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Healing Interpersonal and Racial Trauma: Integrating Racial Socialization into TF-CBT for African American Youth

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RUNNING HEAD: RACIAL SOCIALIZATION IN TF-CBT

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Abstract

African American youth are more likely than their peers from other racial and ethnic groups to experience interpersonal traumas and traumatic racist and discriminatory encounters. Unfortunately, evidenced-based trauma treatments have been less effective among these youth likely due to these treatments not being culturally tailored to address both interpersonal and racial trauma. In this article, we utilize the Racial Encounter Coping Appraisal and Socialization Theory (RECAST) to propose an adaptation to Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)—an evidence-based trauma treatment for children and adolescents—to include racial socialization, or the process of transmitting culture, attitudes, and values to help youth overcome stressors associated with an ethnic minority status. We conclude by discussing implications for the research and clinical community to best promote healing from both interpersonal and racial trauma for African American youth.

Healing Interpersonal and Racial Trauma: Integrating Racial Socialization into TF-CBT for African American Youth

African American[1] youth (10 to 17 years old) are disproportionately impacted by trauma (e.g., physical and sexual abuse, witnessing domestic violence): almost 65% of African American youth report traumatic experiences compared to 30% of their peers from other races (Briere, 2002; Finkelhor et al., 2013). Additionally, they are more likely to report adverse emotional and behavioral sequelae to trauma exposure, including poor mental health (Andrews et al., 2015; Roberts et al., 2011), substance abuse (Danielson et al., 2006), decreased well-being (Neblett et al., 2008), and risky sexual behavior (Lalor & McElvaney, 2010; Senn & Carey, 2010). The disproportionate rates of trauma and the associated outcomes observed among African Americans may be due to unique racism-related stressors (e.g., Tynes et al., 2019). Prior research estimated that 38% of African American youth aged 13-18 years old experience an average of six instances of racism over the course of a single year (Sellers et al., 2003), while recent research indicates as many in one day given the proliferation of discriminatory social media experiences (English et al., 2020). Harrell (2000) further elaborates on ways that such race-related trauma can be experienced: time-limited life events, direct and vicarious experiences, daily microaggressions, chronic-contextual and collective experiences, and transgenerational transmission.

Although African American youth demonstrate resilience through utilizing familial and cultural strengths to thrive in the midst of compounded and continuous social challenges (Hiller et al. 2016; Jones, 2006), some may be at increased risk for developing Post-Traumatic Stress Disorder (PTSD) if they have difficulty recovering from a particularly distressing experience.

[1] Within this article, African American refers to youth who identify racially as "Black" and whose ancestry in the United States goes back at least one generation.

Research suggests that racial trauma exacerbates the impact of interpersonal trauma on African American youth's emotional and behavioral outcomes (Jernigan & Daniel, 2011; Williams et al., 2014). Therapies that focus on general coping strategies for healing from interpersonal trauma (e.g., diaphragmatic breathing) may ignore culturally-specific strategies essential to addressing both trauma for African American youth (Anderson et al., 2018), potentially explaining poorer treatment engagement and outcomes among this population. Indeed, African American youth are approximately three times less likely to initiate or be retained in trauma treatment compared to their peers (Kilpatrick et al., 2003; Lester, 2010). As such, this article aims to provide guidance on approaches to integrating racial socialization (RS)— a culturally-relevant and commonly practiced familial coping strategy—into Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) to improve trauma-related outcomes among African American youth.

Trauma-Focused Cognitive Behavioral Therapy

TF-CBT is a short-term, evidenced-based trauma treatment for youth between the ages of three and 18 (Cohen et al., 2016). TF-CBT is divided into eight treatment modules that emphasize cognitive-behavioral strategies to address PTSD, trauma-related depressive and anxiety symptoms, and behavioral problems (Cohen et al., 2016). These intervention components are commonly referred to as PRACTICE: ***P****sychoeducation/Parenting,* ***R****elaxation,* ***A****ffective Expression & Modulation,* ***C****ognitive Coping,* ***T****rauma Narration & Processing,* ***I****n-vivo Mastery,* ***C****onjoint Sessions*, and ***E****nhancing Future Safety & Development* (Cohen et al., 2016).

