, social work doctoral student who have both had previous exposure to clinical social work practice.

Findings

Focus group data were analyzed and are organized below in four categories, with several themes emerging within each category. Categories 1–3 include: Clinical Confidence With Race-Based Stress, Training Impact, and Posttraining Considerations. Within each category, some themes were consistent among both BIPOC clinicians and White clinicians. Finally, the fourth category, Suggestions for Training Improvement, offers clinicians' recommendations for improving the training, based on both sets of focus group data (i.e., BIPOC clinician focus groups and White clinician focus groups).

Clinical Confidence with Race-Based Stress

In this thematic category, clinicians described their confidence (or lack thereof) in their knowledge and skills related to race-based stress. In the BIPOC focus groups, clinicians described personal knowledge of and experience with both trauma and racism. They described their own experiences with racism and oppression and how this allows them to connect with the experiences of their racial/ethnic minority clients. However, they expressed a lack of knowledge about specific terminology and clinical tools for addressing race-based stress with clients. They described this as a tremendous deficit in current mental health practice and clinical training, affirming the need for the decolonization of mental health via more inclusive training and resources on theories, interventions, and practices that are relevant to BIPOC clients. One BIPOC clinician described:

> (BIPOC Clinician #3) I can say that I have felt mostly confident about addressing race-based issues with clients, and that's the key with clients. Sometimes I'm not able to address my own reaction to what's going on with the client . . . . but as far as being able to reflect and listen and be able to come up with different coping skills, I felt confident about that. I do feel like the training gave me a boost . . . . giving another language, giving more language to that and that. OK, here are some other skills that maybe I had not used before that I wasn't aware of and updated research and kind of things that can help others.

> (BIPOC Clinician #2) I'm a person who believes in decolonizing mental health. I have known that for a while, right? It's difficult though to explore that because of the way I learn, because in most settings I am the only person of color. Or if there are other people, there may be one or two, right? . . . All the theories that we're learning in school and even then are very like Eurocentric, right? A lot of the healing comes from methods that were not created for our people, but have been modified . . . . Like these are things that have been existing for a while, but academically I'm not able to find things where I can learn deeper, where I can say "OK, I don't have to pull this out of my butt in session."

White clinicians described themselves as feeling relatively confident with the theoretical concept of race and race-based stress. However, they reported having very little confidence in their ability to effectively approach the subject of race with clients—some describing themselves as being fearful of this—or how to address race-based stress in treatment. For example, two White clinicians stated the following:

> (White Clinician #6) I have a few clients that seem like they might be eligible for it, but when I approach them or talk to them about it, they kind of . . . I had one of them, the sister was in the background and she kind of laughed out loud when I mentioned it. I think some of that is her thought of, "Who's this White therapist going to talk to you about your trauma as a Black person?" We're going to talk a little bit more about what that looks like at our next session, but I think there's a lot of hesitancy there because I don't know the experience.

> (White Clinician #4) I think a lot of times people get scared, as White people, to bring it up, because we didn't grow up Black. We're not Black. We don't know everything. We don't want to put it on Black people to be like, "Oh, teach me everything I need to know," but also being very real in a helping, human relationship and having that ability to say it and name it, and then throw it out there as, "Do we need to talk about this and can we talk about it?"

Training Impact

While the previous section describes how White clinicians felt unsure or even afraid to discuss race with their clients, they still acknowledged the importance of addressing it. These clinicians strongly described how the training validated the need to be direct with clients about race and how the training content provided concrete language and practical examples of how to broach the subject of race in treatment. For example:

> (White Clinician #4) I think this training validated the need to just put that out there: "Yes, this is true. I can't hide it, I can't change it. I'm still in it for you, but I don't want you to feel like there are things you can't tell me because they're related to race." Just even

having the balls to go there when it comes up . . . . Just to be like, "Well, do you think that's partially because you're Black?" Just to put it out there, kids sometimes will be like, "Well, yeah."

(White Clinician #1) I think for me, I feel more comfortable. I think that those conversations have come up naturally for me with a lot of my clients, but I definitely feel more comfortable bringing it up versus waiting for them to identify something, which I am happy for, because I think especially when you're working with . . . I've got kids that are in second, third grade and you don't always want to put that on them. You don't always know what their experiences have been or if they've identified for themselves that that was something that made them uncomfortable or not. But I think that this has helped me feel more comfortable with being more vocal about it . . . especially with parents, talking with them about that.

Both BIPOC clinicians and White clinicians discussed not having knowledge about clinical tools for addressing race and racial trauma with BIPOC clients. Even clinicians of color expressed a lack of exposure to such tools due to the lack of diversity in their clinical training programs, but described learning quite a bit from the training about a standardized framework as well as various scales and tools that were available for this work through KRTT, rather than having to rely on relational practices alone.

