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Being Essential and Feeling Expendable: Black Female Clinicians' Narratives About Working in the U.S. During Dual Pandemics

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ABSTRACT
Historically and in the present day, Black women's positionality in the U.S. has paradoxically situated them in a society where they are both intrinsically essential and treated as expendable. This positionality, known as gendered racism, manifests commonly in professional environments and results in myriad harms. In response, Black women have developed, honed, and practiced a range of coping styles to mitigate the insidious effects of gendered racism. While often effective in the short-term, these techniques frequently complicate Black women's well-being. For Black female clinicians who experience gendered racism and work on the frontlines of community mental health, myriad bio-psycho-social-spiritual harms compound. This project provided an opportunity for Black female clinicians from across the U.S. to share their experiences during the dual pandemics of COVID-19 and anti-Black violence. I conducted in-depth interviews with clinicians (n=14) between the ages of 30 and 58. Using the Listening Guide voice-centered approach to data generation and analysis, I identified four voices to help answer this project's central question: How do you experience being a Black female clinician in the U.S.? The voices of self, pride, vigilance, and mediating narrated the complex ways participants experienced their workplaces. This complexity seemed to be context-specific, depending on whether the clinicians worked in predominantly White workplaces (PWW), a mix of PWW and private practice, or private practice exclusively. Participants who worked only in PWW experienced the greatest stress, oppression, and burnout risk, while participants who worked exclusively in private practice reported more joy, more authenticity, and more job satisfaction. These findings have implications for mentoring, supporting, and retaining Black female clinicians.

KEYWORDS: Black female clinicians, professional experiences, gendered racism, Listening Guide voice-centered approach.

I entered a doctoral program knowing that I wanted to examine some facet of mental health clinician experiences with suicide. In fall 2019, as a first-year student, I was asked to design and conduct a qualitative pilot project based on my research interests. Each member of the cohort was encouraged to consider their topics from a social justice vantage point.

One afternoon that October, while driving home from work, I heard an NPR news report indicating that suicide fatalities among Black children ages 5- to 11-years had increased 111%

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since 1980. Appalled by this news, I pulled over to the shoulder of the road and sobbed. I wondered *why* and *how could that finding be true?*

Once I got home, I searched the NPR website for the news report details and found the citation for Lindsey and his co-researchers' (2017) work. I downloaded their article, read it, and then tracked down their cited sources. I discovered that multiple Black researchers had been observing alarming increases in suicide among multiple Black community cohorts, such as Black female youth, and Black male emerging adults.

This preliminary review of the literature compelled me to focus my research on suicide in Black communities. That decision prompted me to interview Black clinicians and explore this research question: How do Black clinicians understand suicide in Black communities? I interviewed one self-identified Black cisgender man and two cisgender women. The interviews revealed complex and nuanced narratives about the interplay among anti-Black macrosystemic forces, harmful intrapsychic experiences, and suicidality.

While all the participant narratives were data rich, the Black female clinician stories illuminated more detailed descriptions about the connections among historical, cultural, social, political, and psychological factors and suicide in Black communities. This revelation—coupled with the reality that Black women occupy multiple marginalized positionalities in the U.S.—resulted in my decision to further focus on Black women's critical understandings of suicide in Black communities.

The interviews for my dissertation research included four interconnected topic areas: Black female clinicians' lived experiences in the U.S., their critical consciousness development, experiences with suicide in Black communities, and critical understandings of why deaths by suicide occur in Black communities (Hightower, 2022). This article aims to amplify Black female clinicians' lived professional experiences, which were described to me in late summer 2021—over a year after the COVID-19 pandemic began and the brutal, racialized murders of Black people, such as George Floyd and Breonna Taylor, occurred. By focusing on participants' narratives that emerged in the first topic area, I hope to contribute to advocacy efforts to promote Black female clinicians' personal and professional well-being. Such efforts are critical to safeguard these clinicians' health and ensure that Black communities and predominantly White workplaces (PWW) continue to have access to high-quality, culturally-skilled professionals.

To better contextualize Black female clinicians' professional experiences in the U.S., I offer a brief examination of the literature. This review first establishes Black women's historical and current paradoxical positionality in the U.S. Next, I summarize the various harms Black women have endured—and continue to experience—due to their minoritized statuses. Then, I connect this complex positionality to identity-influenced strategies and coping styles often employed by Black women as they navigate professional spaces. Additionally, I detail the methodology and findings of my secondary analysis using The Listening Guide voice-centered method (Gilligan et al., 2003; Tolman & Head, 2021). Furthermore, this article explores this project's implications and limitations for mental health professionals and employers who are trying to hire, support, and promote Black female clinicians. Finally, I conclude with suggestions for future research.

Black Women's Paradoxical Positionality in the U.S.

Black women's identity-based statuses in the U.S. are—and have been—complicated by violent and oppressive contexts. Snyder (2015) noted that Black African women sometimes died by suicide to avoid enslavement—acts of resistance—and enslavers attempted to prevent such deaths to protect their economic interests. Such interplay between Black female deaths of resistance and White enslaver' dehumanizing greed contributed to Black women's status as *essential yet*

expendable. Furthermore, Nunley's (2021) analysis of the initial development of the U.S. capitol observed, "African American women in early Washington understood that the stratification of society often relegated them to the bottom and that their labor subsequently buoyed the aims of a burgeoning genteel class" (p. 20). Moreover, this understanding intergenerationally shaped enslaved Black girls' socialization and positionality:

> *Enslaved girls learned at an early age how to navigate the expectations of upper-class [W]hite families. The demands on [B]lack girls, [W]hite entitlement to deference, and the expectations of positive dispositions indicate ways that slavery shaped their understandings of labor and power.* (Nunley, 2021, p. 21)

These examples highlight the importance of Black females to U.S. societal development and maintenance. Concurrently, their central contributions to society exist in the contexts of the violence and oppression they frequently endured, as well as Black females' resistance to these harms (Apugo, 2019; Coleman, 2016; Collins, 2009; Williams-Washington & Mills, 2018). Such identity-based violence, oppression, resistance, and precarity continue in the present-day.

While Black women have been aware of their minoritized status in the U.S., and championed efforts to secure sustained and meaningful equity since the nation's inception, they continue to experience marginalization in the present-day. Citing a 2020 executive summary report, Robinson (2022) remarked:

> *Despite being leaders in their communities and making significant contributions to the society and economy of the United States, Black women continue to be underpaid and consistently receive fewer benefits compared to the level of their labor productivity, a reality that has persisted since enslavement.* (p. 1)

Contemporary social scientists understand this *essential yet expendable* dynamic—and its harms—in terms of multi-oppressive synergies.