Racial Socialization

Racial socialization (RS) is the process of transmitting culture, attitudes, and values to prepare youth to cope with stressors and oppression associated with a racial minority status (Hughes et al., 2006; Lesane-Brown et al., 2005). RS is associated with many positive

psychosocial outcomes, including improved self-esteem and resilience (Buckely & Carter, 2005), lower rates of depression and perceived stress (Neblett et al., 2008), stronger racial identity (Neblett et al., 2009), reduced behavioral problems (Cooper & Smalls, 2010), and better use of coping skills during experiences of stressful life events including prejudice and discrimination (Hughes et al., 2006; Suizzo, Robinson, & Pahlke, 2008). Racial pride, barriers, equality, and achievement are among the RS messages most often employed by African American parents and frequently cited in the literature as linked to positive behavioral and psychological outcomes for African American youth (Hughes et al., 2006; Neblett et al., 2008). Racial pride messages teach children about African American heritage and culture to promote group unity and combat negative majority opinions (e.g., talking about important historical figures; Neblett et al., 2009; Stevenson et al., 2002). Racial barrier messages teach children about discrimination and racism and highlight complexities in managing social interactions between African Americans and majority populations on individual, cultural, and institutional levels. These messages include deliberate efforts by parents to promote their children's awareness of discrimination and prepare them to cope with discriminatory experiences (e.g., messages pertaining to having to work twice as hard as their majority counterparts to succeed; Brown & Krishnakumar, 2007; Lesane-Brown et al., 2005; Neblett et al., 2009; 2002). In addition, messages that parents deliver that teach their children about religion are key sources of resilience for many African American families (Stevenson et al., 2002). Appreciation of extended family involvement is also an important RS practice wherein other elders (e.g., grandparents and non-blood relatives) perform caretaking, child rearing, and socialization responsibilities to optimize youth development (Grills et al., 2016). As parents are actively involved in the administration of TF-CBT and influential sources of support when teaching appropriate cognitive and behavioral coping strategies, the integration

of RS practices in TF-CBT for treating both interpersonal and racial trauma in African American youth may lead to better trauma-related outcomes for this population (Williams et al., 2014).

Theoretical advancements for racial socialization and therapeutic treatment. A burgeoning theory conceptualizes the mechanisms responsible for behavioral change in response to RS. The Racial Encounter Coping Appraisal and Socialization Theory (RECAST; see Anderson & Stevenson, 2019; Stevenson, 2014) posits that the transmission of racially-specific coping strategies from the parent to the child helps to fortify behavioral and cognitive strategies inherent in confronting racist encounters. RECAST connects the stress, coping, and RS literatures and recommends the integration of RS practices into the therapeutic and coping strategies imbued in TF-CBT for stressors that are exclusive to or exacerbated by racial phenomenon.

Cognitive behavioral frameworks emphasize the notion that thoughts influence feelings, which in turn influence behaviors in a cyclical and bidirectional manner (Carlson & Dalenberg, 2000). TF-CBT seeks to identify and correct inaccurate and unhelpful thoughts, distressing feelings, and harmful behaviors utilizing intervention strategies designed to produce realistic and helpful thoughts, positive and calm feelings, and constructive and adaptive behaviors following a stressful event (Cohen et al., 2016). Given the unique manifestation of stress intrinsic in racial trauma—particularly through familial mechanisms like parental depression and compromised parenting practices (e.g., Anderson et al., 2015)—unique coping strategies must also be employed to contend with racial stressors (Anderson et al., 2019). Guided by RECAST, we posit that integrating RS into TF-CBT goes beyond general cultural tailoring that alters various factors such as content, goals, and methods (Bernal et al., 1995) to provide African American youth with cognitive and behavioral strategies to process interpersonal and racial trauma (Huey et al, 2014).

Clinical considerations for racial socialization and therapeutic treatment. RS fits well within the cognitive behavioral framework underlying trauma treatments that address the unique needs of children with PTSD symptoms (e.g., depression, engagement in risky behaviors; Cohen et al., 2004). Through practices intended to improve youths' racial pride and help youth understand how racism and discrimination may impact themselves, others, and their futures, we are able to emphasize the importance of RS, while increasing the likelihood that families will remain in treatment. The verbal communication, modeling, and exposure methods used to convey RS messages (Caughy et al., 2002) are congruent with basic techniques emphasized in CBT. As such, it is important for clinicians to utilize cognitive (e.g., restructuring through Socratic questioning) and behavioral (e.g., roleplaying how to respond to negative racial encounters) strategies with youth who have experienced interpersonal and racial trauma. Indeed, recent findings (Anderson et al., 2018) show improved coping strategies for families that utilize RS with traditional CBT strategies (e.g., mindfulness and relaxation) in response to racial stressors.