(BIPOC Clinician #2): I have something that can guide me. I have other professionals that are having conversations about this [racial trauma]. And so in that sense, it's [the training] giving me that thing that I always am in search of; this other piece that's missing in my education as a clinician.

(White Clinician #7): I didn't know there were some of the scales to really put a number and some concrete pieces on how much space [racial trauma] was taking up for folks. . . . I think that was probably my favorite thing about this training, is that I have some more concrete things to get my hands on to be able to facilitate those conversations, where before, which is very powerful, it was just about trust.

Finally, across all focus groups, clinicians discussed the ways in which they now understand the impact of macro-level factors on the racial challenges in their field. For BIPOC clinicians this related to the need for enhanced agency and system-wide support for antiracist interventions, practices, and policies. White clinicians also echoed this concern, discussing the high training requirements at their agency, yet the lack of time provided for them to complete the KRTT training. This theme is further illustrated in the following quotes:

(BIPOC Clinician #2): My hope is that it changes the way my agency and just like mental health in [our city] operates . . . It's kind of like, yeah, we're kind of learning this model, but we are people that need to work with a lot of other people, and so it's kind of like, if we're the only ones that talk about this, like who else is going to help? And having this treatment, it says, "See! All along we've been saying it's real, right?" The way it even functions like the partnership we have with the courts, the way we do things, our policies. I mean, a lot of things within our agency are very oppressive and do not support the well-being of our communities, and so I'm hoping that it's something that more people are able to get trained on. And it's something that is actually like we're saying, it's been real all along. So what are we actually going to do as an agency? And I know that's like a macro thing and a big thing, and it requires a lot of changes, but I like to dream big . . . .

(White Clinician #2): Another thing too . . . the whole productivity thing, if [our agency] could give some kind of leeway, maybe not count the time that we're in that training . . . this is so important and they're going on and on about diversity and inclusion and all that. Well, give us something, some time to do it. Then maybe the change in your agency might actually happen.

For the White clinicians, a micro versus macro theme also emerged related to the need for their White peers to move beyond the individual blame that is often placed on BIPOC clients in order to begin recognizing how the macro level influences create challenges that impact their clients' lives. Two White clinicians explained:

(White Clinician #3) I don't know if what I'm about to say makes sense, but I'm going to try to talk this out, anyways. But something that was helpful for me with the training was kind of labeling it specifically as racial *trauma*. I think it's important to put that word with it because at least in the learning that I've gotten so far, a lot of the times we think of racism as this systemic issue that exists out there, and I think by calling it racial *trauma*, it helps change the thinking that the effects really impact that person deeply within them.

(White Clinician #8) I think for me, it's helped me to kind of have a better understanding of how all of those little things, all of the little stressors and experiences build up, that it can just be a comment that somebody makes or seeing something one time. It could be things like that, just where all of those things build up and kind of give me that understanding that it's not just a failure of being able to cope. They're able to cope with it to a point, but at some point, you can't cope with that stress anymore, and kind of recognizing just how all those little things build up and overcome the defenses that someone might have. I thought that's been kind of most helpful for me to kind of think about.

Posttraining Considerations

White clinicians described the importance of cultural humility, never feeling 100% confident regardless of their training or perceived knowledge,

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and the utility of constant growth in relation to race and racism. Additionally, BIPOC clinicians also acknowledged their own personal gaps in knowledge (e.g., working with biracial clients or clients from a different racial background), and the need to remain vigilant in their practice.

> (White Clinician #8): Maybe some of that comfort is I am comfortable recognizing that I will never be able to 100% stand in that person's shoes, and therefore may or may not ever do it without messing up. Maybe that's part of it.

> (BIPOC Clinician #4): So, I feel like I definitely need to do my own self work. But in talking with my clients, I feel like you know, for the most part I'm able to strike a balance and in trying to get to the goals that they have in mind. But if there is a place where I am having a blind spot, I feel like these kind of discussions and the consultation calls will kind of help me too .... So, keeping in mind some of those blind spots that I have and making sure with clients because I do have multiracial clients and making sure that I'm giving respect to all parts of them.

