

We Got You BRUH? An Anti-Oppressive and Anti-Racist Clinical Approach for Working with African American Men Experiencing Grief, Loss and Trauma

Allen Eugene Lipscomb¹, Psy.D, LCSW

Abstract

This article introduces a culturally congruent, anti-oppressive and antiracist therapeutic approach for promoting healing among African American/Black men who are receiving psychotherapy and other related counseling services. Specifically, African American/Black men who have experienced racialized traumatic grief and loss. Racialized traumatic grief for African American/Black men can come as a result of witnessing the traumatic unjust death/murder of another Black man regardless of proximity and kinship. In addition, grief can come from racialized experiences and encounters in society and the blatant disregard of Black bodies in America. Due to white supremacy, institutional racism and oppression these experiences often go ignored, dismissed, discounted or even denied by clinicians when African American/Black men present for mental health services within various practice settings. Thus, it is vital that clinicians utilize a culturally congruent clinical approach when engaging, assessing and providing trauma treatment to African American/Black men. Bonding through recognition to promote understanding and healing (a.k.a. *BRuH Approach to Therapy* or *BAT*) can be utilized as an auxiliary approach in conjunction with other therapeutic models, protocols and interventions. The BRuH approach to therapy has been gleaned from (n = 50) clinical case studies and surveys (n = 200) of African American/Black men who have experienced racialized traumatic grief and loss in the United States. This article briefly summarizes the conceptual underpinnings of *BAT* and explores the promising practice of this approach, and presents three clinical case studies of African American/Black man who received mental health services that utilized the *BAT* approach protocol. The article concludes with implications for clinical practice and future recommendations for the ongoing study of the *BAT* approach protocol.

Keywords: Traumatic grief, Black men, racialized, anti-oppressive, antiracist, psychotherapy

“Black men have stood so long in such peculiar jeopardy in America, that a black norm has developed—a suspiciousness of one’s environment which is necessary for survival. Black people, to a degree that approaches paranoia, must be ever alert to danger from their fellow citizens. It is a cultural phenomenon peculiar to black Americans. And it is a posture which is so close to paranoid thinking that the mental disorder into which black people most frequently fall is paranoid psychosis.” (p. 206)

Black Rage (1968)

— William Grier & Price Cobbs

Introduction

Within the African American/Black community among men the phrase, “You Good Bruh/Bro?” means to cover you, to understand you and I can handle you [in all that you are and bring] (Urbandictionary.com, 2020). More now than ever African American/Black men must be understood, protected and supported due to race-based trauma resulting death. Racial oppression is a traumatic form of interpersonal violence which can pierce the spirit, scar the soul, and puncture the psyche. Without a clear and descriptive language to describe this experience, those who suffer from this form of loss cannot coherently convey their pain, let alone heal. The source of their hurt is often confused with distracting secondary symptoms ranging from fear, hypervigilance, paranoid thinking, anger, hopelessness and even shame. Racialized trauma and oppression is rarely seen as contributing to these difficulties, and discussions around and about race are dismissed, denied or deflected resulted in nonracist stance which further justifies the biased actions. Rarely do mental health and other human service professionals see, honor and believe of these truth experiences lived by African American/Black men.

¹ Associate Professor, California State University Northridge, 18111 Nordhoff Street, Northridge, CA 91330-8226, 818.677.7630 E-mail: Allen.Lipscomb@csun.edu

Thus, the treating the scars of racial traumatic losses are honored as a focal point of clinical services. Conversely, traditional Eurocentric “white” psychotherapeutic approaches attend to pathologizing the African American man’s experience to “psychological issues” or “behavioral issues/problems”, and even “substance issues” (Franklin, 1999; Hammond, 2010; Hardy & Qureshi, 2012). Thus leading to the belief that they need to be fixed or cured or even normal. These are crucial factors that need to be disrupted and reimaged in a way that is anti-racist and anti-oppressive in order to truly serve and aid African American/Black men in healing from traumatic losses. This article introduces an approach that honors, respects and collaborates with African American/Black men in their healing journey (i.e. *BAT*).

