The encounter between black student clinicians and the racial reckoning

El encuentro entre estudiantes clínicos negros y la estimación racial

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Abstract

This article offers an exploration into our experiences as six, Black student trainees navigating a psychodynamically oriented program located in Washington, D.C. Our experiences, which included examining political consciousness with patients, microaggressions from supervisors, and combating the "Superwoman/Strong Black woman" stereotype, were heavily influenced by the intersection of our racial and gender identities coupled with our location within the United States' capitol during heightened racial tension. Through this article, we offer self-reflections of our experiences in cross-cultural dyads and supervision, while also posing several charges for our field with regards to the recognition and inclusion of diverse voices, particularly from individuals of African descent, within psychoanalytic theory and training.

Keywords: black, student trainees, African diaspora, psychoanalysis, racial reckoning, graduate school, cross-cultural supervision

Resumen

Este artículo ofrece una exploración de nuestras experiencias como estudiantes en formación negros navegando por un programa de formación de orientación psicodinámica en Washington D.C. Nuestras experiencias, que incluyeron el examen de la conciencia política con pacientes, microagresiones por parte de los supervisores, y combatir el estereotipo de "*superwoman*/mujer negra fuerte", estuvieron muy influenciadas por la intersección de nuestras identidades raciales y de género, además de por nuestra ubicación en la capital de los Estados Unidos durante el aumento de la tensión racial. A lo largo de este artículo, ofrecemos reflexiones propias de nuestras experiencias en las diadas y la supervisión intercultural, al tiempo que formulamos varias

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reclamaciones a nuestro campo con respecto al reconocimiento y la inclusión de voces diversas, especialmente las de individuos de ascendencia africana, dentro de la teoría y la formación psicoanalítica.

Palabras clave: negros, estudiantes en formación, diáspora africana, psicoanálisis, estimación racial, graduados, supervisión intercultural

This article serves as a space for Black interiority to emerge in analytic consciousness and analytic discourse. Given psychoanalysis's history of contributing to racist discourses of Blackness and primitivism and its denial of race as an essential factor of identity, we feel that it's our racial and ethnic imperative to highlight the modern ways that psychoanalytic and psychodynamic literature continues to perpetuate racialized trauma in clinical psychology spaces. At the heart of this literature, the question is: What does it mean to be Black and a clinician during a racial reckoning.

This article is a response to the perverse action of micro and macro aggressions of assumed authority and ownership of Black bodies. This is an uncensored conversation by the pretense that too often Black people are taught to be cordial when someone invades our personal space. The overarching veil of this conversation is that Black people in the United States are still suffering from the consequences of Slavery and Jim Crow. The results of this intergenerational trauma have manifested into a variety of psychological processes such as W.E.B DuBois's "double consciousness", Hubert Harrison's concept of "Race- consciousness", Dorothy Holmes's notion of "signal anxiety", Joy DeGruy's conceptualization of "Post Traumatic Slave syndrome" to name of few. The underlying content of all of these theories is that racism is psychologically damaging to raced individuals.

To further set the frame, we want to parallel the aforementioned theories to the 2020 racial reckoning where we as Black clinicians were exposed to and co-victimized by a series of traumatic events. The timeline was commenced by the sudden death of our Black icon Kobe Bryant in a helicopter crash on January 23rd, succeeded by the murder of an unarmed Black man Ahmaud Arbery that was shot by civilians for jogging in his neighborhood while Black on February 23rd, The murder of Breonna Taylor, a woman that was fatally shot in her home by police officers while she was sleeping in March 13; On this same day, the president declared the coronavirus a national emergency and stay at home orders were executed. While at home for three months, isolated from our friends and family, which was traumatic within itself given our identification as a collectivist community, we watched as the news outlets reported that the virus was disproportionately killing Black people. The series was culminated on May 25th by the murder of George Floyd, where we collectively watched a white police officers pin his knee on the neck of George Floyd for 8 minutes and 46 seconds. We listened to a man that looked like our fathers, brothers, cousins, and sons, beg and plead for his life…uttering repeatedly, "I can't breathe".

As we were collectively traumatized by these events, Black clinicians were further threatened with annihilation due to various psychology organization's failure to publicly recognize these event's as traumatic and unjust. What some may deem a "minor" mistake was experienced as an inexplicit message that we as Black clinicians, were not seen as valuable humans, and that our colleague's ability to mentalize, empathize, and

sympathize did not extend to our Blackness. This discriminatory gesture inherently left us feeling breathless; a parallel process to knee on George Floyd's neck…. we could not breathe.