Current Aims

Given the congruence between CBT-oriented strategies and RS practices, we posit that RS can be: 1) integrated into trauma treatment to help youth process and cope with racially-charged traumatic experiences; 2) utilized to manage additional race-related stress that may compound more general traumatic experiences; and 3) used to bolster treatment engagement to promote positive therapeutic outcomes for African American youth. Although RS has been successfully integrated into treatments seeking to reduce internalizing and externalizing problems in African American children and families, reduce abusive parenting, and increase positive parent-child interactions (Coard et al., 2004), no treatment enhancements exist for TF-CBT for African American youth who have experienced interpersonal trauma and are at risk for encountering

racial trauma. And, while stand-alone RS programs (e.g., Engaging, Managing, and Bonding through Race [EMBRace]) are beginning to advance evidence on improved familial functioning and child coping strategies in the face of racial discrimination (see Anderson et al., 2018), the utilization of RS as a means to enhance treatment engagement and outcomes among trauma-exposed African American children is relatively absent (Anderson & Stevenson, 2019). Thus, in the sections that follow, we present recommendations and practices for clinicians to expound upon these suggestions when working with trauma-exposed youth.

Proposed Treatment Integration

TF-CBT is a short-term, evidence-based child and family treatment that has effectively reduced a variety of trauma-related symptoms (Cohen et al., 2016; Weiner et al., 2009). However, it neither adequately addresses racial trauma as an impetus for treatment nor does it address cultural factors (e.g., religiosity, beliefs about corporal punishment, stigma associated with seeking mental healthcare) that may influence whether African American families engage in trauma therapies (Coard et al., 2004; Phipps & Thorne, 2019). Given that some of these cultural factors are promotive or protective (e.g., religious beliefs) and others are more associated with risk for limited engagement in therapy (e.g., historical trauma), such cultural obtuseness by existing treatments not only reifies racial disconnectivity, but also excludes cultural strengths important in the healing process (Anderson & Stevenson, 2019). An exception is a recent article by Phipps and Thorne (2019) in which the authors propose a framework for utilizing TF-CBT to address racial or 'cultural' trauma in African American children and youth utilizing a community-based group application of TF-CBT through adaptations such as increasing active listening on the part of program leaders and altering the environment in which treatment is provided so that it is not a reminder of the school environment. This framework, however, does not address the

intersection of interpersonal trauma and racial trauma, nor does it integrate promotive cultural factors such as RS that may be utilized by caregivers in individual child and family therapy.

In this article, we emphasize the importance of considering the unique culture, experiences, and needs of each family while guiding them through PRACTICE, as certain demographic and contextual factors may impact the RS practices parents employ. As such, the suggested strategies provide specific examples for including RS messages and practices into TF-CBT as well as present examples of broad-based cultural modifications for use with African American youth. It is important to note that heterogeneity exists between and within groups, and that the following are suggestions to cultivate a line of inquiry about values and experiences that may be shared among African American clients. Three points are important to clarify from this line of inquiry. First, not all African American clients experience the same degree of stress resulting from specific encounters. We, therefore, encourage self-examination to increase awareness of one's own biases and how these may impact assessment and care, which may be accomplished through peer consultation and professional development to stay abreast of appropriate dialogue and current practices (see Williams et al., 2019). Secondly, clients of other racial and cultural groups may benefit from the general cultural considerations within this text, though we encourage tailoring to fit their various circumstances. It is notable that RS is a process that is relevant to diverse families, and we suggest this text as a starting point for those considerations. Third, although it is possible that these recommendations may add to the time spent within sessions or require additional treatment sessions, we offer that these strategies may be critical to better target the problems experienced by African American clients. Thus, our suggestions are intended to assist clinicians and families with engaging in this important dialogue. As research continues to stress the importance of RS as an ongoing series of discussions and

interactions between caregivers and youth, we posit that therapy is an ideal setting for clinicians to help families engage in these practices. A summary of the PRACTICE components and our suggestions for integrating RS are provided in Table 1.

Pre-Treatment Assessment

Given that internalizing problems are often overlooked in African American youth, we encourage clinicians to preemptively consider whether tailoring their assessment battery could enable them to better capture youth's symptom presentation (e.g., measures that better assess somatic symptoms) and ensure comprehensive assessment through the use of multi-method assessment techniques (e.g., semi-structured interviews, self-report, multiple reporters). This could include assessing youth and caregivers' experiences with discrimination and racism and identifying PTSD symptoms related not only to the interpersonal trauma the youth has encountered, but also pertaining to racial stress and trauma. It may be helpful for clinicians to pay special attention to instances when their clients have difficulty pinpointing one major stressor when assessing for racism, considering that the impact of racial discrimination may be chronic, discrete, and/or systemic. In such cases, the use of clinical tools designed to screen for needed cultural considerations in treatment (e.g., the Cultural Formulation Interview [CFI]; American Psychiatric Association, 2013) and those developed to aid in the assessment of experiences with discrimination and socialization may be warranted.