The relentless experiences of race-based trauma, grief and loss has subsequent adverse impact on the mental health of African Americans underscores the need for social workers, marriage and family therapist, clinical counselors and psychologists to be trained in race-based trauma assessment, treatment and interventions due to the psychological and the emotional impact (Aymer, 2016; Brondolo, Brady, Pencille, & Contrada, 2009; Bryant-Davis, 2007; Bryant-Davis & Ocampo, 2005; Carter, 2007; Carter, 2009; Lipscomb, 2020; Lipscomb & Ashley, 2018). However, once trained in how to assess these types of traumatic loss experiences rooted in race—clinicians must utilize approaches that center the person (i.e. the client) and not theory. For it is far more important to honor their lived and living experience in the clinical space. Approaches that are Afrocentric based intervention model for the treatment of racialized traumatic losses. This will support the clinician in building a trusting therapeutic alliance and attunement with African American men who have experienced these forms of losses.

Traumatic grief for African American/Black Men

Traumatic grief is an aspect of grief that is not often explored when assessing loss experiences among Black men. Although it is recognized that grief itself is an expected process of adapting emotionally and mentally to the death of a significant relationship, sometimes the intensity of an African American man’s grief may be more overwhelming or last longer than is expected and can be complicated grief (APA, 2013; Comas-Díaz, 2016; Granek & Peleg-Sagy, 2017). Thus, needing to explore to better assist and support Black men with their bereavement process. Given the insidious and relentless murders of unarmed African American/Black men by police officers more and more trauma responses are being experienced by this population; race-based or race-related trauma have been visibly growing across America over the past years (Comas-Díaz, 2016). This form of racialized trauma is experienced as traumatic grief even if the African American/Black man did not know the other Black male that they watched or heard about their murder by law enforcement (Aymer, 2016; Lipscomb & Ashley, 2018; Lipscomb, Emeka, Bracy, et. al., 2019). This psychological impact is significant and must be recognized as such in clinical mental health spaces. With growing intense racial traumas such as this it may be African American/Black men may be seeking professional mental health services in order to resolve, address and heal from this type of traumatic grief.

Anti-oppression psychotherapy and practice

According to Jason Brown (2019) AOP examines the impact of structural inequality on mental health and provides a framework. This model is a resistance and a revolutionary model that grows out of Black feminist and intersectional theories and practices (Baines, 2017; Brown, Wiendels, & Eyre, 2019). AOP examines and explores the effects and intersections of oppressions as they intersect with each other. It interprets issues of racism as acts of trauma and violence to our health and it incorporates resistance strategies and healthy coping tools — to aid community members and clients through grief, loss and identity formation around racialized trauma. This model exists because the erasure of African American men’s grief, loss, needs to be seen, honored, supported for and released. Self and community care is critical to combating the effects of racism and intersectional violence. Anti-oppression psychotherapy directly addresses and confronts racism as a health factor and gives the power to heal back to the communities who are suffering from it (Brown, 2019).

Description of BRuH Approach to Therapy (*B.A.T*)

As noted above, the therapeutic approach includes elements drawn from Anti-oppressive psychotherapy (AOP). In general, the AOP techniques focuses on interventions that seeks to recognize the oppressions that exist in our society, and attempts to mitigate and eradicate its psychological and emotional impact on the individual and returning healing to them. Utilizing that framework, the *BAT* is unapologetically geared to have successful healing outcomes for African American/Black men whose traumatic grief reactions have been consciously and unconsciously missed, dismissed, punished and pathologized in clinical practice spaces.

While *BAT* can be flexibly applied in clinical practice settings, the approach came from successful healing work from clinical case studies of African American/Black men receiving psychotherapy in both community-based and private-practice based mental health settings. Each session is conducted, with a goal to promote true healing through bonding, recognition of the lived and living traumatic experiences including racialization (i.e. race-based traumas and losses); to enhance the clinicians understanding of their positionality and their understanding of what they are psychologically and emotionally experiencing to support their client's healing process. In other words, joining with rather than taking over their healing process. The treatment approach includes the following four phases.

Phase One: Bonding

The goal of this phase is to building the trust in the space by being consistent in how you show up in front of them and outside of them (i.e. advocacy, black anti-racist actions and inclusion efforts). It also entails pacing yourself and checking your anxieties and discomforts around their grief, loss and trauma narratives/experiences. *Approximately 1-10 sessions.*

Phase Two: Recognition

The goal of this phase is to honor their experiences of complex trauma based on who they are (intersectionally), their loss(es) and grief (e.g. around racism, health, etc.) and bereavement. Trusting without questioning, judging, hijacking the space, infantilizing, rescuing or feeling sorry for them. This is done throughout services.