In the 1940's Lauren Berlant addressed the trauma that Black people experienced as they were denied full rights of citizenship and specifically linked this experience to the denial of Black humanity and Black interiority (Ahad, 2010). Subsequently, Gwen Bergner conceptualized the relationship between citizenship, psychoanalysis, and race with the phrase "racial symbolic" (Ahad, 2010). Her literature examines the ways that racial constructs and symbolic order work together to create racial subjectivities (Ahad, 2010). This theory emphasized the significance of the unconscious in the production of "raced- citizen subjects" (Ahad, 2010). In Tandem, Anne Cheng wrote "The Melancholy of Race: Psychoanalysis, assimilation, and Hidden grief (Cheng, 1997). Cheng utilizes Freud's model of melancholia to illustrate that social, political, and psychological factors are a complex dynamic that carries substantial material consequences in the lives of raced individuals, specifically, what we know as racial injury (Cheng, 1997). In this text, Cheng identifies Brown V. Board of education as a historical event that produced a space for the psychological response to racism and grief (Cheng, 1997). She declared this example as a momentous response to "racial injury." Cheng asserted that Brown V. Board of education provoked a psychoanalytic model by which social and political subjugation played a critical role in the formation of racial subjectivity (Cheng, 1997). This phenomenon served as psychological proof that racism was psychologically damaging as it illuminated that psychological experiences are not separate from social and political constructs because it is the very place where these constructs are processed (Cheng, 1997).

Parallel to the way Cheng observed the symptoms of melancholy in Black people in response to Brown vs. Board of education, we want to explore and process our experiences of melancholy in response to the 2020 racial reckoning. While these experiences are complemented by the aforementioned psychoanalytic references that sought to bridge the divide between the Black community and psychoanalysis, we also believe it is our racial imperative to highlight that there is still a significant gap between these two positions that puts a significant emotional toll on Black clinicians. We strive to illustrate how these racial disparities show up from the racial makeup of clinical psychology cohorts, specifically the lack of Black student representation to the white-normative psychoanalytic literature that we are exposed to in training all the way to supervision experiences where we have all experienced micro and macro aggressions as well as the lack of Black supervisor representation.

Each author is seeking to make sense of a unique, painful paradox: they are recipients of some of the most highly regarded forms of training in clinical psychology; and yet, are still so disenfranchised. They share the experience of being asked in their class papers and presentations to honor one's expansiveness and variability; and yet, when discussing race, are encouraged to minimize, avoid, and stay in an intellectual zone. They are assured of their exceptionalism; and yet, their competency in clinical training is measured against white, Eurocentric standards of excellence. They are told that others are aware of their struggles; and yet, continually made to feel invisible and invalidated. They are placed into unavoidable racial encounters within the clinical space; and yet, offered little guidance and support regarding how to cope effectively with those encounters. Whiteness is still centered and considered the default in most contemporary conversations surrounding clinical training in psychology. However, this literature is not centered

around white people. It is meant to amplify, uplift, and support Black voices. This is for all Black people -- those who are differently abled, queer, mixed, trans and non-binary.

This article is not designed to be formal or complete. Blackness is vast - a single conversation cannot attempt to contain the multitudes and multiverse. And while the majority of our authors come from the same graduate program, we believe their stories are widely understood and recognized by any Black student who has studied in a predominantly white graduate training institution. Our hope is that, as we Black clinicians recognize our deepest feelings, we begin to unlearn being satisfied with suffering, and self-negation, and with the numbness which so often seems like the only alternative in our field. That our acts against oppression become integral with self-motivation and empowerment from within.

As writer and activist, Adrienne Maree Brown shared in a blog post, speaking about the Black experience in 2020:

> I am not constructed for suffering. I am not a miraculous being meant to toil to the bone for other people's imaginations which are based in us shrinking and serving them. I am not meant to give continuously of my gifts and talents where there is no love -- that is self-denial (Brown, 2020).

We are all learning how to navigate complexity and divergent paths towards liberation. We have disagreements, we have differences and contradictions, and of course, we make mistakes. Today, we are striving for a perspective that is universal; atemporal; not solely constructed by binaries and as dynamic as possible for a wide range of audiences.

Navigating psychoanalytic and psychodynamic spaces as Black, scholar-trainees has brought its challenges, particularly as we confronted that demands of clinical training within our nation's capitol and amid a racial reckoning. Through our reflections, we hope to highlight some of these challenges, including the emotional and psychological impact of our various experiences in classes, with patients, as well as supervisors. Our experiences are not unique, isolated, or confined to our home program, or even our experiences as women from various parts of the African diaspora living in America. As such, we hope to evoke increased insight into the experiences of other Black student trainees within this field. It is through this increased insight and acknowledgement that we can strengthen the foundation of psychanalytic training, making it more inclusive to non-White participants, particularly students of African descent.

