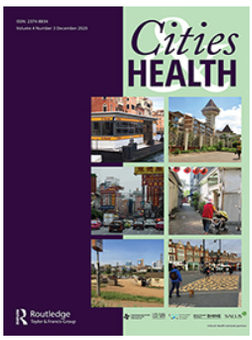

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Practitioner driven psychological resilience interventions in urban communities facing minority stress and public health emergencies

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ABSTRACT

Current uses and interpretations of psychological resilience by behavioral health practitioners are contextually blind to social and political issues requiring psychological resilience. This contextual blindness leads to inaccurate case conceptualizations, ineffective interventions, and microinvalidations in healthcare (MIH). This paper highlights the synergistic nature of micro and macro issues while outlining practical implications of infusing both perspectives into healthcare practice for Black women in an urban American city context.

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Microaggression; racism; mental health; psychological resilience; socioeducation; implicit bias

Introduction

In health professional settings, the concept of psychological resilience has become a standard term used to describe a set of cognitive skills, behaviors, and instincts used to successfully adapt to immediate and long-term effects of stress, trauma, and adversity. The primary premise of resilience theory frames stress and adversity as commonplace and highlights an individual's capacity to recover from and possibly experience growth as a result of stress or crisis (Allen and Henderson 2016, p. 166). Psychological resilience pedagogy is taught and promoted within and outside of educational and healthcare settings across the USA. While psychological resilience is a helpful framework to understand and promote recovery from adversity and stress, a narrow view of resilience and subsequent resilience interventions often fail to attend to ways in which environmental injustice, structural racism, harmful gender norms, and classism operate as negative social determinants of health (NSDOH), especially for Black women and other people of color. Devaluing or ignoring the impact of these macro or societal issues while promoting individual resilience within healthcare settings can unintentionally reinforce NSDOH and prime healthcare interventions to deliver harmful microaggressions during client and provider interactions. This paper highlights the synergistic nature of micro and macro issues, outlines practical implications of infusing both perspectives into healthcare practice, and makes intervention considerations for helping Black women in an urban American city context. This paper focuses on providers engaging in critical self examination and its impact on service delivery. Therefore, the author makes no specific recommendations about training and recruitment, but highlights the opportunities for higher education institutions and licensing boards to implement new approaches and requirements.

Microaggressions, contextual blindness, and socioeducation in healthcare

Racial microaggressions are subtle forms of racism manifesting as everyday slights, insults, putdowns, and offensive behavior that people of color (inclusive of others with marginalized or minority identities) experience daily in interactions with generally well-intentioned White Americans who may be unaware they've behaved in demeaning ways (Sue *et al.* 2019). White healthcare practitioners often deliver unintentional and well-meaning racial microaggressions toward Black people throughout treatment due to implicit bias and belief in racial stereotypes (Acholonu *et al.* 2020, Kanter *et al.* 2020, Sandoval *et al.* 2020, Sotto-Santiago *et al.* 2020) which results in misdiagnosis, invalid interventions, and inaccurate treatment recommendations for Black patients (American Psychiatric Association, 2020; Hoffman *et al.* 2016, Sandoval *et al.* 2020). Relevant literature offers several interventions and frameworks aimed at reducing or effectively responding to microaggressions in healthcare (Acholonu *et al.* 2020, Kanter *et al.* 2020, Sandoval *et al.* 2020, Sotto-Santiago *et al.* 2020), however; many studies lack empirical evidence of long-term effectiveness (FitzGerald *et al.* 2019). Continued exposure to bias maintained by society and institutions outside of the intervention or study environment may reinforce thoughts and behaviors leading to microaggressions (Fitzerald *et al.*, 2019) such as ethnocentric monoculturalism. Ethnocentric monoculturalism occurs when one culture upholds its culture and history as superior and also has the power to impose and

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implement its cultural standards when making value judgments of right vs. wrong, good vs. bad, or normal vs. abnormal, and in the case of behavioral health, adaptive vs. maladaptive (Sue 2003). Using ethnocentric monoculturalism as a framework, perceived power dynamics inherent in provider and client relationships and established racial hierarchies in the USA, whereas most of the power is typically attributed to and/or held by the provider in interracial provider and client relationships, the provider's cultural framework and worldview may be imposed onto the client and the client's culture, context, and worldview may be diminished or pathologized within the helping relationship. While well-intended, this diminishing and invalidating behavior often manifests as an overreliance on building individual resilience instead of centering and validating the client's lived experiences of minority stress related to structural and societal issues contributing to NSDOH. According to microaggression theory, this diminishing behavior is a microinvalidation because it nullifies the experiential reality of the client of color (Sue *et al.* 2019) and allows the provider to remain contextually blind.