One unique feature of racial discrimination as a stressor is its intergenerational impact; while it may be unusual to screen for parental experiences with interpersonal trauma within youths' trauma treatment, parental experiences of racism and discrimination may directly or indirectly impact childrearing practices (see Anderson et al., 2015). Previous research, for example, suggests that parents who report greater discriminatory experiences are more likely to

communicate RS messages to their children that prepare them for racial barriers (Thomas et al., 2010). This is likely due to the notion that parents who experience discrimination will be more likely than others to anticipate that their children will also need the tools for coping with racial stressors (Hughley et al., 2019). Thus, therapists can discuss the impact of caregivers' own experiences with discrimination on their RS messages and identify strategies that could inform treatment and alleviate symptoms related to stress for their children (Williams et al., 2018).

It is important that clinicians assess each family's use of RS messages and practices. Clinicians may broach the topic by asking parents and youth, "How do you talk about race in your family?" or "Are there any important messages or values around race that you emphasize in your family?". This could provide the clinician with preliminary information regarding the frequency and degree to which RS is emphasized within their family and suggest options for more formal assessment. To date, there are few standardized, empirically-supported measures to assess racism (e.g., Daily Life Experiences with Racism Scale [DLER]; Harrell, 2000), racial trauma (e.g., UConn Racial/Ethnic Stress & Trauma Survey [UnRESTS]; Williams et al., 2018), and RS (e.g., Racial Socialization Competence Scale [RaSCS]; Anderson, Jones, & Stevenson, 2019; The Comprehensive Race Socialization Inventory; Lesane-Brown, 2005; Teenager Experience of Racial Socialization Scale; Stevenson et al., 2002) for utilization in clinical settings.

Psychoeducation/Parenting (P)

During *Psychoeducation*, clinicians validate youth and caregivers' responses to the traumatic event, provide information about common reactions to trauma and specific diagnostic information, and orient the family to trauma treatment. For African American clients, clinicians are encouraged to discuss results of both formal and informal assessment of RS and youths' experiences with and reactions to discrimination and incorporate this into the proposed treatment

plan within the context of the child's cultural background and family environment. The psychoeducation module provides clinicians with an opportunity to share their awareness of and commitment to learning more about the tools that their clients' families use to cope with stress and trauma. Moreover, clinicians are encouraged to inform clients that treatment could enable them to learn and adopt additional coping strategies. Clinicians may also choose to discuss racial barriers, including beliefs or expectations that may influence the types of messages that parents share with their children. Using language that validates negative experiences that families may have had in the past may encourage them to open up to clinicians, regardless of the clinician's cultural background. For example, clinicians may begin a statement with "Many of the families with whom I have worked haven't had good experiences with mental health treatment or the school system" and ask if their experiences have been similar or different. Clinicians could then encourage clients to share concerns from their own perspectives.

Parenting skills training in TF-CBT teaches parents behavioral skills to address children's behavior problems that may have developed following the child's traumatic experience or how to manage those behaviors that may have been exacerbated as a result of the child's traumatic experience. Clinicians may want to inquire about caregiver's beliefs and values around child rearing and discuss these in session. When working with African American caregivers, emphasizing a functional behavioral analysis approach to problem behaviors may be particularly useful given strongly held beliefs about the importance of 'respecting your elders'. As such, parents may believe that a child's behavior problems are deliberate attempts to disrespect them. Completing a functional analysis with caregivers may help them identify trauma triggers that serve as antecedents to behaviors or other influences that may reinforce inappropriate behaviors.

Parallel parent sessions are an important component of TF-CBT treatment, as a child experiencing a traumatic event is likely to have a significant impact on their caregivers (Cohen et al., 2016) as well. When engaging families in treatment, clinicians may inquire about attitudes and beliefs that might be barriers to treatment (e.g., family matters should stay within the family) and use those beliefs to better engage families (e.g., "With your mom's permission, you can consider me a part of your extended family"). Parents are encouraged to discuss and express their own reactions to their child's traumatic experiences and their understanding of the impact of trauma on their child's life. During this conversation, clinicians may share materials, readings, and examples designed to teach caregivers and youth about the utility of RS.

Relaxation (R)

*Relaxation s*kills are introduced to help children and caregivers manage physiological reactions to traumatic experiences. A family's cultural background and values can affect how they respond to stress. A common RS message is that African Americans must work twice as hard to get half as much; as such, African American families may place less importance on relaxation. Therapists may want to explore whether the family they are working with ascribes to this belief and, if so, discuss the importance of relaxation for recharging and healing. For example, therapists may ask what a family does to relax after a long day or whether there are ways that they deal with stress that are particularly helpful. While it should not be assumed that families share the same beliefs and practices, a good working knowledge of common cultural values (e.g., prayer) can help guide the clinician in identifying relaxation strategies that will be most helpful for the client.