Gendered Racism: Understanding Black Women's Present-Day Positionality

Essed (1991) coined the term *gendered racism* to describe the unique, dynamic, and nuanced interplay of sexism and racism: an interplay that results in an insidious, hybrid oppression. Jones Thomas and her colleagues (2008) detailed three theoretical evolutions of the concept. The initial *double jeopardy* framing emphasized the accumulative effects of both sexism and racism yet treated both forms of oppression as equal in terms of their experiential consequences. The subsequent *interactional* approach focused on the ways sexism and racism interact to generate negative impacts. While more complex, this framing "still tends to fragment and parcel their experience into a female one and an African American one" (Thomas et al., 2008, p. 308). Ultimately, the authors supported Anderson and Collins's (2004) advocacy for an *intersectional* paradigm:

> *Fundamentally, race, class, and gender are intersecting categories of experience that affect all aspects of human life: thus, they simultaneously structure the experiences of all people in this society. At any moment, race, class, or gender may feel more salient or meaningful in a given person's*

> *life, but they are overlapping and cumulative in their effect on people's experience.* (p. 7)

This intersectional perspective better illuminates the unique, multi-faceted and ever-shifting oppressive forces that influence Black women's daily lived experiences. For example, Crenshaw's (1991) critical legal analysis of employment law revealed that hiring practices at a car company often protected Black men (based on their sex) and White women (based on race), but consistently and empirically failed to protect Black women (because of their marginalized race and sex identities). In tandem, this concrete legal example and the gendered racism framework have revealed unique harms experienced by Black women.

Gendered Racism and Its Harms to Black Women

An intersectional analysis underscores the damaging effects of gendered racism on Black women's bio-psycho-social lived experiences. Spates (2012) observed that the consistent dearth of Black women in the entire research process—from who the investigators are to who benefits from findings—harms them by rendering their lived experiences invisible. Despite the pervasive erasure of Black females from research, more scholars are illuminating the detrimental consequences of gendered racism. Black female scholars and activists have reported that between 67% and 80% of Black women in the U.S. are the primary or sole providers for their households (Frye, 2020; Geyton et al., 2022; Spates et al., 2020). These researchers further noted that approximately 40% of single-headed households in the U.S. are comprised of Black women. Concurrently, these same Black women earn 62 cents for every dollar earned by a White man. As a result, Black women experience the compounded stress of having to provide for their families on their own with fewer resources. Moreover, Chinn and her co-investigators (2021) examined the interplay among Black women's statuses, socio-historical contexts, and health inequities. These authors reported that this race-gender cohort disproportionately experiences health conditions like anemia, cancer, heart disease, maternal morbidities, obesity, and strokes compared to U.S. White females. Additionally, Cooke and Hastings (2023) argued that understanding Black female stress-related harms ought to be conceptualized at the intersection of "historical trauma, sexism, racism, daily microaggressions, and classism" (p. 2). The scholars emphasized that these harms were compounded for Black female social workers during the COVID-19 pandemic, as many such professionals provided *essential services* (Abrams & Dettlaff, 2020, p. 302) in sexist, racist, and existentially threatening professional spaces (Cupid & Bogues, 2023; Godoy et al., 2023). To cope with these multifaceted intersectional harms, Black women have been compelled to develop a variety of complex coping strategies.

Black Women's Coping Strategies

Black women's marginalized positionality, exposure to harms, and endured violence necessitate strategies to survive and thrive. Apugo (2019) observed that African American women at predominantly White colleges "often encounter race- and culture-based stereotypes and stereotype threat that often led to the affixation of false labels, which give way to *shifting* and, in many cases, *code-switching* and hypervigilance" (p. 53). While such identity-specific emotional and behavioral modifications may help Black women navigate White spaces, the experienced racial and cultural inauthenticity exacts a psychological toll. M. S. Jones and her co-authors (2021) explored the relationship among gendered racism, *identity centrality* (the degree to which identities are important to individuals), and mental health. They found that higher levels of gendered racial

identity centrality coupled with higher levels of identity-shifting resulted in greater levels of depression. This pattern—coupled with gendered-racialized stereotypes—complicates individual, community, and societal narratives about Black female coping.

The Superwoman Schema (SWS) and John Henryism construct shape Black female coping through complex psychological, Black-community, and White-dominant culture interactions. According to Perez and her co-researchers (2023), the SWS is a collection of attitudes, beliefs, affective states, and behaviors cultivated and internalized "to withstand/overcome/survive the oppressive socio-historical and sociopolitical context[s] of gendered racism" (p. 2). These scholars described a suite of coping strategies that include experiencing the need to perform strength regardless of authentic feelings, suppressing emotions, resisting vulnerability and dependence, succeeding even with limited resources, and caretaking for family, community, and society. This schema derives, in part, from the strong Black woman (SBW) role, which emerged as a response to Black community survival needs and White dominant culture's multi-pronged oppression (Parnell et al., 2022; Spates et al., 2020).

In addition to SWS and SBW approaches, Black female coping is influenced by John Henryism. This coping model emerged from a folktale about a Black man, John Henry, who demonstrated his strength and competence by competing against a machine and winning. The story concludes with Henry's death by overexertion. According to the *John Henry Hypothesis*, Black peoples' valued and recognized displays of strength and competence result in benefits—no matter the cost. Internalizing such a belief likely creates both advantages, such as increased education and employment opportunities, and chronic problems, like hypertension and other stress-related conditions (Perez et al., 2023). While the John Henry, SWS, and SBW frameworks underscore the dual-edged nature of Black female coping styles, several Black female scholars are highlighting empowering strategies.

Several Africultural-specific coping methods are frequently employed to mitigate Black females' stress and promote well-being. Graham and her co-investigators (2022) empirically examined the coping strategies employed by participants to manage SBW-related stressors. Four categories of coping were measured and examples of each appear in parentheses: cognitive-emotional debriefing (reframing stressors internally and/or with others), spiritual-centered coping (praying and/or attending church services), collective coping (brainstorming solutions and/or creating action plans with friends and/or family members), and ritual-centered coping (lighting candles and/or interacting with an object perceived to have healing properties). This research team observed that the first three coping methods were almost equally used among their participants. Such findings suggest that successful coping among Black women necessitates myriad techniques to address multi-faceted gender-racialized stressors.