Experiences Training while Black

In the summer of 2020, I joined a predominantly white team of psychologists at a pediatric hospital for externship training. I was faced with encounters of overt and covert racism where there was questioning of my reality testing, where power and authority reigned over trainees, and where I was challenged about how I showed up in the room with other clinicians. I often brought to the attention of my white cisgender supervisor my fears of not being seen, given my Black identity, not only in our supervision, but in the entire facility through training, which ultimately influenced my work with patients. While I was met with empathic statements, gas lighting occurred, and I often suffered retaliation at the hands of the faculty in the form of not being assigned patients of color

against my desires, and the level of micromanaged supervision over me - I was watched closely. When I raised concerns about the depiction of Black patients with labels of aggression and frequent diagnoses of Conduct disorder and Oppositional Defiant Disorder given significant consequences of these diagnoses in the Black community, I was reminded of my credentials - that I am NOT a licensed psychologist, hence my training and supervision by licensed psychologists. Conversations alluded to the idea that because I was in training, I was ill-equipped to provide hypotheses and disagree with diagnoses, which ignited anger and fury and the need to protect my Black and minority patients from my white counterparts.

In sharing these moments of racial encounters during my training, I think about the differences between the better and good experiences of supervision, versus the worst of my experiences. I think about what each supervisor has likely brought to the table, in conjunction with my clinical identity, to create a collaborative experience, versus a dictatorship through the dismissal of marginalized communities. I think about the words of Audre Lorde

> in order to survive, those of us for whom oppression is as American as apple pie have always had to be watchers, become familiar with the language, and manners of the oppressor, even sometimes adopting them for some illusion of protection. (Lorde, 1997, p. 374)

Being "free" and involved in actions like those who are not oppressed, is almost non-existent. My identity as a Black woman has limited me in ways much like Audre Lorde, having adopted the language, look, style, and manners of the oppressor to stay alive, figuratively, and literally. Historical and systemic issues have placed me in situations where particularly when at primarily white institutions, expectations exist along the lines of surviving in the white spaces that I am a part of or leaving. I associate "Apple Pie," with the exploration of gender and race; specifically, the intersectionality between race, gender and when in white spaces, renders my identity as a Black woman has often been misrepresented and deemed incompetent. The reality is not simply about learning theory and textbook material, or citing literature for that matter, but like "Apple Pie," being competent and looking "good" in a way that white people approve of in a chameleon-like manner. Apple pie at the root of colonialization and slave trade, much like oppression in America, but made to look "pretty" on the forefront. It speaks to the "Uncle Tom" syndrome most Black women face in academia because they are at the bottom of the barrel and struggle to earn deserved respect. The most disrespected person in America is the Black Woman. I contrast the experiences of Black women in America versus White females of the feminist movement in America. Feminists like Naomi Weinsteein, who although discriminated against because of her gender, was able to receive a level of respect that differed from her counterparts of color. While feminists like Karen Wyche, a professor of Psychiatry and Behavioral Sciences at the University of Oklahoma, battled with competency, race, and gender as it related to reality testing. Being a Black woman learning in White spaces in America has equated to adaptation and adjustment without question when rules are unevenly leveled against us. A simple recreation of slavery violating our culture through our physical bodies and manipulation of the mind. The expectation: Blacks should get past their negative experiences because there is a job to be done.

Training in Washington, D.C.

Upon entering my doctoral program in the Fall of 2018, I was introduced to a variety of psychoanalytic and psychodynamic trains of thought. Being new to the psychoanalytic world, many of these concepts initially felt odd and unfamiliar to me. The idea of "being a blank slate" was discussed, however; my professors appeared to hold more contemporary views with regards to the clinician's role within a therapeutic dyad. Although they often vocalized a more modern view that differed from classical psychoanalytic theory, I still felt a resistance and hesitancy to bring oneself fully into the room. This was evidenced in each course I enrolled in via discussions that centered self-disclosure. I observed and participated in lively debates centering the potential pros and cons of disclosing information, such as one's hometown, one's place of undergraduate study, and details of one's family (e.g. family composition). While these matters felt trivial to me, they did not stand out nearly as much as discussions that centered disclosing political affiliation and identity. As we were halfway through Trump's presidency and literally blocks away from the White House, this debate of whether it was appropriate to discuss politics or disclose political views with patients was extremely activating. As a first year student, who was new to clinical training and new to psychoanalysis and psychodynamic thought, I did not fully understand what was activating about this particular debate--but I knew that something about it felt off.

After further reflection coupled with beginning practicum the following summer, I began to understand why the notion of even questioning the appropriateness of discussing topics centering politics and social justice in therapy was activating. The ability to distance yourself from politics is a form of privilege, typically held by individuals, who may not hold one or more marginalized identities. As a cisgender Black woman from the South, my very existence is political. Due to my visible identities, communicating political views is a form of disclosure that provides safety for not only myself, but may also provide safety for those with whom I work with clinically, especially those who hold marginalized identities. However, this form of voluntary self-disclosure was often preceded by assumptions associated with my involuntary self-disclosures--my race and gender.