When deciding how to present relaxation techniques, clinicians are encouraged to be creative as they identify and bolster culturally relevant skills the youth is already using (e.g., hobbies, music, sports). Relatedly, clinicians could assist their clients with developing new skills

that can be used to reduce stress in different environments. Analogies used to demonstrate key concepts may be adapted to fit the child's culture, and relaxation techniques could include exercises that are culturally relevant for the child. As relaxation strategies vary greatly, clinicians may choose to assign relaxation practice for homework and ask open-ended questions to elicit feedback on the effectiveness of the practice, for instance, "Which strategies have been the most helpful or useless?" or "What is a recent example of when you tried to relax and it did not go as planned?" It may also be important for clinicians to incorporate RS by discussing and assessing families' spiritual beliefs, as appreciation for spirituality is a RS practice shown to foster resilience (Brown & Tylka, 2011). Therapists may explore whether religious practices (e.g., praise and worship music, prayer, meditation) may be incorporated into relaxation techniques. By integrating RS with typically suggested relaxation strategies for clients (e.g., prayer; deep breathing), there is an increased likelihood of a client using both strategies when stressed.

Some African Americans may express stress responses in psychosomatic ways. For youth who are having these symptoms (e.g., headaches, stomach aches, nausea, nondescript aches and pains) that are thought to be caused or exacerbated by stress, it may be helpful to explicitly state that one of the goals of relaxation is to reduce physical symptoms through diaphragmatic breathing and progressive muscle relaxation. In addition to emphasizing the utility of relaxation for dealing with interpersonal stressors, we encourage clients to use these strategies in response to racial stressors. When doing so, care should be taken not to imply that the somatic symptoms are a matter of the client's imagination or not real. Rather, clinicians can assure clients that they are using a physical intervention to help address physical symptoms. This can be used to help families understand the connection between stress and physical health (e.g., high blood pressure).

Affective Expression and Modulation (A)

The *Affective expression and modulation* component of TF-CBT is to help clients identify and discuss their feelings associated with the interpersonal trauma they experienced (e.g., sexual abuse, witnessing domestic violence). Although several handouts focused on the identification of feelings may be readily available online, these materials often do not include a diverse range of faces. As RS emphasizes the importance of communicating and fostering positive racial pride messages, clinicians are encouraged to seek out therapy materials that include African American faces or create them together in session to increase children's ability to self-identify with the treatment components and enhance their engagement. To utilize and encourage RS in sessions, clinicians may need to help their clients identify feelings associated with experiences of racism and discrimination (e.g., microaggressions, witnessing police brutality in the media) so that they can communicate their feelings. Burgeoning literature has suggested that African American parents may socialize their children to suppress affective expression to contend with discrimination due to fear that negative affect expression is more likely to be interpreted as aggressive by individuals from the majority culture (Kang & Chasteen, 2009; Stevenson et al., 2002). Clinicians may need to work with caregivers to role play with youth ways to label their emotions and feelings in situations where there may be heightened racial tension.

When working with issues surrounding death and traumatic grief in particular, it is important for clinicians to be aware that, in some instances, prolonged periods of grief may be normal for some African American clients. Clinicians may choose to utilize RS in session to explore familial customs and beliefs around death and mourning and identify possible feelings of guilt (e.g., clients feeling guilty about "moving on too quickly", family customs and traditions that they "must mourn for 40 days", or feeling as if they "shouldn't be enjoying life when [their loved one] is no longer able to") that may be present following the loss of a loved one. After

asking about clients' beliefs, cultural expectations, and personal standards surrounding grief and mourning, clinicians could then determine which affective symptoms are above and beyond what one would expect of other grieving clients and treat accordingly.

Cognitive Coping (C)

The goal of *Cognitive coping* is to teach youth and caregivers the association between thoughts, feelings, and behaviors. In addition to helping youth identify automatic thoughts that relate to interpersonal stressors (e.g., "You pass a friend and she doesn't acknowledge you, what is your first thought?"), clinicians could utilize RS to process their thoughts and feelings resulting from previous discriminatory encounters and identify coping strategies to be better prepared for potential future encounters (e.g., "An employee of a store follows you while you are shopping and you believe that it's because of your race. How does that make you feel? How would you react?"). Some thoughts, while accurate, may be unhelpful if dwelling on them leads to additional distress (i.e., "The store employee followed me because I'm African American."). In these cases, therapists can validate these thoughts, acknowledge that their experience is due to systemic racism, and encourage more helpful and productive cognitions (e.g., "I was followed because the clerk is racist, not because I did anything wrong."). Through this, cognitive coping allows the client to challenge unhelpful or negative thoughts and feelings related to their experience.

Trauma Narration and Processing (T)

The purpose of *Trauma narration* is to expose the client to trauma-related memories to weaken their connection to overwhelming feelings of distress. The narrative can take the form of a written story, book with chapters, comic strip, collage, or drawing. As racial pride messages consider appreciation of African American customs and traditions, clinicians can also consider culturally relevant forms of communication including fables with morals, rap music, poetry) to

encourage client engagement in treatment at this critical stage. When constructing the trauma narrative and outlining topics to be explored (e.g., all about me, before the trauma, when it happened), clinicians could also encourage youth to include a chapter that describes the historical plight of their racial group and ways that their ancestors overcame challenges (e.g., segregation).