Also, we intentionally asked clinicians in the BIPOC-only focus group to discuss their perception of how the training may have impacted their management of their own self-care needs, given that they may have experienced their own racial trauma while also providing services to address the racial trauma of others. We found that BIPOC clinicians struggled to identify specific self-care tools that they gleaned from the intervention model to help them deal with the compounded impact of treating race-based stress while also experiencing it. Instead, they described their own experiences working in agency settings and broader systems that are steeped in microaggressions and White supremacy. For example, one BIPOC clinician stated:

> (BIPOC Clinician #1) As far as our coworkers who are not brown, who are not Black? I don't think that they necessarily think really about how they communicate. So, like an example would be one day I had a relaxer in [my hair] and I usually wear my hair natural. And you know that seems like a normal thing. But then the day I had my hair straight, it's like, "Oh, you look really pretty today. Today your hair is really pretty." But then any other day is just like, "OK, cool. How you doing?" And so, just things like that ....

As illustrated in the following quote, another clinician provided their experience, then described how they chose to set boundaries as a form of self-care in their agency.

> (BIPOC Clinician #2) I had a 12 year old Black boy who was under house arrest because he was singing some rap song in front of his White teacher and she felt threatened, and it made me feel furious! You know, it makes me even feel more furious that I have to tell the judge that he's [the 12 year old boy] coming to session. Because if he doesn't come to session then it's going to be worse, you know. And so it makes me furious sometimes to work at an agency that doesn't want to understand that. And at this time and age, where research is available, where things are there, when someone is not keeping up, it's because you're choosing not to. .... I now I tell my managers: "I'm never going to work with kids who we have to report back to the court." And that's a very strict boundary that I have ....

Still, none of the self-care techniques that our clinicians mentioned were specifically informed by the training. However, they did identify that the KRTT training has created a conversation at their agency and among their coworkers that has never previously existed. This, alone, was seen as healing in some ways for these clinicians. Additionally, the agency itself, while it seems to be making a step toward acknowledging the need for these types of training, will need to remain consistent in providing the opportunities and the space for continued conversations surrounding race and the impact that it has on not only clients but clinicians as well.

Suggestions for Training Improvement

Data from focus groups also captured clinicians' recommendations for improving the training, which are organized into three groups and summarized below:

1. Suggestions for Training Content: Participants recommended that more age-specific tools and information be integrated into the training content to assist clinicians working with youth. Additionally, some suggested creating training cohorts where more group-specific content can be provided to address specific types of clients (e.g., young children, adolescents, adults, etc.).
2. Suggestions for Training Environment and Delivery: The training was conducted in a largely asynchronous format. It was suggested that there be more live/synchronous interaction where participants are able to collaborate, engage with experiential content, and have more dialogue with interactive experiences. It was also recommended that electronic tests and quizzes be graded via automated scoring so that

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participants get their grades and feedback more quickly during the training process.

3. Suggested Additional Tools or Training: It was suggested that prerequisite trainings be added prior to the full training. Participants recommended the addition of pretraining suggested readings or resources focused on related topics, such as implicit bias, self-awareness, and navigating missteps when having conversations about race. For example, White clinicians identified that some of their White counterparts came into the training with less knowledge and cultural humility than one would expect for this level of service provision, underscoring the need for prerequisite resources.

Discussion

The findings illustrate the importance of considering intersectionality in regard to how clinicians may or may not be able to relate to their clients based upon their experiences with systemic oppression (Crenshaw, 1990, 2017). While it is critical to understand and address the role of race, the importance of other client identities must not be discounted even when working with a client of the same race. Findings also shed light on the need for further training and resources related to cultural humility, racial bias, and self-awareness for White clinicians, as well as more support for self-care/preservation for BIPOC clinicians. As participants noted, pretraining may be an important addition to the KRTT curriculum and further research is needed to assess how this should be integrated, what trainee baseline knowledge is needed, and how to evaluate this baseline knowledge in preparation for the training. Overall, data point to KRTT as a potentially viable way of moving toward the decolonization of mental health via clinical training that promotes critical reflection, pushes clinicians beyond cultural competence, elevates client healing narratives (i.e., racial trauma narrative), and prioritizes lived experience (see Bracken et al., 2021). Given the manualized nature of KRTT as well as the clinical consultation that accompanies the training, it may be feasibly implemented with fidelity in a number of mental health settings, including community mental health and independent practice environments. While there is a cost attached to the training and consultation, agencies and private practices alike may benefit from providing treatment modalities that will increase service utilization, especially among populations that have been disproportionately underserved.

Implications

There are many implications for practice, policy, and research from the results of the focus groups. In regards to practice implications, the discussion of a lack of knowledge and exposure to culturally diverse and inclusive approaches that center diverse racial experiences prior to this training has major implications to clinical service training. Many people may fail to recognize and acknowledge the influence of race on their judgments, not because it does not exist, but because they may be unaware of it or even unwilling to acknowledge it (McGhee, 2021). Specifically, it would be beneficial for mental health agencies and universities to expose clinicians and students to culturally diverse frameworks during clinical service training and service provision (Ranjbar et al., 2020). For example, clinical preservice training programs, like MSW programs, should consider including more experiential and race-specific practice content to ensure that emerging clinicians entering the field are able to best address the needs of their clients (Davis & Francois, 2021).