Typically, therapist disclosure applies to either nonverbal or verbal therapist behaviors that reveal something personal about the therapist to the patient (Constantine & Kwan, 2003). Examples of nonverbal therapist disclosures may be gender presentation, race and/or ethnicity, and marital status (e.g., wearing a wedding ring or band. Other forms of therapist disclosure that are verbalized, which may pertain to their thoughts or feelings about the patient, have been referred to as *self-involving statements* (Danish, D'Augelli, & Brock, 1976). The goal or motivation related to the potential benefits of therapist disclosure is the belief that it will assist in facilitating a connection between therapist and patient, thus leading to the establishment and maintaining of rapport and the bond between therapist and patient. Additionally, it is thought that a therapist can model human exchange via disclosure, thus inviting the patient to engage in a more open exchange. Further, via self-disclosure, the therapist is better able to disrupt the existing power dynamic within the dyad, which may contribute to the patient feeling objectified (Audet et al., 2010).

While the goal of therapist disclosure is often to increase engagement and support rapport, these goals are not always achieved. Because self-disclosure is known to influence treatment outcomes, understanding how all forms, especially nonverbal forms,

of self-disclosure can influence the therapeutic alliance is vital for understanding potential implications for treatment. Much of the self-disclosure literature related to physical characteristics, such as gender presentation and race/ethnicity, has emphasized White, often cisgender women, engaged in a cross-cultural dyad. My identity and physical presentation as a Black woman embody a non-negotiable and irrefutable form of self-disclosure that shapes my clinical experiences at first introduction. Kimberly Leary (1997) discusses this experience, and goes on to note that many of her clients of color have sought her out due to her racial identity, allowing for the opportunity to process the realities and fantasies associated with the patient's choice. In contrast to Dr. Leary's experiences as a clinician in the professional realm, as a student clinician, I am assigned patients regardless of choice. This difference in the introduction and formation of the initial therapeutic alliance is significant, as the pressure to discuss the realities and fantasies associated with our race may feel intensified in cross-cultural dyads. This feeling may be particularly intense in dyads involving a therapist from a marginalized background, who is paired with a patient, who does not hold a marginalized identity.

As I continued my clinical training throughout 2020, this became increasingly apparent. My visible identities coupled with the racial reckoning of America infiltrated many of my therapeutic dyads, specifically cross-cultural dyads involving cisgender, queer white women. Given my physical characteristics and presentation as an unambiguously Black woman, patients often made assumptions about my identities and affiliations. In several first sessions with White patients, I was met with awkward and misplaced stories centering their experiences of racist family members followed by fumbled apologies and a shaky disavowal of their own racist biases. As these occurrences centering race and politics continued to arise in my work with patients, I often found myself ill equipped to navigate these conversations with patients, as my instincts rarely aligned with theory and discourse that had circled around me during my first two years of doctoral studies. Leary (1997) notes her tendency to address race, particularly racial difference, early in treatment, which is a practice that was suggested throughout my psychotherapy courses. But how do you navigate these conversations when you are not who initiates this conversation? Or when your mere presence evokes a level of discomfort in your patients? Additionally, as your race is directly reflected in current events, such as the ongoing murder and public abuse of Black bodies, how do you begin to process these experiences with non-Black patients, especially when self-disclosure or "political" discussions are viewed as taboo?

Although the two aforementioned interactions differed, they both illustrate a dark similarity in their message: our voices, our advocacy, our own cultural awareness are not welcomed. You are to be silent, unseen, and unheard. This message, especially when communicated to trainees of color, appears to parallel the not-so-subtle messages of psychoanalysis' foundation. It was not until 1954 and 1958 that the first Black individuals, Margret Lawrence and Ellis Toney, respectively, graduated from American Psychoanalytic Association institutes (Stoute, 2017).

Due to our role as trainees, we are often assumed to be less knowledgeable. Our status as "expert" is nonexistent when in communication with our implied superiors, such as professors and supervisors, just as Black individuals have been seen as intellectually inferior throughout history. Specifically, within psychoanalysis, early analysts, such as John Lind asserted that the "Negroes' development is lower than the white race…similar

to those of the savage," and that "their psychological activities are analogous with those of the child," (Lind, 1914, p. 295). It is the foundational views of early analysts that continue to permeate today's training. Although not explicit, the messages are clearly received through actions riddled with dismissiveness, silencing, and microaggressions. In order to remove ourselves from these reenactments, historical views and perceptions must be brought to the field's collective consciousness and patterns must be addressed and corrected.