Given that Black female coping strategies often emerge in response to gender-racist harms, critical-consciousness of their intersectional oppression likely bolsters healing efforts. Mosley and her colleagues (2021) collaborated with Black Lives Matter associates to develop a Critical Consciousness of anti-Black Racism model (CCABR). The model includes three interconnected components: *Witnessing ABR*, *Processing ABR*, and *Acting Critically Against ABR*. The authors noted that this model both facilitates movement from a sense of powerlessness to empowerment and mirrors the health-promoting benefits of critical consciousness described in the extant research literature (Kelso et al., 2014; Zimmerman et al., 1999).

Another empowering coping approach often employed by Black females is known as *sister circles*. Cupid and Bogues (2023) described this coping method:

> *informal or formal support groups that build upon existing friendships, fictive kin networks, and the sense of community. . . [in which] members refer to each other as sister or sis as a term of endearment. . . From historical to contemporary times, sister circles are activist spaces where Black women theorize and strategize ways to address Black womanhood, family, and community upliftment.* (p. 2)

This relational coping strategy has been found to generate positive benefits for Black women, such as expanding and deepening social connections and improving mental health (Neal-Barnett, 2010; Neal-Barnett et al., 2011). Such relational benefits also emerge from narrative approaches that center on collective healing.

Black females' coping experiences in response to gendered racism necessitate collective as well as individual-level interventions. McNeil-Young and her co-authors (2023) asserted, "individual-level approaches often do not address the structural forces that contribute to racial trauma and thus may fail to meet the unique needs of Black individuals and communities" (p. 277). These scholars highlighted an ethnoculturally-relevant approach known as *storying survival*. This coping method involves sharing detailed narratives, observations, critiques, testimonies, and expressed forms of advocacy related to ABR in service of Black liberation (Mosley et al., 2021). In their investigation of storying survival, McNeil-Young et al. (2023) explored the coping technique's thematic components and processes. They found that storying survival involved participants' recognition of people, lived experiences, and historical figure's influence on their narratives. This recognition is interconnected with the various mechanisms of storying survival, such as acquiring storying survival skills through mutual deep listening. Other mechanisms include understanding the implications of narratives through seeing intergenerational ABR, recognizing White supremacist historical and systemic forces, being vulnerable by sharing personal examples, and attuning to the power of storying survival language choices (what is included and what is not). These components and processes inform individual's survival storying content, decisions about the contexts in which narratives are shared, and ongoing re-examinations of survival storying impacts on oneself and others.

The reviewed historical and social science research establishes that Black female's positionality is, and has been, influenced by complex oppressive forces currently framed as gendered racism. This intersectional dynamic significantly contributes to a range of bio-psycho-social harms that Black females must anticipate, negotiate, resist, and resolve, often with limited resources. Such multifaceted efforts frequently require Black females to develop and employ myriad coping strategies. These strategies vary in effectiveness, and often, several techniques need to be used to experience any benefits. However, this necessity to create and use multiple coping methods can be sources of pride and resilience, as well as shame and vulnerability. Recently, though, Black female scholars and their allies have been examining the benefits of empowerment approaches to addressing intersectional traumas. These approaches typically involve critical consciousness-raising, relationship-building, and social justice-centered collective advocating. Such approaches include identifying, reflecting on, and learning from personal and community ABR narratives. Such emphasis on intentional, iterative, and complex story-telling mirrors the methodology used in this study to better understand the unique and complex professional experiences of U.S. Black female clinicians.

Methodology

Within this section, I explain the overarching framework for this project, as well as its step-by-step design and data analysis procedures. This explanation begins with a brief introduction of narrative inquiry and the Listening Guide voice-centered approach (LG). Next, I describe my positionality in relation to this project and the participants. Then, I detail the research design and implementation processes including Institutional Review Board (IRB) approval, sampling strategy, participant recruitment, data generation and analysis, and validity techniques. Finally, I provide socio-demographic information about the 14 Black female clinicians who participated in this project.

Narrative Inquiry and LG

Investigating Black female clinicians' professional experiences in the U.S. necessitates a methodology that foregrounds complex and layered psychological meanings. Because such complex meaning-making frequently takes the form of *stories*, narrative inquiry provides the overarching methodological framework for this project (Kim, 2016). Additionally, LG specifically focuses on the multiple, layered, and complex voices embedded in stories (Gilligan et al., 2003; Tolman & Head, 2021). This method aligns well with an exploration of Black female clinicians' experiences because their lives in the U.S. are complex—often evoking myriad paradoxical understandings simultaneously, such as feeling expendable and hearing one is essential. Moreover, these lived experiences frequently occur in traumatic, violent, and oppressive contexts that deeply affect all members of Black communities. Such effects are consistently embedded in the narrative voices of the research participants (Cruz, 2021). Thus, narrative inquiry and LG privilege the polyvocal nature of lived experience knowledge embedded in people's stories.

Investigator's Positionality Statement

As a White cisgender male, I have predominantly experienced unearned privileges across societal contexts. Also, as a person who self-identifies as gay, I have experienced moments of interpersonal and systemic homophobia, as well as the ongoing threats created by anti-LGBTQI+ policies in the United States and abroad. These co-existing experiences of privilege and marginalization sensitize me to the intersectional dynamics that often unfold between dominant culture and marginalized groups. Such heightened awareness of this complexity, coupled with a shared professional identity and commitment to continued critical consciousness, enhanced the researcher-participant relationship. For example, several participants communicated to me directly that I was "easy to open up to." Concurrently, my White, gay, cisgender male identities posed *outsider* challenges. The first prospective participant I pre-screened remarked, "Ugh, I really want to participate in this study, but why do you have to be the one to do it." Beals and her co-authors (2021) discussed the tensions and liminal spaces between insider and outsider statuses. The authors concluded that qualitative researchers should consider being *edgewalkers*—people who embrace "the complexity of culture and identity to walk the edge between multiple worlds and positions" (Beals et al., 2021, p. 597). This stance requires ongoing, vigilant, and honest self-reflection which I engaged in through ongoing reflexivity journaling, discussions with my dissertation research committee, and follow-up conversations with research participants.

IRB Approval Process

I submitted an IRB application and supporting documents to the University review committee chair in June 2021 and received approval in July 2021 (IRB# 20/21-055).