Phase Three: Understanding

The goal of this phase is to understand who you are (i.e. privileges, power, and intersectionality) in the space, while simultaneously understanding oppressive systems rooted in black racism and how they are coping with them the best they know how. In addition, in understanding who you are (i.e. privileges/power) working in ways inside and outside of the therapeutic space to disrupt, dismantle and change racist practices, policies and procedures (i.e. including the evidence-based model that you are utilizing in conjunction with this approach). This is done throughout service and beyond.

Phase Four: Healing

The goal of this phase is to Through holding space, validating, fostering community connection or reconnection, building on protective factors and resiliency and utilizing cultural practices, beliefs, etc. (e.g. embodying somatics). The aim is to facilitate *integrated healing* holistically. Be aware that pacing, pausing and omitting additional treatment protocols and interventions (e.g. CBT, EMDR, DBT, TF-CBT) maybe needed and necessary.

Methods

Locating self within the research

With the author being a mental health clinician for the past 15 years in Los Angeles and San Bernardino county, I have extensive experience working with African American/Black men who have experienced various forms of trauma rooted in oppression. My identity as a Black male, clinician, scholar and researcher serves as a unique position as I approached this research. While I have an intimate connection with the community based on my intersecting identities I also hold privilege and power being a clinical social worker who holds a doctorate in clinical psychology. Being keenly aware of such privilege and power in the therapeutic space was of the utmost importance during the course of the study. It was equally important that I as a Black man managed my countertransference through seeking clinical consultation so as to not impact the clinical treatment that I was providing during that time. It is from this lived experience and lens that I bring to this body of research to gain a deeper understanding utilizing *BAT*. The aim is to use this study to expand the approach so that other clinicians and providers alike can provide services that are rooted in anti-oppressive and anti-racist practices, interventions and frameworks.

Clinical Case Study

In this study, a qualitative case study inquiry approach was used to explore the experiences of African American/Black men ($n = 3$) to assist clinical mental health therapist with aiding resilience and healing, and better work with their traumatic grief reactions. According to Creswell (2009) a qualitative study can add to existing research, fill in gaps, provide opportunity for original ideas, and evaluate an issue of great concern within an underrepresented and marginalized population. A qualitative design can provide a more in-depth understanding of a phenomenon being explored (Butler-Kisber, 2010). Specifically employed in this qualitative study were treatment evaluation interviews to help determine the success of African American/Black men receiving the *BAT*.

Through an exploration of the clinical findings, the researcher attempted to describe a clinical framework approach for building trust, rapport to ultimately assist African American men in healing from traumatic grief. The malleable nature of a qualitative research design approach allowed the researcher to consider how these nuanced clinical experiences may contribute to their resilience and healing process. Thus, the following are clinical case study narratives utilized to honor the voices and experiences of African American/Black men who received the *BAT* during their psychotherapy treatment. These case studies were especially important for gaining access to the clinical experiences of African American/Black men. The case studies shared are in alignment with *Black action research* (BAR) which is research that strives to honor Black living and lived experiences. It seeks to celebrate and highlight unapologetically the uniqueness that is Black people to promote community healing and resiliency (Lipscomb, 2020).

Participants

All Participants in this study ($n = 3$) were specifically selected due to their access to mental health treatment and services. A purposive sampling technique was utilized to select the three African American/Black men who had successfully obtained and received mental health treatment utilizing *BAT*. Recruitment for the purpose of this study were based on five criteria: (a) successful matriculation through treatment services; (b) no severe mental health related challenges (i.e. actively suicidal) and (c) have experienced traumatic grief within the past five years; (d) their willingness to share their clinical narratives; (e) all identified as African American or Black men ages 18 and older. All participants received clinical services from the same mental health clinician in an outpatient community based setting located in Southern California. The participants all had met the diagnostic criteria for one or more of the following diagnosis: (1) Major depressive disorder recurrent; posttraumatic stress disorder; anxiety related; and complicated grief (APA, 2013). The treating clinician utilized the *BAT* with each one of the participants throughout the course of their treatment. Pseudonyms have been assigned to each clinical case study to maintain confidentiality while humanizing and honoring their experiences.