Supervision while Black

I struggled to formulate my thoughts and questioned the organization of this piece wondering how the written structure might be viewed by others. I struggled with supporting literature, and ways I might want to articulate my thoughts given the number of racial encounters endured. Consultation with another author of this paper, a Black woman, took place to help locate and organize what I wanted to communicate. A level of validation if you will; and yet another replication of what Black people face before distributing their thoughts in White spaces. Constant questions of thought, language, validity, reality, and creativity, while providing treatment and services to patients coupled with learning the "rights and wrongs" of the field. A constant worry of who may or may not understand, the majority being White people, and providing adequate literature to support and communicate the proof of experiences.

As I sift through supervision and the racial encounters of many Black clinicians in the field, I ground myself in some literature and rely on my own experiences to speak to the importance of a working supervisory alliance—inclusive of all identities. Simply because the majority of the literature present is inclusive of Eurocentric theories and how a clinician might approach supervision with their white supervisees and patients. While there is some literature indicative of culture and diversity, *we,* Black clinicians are often left with the question of how we might approach our white supervisors who are ignorant of their privilege and white fragility, and whose job is it to initiate topics of race given historic review of Black and marginalized populations being tasked with the more difficult pieces of a conversation, and how might our identities present itself in the supervisory dyad and triad while providing treatment? We ask ourselves these questions and are often taught in training the importance of consultation, rather than considering perspectives of marginalized individuals tasked with our unanswered questions—for lack of better words, ultimately picking up the pieces ourselves and learning through traumatic experiences. The majority of the field can agree that supervision is vital to the development of a clinician's identity. It is inclusive of the learning and teaching of both parties, where processing encounters of the dyad and triad can be explored. However, the majority of marginalized communities in the field are tasked with holding the heavier side of "teaching" both our colleagues and supervisors, rather than feeling safe as a clinician in training to explore, speculate, and think vividly about who we are and how we might show up when interacting with patients, colleagues, supervisors, and teachers. We are often left wondering who might show up for us when hurt, ridiculed, gaslit, and insulted, leaving us no choice, but to painfully grow in our own clinical identity.

In a recent description of racial encounters experienced in the field, Dr. Annie Lee Jones referred to the importance of freedom for a Black clinician in a supervisory

relationship in white spaces (Jones, 2020). The resignation of freedom speaks to the symbolic history that our country has subjected us to, given non freedom and conformity within slavery. It speaks to the generational mishap of being limited while learning in white spaces, with little to no room for *us* to represent ourselves and show up for our communities. To provide some context, I located racial encounters in the year 2020 where the rise of Black Lives Matter protests existed after the senseless killings of Ahmaud Arbery, Breonna Taylor, and George Floyd. A time where the United States president encouraged hate crimes against protesters, labeling them as rioters, and in the midst of a global pandemic. I'd like to begin with a few factors to locate my cultural exposures regarding Black culture, all of which have contributed to the development of my identity as a person and my clinical identity in the field.

Daughter of an immigrant via Guyana, South America, and descendant of enslaved peoples, I identify as a Black, cisgender hetero sexual, able bodied, Christian woman (she, her/hers). My economic status is associated with middle to upper class, having been raised in the northern part of the East Coast. I've lived in the Southern part of the East coast, which includes Alabama and North Carolina for 6 years, prior to moving to the District of Columbia to begin my tenure in my doctoral program. I have been met with explicit acts of micro & macro-aggressions inclusive of supervisors touching my hair, being held to higher clinical standards than my white colleagues, and my career being threatened when not meeting those standards. I have also been pathologized after recognizing and speaking about acts of covert racism, where my reality testing was questioned about events experienced and described. While all experiences, both good and bad, have been profound and of importance, I'd like to shed light on a few experiences, particularly given the historic context of Black women. Those being, the violation of our physical bodies and the manipulation of our minds at the hands of white ignorance and fragility, often resulting in fear, withdrawal, and question of self, a trauma response often not acknowledged in the Black or other marginalized communities by our White counterparts.

Case Example: Blue

I remember vividly scrolling through social media for my next birthday hairstyle. Our hair is a statement of not just our appearance, but our character, it is our crown, and embodies the epitome of a Black woman's strength and emotion. And further, always should be respected. Blue was my desire, but my dilemma was every mental battle a Black woman experiences: the perceived lack of professionalism if my hair were of a different color than the brown I was birthed with or rejection of my tightly coiled thicke stranded hair, different than that of the accepted westernized straight hair. Live and colorful, which is often demonstrated through my hair, complementing my unique Black personality is how I felt. Consultation took place as I asked 3 colleagues and a friend if I should continue with blue appearance or resort to the typical straight dark hair my colleagues were used to seeing me with. I received responses including, "Are you sure? They already think of you as disorganized," based on a false depiction of my character, and "Do it girl, it's just hair." So, I did it! — and encountered my white cisgender supervisor. Her response, "I love your hair, it's so pretty and reminds me of the show my daughter watches, *The Descendants*," as she casually caressed my hair. I froze and at the time, could only see white hands and black fingernails. My thought process included never telling a soul so as to avoid drawing further attention to myself because it was my fault, I chose to wear blue hair.