Sampling Strategy

This project used a *purposive sampling* strategy. According to Zhao and her colleagues (2021), "With purposive sampling strategies, researchers handpick subjects to participate in the study based on identified issues being examined" (p. 249). This sampling strategy enabled me to recruit 14 participants who met the inclusion/exclusion criteria for the original project from which this secondary analysis was derived:

1. Self-identify as Black or African American
2. Self-identify as female, transwoman, woman, and/or womyn
3. Be a fully licensed mental health clinician who is currently working as a clinician
4. Have personal or professional experience with a member of the Black community who experienced suicidal ideation, a suicide attempt, or a death by suicide
5. Live and practice in the United States

Participant Recruitment

To recruit participants, I reached out to doctoral program faculty and student cohorts, LinkedIn contacts, Black professional groups, National Association for Social Workers (NASW) members via discussion boards, American Association of Suicidology members via the member listserv, and clinicians listed in the Psychology Today Therapist Directory. A standardized recruitment letter was used on each internet platform. All enrolled participants learned about the study from either internet-based recruitment efforts or through spontaneous *snowball sampling*—recruiting new participants through current participant social and professional networks (Zhao et al., 2021).

Data Generation and Analysis

I developed a recruitment flyer that explicated my positionality, research question(s), and goals. Next, I used brief telephone or Zoom screening interviews to determine the alignment between the participants' experiences and this project's focus. The screening interview also provided an opportunity to address questions and concerns. Screened participants who completed the informed consent form received a Survey Monkey link to a socio-demographic questionnaire. The 19-item questionnaire was designed to represent participants' socio-demographic identities accurately using their own language, not pre-determined categories. After the pre-interview documents were completed, I scheduled and conducted a 60- to 90-minute semi-structured interview. These interviews occurred and were recorded using the Zoom teleconferencing platform. Finally, all recorded interviews were transcribed using the Rev.com transcription service.

To analyze interview data, LG was used to hear, understand, and represent the multiple voices embedded in participants' narratives related to their experiences of being Black female clinicians in the U.S. LG is a feminist qualitative research method of psychosocial analysis that emphasizes inter-actions among voices, relationships, resonance patterns, material contexts, social environments, and cultural milieus (Gilligan et al. 2003; Tolman & Head, 2021). To better

understand the significance of participants voices, LG involves a series of at least three sequential *listenings*. These steps typically include first listening for plot, i.e., how participants' stories unfold psychologically and relationally. Then, researchers listen for first-person narrative voices. Finally, researchers attune to and interpret contrapuntal voices—the multiple, simultaneous, and dynamic voices embedded in human speech or writing that create complex and unique patterns of meaning. These voices are understood in the context of a researcher's questions. In listening for the first-person narrative voices, each instance of "I" and its corresponding verb (and sometimes direct object) are highlighted and re-written sequentially to form *I poems*. For this project, I tracked participants' voices using I poems specific to their lived experiences of being Black female clinicians in the U.S. Heeding Tolman and Head's (2021) warnings about LG data analysis fidelity, I formulated tentative interpretations by considering the Black feminist historical and social science scholarship I reviewed in the previous introductory sections of this article and revisited the central question of this project: How do you experience being a Black female clinician in the U.S? Finally, I concluded the data analysis process by synthesizing each component of the iterative process to "compose an analysis" (Tolman & Head, 2021, p. 158).

Trustworthiness and Credibility Techniques

For this study, my interview transcripts, interview audio-visual recordings, written plot-based records created after my first listening, field notes, and research journal entries provided multiple ways to access, interpret, clarify, and evaluate the trustworthiness of data and my analysis. Furthermore, the LG data analysis method explicitly establishes the expectation that researchers will engage in transparent reflexive practices. To operationalize this expectation, I kept a reflexivity journal that emphasized the cognitive, affective, and behavioral dimensions of my insider and outsider statuses in relation to each participant. Additionally, I attempted to foster comfort and genuineness between the Black female clinician participants and myself. I endeavored to communicate clearly and candidly in writing and verbally and shared my interview protocol with the participants in advance to promote transparency. This protocol included non-leading, open-ended questions that communicated a sincere interest in understanding. Finally, I used *member-checking* throughout this project's data analysis and interpretation phases. The strategy involved ongoing dialogues between the researcher and participants about the researcher's interpretations of the data (Creswell & Creswell, 2018). While this technique is commonly considered a *gold standard* validity measurement in qualitative research, Motulsky (2021) cautioned that researchers should be critical and intentional about its use. Given my positionality as a White cisgender man, the historical under- and misrepresentation of Black women in research, the relational nature of this project, and my social justice intentions for this study, I applied this strategy.

Participant Socio-demographic Information

For this project, fourteen self-identified heterosexual, cisgender, Black female clinicians with a range of religious/spiritual beliefs narrated their experiences of living and practicing in the U.S. Table 1 summarizes other germane socio-demographic information collected.

This information—coupled with the reviewed literature—both offers an additional layer of context and aligns with the Black feminist scholarship and narrative inquiry tenets that knowledge emerges as a dialogue among lived experiences, theoretical lenses, relational dynamics, and iterative meaning-making stories. In the next section, I articulate this study's findings by systemically describing each step of LG data analysis.

Table 1

Participants' Socio-demographic Information

Participant Self-Identifier	Prof. Lic.	Years of Prac.	Practice Setting(s)/Salary	U.S. Region	Age	Ethno-racial Self-Identifier(s)
Nicole	LCSW	10	Priv. Pract./$120,000	West	39	Black/West African/European
Dominique	LCSW	6	School; Priv. Pract./$60,000	East	30	Black/African American
Andrea	LCSW	11	Hospital; Priv. Pract./$95,000	South	35	Black/Black American
Paula	LCSW	7	Public School/$60,000	East	38	Black/Dominican
Artistine	LISW	10	Priv. Pract./$85,000	M.W.	35	Black/American
Faith	LSW	11	Priv. Pract./$60,000	East	58	Black/African
Brandi	LCSW	11	Private Practice/$68,000	South	36	Black/N/A
Ciara	LCSW	7	Priv. Pract; Clinic/$86,000	M.W.	32	Black/N/A
Natasha	LCSW	7	Hospital; Priv. Pract./$85,000	South	35	Black/Black
Joanna	LMHC	7	Outpatient/$62,000	N. E.	32	Black/Cape Verdean
Noelle	LMFT	9.5	Priv. Pract./$165,000	M.W.	36	Black/American
Virginia	LCP	8	Priv. Pract./$70,000	East	41	African American
Elizabeth	LMHC	9	Outpatient; ER/$62,000	N.E.	33	Black/African Liberian
Sonya	LCSW	10	Telehealth; College/$108,000	South	38	Black/African American

Findings

My reporting of this project's findings begins with a description of the psychosocial plots that undergirded participant narratives, as well as my reactions to them. Next, I highlight the "self" voices participants revealed in their stories. Then, I describe the contrapuntal voices that unfolded through multiple listenings and interpretative processes. Finally, I share my voice analysis and supporting evidence, and compose my interpretations.