Data collection and analysis

Narratives were captured through the combination of the clinician's process notes, progress session notes and treatment outcome session evaluation feedback surveys once services were terminated. The data was collected throughout the course of their treatment while in services. Analysis of the data was based on session notes and process notes of individual sessions and documents provided from the clinician as it relates to session outcome measures to gain feedback from experience. Data analysis was accomplished in three main phases: a) preparing and arranging the data for analysis; b) coding the data into themes; and c) presenting the data through figures and discussion in a meaningful manner (Creswell, 2013; Saldaña, 2016). All of the session progress and process notes including outcome session evaluation forms were transcribed into text using NVivo, a professional qualitative transcription software. As the transcriptions were submitted, I reviewed each one for legibility. The second phase of data analysis consisted of organizing and structuring the data into emergent themes. "Coding is...a data condensation task that enables you to retrieve the most meaningful material, to assemble chunks of data that go together, and to further condense the bulk into readily analyzable units" (Miles, Huberman, & Saldaña, 2014, p. 73). According to Saldaña (2016) believed that codes are labels of words or short phrases that symbolically attach summative qualities or reminiscent attributes to a portion or chunk of data. With this study, data coding occurred in two phases: (1) applying initial codes to the data using process coding, (i.e. uses "-ing" end words) to indicate action in the data; and (2) transforming codes into emergent themes utilizing focused coding, which entails the grouping coded data based on thematic commonalities (Creswell, 2013; Saldaña, 2016). Themes within the data emerged through an iterative, constant comparative process (Creswell, 2013) which required deep reflection and critical analysis. The final phase of data analysis included presenting the data in discussions and illustrated figures (see figure 1. Below).

Table 1. Demographic and clinical information of the participants

Demographic Characteristics	Client - 1 Derrick	Client - 2 Martrell	Client - 3 Keon
Ethnicity and age	<i>Black/AA</i> <i>21 years old</i>	<i>Black/AA</i> <i>35 years old</i>	<i>Black/AA</i> <i>68 years old</i>
Sexual Orientation	<i>Heterosexual</i>	<i>Heterosexual</i>	<i>Gay</i>
Gender Identity	<i>Cisgender male</i>	<i>Cisgender male</i>	<i>Cisgender male</i>
Length of therapy	<i>13</i>	<i>12</i>	<i>18</i>
Clinical dxs	<i>PTSD</i>	<i>MDD - single epi.</i>	<i>Complicated grief</i>

Case study participant profiles

Derrick

Derrick is a 21-year-old cisgender, heterosexual Black male who reports that he was in foster care since the age of 5 and aged out of the system when he became an adult. He shared that he always wanted to be adopted but it never happened. He was released from jail a few months prior to commencing therapy due possession of illegal substances. In addition, when he was 18 he decided to move from Florida to California to start a new life. Derrick also shared that his younger (biological) brother died in a shooting six months ago. Derrick also shared that he was stopped by two police officers in front of the courthouse located downtown last week because he looked suspicious. When asked about what he would like to get out of services he replied, "Whatever I can get!" His clinical diagnosis at the time was posttraumatic stress disorder. He completed thirteen months of therapy. The therapist utilized BAT in addition to other treatment approaches throughout the course of treatment.

Martrell

Martrell is a 35-year-old cisgender, heterosexual Black male who currently works at a car dealership as a sales rep. His mother died two months ago and his grandmother was currently receiving hospice care at the time when he started therapy. He shared that his job strongly encouraged him to receive counseling to address his hostility and aggression. When asked how he was doing today during his first session, he said, "I don't think I can continue on this way" and started crying. His clinical diagnosis at the time was major depressive disorder single episode. He completed 12 months of therapy. The therapist utilized BAT in addition to other treatment approaches throughout the course of treatment.

Kenneth

Kenneth is a 68-year-old cisgender, gay Black male who lost his romantic partner of 25 years to cancer last month. Keon shared that he has never told anyone in his family that he was gay due to strong religious beliefs and fear of being rejected by extended family. He shared that he has no support and many of his friends have died. When asked how does he feel, he replied, "I'm not sure...". His clinical diagnosis at the time was complicated grief and bereavement. He completed eighteen months of therapy. The therapist utilized BAT in addition to other treatment approaches throughout the course of treatment.

Results

All of the participants reported 100% satisfaction and positive experiences with receiving the BAT. The clinician provided on average a year and half of clinical mental health services utilizing the BAT to all three clients. The researcher then analyzed the transcripts and reflective notes for thematic content. The analysis was an iterative process which occurred throughout the course of treatment and beyond. The researcher then listed the categories and the concepts that emerged from the data.

Emergent Themes

Theme 1: Delayed trust in the therapeutic relationship

The following is a quote from one of the participants which captured this theme.