Shame is a common emotional reaction following the violation of one's personal boundaries. The invitation that was never extended and the expectation of consent and ownership of Black bodies is just another historical precedent that continues to infiltrate our encounters with non-Black individuals, even in professional settings. Aside from the violation of the physical boundary, it is evident that this encounter was also influenced by a lack of cultural competence. Wong and Wong (1999) developed the Multicultural Supervision Competencies Questionnaire (MSCQ) which aimed to assess supervisor's cross-cultural competence across four scales: attitude, knowledge, skills, and relationship. As described above, hair in the Black community holds special and numerous meanings. While it is impossible to know the nuances of every culture, this interaction illustrates several imperatives for supervisors in cross-cultural dyads to consider. Supervisors must take heed to reflect on their attitudes centering boundaries and access, especially when working with individuals of African descent whose boundaries have historically been ignored and violated. Additionally, knowledge and curiosity into supervisee's culture is vital in facilitating a safe and trusting supervisor relationship. However, the onus to educate one's supervisor about their unique cultural norms should not be placed on the supervisee. Rather, supervisors should pause in both their assumptions and curiosity of their supervisee and take time to review culturally specific literature. Thus, not only communicating genuine interest and respect for their supervisee, but also developing their supervisory skillset and strengthening the relationship.

Racial identities and shared racialized experiences

Black mental health has taken center stage in the midst of a racial movement and racial reckoning that is being recognized by mainstream media. The idea of Black Lives Matter is not a new phenomenon for Black people, we've always felt this way about our collective. But there is something unique about the tasks of a Black therapist during this time when more Black people are seeking mental health treatment, whether for therapy or assessment. I operate from a standpoint of only working with Black patients. I requested to only work with Black patients at GW's Center Clinic because I'm aware that there are many patient requests for Black clinicians that are often ignored or unanswered and I wanted to make myself available to patients in that way. The work that I do is very personal because I'm working with people within my community. There's a certain sense of familiarity and comfort that comes with working with someone who looks like you. I realize the responsibility that I have to not give in to assumptions that may play out in these therapeutic dyads, such as "oh, you know what I mean" or "my White supervisor microaggressed me again." So, the intersection of being a Black student and therapist is multi-faceted and requires a lot of self-reflection. I have to reflect on my responsibility of promoting Black mental health wellness and being aware of the current struggles that my patients face because I am also experiencing the racialized violence. My experience is that many patients want to talk about the executions of Elijah McClain, Ahmaud Arbery, Breonna Taylor, Dreasjon Reed, or George Floyd, express their anger, and be vulnerable in discussing how they are coping. Other patients, however, choose to gloss over the subject because they would rather not think of their pain, as they may need to save their energy for a protest that they plan on attending. It's more important for me to hold the space for patients in either scenario and help them to feel contained as they think about their own safety and other matters, such as the performative acts of public companies that promote Black Lives Matter in service of maintaining profit from the Black community. I also realize that I have to hold space for my own anger and disgust, which is particularly taxing in a White training program in the District of Columbia.

Oliver is a Black patient of mine who often reflected upon his work environment. In this short vignette, he, like myself, expressed his experience of double-consciousness (Du Bois, 1903) within the workplace, which parallels my performative professionalism within the academic environment. “Nobody trying to hear a Black man complain. Really, with George Floyd, and then after that it was like, okay, we all understand, you know. And it's like, no, you don’t. No, don't lie. And you've seen a video like that that's happened to multiple people and that's not the first guy that’s ever had a policeman on his neck to kill him and so. Yeah, that's the emotion. Trying to figure out how to merge those would be great, but I don't even know if that's possible. I can't be out here storming the Capitol (Munn, 2021) but being able to actually have feelings behind what I say will be important. I can't really pop off like that like a White person at a police officer or pop off while I'm at work like the other people, because I still have to navigate this thing called America as a Black man, as a Black person in general”.

It’s clear that, per usual, Black people have to deal with their traumas publicly, as when having to educate a White supervisor about a patient’s decision to suppress their feelings in order to get through their workday. It is voyeuristic and leaves little room for White colleagues to self-reflect on what they uphold and enact. The intersection of being a Black student-therapist during this racial reckoning is unprecedented because I do not think any amount of research or training could have prepared me for this moment in America’s history.