Participants' Plots and Investigator Reactions

While no two narratives contain the exact same content, all stories have beginnings, middles, and endings. I was struck by the differences in how each participant literally and psychologically began her story, as well as the similarities among their observations about self, other, and contextual interrelationships. Some of the Black female clinicians began their narratives with a definitive answer to my question: How do you experience being a Black female clinician in the U.S.? Their answers were frequently accompanied by emotionally congruent affective expressions. One example emerged at the start of Faith's narrative, "I'm gonna say it's empowering." These words were mirrored by her bright smile and a twinkle in her eye, which seemed to communicate her positive sense of accomplishment. Other more critical and psychologically dispirited beginnings included: "It's really rough" (Natasha), "It's everyday oppression" (Sonya), and ". . .being a Black clinician in the United States specifically can be really difficult" (Paula). Still, other participants began their stories with observations and feelings related to their identities. For instance, Virginia expressed, "With my name most people don't assume that I am African American or identify as Black, or even a Brown person, which is still fascinating to me." She delivered this line with levity in her voice, as if being mildly amused by people's surprise about the connection between her racial identity and name. At the same time, the curiosity she mentioned at the end of her line seemed slightly more emotionally reserved and clinical in nature, as indicated by a more neutral tone and facial expression. Additionally, Joanna started her story with an important clarification: "I think I'd like to add that I'm a Black Cape Verdean therapist." Such a clarification emphasized the significance of both racial and ethnic identities. These

variations in *beginnings* reminded me of Hill Collin's (2009) observation that Black women exist in unique and shared contexts simultaneously, and therefore, any analysis of Black women's experiences must include both racial and gender experiences. Her latter observation appeared relevant as common experiential and emotional themes frequently emerged in the middle and ending moments of the participants' stories.

The middle sections of participants' narratives often revealed potent lived experience truths. Sonya shared, "I'm just going to be really raw. It's hard just being like Black in America, you know, it's just hard and people don't understand." The tears she shed and the hyperventilating breathing pattern Sonya presented as she spoke these words brought images of client grief I had witnessed to mind. Furthermore, Elle observed, "I find that working in private practice as a Black female clinician is the safest, the safest for me in terms of, you know, particularly my race." Her comments, spoken in a matter-of-fact timbre, underscored a significant insight shared by most of the participants: Black women must create and maintain their own spaces in order to feel safe. Additionally, Paula disclosed, "So when you are at work, and you have, especially a kid saying stuff, and you're like, 'Wow, yeah, that's, that's how I felt, too.' It can bring up stuff that you didn't even think about." Her revelation exposed one way that gendered racist stress and trauma emerge and affect Black female clinicians: intergenerational clinical practice. This revelation about gendered racist stressors and exposure to multiple forms of trauma influenced most participants' concluding thoughts to my research question.

Many participants ended their stories by drawing conclusions about themselves, their roles, workplaces, colleagues, and/or clients in that moment. Andrea explained her role in the context of working with Black clients in a predominantly White workplace (PWW): "So, um, sometimes having to be that, I guess, mediator in between making sure that this person is getting appropriate care versus an automatic mental health diagnosis with no substantiation." This described mediating role likely contributes to the fatigue many participants noted. For instance, Artistine expressed at the end of her narrative, "More recently, with the pandemic, I've been tired (laughs). With everything that has gone on with George Floyd, I'm tired—there's just a lot of stuff going on." This description of weariness in the context of anti-Black racist violence aligns with other Black female clinicians' experiences at work. Elizabeth described her reactions at work when her co-workers did not acknowledge the murders of Breonna Taylor or George Floyd, "It makes you look at your peers differently, right? Or question their identities and it isolates you further because I know that I'm the only one thinking about that." While this observation about feeling and being isolated in PWW was common, one participant shared a different viewpoint. Faith noted that despite the gendered racist messages she had received over the years, she felt positive about her work and workspace (private practice): "I'm surprised that I'm still here, but I'm making such a big difference in my community." The common narrative thread among participants was that PWW seemed to generate the most acute stress for them which was compounded if Black clients were being harmed by the same helping systems where they were employed. This intersection between workplace context and the participants' feelings about their work shaped my reactions to their stories.

I was emotionally struck by the palpable differences among participants who worked exclusively in private practice, maintained both private practices and organization-based jobs, and served only in PWW. The clinicians who worked in private practice facially beamed with pride, presented with a more relaxed mood, and described how much they "loved their clients" (Artistine) and "always wanted to work for myself" (Elle). This professional flourishing was experienced to a lesser degree by the clinicians who split their professional lives between private practice and PWW (to secure needed benefits for themselves and their families). In contrasting her private practice experience with her full-time job, Andrea noted, "And, I guess, corporate America in a hospital

setting, being a Black clinician is different. I frequently feel like I have to prove myself, my skillset, my knowledge." For clinicians like Andrea, private practice was not only a way to earn additional money, it was a way to offer culturally relevant services to their local Black communities. Private practice also empowered the participants to experience the respect and autonomy often lacking in PWW. Finally, for clinicians working in majority-White environments exclusively, a range of consistent psychosocial burdens were experienced. Sonya expressed, "Man, you get tired sometimes, but you have to be aware, you have to be strong and you gotta be able to just stand your ground and be aware of what's going on." This exhaustion—coupled with the drive to persevere—underscores the cognitive, emotional, and health-related harms Black women are compelled to endure to survive and thrive in PWW.