The work of (Shaia *et al.* 2019) teaches us that context-blindness is the inability or unwillingness to investigate the relevant political, social, and historical conditions requiring resilience. Void of a holistic, honest, and comprehensive view of resilience, practitioners can view minority stress as an absence of resilience instead of a normal and adaptive response to social and environmentally engineered pressure or social engineered traumas (SET). Socially-engineered traumas (SETs) are defined as traumatic events rooted in social forces of oppression and inequality (Shaia *et al.* 2019).

It is incumbent upon health practitioners to understand the SETs impacting the client, explicitly name and denormalize 'normal' SET-inducing practices, and overtly acknowledge the everyday microaggressions causing stress and other mental injuries when working with clients of color to build resilience. Many practitioners choose to remain hyperfocused on behavioral changes that will demonstrate achievement of resilience skills instead of critically examining fractured systems requiring continuous resilient responses. This narrow and heightened focus on resilience can lead to interventions that lack psychopolitical validity. Psychopolitical validity refers to the extent to which research and action take into account power dynamics in psychological and political domains affecting oppression, liberation, and wellness on the personal, group, and community levels, (Hage and Romano 2013, p. 18). If a client is unaware of fractured systems leading to stress and adversity, practitioners should use their clinical judgment to assess the client's readiness to engage in socioeducation and offer socioeducation as an intervention. Socioeducation describes the act of assisting clients to reinterpret their experiences through the lens of SET (Shaia *et al.* 2019).

Importance of health professional critical self examination for work with Black women clients

Ensuring psychopolitical validity of interventions requires the practitioner to accept that conscious, unconscious, and ethnocentric biases are held by everyone and that biases held by White healthcare providers about Black people are often false, fantastical in nature, and are harmful or even lethal for Black clients and patients (Sue 2003, Hoffman *et al.* 2016, Kanter *et al.* 2020). After this acceptance, a viable first step for health practitioners seeking to ensure their resilience-focused interventions are delivered within the proper social and political context would be to engage in socioeducation for themselves while actively seeking professional consultation and development opportunities related to bias and multicultural counseling. The practitioner should also anticipate how critical self-examination could be personally and professionally challenging and bring about intense feelings of defensiveness (Nichols, 2010). At the risk of discomfort, the practitioner may wish to center the impact their increased awareness would have on efficacious practice with Black clients (e.g. better treatment outcomes and decrease in health disparities), especially efficacy when working with Black women contending with stereotypical 'Strong Black Woman' and ' Black Superwoman' expectations related to stress, coping, and resilience.

Woods-Giscombé's (2010) research on the superwoman schema found five themes when exploring phenomena present within the Black Superwoman persona. Black women's roles were grouped into five major topic areas: obligation to manifest strength, obligation to suppress emotions, resistance to being vulnerable or dependent, determination to succeed despite limited resources, and obligation to help others (Woods-Giscombé 2010). Internalization and manifestations of the superwoman role within Black women and a healthcare provider's overreliance on contextually blind resilience-focused interventions may deepen the harmful effects of the superwoman persona such as emotional suppression and obligatory caretaking. A provider's inability to relate to a Black women's racial and gendered realities may make the health interaction feel unsafe, resulting in emotional suppression behaviors (e.g. silence or reluctant agreement) that are contraindicated for optimal health and well-being. Additionally, Black women who have been obligated or feel obligated to help others may choose to facilitate the critical self-awareness process of their practitioner and educate them about SET when they've become aware that interventions are socially and politically decontextualized. This teaching and facilitation process can result in harmful role reversals, additional psychological labor, and provider/client

relationship ruptures for Black women in a setting that expresses a desire to help them decrease or manage psychological or somatic pain. This role reversal invalidates the client's experiences and centers the needs and gaps of the provider, subsequently delivering microinvalidations in the helping relationship.

Therefore, a deep critical self-examination on behalf of the practitioner paired with an emphasis on psychopolitical validity of interventions can strengthen client/provider alliances, client case conceptualizations, treatment, and prevention efforts. This critical self-examination will prepare the practitioner to parse out centralized client issues from larger systemic or environmental issues and then make interventions more holistic and realistic while also validating and informing future resilient responses for clients facing minority stress.