Taking Care of Self: Combating the “Superwoman” Stereotype

Perfectionism is exhausting, and yet as black women, we are tasked with it. At the intersection of blackness and gender identity, we know the need to fight for ourselves all too well, as we were not thought of through the women’s suffrage movement of the early 19th century and similarly, often are not spoken about within the context of police brutality. A report from the Washington Post indicated that while black women account for 13% of the population in the United States, they make up 20% of the women fatally shot by the police and 28 % of unarmed killings. Combine this with the percentages of black women pursuing higher education (64%) and being the highest educated group in America, and you can start to see the beginnings of black women being tasked to be superwoman. Our resilience is often marked, but there is a failure to see us as human beings who are continuously having to be resilient due to continuous sociopolitical and cultural trauma. To many of us, we are tired of being spoken of as “resilient,” when in all actuality, we would rather have a time to experience peace and to not have to experience continuous uphill battles that attack the fiber of our being. Our resiliency is the product of capitalism in which we are the “little engine that could” without anyone caring about how the engine will refuel, when the engine will refuel, or what if the train would simply like to be seen for what it is rather than what it can produce.

It is therefore no surprise, structurally, that the field of work black women tend to occupy are the service, healthcare, and education industries, in which despite being necessities of civilization are paid the least. This is parallel to our experience, as my colleagues have described the ways in which we have repeatedly been charged with educating our peers and supervisors all while being within our own training. Rather than having an experience of support and care, our pain was often used in the service of others

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- with no compensation or exploration of how it may feel for us to constantly relive our traumas whilst simultaneously still being traumatized. Watson and Hunter (2015) articulate that the "Strong Black Woman" schema dates back to slavery and continues to exist as black women still experience financial hardships, primary caregiving roles, and racism and sexism. Further they posit how our resilience is based on a sense of self efficacy, self reliance and self silence. This leads us to feeling like failures if we are unable to self soothe, as if we deserve to suffer in silence (Watson and Hunter, 2016). Over the years researchers have begun to see how this is affecting the mental health of black women. Black women may inhibit their emotionality and may view needing therapy as "weak" thus exacerbating symptoms of anxiety and depression. Thus black women are faced with the conflict of appearing emotionally unaffected and hiding their vulnerability due to the harsh societal expectation that they can only be strong through being silent.

Case Example

For the purposes of this case example the patient's name and initials have been changed to protect her identity. KJ is a 26 year old cisgender heterosexual woman who identifies as black and Puerto Rican. Similarly, the therapist is 25 years old cisgender heterosexual woman who also identifies as black and Puerto Rican. The culmination of our work has surrounded closeness in identity, and what it means for her to have a therapist who represents and parallels many of her experiences with identity and culture. Usually, in our work, KJ finds our closeness to be disorganizing but these transcripts were the beginning of a change in our treatment, as I found myself more vulnerable and disclosing more of my own sense of self as we both processed the racial reckoning happening simultaneously with the pandemic.

It is further important to note that KJ is also in the helping profession, a doctorate level student, taking her comprehensive exam around the same time as I was, which also highlights both the parallel process that we both were grappling with in being tasked to be "superwoman." KJ has experienced the world and others as "uncaring" making it hard to provide that self care, love and nourishment to herself. In this session, she finally shares her experiences with her parents as she reconciles with what is happening in society.

Session 1

KJ: Yeah. So, I had a breakdown and cried and like you know that is hard for me to do but I had a moment.

Therapist: (nods)

KJ: Idk just everything came flooding in at once. I thought about ____ again, and then just like how I've been holding everything in and how I've felt I had to hold it in for all these years because of the pressure of being black and just my family's expectation too

Therapist: It seems like a lot was registering for you.

KJ: (laughs) yeah it was but I just started seeing things and making connections and once I started it became really hard to stop. And then it was like you know, I appreciated our space to just be able to talk about what's happening in the world

and when we weren't meeting and black people kept getting shot and then Chadwick Boseman died.. it was just a lot.

Therapist: (nodding) yeah, these weeks have been extremely heavy and you were left to hold a lot of that on your own without a space to process it.

KJ: Yeah, like when Chadwick died I just think that was when everything hit. Like how much more are black people supposed to take? How much more are we supposed to be strong about?

Therapist: I think a lot of us have been feeling that way and have been in touch with the deeper level of pain that keeps occurring. I'm sorry that you had to sit with that while also being in the middle of comps.

KJ: Yeah, yeah. Which is why I'm glad I had the extra time to take it because I felt like I was all over the self and it felt so hard to separate what's happening in the world from what's happening in my life and it just felt like they were all jumbled.

Me: Well, maybe they aren't all that separate. Your feelings about what's happening in the world can be valid to enter where you are with things as well.

KJ: Yeah, and I guess I came to that when I finally broke down and everything hit because I realized I was expecting so much from myself too because I am black and it just hit that maybe I don't need to do that and it's ok for me to need therapy and medicine, even if I don't like it all the time, its ok. I deserve care.

Session 2

KJ: Well I actually talked to my parents after our session last week!