In listening to the participants' narratives, reviewing their interview transcripts, and re-watching the video recordings of my interactions with the Black female clinicians, I noticed three reactions I had. As a clinician-qualitative inquirer, I entered this project aware of the overlap between the two roles, such as asking people follow-up questions to clarify their personal meaning-making processes. What surprised me was that listening to the participants' stories catalyzed my use of grounding techniques I use as a clinician who works with trauma survivors, such as repeating the mantra, "Remember, what's being described right now is not actually happening to you." The frequent exposure to participants' intense emotional expressions and my use of such coping techniques underscored the tremendous, multi-pronged stressors Black women face consistently in the U.S.—often in silence and isolation. Furthermore, I was genuinely struck by the candor of the participants. I had wondered, and at times worried, that my sex-gender-racial outsider positionality would limit the breadth and/or depth of the information shared during interviews. Consistently, participants expressed a range of emotions (pride, rage, and sadness), leveraged descriptive critiques of White colleagues, workspaces, and systems, and struggled to balance their personal identities, professional roles, client responsibilities, community needs, and workplace cultural norms. Finally, in response to participant stories, I noticed myself hesitating as I worked through the iterative process of choosing a language to accurately describe their lived experiences without pathologizing their distress or romanticizing their resilience in the face of oppressive circumstances. This process involved member checking, consulting dictionaries and thesauruses, and using participants' words as much as possible. These struggles and mitigation efforts shaped the development of the participant voices that helped me answer my research question.

Voice of Self

In shifting from the psychological topography of the participants' narratives to their self-representations, I next focused on every sequential instance of the personal pronoun "I" or its proxy, such as "you," and the corresponding verbs for each participant's stories. This voice is represented in **bold letters**.

Consistently, many participants employed in PWW revealed that being a Black female clinician required an almost constant state of preparation. For example, Sonya narrated, "**You have to**, **You get**, **You have to, You have to be.**" I noticed her use of "you" as a representation of self. The pronoun is both singular and plural and carries with it the psychological weight of individual and community mandates, as exemplified by Sonya's repetitive use of the imperative "have to." When read aloud with the same tone and emphasis as she presented in the interview, the voice exposed the persistent state of bracing for and enduring incoming assaults. It also illustrated the way in which an external authoritative voice may become an internalized self-voice. Such persistent preparation likely drives Black women to be skillfully attuned to PWW interpersonal and cultural dynamics. This attunement was demonstrated in Elizabeth's voice of self as she

described navigating professional relationships and spaces: "**You know**, **I hear**, **I don't know**, **I don't know**, **You know**, **I think**, **I don't necessarily see**, **You know**." Her vacillation between "I" and "You," and "knowing" and "not knowing" highlighted the emotional, cognitive, and sensory energy she expended to be aware of—and respond appropriately to—the mixed messages she frequently encountered at work.

In contrast to the self-voices that manifested in the contexts of PWW, the Black female clinicians who maintained private practices—either full-time or part-time—presented, sounded, and felt different: **I can**, **I know**, **I am** (Virginia); **I knew**, **I knew**, **I would be** (Faith); **I think**, **I feel**, **I have**, **I am**, **I think**, **I have** (Ciara). The differences in these voices appeared to emerge from senses of professional competence and control—delivered with definitive terms and affirmative tones. Moreover, this self-voice often accompanied an expressed, deep, and authentic desire to serve their communities—to be for others what they wanted for themselves.

Assembling Contrapuntal Voices' Analysis and Evidence

The voice of self-interacted in an ongoing dialogue with three other voices that revealed simultaneous degrees of joy, a persistent heightened awareness of self-other-context intersections, and relentless efforts to balance self-care, client-care, and White work cultural dynamics. These voices, and the evidence to support their existence are detailed in the next section.

Voice of Pride

This voice—which appears <u>underlined</u>—a embodied a confidence linked to professional knowledge and skill mastery, personal achievement and empowerment, and Black community advocacy and service. The voice of pride presented as assertive, certain, and joyful. In considering the intersections of her gender, race, ethnicity, and client work Nicole remarked, "<u>it's also kind of like a good feeling, as well, (laughs) to be able to serve and know that I'm in the right place.</u>" Furthermore, Artistine contrasted her current sense of being a Black female clinician with her initial experiences working in PWW, "<u>But, there's another part where then I know like I'm healed, I'm educated, I know how to do the job, I know how to work with my clients. I love working with my clients, you know, it's enjoyable</u>." For the women in this study, the voice of pride grounded them emotionally in the face of professional assaults consistently experienced in PWW, and cognitively provided them with a counter-narrative to the anti-Black messages they encountered from colleagues, supervisors, and the broader macro-culture.

Voice of Vigilance

One of my earliest observations of the Black female clinicians I interviewed was all the ways in which they described attuning to the interpersonal and cultural forces that shaped their workplace experiences. The voice of vigilance—*italicized*—involved sensing and interpreting subtle and overt social and environmental cues, such as PWW verbal tones, eye glances, and non-verbal reactions. Such social cue discernment appeared to undergird participants' ability to accurately anticipate potential threats to self, PWW relationships, or clients. In direct response to my research question, Elizabeth shared, "*Everybody, you know, is apparently looking for a Black clinician, or a clinician of color. At least that's what I hear. I don't know that that's the way you feel when you arrive somewhere.*" Here, Elizabeth illuminated an important distinction between hearing she is valued (essential) and feeling devalued (expendable). Moreover, Virginia commented on her attunement to new clients who visibly react to her differently because her

stereotypically White name does not align with their preconceived notions about her racial identity, "*I get that look and I'm like, okay. 'Yeah, you were expecting anybody, anybody but not me.' So that piece is always kind of the first thing in the room.*" Virginia's comment revealed an important connection between her observation of White clients and her internal process for interpreting her clients' non-verbal behavior. This voice of vigilance is in conversation with another participant's voice that emphasizes effectively navigating PWW.

Voice of Mediating

The voice of mediating narrated the various strategies the Black female clinicians in this study employed to successfully balance their personal identities, professional roles, client needs, and/or workplace relationships. This voice—written in 10-point font—existed in tandem with the voice of vigilance, much the same way that assessment (gathering information) and intervention (responses to gathered information) co-exist. Manifestations of this voice sometimes involved conscious and assertive action, and other times necessitated intentional codeswitching. In response to her pervasive experiences of anti-Black racism in the workplace, Sonya declared, "you gotta be able to just stand your ground and be aware of what's going on, that's why it was so important for me to get a doctorate 'cause is knowledge is power." Here, Sonya storied a connection between an empowering action and her lived experiences of being and feeling oppressed in her professional spaces. Additionally, Artistine discussed the ways in which she negotiated the tensions between experiencing imposter syndrome and managing White supervisors' expectations about her and her work: "Sometimes having imposter syndrome, you know, I was feeling like I have to double check myself and kind of police myself sometimes. So, I'm not either too much or too something, whatever that may be." In this excerpt, Artistine interestingly used the language of White power—policing—to describe her identity-role-work relationship mediating efforts. Eventually for Artistine, like many of the participants in this study, sustaining such mediating efforts resulted in feeling inauthentic and resulted in the choice to work exclusively in private practice.