Related to the training itself, the clinicians' "suggestions for training improvement" should be considered and potentially integrated into future training. In addition, it may be important to think about how to include self-care content to address the double load that BIPOC clinicians face when addressing race-based stress with clients. Moreover, training content should include an intentional focus on evidence-based self-care practices for all clinicians that acknowledge the whole person and include aspects that focus on physical, mental, emotional, social, and spiritual restoration (Pyles, 2020). In addition, considering the ongoing, daily exposure to traumatic material, stories, and experiences, the additional self-care-focused curriculum should include protective strategies to mitigate secondary trauma exposure before, during, and after each KRTT session (e.g., the four quadrants of self-care; Middleton, 2015).

As aforementioned, more work is needed to bolster clinician preparedness for addressing race/racism in the ongoing treatment of trauma. While this study evaluated the training component, it is important to note that training is only one component of

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clinician preparedness for this area of clinical practice. Training should be accompanied by practices that ensure transfer of learning will occur. Ongoing development plans for clinicians regarding race-based trauma should promote embedding practices that include coaching, consultation, collaborative peer learning sessions, and supervision. In addition, the development plans should name and normalize the possibility of racial harm and include an agreed-upon plan to address microaggressions and other incidents of racial harm in the clinical setting.

Further, from a policy and procedures standpoint, mental health agencies seeking to reflect the values of trauma-informed practice must invest time and resources in ongoing training on race-based issues and cultural humility, while also integrating practice and policy changes across all staff levels. A long-term organizational plan needs to be developed and implemented with an emphasis on embedding anti-racist principles that support BIPOC staff, as well as BIPOC clients, throughout the organization. In this manner, the burden of undoing racism does not rest solely on the clients and/or the clinicians, but the organization as a whole.

The findings underscore the importance of cross-system recognition of race-based trauma as being essential for decolonizing mental health treatment. If the mental health system is trauma-informed, but the court-system individuals interact with are not (see Drabble et al., 2013), then clinicians are forced to disentangle more trauma with the communities they serve. This could also be said for other systems that individuals interact with on a regular basis to include policing, education, and housing, to name a few. Furthermore, systemic cross-system cohesion may be necessary. To be sure, more research and support is needed in this area.

Lastly, in regard to research implications, there is a need for more research and practice knowledge related to clinical interventions, and their related training curricula and protocols, that are designed specifically for BIPOC populations. Furthermore, more research is needed to explore the variation in experiences and clinical outcomes for BIPOC clients who receive services from BIPOC clinicians versus White clinicians who have received KRTT training.

Strengths and Limitations

The current study provides a unique contribution to the field as it serves to contextualize clinicians' perceptions of competence with addressing KRTT and explores clinicians' perceptions of growth and skill development in relation to KRTT practice. It is important to note that although the sample represents a diverse group of clinicians, it only represents one cohort of clinicians who participated in KRTT training in a midsize Southern city. In addition, individual participant ethnicity data was not collected (only race) and while the focus group included clinicians from a few different racial groups, we still need to include other groups, including more non-White participants from different cultural backgrounds in order to better understand the experiences and impacts of the training. Furthermore, the clinicians who participated in the study were not specifically asked about their own personal experiences with trauma (including racial trauma); however, as their narrative responses indicate, BIPOC clinicians' own racial trauma histories may have impacted their uptake of KRTT training, as well as how they implement KRTT clinical practice. Further research is needed to understand how clinician trauma history impacts their experiences and application of the KRTT training. Also, focus group data were not quantified across individual participants. Finally, the fact that the training was delivered asynchronously online, has implications regarding missed opportunities for peer support and social learning, which can enrich the learning experience.

Conclusion

Racism is global, occurring daily in the lives of BIPOC individuals and impacting all aspects of their well-being. The current study addresses the absence of racial trauma therapy training opportunities for clinicians and sheds light on the potential impact of the KRTT training on both BIPOC and White clinicians. Results highlight the importance of a clear clinical protocol that addresses racial trauma and provides concrete language and strategies to broach the subject of race in treatment. Both BIPOC and White clinicians discuss ways the KRTT helps to fill the gap in clinical training and provides standardized scales and tools to address race-based stress. As the evaluation of the KRTT continues, it may pave the way for further advances in the field of clinical treatment of racial trauma.

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Received February 19, 2022
Revision received July 19, 2022
Accepted July 20, 2022 ■

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