MicroInvalidations in healthcare

A practitioner's unwillingness or inability to critically examine their bias while simultaneously considering, deeply validating, and legitimizing client stress responses related to current and historical issues of systemic and interpersonal injustice during an intervention could lead to microinvalidations in healthcare (MIH). Microinvalidations in healthcare can stem from ethnocentric monocultural ideals allowing the health professional to use the power dynamic and privileges inherent in the helping relationship to ignore or overlook the effects of SET and other intersecting minority stressors while centering their worldview and making the intervention psychopolitically invalid. MIH diverts attention away from and undermines real health consequences of SET during healthcare interactions. Clients experiencing MIH can experience confusion, disempowerment, guilt, feelings of insanity, and an inability to understand and safely respond to their intersecting realities.

Although well-meaning, the absence of psychopolitical validity of interventions blindly deepen and amplify SET, fosters a dependency on health practitioners, and reinforces helplessness – the direct opposite of resilience promotion. MIH weaponizes health interventions and healthcare practitioners become tools utilized to uphold unjust systems causing SET instead of agents promoting contextualized resilience and empowerment. Shaia *et al.* (2019) suggest the SHARP framework (See Figure 1) for social work practitioners to co-explore the historical and systemic causes of social injustice as well as approaches to reclaiming social power. The SHARP framework recommends five points of consideration when working with clients. Points include structural oppression, historical context, analysis of role, reciprocity, and mutuality, and power. Although SHARP is presented as pedagogy designed for social work practitioners, it has utility for allied health professionals working in ethnically diverse urban environments during public health emergencies such as COVID-19 and racism.

Case vignette

Globally, there is a collective awareness surrounding the power of narrative and storytelling, highlighting its ability to inspire, influence, and teach. Traditionally, health practitioners have used fictional case vignettes as both learning and teaching tools to deepen clinical knowledge and critical thinking necessary for effective practical application of theory. In this article, a fictitious case vignette is used to show an example of how MIH happens in a practitioner-client relationship.

For context, at the time of this writing, cities, towns, and countries are responding to the COVID-19 global pandemic, the USA has experienced several COVID-19 and race-related protests and riots, and racism has been named a public health emergency in major cities

Figure 1. Therapeutic Themes and Blindspot Considerations (Shaia *et al.* 2019).

across the United States of America. In response to COVID-19, many health practitioners have quickly migrated to telehealth to honor continuity of care and to maintain access to care for individuals who have sufficient access to information and communication technologies. With consideration of this journal's focus, the case study aims to capture common issues impacting the mental health of underrepresented minority women in an urban American city context.

Case: Karima/Karen

Karima is a 25-year-old, cisgender, African American citizen who immigrated to the United States from a Francophone country in West Africa at age 11 with her mother. Karima and her mother currently live together in an affluent community in Washington, DC. Her father lives in France for half of the year for work and she is very close to her extended family in West Africa, France, and the USA. Karima is fluent in French and English. She is a graduate student studying public health and she is preparing to submit applications to medical school.

Karima's therapist, Karen, is a 35-year-old cisgender white female born and raised in Washington, DC. She is a licensed clinical social worker who works in the college counseling center at Karima's university and also has a small economically viable private practice in Washington DC.

Karima has been having bi-weekly sessions with Karen for two months in the college counseling center. Karima is being treated for general stress and anxiety using cognitive-behavioral and solution-focused approaches to therapy. Due to COVID-19 Karima's sessions moved to telehealth.

Karima logged in to her scheduled telehealth session with Karen. Karima expressed that she really wanted to talk but was reluctant because her mother was within earshot and 'African families' do not really 'believe in mental health.' Karima asked if she could have her session while going for a walk. Both agreed to move forward with the session while Karima went for a walk. Karima expressed a feeling of 'heaviness' following the news of police killings of minorities. She stated, 'I don't know why I feel so sad about these people. I did not know them.' "On my Twitter, I see people talking about 'Black Lives Matter' and I agree, but doesn't 'All lives Matter?' Karen nods in support of, 'All lives Matter.' Karima continues, 'People face discrimination every day. As an immigrant, I was teased in school for speaking with an accent and treated unfairly for being the only Black person on the softball team at my school . . . but I just dealt with it. It's just how things are. You have to be strong.'