When processing the trauma narrative, where applicable, the clinician may need to help the client identify thoughts and evaluate ways trauma exposure may have changed views of the self, world, family, or future. Clinicians may use Socratic questioning and thought classifications (e.g., accurate vs. inaccurate; helpful vs. unhelpful; regret vs. responsibility) to ensure the client is able to identify ways to externalize racist and discriminatory encounters and internalize ethnic and self-pride to counteract beliefs about themselves and others that may give unwarranted leverage to interpersonal traumas or negative racial encounters over their future. Specifically, clinicians could help youth identify culturally specific, unhelpful or inaccurate cognitions that need to be challenged during the processing component (e.g., "this type of trauma doesn't happen to Black people", "because I'm Black, I'll never be able to get over this"). Additionally, through the identification of culturally specific cognitions, clinicians may also help youth identify thoughts related to an altered world view or view of self, related to trauma exposure and culture (e.g., "don't trust White people", "don't trust Black people"). Some youth may benefit from clinicians placing youth's trauma exposure into current or historical contexts (e.g., "African Americans have historically been able to overcome great stressors" or "African Americans continue to experience racism regularly yet they are still successful in overcoming these negative experiences").

An additional job of the clinician in processing the trauma narrative is to help the client identify cognitions (e.g., self-blame) that are rooted in cultural beliefs but may need to be processed in relation to oneself, others, and the world around them as a result of racial trauma.

For instance, because many African American families value spirituality and religion (Brown & Tylka, 2011), shame and stigma might make it difficult for clients to accept sexual abuse if premarital virginity is a strongly held value. Clinicians are encouraged to explore clients' cultural beliefs and may frame the concept of virginity as not only physical in nature but rather as something the client has the power, control, and choice to still willingly give to another.

As an example of a racial stressor, if an African American client is pulled over for "speeding" but was then told to step out of the vehicle, it would be helpful to process the client's fears and thoughts about the situation. Because high profile cases have shone a light on race-based police misconduct, there is a likelihood that the client would feel unsafe in this situation despite returning safely to the vehicle. As such, clinicians can help clients process a police encounter by reminding them of the toll of racism, helping clients to use their relaxation strategies (e.g., deep breathing) to calm their physiological responses, assisting them in identifying their feelings (e.g., anger), and helping them process frustrations concerning the event.

Gender and age are also important for clinicians to consider. The idea of the "Strong Black Woman" or "Superwoman," for example, is used to describe women who have the belief that it is their responsibility to bear certain burdens without complaining (Woods-Giscombe, 2010). Likewise, African American boys may feel pressured to not emote and remain hypervigilant to uphold racialized gendered stereotypes (Hammond, 2012). Clinicians may help clients realize that not getting support in addressing traumatic experiences could leave them incapable of experiencing life's pleasures, being a source of support for others, and dealing with other stressors. With these clients, a therapist can refer to Marvel Comics' Black Panther and his team of warriors from Wakanda, and suggest that, similarly, therapy is designed to build the client's support team as they work to "fight off" the potentially detrimental effects of trauma.

In-Vivo Mastery (I)

The purpose of *In-vivo mastery* is to gradually expose the client to trauma-related memories and cues and to reduce avoidance that interferes with daily functioning. In addition to triggers from the interpersonal traumas clients experience, clinicians can also help clients separate harmless reminders or triggers from previous negative racial experiences (learned anxiety response; e.g., not speaking up in class for fear of being treated like they are not smart enough) and allow clients the opportunity to practice skills that will reduce negative cognitions, emotions, and behaviors in response to future triggering events. To do so effectively, clinicians make efforts to ensure that they are gaining an accurate representation of the youth's hierarchy, distress, and support. Clinicians of African American clients may want to revisit measures given in the assessment phase (e.g., the Daily Life Experiences Scale; DLER; Harrell, 2000) to create a fear hierarchy associated with entering into situations where racism or discrimination may be present, and practice ways to overcome distressing situations with the clinician, caregiver, and extended family members. African Americans with traditional male gender roles may minimize or be more hesitant to give accurate subjective units of distress, want to select challenging in-vivos, or attempt to move through the exposure hierarchy too quickly. When working with these clients, clinicians are encouraged to continually assess clients' mastery of skills that are used to overcome feared ambiguous (e.g., microaggressions in the classroom), overt (e.g., being called a racial slur), and vicarious (e.g., witnessing police brutality on social media) racial stressors.

