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Mitigating the health effects of systemic racism: Evaluation of the race-based stress and trauma empowerment intervention

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Abstract

Background: Disparities in physical and mental health among Black, Indigenous, and People of Color (BIPOC) are well-documented and mirrored in the Veteran population. Chronic stress due to racism and discrimination is one possible mechanism driving these negative health outcomes. The Race-Based Stress and Trauma Empowerment (RBSTE) group is a novel, manualized, health promotion intervention designed to address the direct and indirect impacts of racism among Veterans of Color. This paper describes the protocol of the first pilot randomized controlled trial (RCT) of RBSTE. This study will examine the feasibility, acceptability, and appropriateness of RBSTE compared to an active control (an adaptation of Present-Centered Therapy; PCT) in a Veterans Affairs (VA) healthcare setting. A secondary aim is to identify and optimize strategies for holistic evaluation.

Methods: Veterans of Color ($N = 48$) endorsing perceived discrimination and stress will be randomized to RBSTE or PCT; both groups will be delivered in 8 weekly, 90-min virtual group sessions. Outcomes will include measures of psychological distress, discrimination and ethnoracial identity, holistic wellness, and allostatic load. Measures will be administered at baseline and post-intervention.

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Conclusion: This study will inform future interventions targeting identity-based stressors and represents an important step in advancing equity for BIPOC in medicine and research.

Clinical trial registration number: NCT05422638

Keywords

Race-based stress; Minority mental health; Randomized controlled trial; Allostatic load; Veterans; Discrimination

1. Introduction

Racial and ethnic health disparities are well-documented across multiple health domains including cardiovascular disease, obesity, diabetes, renal disease, HIV, and all-cause mortality [7,9,20,26,49,69]. Disparities also exist in mental health. Black and Latinx individuals develop posttraumatic stress disorder (PTSD) at higher rates than White individuals [56]. Although rates of other mental health disorders are roughly equal to those of White people, Black, Indigenous, and People of Color (BIPOC) experience greater severity and chronicity of symptoms yet are less likely to seek treatment ([31]; [70]). Allostatic load (AL), which quantifies the cumulative biological impact of chronic stress exposure and is associated with increased disease burden and mortality [4], is higher among BIPOC compared to White Americans ([45]). BIPOC have worse access to and poorer quality of health care compared to White people ([1]; [3,38]). Such disparities are upheld not by innate biological differences, but rather by inequities in social, political, and economic systems [28].

The US Veteran population is not exempt from these inequities: Veterans of Color (VOC) show poorer clinical outcomes such as elevated blood pressure, cholesterol, and glucose, and greater heart disease mortality [60,62,67]. VOC are more frequently diagnosed with mental health issues such as PTSD [43] and are less likely to receive minimally adequate mental health care [41,57].

Race-based discrimination appears to directly and indirectly contribute to health disparities. A meta-analysis of 192 studies found associations between perceived discrimination and increased physical and mental health problems [51]. Perceived discrimination is linked to cardiovascular disease and associated risk factors including hypertension and obesity ([71]; [9]; [72]), predicts increased AL when controlling for other known risk factors [61], and is associated with more rapid telomere shortening, a marker of an organism's systemic aging [15]. Experiences of discrimination are also associated with poorer mental health. A longitudinal study of Black Americans found an association between increased frequency of racial discrimination and greater general psychological distress, depressive symptoms, and days with poor mental health [36]. Discrimination has been shown to mediate the association between minority status and problems with mental health [17] and sleep [16]. Perceived discrimination also appears to indirectly influence health via medical mistrust, decreased healthcare utilization, and poorer health behavior [3,38,44]. Perceived discrimination is linked to poorer medication adherence [35], less engagement in preventive services ([42]), and risky health behaviors [8]. More specifically, Veterans' reports of past discrimination in

Veterans Affairs (VA) healthcare settings have been associated with poorer Veteran-provider interactions during current visits [30].

Taken together, these findings are consistent with models that conceptualize racism as an acute and chronic psychosocial stressor that contributes to poor physiological and mental health via neurobiological stress pathways and negative health behaviors [5,14,51]. Chronic stress interventions have been fruitful in many contexts; for example, AL has been shown to be modifiable via group behavioral interventions among African-American women at risk for diabetes [59], Chinese women with metastatic breast cancer [68], and older adults with insomnia [13]. The Race-Based Stress and Trauma Empowerment (RBSTE) group [12] is a novel health promotion intervention designed to address individual-level direct (i.e., chronic stress) and indirect (i.e., health behaviors) factors that sustain health disparities among VOC. The RBSTE group is an 8-session, manualized, group intervention to promote wellness among VOC who have experienced distress due to racism and discrimination. Modules include psychoeducation, skill development, and ethnoracial identity-based exercises to promote healthy coping, self-advocacy, and empowerment.