Karima expressed difficulty being productive at work while simultaneously feeling guilty for her lack of productivity amidst the busy season in her industry. Karima attempted to speak with her mother about her feelings, however, she was told she needed to work harder and, 'not be lazy.' Karima states to Karen, 'I just want to get some tools to remain productive. I don't want to fall behind in my classes.' How can I increase my productivity?

Karen says, 'yes, there is a lot happening that can distract you from your coursework.' Karen attempts to validate Karima's minority stress by saying, 'I acknowledge my privilege and I feel really bad about all that is happening in our country and our city specifically. It is embarrassing.' Karima responds, 'It's ok, it's not your fault.' Karen continues, ' Many of my clients have opted to go on a 'news diet' and limit the amount of news and social media they consume. Does that sound like something that could work for you? Karima replies yes, 'I guess if I don't see it daily, it can't impact me.' Karen replies, 'Yes and this seems like your anxiety may be increasing. I remember we discussed how exercise and meditation help you. Have you tried those things?' Karima replies, 'You're right, I have not been exercising much since the gyms have closed due to COVID . . . I can try to get back on track by running in my neighborhood.'

Karima continues, 'Sometimes I feel guilty for being able to go for a jog in my neighborhood though . . . that's how one of the young men was killed.' Karima's voice drops and Karen notices. Karen attempts to validate that the recent death is sad while gently reminding Karima to focus on her experience in her own neighborhood asking, 'have you ever felt unsafe jogging in your community?' Karima replies 'no.' Karen replies, 'I understand the need to think about things like this but when it begins to bring guilt, you have to think about if this thought process is helping or hurting you . . . especially if it stops you from self-care and doing things like completing schoolwork.' Karima says, 'you're right, I plan to start exercising tomorrow. I even feel a little better walking right now.' Karen and Karima continue to review previous coping strategies, make a plan for implementation, and the session ends.

Case analysis

A thematic analysis in the Karima/Karen case study reveals several themes where a SHARP framework could be useful. Table 1 was constructed to identify relevant therapeutic themes outlined in the case study along with specific client statements which may help the healthcare practitioner know when a psychopolitically valid intervention may be necessary. Additionally, Table 1 outlines a few of Karen's interventions that, when examined closely, may demonstrate MIH. The last column presents potential therapeutic contextual blindspots for consideration.

Table 1. Therapeutic themes and blindspot considerations.

Therapeutic Theme	Karima's Statement	Karen's Intervention	Potential Contextual Blindspots for Consideration
Individual identity development Potential cultural assimilation ambivalence	I don't know why I feel so sad about these people. I did not know them	Silence	Karen may wish to explore the use of the word, 'these people' and probe to understand how capitalistic values of individualism and separateness may be causing stress while acknowledging the traditional communal nature of West African cultures.
Socially and Politically Misinformed Individual identity development	I see people talking about 'Black Lives Matter' and I agree, but doesn't "All lives Matter	Karen nods in support of, "All lives Matter.	Karen could have used socioeducation to teach Karima how the phrase, 'All Lives Matter' is true, however; when used as a response to, 'Black Lives Matter' protests it diminishes the purpose of the international human rights movement focused specifically on the disproportionate violence against Black people by police. Validating Black Lives Matter as a unique issue for Black people may support Karima in her understanding of the movement while creating opportunities to compare and contrast her own racial and cultural identity in both American and African contexts. Additionally, Karen could have explored themes of internalized anti-blackness and/or xenophobia related to Karima's immigrant identity. Karen's non-verbal agreement with 'All Lives Matter' in this context could reinforce those themes and deepen them if they are present.
Resiliency Potential Childhood Trauma Possible negative internalization of superwoman trait: Obligation to manifest strength	It's just how things are. You have to be strong."	Silence	Karen could have encouraged Karima to deeply examine 'ideas of strength' and how current ideas may be invalidating the actual impact of being teased. Karen could have validated it as an effective coping skill in Karima's youth while inviting her to reflect on how she felt as a child. This could support Karima in developing an emotional vocabulary that may help her connect to how she feels about the current social and political affairs discussed in the vignette.
Possible negative internalization of superwoman trait: Obligation to succeed despite limited resources	I don't want to fall behind in my classes." How can I increase my productivity?	Many of my clients have opted to go on a 'news diet" and limit the amount of news and social media they consume. Does that sound like something that could work for you?	Karen could validate Karima's desire to move to productivity and refrain from suggesting resilience tasks. Karen could have adjusted the session's pace to help Karima process her feelings, provide psychoeducation around suppression as distraction from uncomfortable feelings related to the topic while also helping Karima to examine and validate uncomfortable emotions safely. Karen could also draw Karima's attention to how exhaustion of mental resources can impact productivity and support Karima in integrating thoughts of emotional exhaustion and work outputs. Karen may also wish to explore ways in which internalized capitalism can encourage consistent labor output despite the status of well-being.
Emotional Caretaking	Silence	I acknowledge my privilege and I feel really bad about all that is happening in our country and our city specifically. It is embarrassing."	Karen could recognize her own internal feelings of privilege, guilt, shame and/or helplessness before making this statement and make a plan to process it outside of the session, remaining cognizant of therapeutic power dynamics which may shift the focus away from Karima while implying disinterest, discomfort or incompetence.
Emotional Caretaking/Labor Possible negative internalization of superwoman trait: obligation to help others.	"It's ok, it's not your fault.	Silence	Karen could acknowledge the shift toward emotional caretaking and labor happening in the session, apologize while stating her role and misuse of power in the moment with Karima.