Conjoint Parent-Child Sessions (C)

During *Conjoint sessions*, youth and caregivers meet with the clinician to review session materials, practice skills, and receive praise and encouragement. Here, clinicians can prepare and role play strategies for dealing with ongoing racially charged situations that the client is working

on in session. Given that the dyadic process of RS has been implemented throughout treatment, conjoint sessions also provide an opportunity for the client and caregiver to discuss racially charged incidents that they encountered or witnessed and the ways that their thoughts and feelings changed as a result of the activities and conversations that they have had throughout treatment.

Enhancing Future Safety and Development (E)

Clinicians should assess ongoing risk and safety concerns at the beginning of and throughout treatment by monitoring youth and caregivers' encounters with discrimination and vicarious racism that they may have witnessed. For clients who do not report experiencing racial stress throughout treatment, clinicians may work with families to *Enhance future safety* and equip youth with how to respond in the event of future experiences with discrimination and racism. Additionally, clinicians could help identify risks, triggers, and warning signs of danger and skills both that can be used in future encounters (e.g., how to respond to discriminatory experiences with people in authority, like teachers and law enforcement). For some families, ongoing safety concerns exist, and when the need for new skills are indicated (e.g., an unexpected experience with racism), enhancing safety allows clinicians the opportunity to role playing with clients and their caregivers to prepare for and address potential future interpersonal and racial barriers.

Additional Considerations for Race-Related Index Traumas

While the suggestions presented in this article apply to racial stress and trauma as well as more general interpersonal traumas experienced by African American clients, it will be especially important to incorporate RS strategies into TF-CBT treatment for those clients who seek treatment as a result of race-related index traumas. Given that trauma-related anxiety and/or depressive symptoms are likely to be centered around racial experiences, clinicians may want to pay particular attention to racial pride messages that may serve to keep any negative messages

about self-worth or guilt at bay. For instance, clinicians may encourage clients to generate positive self-statements related to their race or remind them of the African American community's resilience in face of several current and historical injustices. Encouraging clients to visit African American museums may further reinforce themes of resilience that may be beneficial to the therapeutic process. Through this, clients may learn to see themselves as capable and resilient in spite of their traumatic experience. When clients seek treatment for a race-related index-trauma, clinicians should take great care during the cognitive coping module to avoid invalidating the client's traumatic experience when presenting cognitive restructuring. From the outset, clinicians should acknowledge that although negative thoughts about the traumatic experience may be true, there may be more helpful or adaptive thoughts that clients' can focus on (e.g., "Although this happened to me because I am African American, I can emerge resilient as other members of my community have in the past") that can ameliorate distressing symptoms.

Conclusion

Although evidence-based interventions like TF-CBT exist to help mitigate the negative effects of trauma exposure, studies indicate that African American youth are also less likely than their peers to receive mental health treatment or to benefit from or complete clinical interventions (Weiner et al., 2009). The literature also demonstrates that RS is a particular strength African American families and communities rely on to reduce youth's negative psychological and behavioral outcomes from interpersonal and race-related stressors (Hughes et al., 2006). To date, however, a gap remains in the examination of the ways in which these cultural processes can be utilized in trauma-focused treatment to combat the compounding impact of negative race-related experiences and racial trauma and improve treatment engagement and outcomes for African American families. RS is related to lower internalizing and externalizing symptoms in children of

color (Neblett et al., 2008; Hughes et al., 2006) and increased positive parent-child interactions (Coard et al., 2007; Smith-Bynum et al., 2016). And, although cultural modifications exist to increase engagement and improve outcomes for other racial (e.g., Latinx, American Indian; de Arellano et al., 2012; Bigfoot & Schmidt, 2010) and sexual groups (i.e., LGBTQ; Cohen et al., 2018), none currently exist for trauma exposed African American youth engaged in TF-CBT. While the limited literature exploring racial differences does not indicate significant disparities in TF-CBT treatment outcomes between racial groups (Cohen et al., 2004; Weiner, Schneider, & Lyons 2009), individuals from traditionally marginalized groups may be at increased risk for trauma exposure (Lopez et al., 2017; Roberts et al., 2010), including unique traumatic experiences directly tied to their marginalized group status (i.e., discrimination, prejudice, hate crimes). We suggest integrating cultural practices to better target precipitating traumatic stressors for this population as researchers emphasize the continued need to improve dissemination efforts for youth of color (see culturally responsive adaptations; Kataoka et al., 2010) who are at increased risk for experiencing interpersonal and racial trauma. The current suggestions to integrate empirically supported cultural practices (i.e., RS) into a well-established trauma treatment are an important first step towards providing treatment that is appropriate for each family.