Participant reported, "although my therapist was black I still didn't trust the system and "therapy" in general at the beginning of therapy. It took me a cool minute to become comfortable talking and sharing during my sessions the deeper stuff that had been built up and never shared with anyone. It was very intimidating when I started because I would think about how this would make me look and if it is a waste of time. I knew I needed it to do something because the pain was too hard to live with day to day. Once I had been going to my counseling for over six months that's when I felt more trust and could open up more to my therapist. I felt like my therapist did not judge my experiences and me as a black man sharing about how I felt when I experienced my losses. He also was willing to name the injustices and racial experiences that was my loss experience which helped me understand myself through seeing that way. I also appreciated that my therapist incorporated other ways of recovering that I felt was appropriate too. I respected him checking in with me too to make sure I was good with everything that he was doin or playing to do in the counseling sessions—I felt like I was equally in control of the direction week to during our sessions."

Theme 2: Expressed more when not being infantilized, pathologized and sympathized by therapist.

The following is a quote from one of the participants which captured this theme.

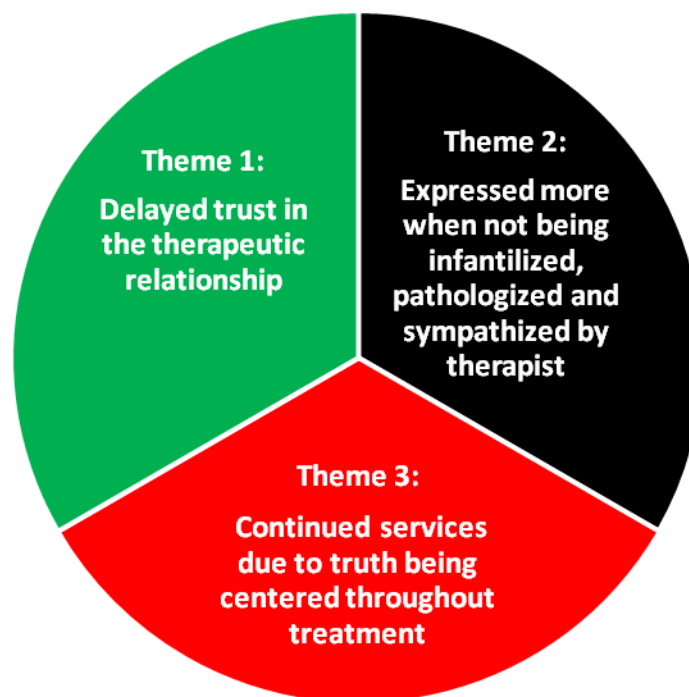
Derrick shared, "I was used to these other professionals treating me like I was stupid and didn't understand myself and what was going on...I hated when they would speak to me like I was a menace just trying to get over the system. I could remember having experiences when my social worker treated me like I was always lying to her and I was like look—I don't got time to be lying about my life—you think I want to be in this situation? I had to stop myself because I knew she had all the power to make major decisions on my life if I did not keep my calm and cooperate."

Theme 3: Continued services due to truth being centered throughout treatment

The following is a quote from one of the participants which captured this theme.

Martrell stated, *“I liked it when my therapist would trust what I was saying and didn’t try to analyze every single word I said which I was nervous about when I first started with therapy. I also liked that I could talk about my experience as it related to race and not have to worry about that being questioned because they didn’t understand what I was trying to say. Basically what I am sayin is that I liked that my therapist believed in me and trusted what I said in session. “He went on to say, “I wasn’t made to feel guilty if I had to cancel my session due to my work schedule—in fact we discussed work during our next session and it felt like he was genuinely concerned about my work and personal balance given my experiences with the death of one of my family members.”*