Therapist: Wow thats big for you

KJ: Yeah! idk it was after Breonna Taylor and I was just feeling really defeated and remembered our convo here and my parents' convo and I just felt like I needed to let some of it out.

Therapist: It's a lot to hold. The news regarding Breonna Taylor broke right after our session last week and I immediately thought of you.

KJ: Yeah, same. I was filled with so much anger and sadness and just defeat, like I really felt betrayed.

Therapist: Im reminded that you said that it felt the world was impinging in and I can imagine there's that sense both as black woman and within this convo with your fam

KJ: (details convo) Yeah, exactly… And that was the other thing, like not only was I extremely vulnerable with them and was able to open up about my own abandonment and trust issues and how a lot of the things that they've done have made me feel but they were able to be vulnerable with me too, especially my dad and it was like woah.

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> Therapist: It seems like you opening up allowed room for you to hear more from them.
>
> KJ: Yeah and it really meant a lot to me to see my dad get emotional because he even mentioned that he realized he also puts his emotions on the back burner and was sad to see that I've done the same and thanked me for bringing it up.
>
> Therapist: you really needed to hear that.
>
> KJ: Yeah because you know my dad and I just haven't always had that kinda relationship. And I do think I needed to hear that because black men have just been fucking up for us lately and I really needed to hear that my dad could be emotional with me and would protect me no matter what.
>
> Therapist: to feel protected in a world where you haven't always felt that.
>
> KJ: Yeah because in what world does someone support these black men that keep doing this? It's like Tory shot Meg but yet black men are still supporting him. Daniel Cameron was the one in charge of Breonna Taylor's case. We can't get any help. Like we fight for them but then we dont matter either and it hurts. How can we do everything and get nothing?
>
> Therapist: It's painful and it's angering. Hard to make sense of. We shoulder it all.
>
> KJ: Yeah it's like. Megan, too. She's pretty, smart, and accomplished and she still gets shot? And then people don't believe her and it's proof. There's proof and still no one believes her. I just don't get it?
>
> Therapist: I get the sense that you're describing a bit of hopelessness there, that if it could happen to her...
>
> KJ: Then it could happen to any of us because really what is there to aspire to? I can't say I hope that if I become successful I will be protected because I know even then, it's not true.

These sessions with KJ and many more are some of my favorite times of working with her because of the closeness I felt with her. It is then interesting for me to reflect on this work and to see that even in my disclosure, the ways in which I spoke in the displacement and was defensive or avoidant to my own vulnerabilities by saying "you were left alone," "it was a lot to hold," when the reality is that I, too, felt alone. KJ was my only patient that was a black woman and therefore, perhaps my only patient that fully saw me. Further, in this transcript, I apologize for her having to sit through these emotions while preparing for comps, knowing that I was in the exact same shoes and left with little to no support. What does it then mean to be a mirror to your patient in the ways that they are for you?

That was my experience in my work with KJ and especially through these sessions, as I struggled with wondering if I was "doing therapy," and more specifically if I was doing "proper psychodynamic work." I landed on the response that I was giving my patient what she needed, which was to be seen and to not feel gaslighted by both reality and her therapist. What would it have meant for her to have a black and Puerto

Rican clinician only for said clinician to pretend she was fine? In doing so, I would have been modeling a schema that has been so harmful and detrimental to our own being. It is because of this that I think the best gift I gave my patient is the best gift that she gave me - our real selves, our pain, our truth, and our tears. We all have a breaking point and within the context of a global pandemic, racial reckoning, and academia we, as black women, deserve to be able to have that and to be able to be held within that.

My sessions with KJ perhaps also parallel my experiences with my relationship with my colleagues, in that in the midst of this year we had each other. A saying that we all know too well… Black women have each other. We have our community and in that, we can find safety. We can breathe.

Conclusion

It is our hope that in reading our experiences, that you can hear our voices. All unique. All individual, but all sharing one message. We do not exist in a vacuum and only to be seen in use of service to others, rather than our humanity. A humanity that time and time again is overtasked and under-supported. We tell our stories for the other Black, scholar-trainees navigating spaces all too similar to our own. We tell our stories to highlight the demands we faced and the community we shaped for each other through the acknowledgment of the shared trauma and that we were stronger when confronting it together. We tell our stories knowing that while our literature is not centered for the appeasement of whiteness, that it will be taken in and exist within white spaces. It is therefore our hope that our white counterparts will read our open letter and gain insight into black students and trainees within this field. It is our hope that the topic of "diversity and inclusion" is not said in a performative, liberal manner but is infused into every fiber of a program's essence- from it's professors, supervisors, student body, and patient demographics. It is our hope that the future of black doctoral students is not shaped by an existence of invisibility, invalidation, and gaslighting but is one where their voices can be included, amplified, and uplifted through questioning, challenging, and ultimately, strengthening the core of psychoanalytic training.

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