We suggest that future research continue to study ways in which RS can be integrated in child trauma treatment. Once preliminary research establishes the feasibility and acceptability of integrating RS into trauma treatment, next steps may also include conducting focus groups as a means for developing a manualized adaptation, determining clinician, caregiver, and client reactions, and piloting the adaptation before testing its efficacy in a randomized controlled trial to show that RS can be readily learned and implemented while maintaining fidelity to TF-CBT, and that it can lead to improvements in trauma outcomes for underserved, high-risk, trauma-exposed

African American youth. Although the perspective of this article addresses individuals who experience racial trauma from White Americans, recent research describes the impact of cultural betrayal (e.g., cultural betrayal trauma theory; Gómez & Gobin, 2019). Future researchers could consider how RS may promote healing (e.g., via cognitive restructuring aimed at restoring clients' private regard) among individuals who have experienced interpersonal trauma (e.g., sexual violence) perpetuated by another African American. Given the preponderance of evidence demonstrating the unique challenges that African American youth face with both interpersonal and racial stressors, we must develop efficacious trauma-focused therapies for this population.

We suggest that therapists take caution and consider rethinking and examining their personal definitions of cultural competence to ensure they are providing clients of color the most appropriate care, free of biases and assumptions. Clinicians are discouraged from adopting an overgeneralized perspective of African American clients and encouraged to keep in mind that within group differences and heterogeneity exist among groups of African Americans. We also caution clinicians against taking too many liberties when it comes to adapting TF-CBT (e.g., leaving out a module or a core element) and suggest that clinicians be mindful about maintaining treatment fidelity by adhering to the PRACTICE components, as some adaptations can be detrimental and reduce treatment effectiveness (Huey et al., 2014). These suggestions may be utilized to help clinicians initiate deeper conversations that may lead to stronger understanding, rapport building, and sustained positive outcomes for African American clients. Clinicians are encouraged to seriously consider the recommendations presented in this article for African American clients to best facilitate healing strategies utilized and upheld within clients' ecologies. It is incumbent on both the research and clinical community to support these healing strategies to best promote African American youth psychological wellness in an otherwise harmful society.

Table 1. Racial socialization integration in TF-CBT via PRACTICE stages.

PRACTICE Component		TF-CBT Focus	Cultural Considerations and Racial Socialization Integration
PRAC: Coping Skills	**P**sycho-education and **P**arenting	Provide information to youth and caregiver about the prevalence of childhood trauma, common reactions to traumatic events, and the structure of TF-CBT	Inquire about cognitive and attitudinal barriers, beliefs about mental health or prior experiences with mental health and provide corrective information as necessary. Introduce RS as a protective factor
	Relaxation	Provide client with additional skills to use in different environments to manage distress	Assess beliefs (e.g., having to work twice as hard) and how the child and family relax and cope with stress (e.g., prayers and spirituality)
	Affective Expression & Modulation	Identify feelings and develop a vocabulary (behavioral, cognitive, problem solving) to use outside and in sessions to regulate or tolerate distressing emotions	Identify feelings associated with previous experiences with racial discrimination. Provide strategies to acknowledge the racial stressor by accurately appraising the source of affective change
	Cognitive Coping	Teach cognitive triangle as the association between thoughts (about trauma, self, world, family, and future), feelings, and behaviors	Process and role play techniques that teach children how to behave in hypothetical situations (e.g., when pulled over by police officers, followed by an employee, etc.
T: Trauma Narrative and Processing	**T**rauma Narration and Processing	Exposure to trauma-related memories that the client avoids or cause distress (intrusive thoughts, nightmares). Identify unhelpful or inaccurate (e.g., self-blame) cognitions that need to be processed. Put traumatic exposure into context (other good things, future hopes). Share narrative with family members as appropriate	Assess the child's/caregiver's understanding of cultural norms around trauma narratives/ "not telling family business" or "having our business out in the street." Consider culturally relevant forms of communication including fables with morals, creating a song, rap, poem, etc.
ICE: Treatment Consolidation and Closure	**I**n-Vivo Exposure	Separate harmless trauma reminders or triggers from fear (learned anxiety response). Exposure to trauma-related memories and cues and reduce avoidance	Allow clients the opportunity to practice skills that will reduce negative cognitions, emotions, and behaviors in response to future triggering racial encounters
	Conjoint Sessions	Praise, support, encouragement from caregiver. Discussion between caregiver and child	Discuss the successes of racial socialization activities that were assigned throughout treatment and the impact that they had on the client's racial identity
	Enhancing Safety	Psychoeducation on risk for revictimization. Develop safety plan to help child (and caregiver) identify risky situations, people, and places, and role-play how to respond	Develop safety plan that equips the youth with how to respond in the event of future experiences with discrimination and racism. Identify warning signs of danger (e.g., what to do when stopped by police officers). Role play new skills, ideally with the caregiver

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