Interpretation Composition

From the very beginning of the interview process, the Black female clinicians in this study emphasized important connections between their professional environments and their lived experiences within these varying contexts. Thus, any meaningful interpretative composition must begin by foregrounding these relationships. Table 2 juxtaposes three participant narratives, each representing clinicians who practice in either PWW, a mix of PWW and private practice, and private practice exclusively. Moreover, each narrative is presented with LG coding so that readers can more easily track participant voices, and my interpretations. The self-voice appears in **bold**, the voice of pride is <u>underlined,</u> the voice of vigilance is *italicized*, and the voice of mediating is presented in 10-point font. Notice that some voices overlap as indicated by more than one LG code. This coding presentation highlights participants' complex psychosocial realities.

Across the three professional contexts described by the participants, answers to this project's central—How do you experience being a Black female clinician in the U.S.?—emerged through their uses of the self-voice and the three contrapuntal voices. For clinicians who work in PWW, like Sonya, awareness of and experiences with workplace oppression seem unrelentingly assaultive—requiring ongoing attention, negotiation, assertiveness, and achievement to experience any feelings of professional pride. Black female clinicians in this context likely exist in perpetual embattled states. Such states likely increase fatigue, burnout, and trauma risk, as well as contribute to the guarded presentations cited by White colleagues and supervisors to critique Black

professionals. These realities create a “damned if you do, damned if you don’t” dynamic that only reinforces Superwoman and Strong Black Woman coping and their associated harms.

Table 2

Example Comparison of U.S. Black Female Clinician Professional Life Narratives by Context

Sonya (PPW)	Andrea (Mixed Practice)	Faith (Private Practice)
I feel like just as a Black female, an African-American female, **you have to be** *aware of your, like the oppressors,* **you know**. *It's everyday oppression, certainly in your workplace*. *Definitely in the workplace, in school, it's everywhere* and **you have to be** *aware of it* and *make sure that* **you have to be** *prepared* and *ready to tackle it*. **I'm just going to be** *really raw*. *It's hard just being like Black in America,* **you know**, *it's just hard* and *people don't understand*, like, it’s everyday **you're** *oppressed*. **You have to fight** it. Man, **you get** *tired sometimes,* but **you have to be** *aware*, **you have to be** strong and **you gotta be able** to just stand your ground and **be aware** *of what's going on* and be, *that's why it was so important for me* to get a doctorate 'cause knowledge is power.’	**I would describe** being a Black female clinician. Well, **I do like** it because this is what **I do**, it's my norm, (laughs) but **I do** feel like there is a lot of navigation in certain senses. *As a private practice clinician, it's like freeing, it's independent* and a lot of my clients are Black females, and so *it's really an opportunity to connect* and *provide services to somebody that looks like you and perhaps certainly has similar experiences.* ***You also understand*** *some of the things that seem to transcend Black community-related mental health or feelings, emotions and things like that*. And, ***I guess***, *corporate America in a hospital setting, being a Black clinician is different*. ***I frequently feel*** *like* ***I have to prove*** *myself, my skillset, my knowledge*. ***I also have to navigate*** *perception and the microaggressions, like, ‘I think you're aggressive,’ because I was firm or, ‘You're being rude,’ because of* ***my perceived tone***, *even though it doesn't change*. Also, **I have to educate** other people on Black experiences or how they might perceive Black people who are coming in to the hospitals with mental health crises, or their attitudes or behaviors on a unit or in an emergency room, and sometimes having to educate to say, ‘That doesn't mean it's a psychosis.’ Um, ‘That doesn't mean that they have bipolar disorder or schizophrenia.’ Like, ‘This could be an appropriate response to what they're reporting is happening,’ and so, um, sometimes having to be that, **I guess**, mediator in between making sure that this person is getting appropriate care versus an automatic mental health diagnosis with no substantiation	**I'm gonna say** it's empowering. **I live** in a community that is becoming diversified, but **I'm** *the only African-American clinician in the area*. And, **I was empowered** to go back to graduate school and to make sure that others like me could see **we are** just as qualified if **we get** the proper training. **I've** been in [Mid-Atlantic state] over 20 years now**. I was married**, had two young kids. **I'm** now divorced. But, when **I was going** through my divorce, **I went back** to graduate school to get my masters in social work. And **I remember just telling** my kids, ‘It's gonna help me and you guys in so many ways, you just don't know. And even during that journey and *being in a,* **I guess**, *male dominant White, Caucasian oriented area, people would say to me, ‘Who are you? Who do you think you are? Why are you in school?”* **I just got** *negative vibes for* trying to educate myself more. **I continued to pursue** it and pursue it. And even after graduating, **I was shunned** *by some people*, but in my heart, **I knew I'm** a good person. **I knew** that **I would be** doing good things. **I stayed** in this area. And **I'm surprised** that **I'm** still here, but **I'm making** such a big difference in my community.

The Black female clinicians who split their professional time between PWW and private practices, like Andrea, narrated multi-layered experiences of pride that involved greater feelings of authenticity. This more genuine sense of identity seemed to foster deeper and more satisfying connections with Black clients and communities more generally. Unlike participants who worked only in PWW, the clinicians who straddled both PWW and private practice seemed to experience feelings of pride that mitigated the deleterious effects of working in PWW and generated enduring joy. Moreover, the participants situated in both professional spaces detailed the ways in which they felt valued and under-appreciated in PWW. Andrea felt both pride and the burdens of translating Black experiences for White colleagues who might otherwise misdiagnose and mistreat Black clients while simultaneously mediating her colleagues' perceptions of her. In this mediating process between advocating for Black client needs and managing White co-worker perceptions, Andrea and the other participants with similar professional lives seemed to be essential and feel expendable. Over time, these conflicting experiences led some Black female clinicians to leave PWW and work exclusively in private practice, where some Black clients may have less access to culturally competent services because they do not have insurance or the ability to pay.