Figure 1. Emergent themes



Implications for Practice

The results from utilizing *B.A.* has suggested the following skills that are vital when providing clinical mental health support and services with African American/Black men. Feeling heard by their therapist or counselor as it related to their lived and living experiences allowed for the trust to be established and a true bonding connection. It is important for the clinician to not interrupt the client (i.e. Black male) when expressing and sharing their lived experiences. Clinicians would benefit from asking themselves, *how am I advocating, dismantling and deconstructing white supremacy in all spaces not just in direct clinical spaces but also as it relates to policies and practices when providing the services to African American/Black men?* In addition, the results indicated that it is not enough to not be racist in your direct service work; but rather they appreciated when their clinician was demonstrating an anti-racist stance in the session by expressing how they are not going to use interventions that are rooted in stereotypes, pathologizing, criminalizing, or denying their truth experiences of racism as Black men. The clinical case study participants all shared that they appreciated not being treated think a child, or link they were dumb and could not comprehend the interventions being utilized. For clinicians to be able to join in the space with them whereby allowing them to experience their emptiness of the loss or death (i.e. true mourning and honoring their bereavement). Clinicians can promote healing in a collaborative way with assisting them with naming of feelings related to their traumatic losses that can be rooted in racism, biases, micro-aggressions and bigotry (Constantine, 2007). It is equally important for the clinicians to encourage and possibly teach affect regulation and culturally appropriate resourcing when stressed (e.g. mindfulness practices, prayer, working out, drumming circles) that is true to them. Without assuming but asking and exploring what types of culturally practices that they are currently engaged in or would be interested in exploring.

According to the author, there are common reactions to traumatic grief and loss that you can see among Black men: (a) *withdrawn* and avoidant; (b) *hypervigilance* and needing to constantly watch or safety purposes due to being a black male body; with *honor* for the individual who has died; (c) *acceptance* (i.e. culturally forced to accept due to long history of power, privilege, racism, white supremacy and historical trauma committed to African American/Black people in the United State) or *activism* depending on how the trauma is expressed; and (d) exhibited a *targeted* response (i.e. feeling as though they are constantly being preyed upon).

What does it mean to be an antiracist clinician?

It is important to note that antiracist work entails actively working in ways that directly oppose racism, discrimination and prejudice within the organization and the community in which you serve. This includes taking an unapologetic stance and utilizing interventions and approaches that directly call out racist and discriminatory practices, policies and behaviors through advocacy, activism and allyship. It means taking a critical look at your clinical practice organizational structure and yourself (i.e. how you move and the interventions you use within that system). To dismantle black racist practices and policies (both overt and covert) and move toward restructuring your practice to ensure that black racism within service delivery is not an option. The following are critical questions that clinicians can ask themselves when providing clinical services to African American/Black men centered around black antiracist practice which is the core concept of *BAT*:

- 1) *Who's truth grief experiences are you centering when you are listening to Black men and youth express themselves?*
- 2) *Are you centering yours, theirs, the Eurocentric westernized theoretical framework, the departments, the agency, the school, the programs, the policies, the religion, your supervisor or director? And if so, WHY? Also, why not change it? What is preventing you?*
- 3) *Are you honestly, earnestly and consciously listening without biases, judgement and projections? If not why? What is getting in your way that you need to address, check and correct?*
- 4) *Are you listening to fix, to preach, to teach, to correct, to sooth (i.e. them or you), to condemn, to punish, to interrogate, to prove, to understand or convince?*

It is important to note that as the clinician you may never understand what it is like to be an African American/Black man in the United States—nor do you need to know as the provider in order to provide effective treatment. Conversely, clinicians must critically think of ways to honor, uplift, affirm, validate that they hear African American/Black men without over compensating due to guilt, shame, fragility or wanting approval or even wanting to comfort them. This can be experienced as sympathy which is truly counterproductive and clinically harming to African American/Black men in their healing process. The essence of the *BAT* is to honor them without taking over, disrupting or racializing their grief, loss and bereavement experience.

Limitations and Conclusion

The Bruh Approach to Therapy (*B.A.T*) for African American/Black men experiencing traumatic grief, may provide some insight to mental health and other human service providers alike to be better able to position themselves within a framework in relation to the Black man that they are providing services to. A major limitation of this study is that it has not been tested and replicated in various practice settings with varying ages of African American men and youth. Due to being a qualitative case study it cannot be generalized but rather used to provide insight and practical steps to take when working with African American/Black experience traumatic grief. Furthermore, with additional research, it is the authors hope that this approach may aid in the creation of additional culturally informed, anti-racist and anti-oppressive mental health treatment for African American/Black men. The incorporation of the common black male grief reactions to traumatic losses can be seen as coping strategies used by African American/Black men in therapeutic practice setting to create a more empathetic and authentic therapeutic environment; thus allow the mental health clinician to truly build a rapport with their client that is helpful and not harmful. Future research testing the validity and reliability of the proposed approach should attempt to incorporate as many of these concepts if not all in order to better understand the traumatic grief healing process among this population.

"Black men feel anxiety. Black men feel depression. Black men feel sadness. Black men feel rage. Black men feel and that's ok."
Twitter

-Jeffrey A.

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