(*Continued*)

Table 1. (Continued).

Therapeutic Theme	Karima's Statement	Karen's Intervention	Potential Contextual Blindspots for Consideration
Anxiety/Worry	Silence	Yes and this seems like your anxiety may be increasing. I remember we discussed how exercise and meditation helps you	Karen focusing on Karima's anxiety without framing it as a normal response to the current socio-political landscape could infer angst is representative of a deficit instead of a healthy response to current community trauma.
Fear Guilt Worry	Silence	'have you ever felt unsafe jogging in your community?'	Karen focusing on feelings of safety as a response to feelings of guilt, misses an opportunity for Karen to support Karima in understanding the function, purpose and emotional utility for guilt. Ignoring this may implicitly validate toxic guilt.
Fear Guilt Worry Trauma	Silence	'I understand the need to think about things like this but when it begins to bring guilt, you have to think about if this thought process is helping or hurting you . . .. especially if it stops you from self-care and doing things like completing schoolwork.'	Karen invalidates Karima's need to process trauma in this statement and reinforces emotional suppression while encouraging productivity. This microinvalidation ignores the need for Karima to grieve and respond to ways in which socially engineered trauma's are affecting her and those in her community. If aware, Karen could provide socioeducation on ways in which neoliberal capitalism determines and measures personal value based on one's degree of productivity and how this ideology may be impacting Karima's prioritization of productivity over healing from individual and community trauma. Next, Karen could explain how continuous suppression weakens resilience responses and can cause or exacerbate mental illness.

The case example seen in Table 1 illustrates an interaction between a single mental health practitioner and a client. However, themes identified in the first column could represent environmental factors that can that impact an individual's physical health. The cross-cutting nature of these themes suggests utility for health practitioners across various disciplines and client systems. In practice, practitioners are often unaware of their blind spots and as a result, they do not know how to broach conversations related to macro-level SET in their individual interactions. This oversight widens health disparities and implicitly upholds unjust practices contributing to poor health outcomes of individuals facing minority stress, particularly for Black women due to intersecting marginalized identities of woman and person of color.

There are opportunities for higher education institutions to explicitly approach topics of SET and the need for psychopolitically valid interventions in their professional training programs. There are also opportunities for state licensing boards to require licensees to receive continuing education credits in topics such as health impacts of racism, gender inequality, and other topics of minority stress. The establishment of race as a public health emergency in cities across the USA may encourage city and state governments to allocate budgets for this type of education, similar to ways in which cities funded initiatives to combat the public health emergency caused by COVID-19.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Notes on contributor

Shatiea Blount is a Licensed Clinical Social Worker with over 13 years of experience in public and private sectors. Currently, Shatiea owns and operates Eye In Me, LLC, a telepsychotherapy practice whose mission is to provide culturally relevant and social justice informed psychotherapy and coaching services to Black people across the diaspora. Often described as a 'Champion for Truth and Healing around Mental Health Topics in Communities of Color', her experience includes social justice informed psychotherapy, life coaching, culturally humble curriculum development, and public/private program management. Due to her long-standing interest in telehealth, Shatiea served as a subject matter expert to The George Washington University's Counseling and Psychological Services Department when deploying a response to the COVID-19 pandemic. She was also integral in designing, piloting, and evaluating diversity seminars at the University of Maryland School of Social Work. Shatiea holds a Masters' degree in Social Work from Howard University in Washington, DC.

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