The private practice clinicians in this project, such as Faith, provided the most consistently positive and optimistic narratives about their current work experiences. They reported optimal levels of professional and personal autonomy and intersectional identity integrity. Moreover, these participants observed direct community benefits as a result of their work, and frequently felt their work aligned with their values. Finally, these clinicians frequently couched their experiences with gendered racist oppression in the past. These pasts often catalyzed the decision to leave public practice in PWW forever.

Discussion: Research Contributions and Corroborations

In this study, the participants' narrative voices amplified context-specific, gender-racial identity-informed consciousnesses, feelings, and behaviors as they related to their professional lives. Their stories both contribute new information to the knowledge bases related to Black female clinicians' workplace experiences and align with the findings of other studies. For example, unlike many qualitative studies whose participants often live in similar geographic areas, the clinicians in this study lived in five different regions of the U.S. across eight different states. Moreover, participants lived and practiced in rural, suburban, and densely populated urban settings. Additionally, their clinical work milieu included in-patient hospital, out-patient medical, community agencies, public schools, military bases, college campuses, and group and solo private practices. Furthermore, the fact that participants worked either in PWW, a mix of PWW and private practice, or private practice exclusively bolstered my ability to explore contextual-polyvocal intersection similarities and differences. For example, the voice of pride appeared to function as a survival tool or catalyzing force for clinicians working in PWW, while the same voice seemed to narrate an intrinsic and enduring joy for clinicians working in private practice.

While this project's unique contributions include greater geographic representation and varied workplace contexts, many of the findings echo other researchers' analyses. B. Jones's (2020) voice-centered work with Black male and female clinicians (n=9) who worked in PWW observed two overarching themes and an intersectional theme. The two overarching themes included *visibility* and *dueling consciousness*. The former theme pertained to clinicians' needs to manage being invisible or hyper-visible in the workplace, which often manifested as "having their competence and intentions scrutinized" (p. 72). The latter theme involved being perceived in racially stereotyped ways, rejecting those stereotypes, and/or adopting all or parts of racial stereotypes to manage conflicts with White colleagues. Similarly, these dynamics were embedded

in the voices of vigilance and mediating described in this study. Furthermore, Godoy and her co-authors (2023) illuminated the reality that Black female essential workers who were exposed to the dual pandemics of COVID-19 and police violence experienced extensive distress and an unrelenting responsibility to be resilient. This finding parallels my participants' narratives about working in PWW, i.e., "You gotta be strong" (Sonya). Finally, the work of Cupid and Bogues (2023) underscored that most of the Black female healthcare workers they interviewed reported feeling "unsafe and undervalued" (p. 5) at work. Such feelings mirror the sentiments of the Black female clinicians in this study who worked in PWW.

Implications

This study's findings—and the insights highlighted by other investigations—revealed that professional settings created and managed by predominantly White people often harm Black women. These harms include experiencing gendered racist microaggressions, feeling inauthentic, navigating institutional obstacles to professional development and promotion, being exposed to pervasive distress and trauma without supportive resources, and enduring gendered racist-related health conditions. To manage these harms, Black women have developed myriad coping strategies which may either alleviate or exacerbate harms. In this study, the voices of vigilance and mediating revealed the complex ways awareness and active problem-solving could produce pride and result in exhaustion depending on the participant's workplace contexts. This reality has implications for hiring, supervising, retaining, and promoting Black female clinicians and assessing and training White colleagues, mentors, and leaders. Such efforts are needed to make PWW better environments to work in for all professionals.

To promote Black female clinicians' thriving in PWW, White professionals need to have their anti-gendered racist skills and knowledge bases assessed by external resources such as consultants. This same type of assessment needs to include organizational policies and procedures, as well as workplace power structures. Such assessments should include specific change and training recommendations that can be operationalized organization wide. These recommendations ought to target necessary attitudes, behaviors, policies, and structures that directly support hiring, mentoring, retaining, and promoting Black female clinicians. One suggestion may include, for example, financially recognizing and awarding Black female clinician's cultural skills the same way organizations often award higher salaries to bi-lingual clinicians. Furthermore, organizations should consider developing systems for ensuring that Black female clinicians are receiving mentoring and other professional development opportunities that align with clinicians' goals, as well as workplace needs. Finally, power structures within PWW need to intentionally, actively, and collaboratively re-create power structures to involve Black female clinicians from the outset. Offering Black women a "seat at the table" that was never designed for them in the first place replicates the tokenism often embedded in White-initiated "power-sharing" efforts. Only when these proactive and thoughtful efforts are completed by White colleagues will Black female clinicians feel safe and valued enough in PWW.

Limitations and Future Research

While this project made several contributions to understanding Black female clinicians' experiences of working in the U.S. during a dual pandemic, limitations exist and future research is needed. One limitation of this project is its exclusive focus on Black female clinicians. While race and gender are arguably the most salient and influential identities that shape lived experiences in the U.S., the experiences of Black female clinicians are not necessarily transferrable to Black men

or Black women in other professions. As a result, future projects should explore these different race-gender-profession intersections. Moreover, while the participants in this study lived with two marginalized identities, other forms of minoritized experiences were not represented, such as LGBTQI+ living in poverty and/or with a disability. Additionally, the insights generated in this study emerged through in-depth interviews and were not quantitatively assessed. Therefore, it is impossible to make probability-based inferences about Black female clinicians' workplace experiences in the U.S. Prospective research projects should empirically investigate the experiences of people living with three or more intersectionally-oppressed identities. Furthermore, while great efforts were made to recruit participants for this project, only 14 participants agreed to participate. Three possible explanations exist. One possibility: my positionality as a White cisgender man. Historically, Black women have experienced violence and exploitation by White men, and thus, my identities may have created a participation barrier. Also, it is possible that my various recruitment efforts did not appear in spaces where Black female clinicians get information. My efforts focused on general professional spaces like LinkedIn and large professional message boards. A third potential explanation for why only 14 participants were recruited for this project may be the fact that I had a limited amount of time for recruitment. This project emerged from dissertation research, which needed to adhere to relatively strict deadlines. As a result of these limitations, future projects should include Black female researchers to address potential positionality concerns, as well as advertise in spaces dedicated to Black mental health professionals. Subsequent research should also expand its recruitment timeframe to increase participation. Finally, more projects need to formally investigate the best ways to assess and address gendered racist dynamics meaningfully in PWW. Such investigations should focus on organizational hiring, mentoring, retaining, and promotion processes. These efforts would likely help create the contexts for Black female clinicians specifically, and Women of Color more broadly, to thrive in the workplace.

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