One novel component of RBSTE is its inclusion of only BIPOC Veterans. This parallels other stressor-specific group interventions that are commonly implemented in VA (i.e., groups for military sexual trauma). Moreover, a BIPOC-only group may be important identity-safe space for VOC. Eliacin et al. [24] found that identity-threatening cues in the hospital environment (e.g., lack of diverse representation among providers and hospital artwork) negatively impacted patient engagement and patient-provider communication, highlighting the need for identity-safe spaces for VOC. Another study found that a PTSD support group for African-American male Vietnam Veterans facilitated open communication, provided support for coping with racism, and improved social support [32]. The group format of RBSTE is theorized to reduce shame, a major barrier to processing and coping with race-based stress [12]. As VA continues to recognize the impact of identity-based stressors and develop programming for those with minoritized identities, a group for BIPOC Veterans represents a significant step toward more inclusive care.

RBSTE has been implemented in over 25 VA hospitals in a variety of clinic settings (e.g., Outpatient Mental Health, Psychosocial Rehabilitation and Recovery Center, Primary Care-Mental Health Integration); however, there have not been any controlled trials of the intervention with VOC. A qualitative study of an adaptation of RBSTE among Black, civilian women at risk for cardiovascular disease found preliminary evidence for its feasibility and acceptability [18]. Participants reported high levels of satisfaction with the program; 81% endorsed practicing the skills learned in real life situations, and 95% stated they would recommend the program to a friend. Participants described that the program increased awareness of racism-related stressors, improved coping with race-based and other stressors, and increased empowerment and emotion regulation. A pilot randomized controlled trial (RCT) of the same community adaptation found that the experimental group had significant declines in avoidant coping compared to the waitlist control group but no significant changes in depression, stress, anxiety, or levels of tumor necrosis factor-alpha (TNF-α) or high sensitivity C-reactive protein (hsCRP; [54]). These results could reflect low

baseline levels of distress among this sample, as participants were recruited based on risk for cardiovascular disease.

This study will be the first pilot RCT of the original RBSTE intervention for VOC compared to an active control. We aim to examine its feasibility, acceptability, and appropriateness. Recruitment feasibility is particularly important given high levels of distrust in medical research among ethnoracial minorities, driven by a history of medical experimentation and ethical violations [6,19]. A secondary aim of this study is to identify and optimize strategies for holistic outcomes evaluation. Our findings may identify outcome measures that increase sensitivity, reduce participant burden, and deepen our understanding of the widespread health impact of racism and discrimination.

2. Method

2.1. Participants

Veterans ($N \approx 48$, potential range 24–60) will be recruited from the VA San Diego Healthcare System and the surrounding community via brochures and flyers, provider referrals from outpatient clinics (e.g., primary care, mental health, transition care management, centralized intake clinic), and lists of Veterans (obtained from Dr. Lang's existing trials) who have expressed interest in learning about ongoing research. The inclusionary criteria, which are assessed by telephone or Qualtrics (VA-approved data collection platform), are: (1) self-identified as a BIPOC; (2) Veteran; (3) age 18 or older; (4) able to consent to study activities; (5) endorsing experiencing one or more perceived discrimination experiences "a few times a year" or more frequently on either the *Everyday Discrimination Form* (short version) or the *Major Experiences of Discrimination Scale* (abbreviated version; [58,65]); and (6) endorsing stress on the validated single-item, "Stress means a situation in which a person feels tense, restless, nervous or anxious or is unable to sleep at night because his/her mind is troubled all of the time. Do you feel this kind of stress these days?" [25]. Exclusionary criteria, which are evaluated via interview over videoconferencing by a trained clinician, include: (1) serious mental illness, alcohol/substance use, or cognitive impairment that may interfere with the ability to benefit from group (e. g., severe depression, psychotic illness, mania, dementia, untreated alcohol/substance dependence); and (2) serious suicidality or homicidality (e.g., ideation with plan/intent) that is likely to require urgent/emergent intervention within the study period.

2.2. Procedures

Veterans who express interest in study participation will be provided with general information about the study. Those who remain interested will engage in the informed consent process (via VA-approved videoconferencing programs), where they will be emailed copies of the IRB-approved written consent document, HIPAA, and the Experimental Subject's Bill of Rights. These documents and participant questions will be reviewed during the consent visit. Veterans will be allowed any amount of time before agreeing to participate and can sign the documents using remote procedures (VA Docusign) at a later date. After providing written consent, Veterans will be emailed a link to complete the baseline assessments online via Qualtrics. Participants will come to the local facility for

collection of biometric data and blood/urine biomarkers. Saliva collection kits with detailed instructions will be mailed to participants and returned at the time of the lab visit.

Randomization will occur at the group level: once a cohort of 4–10 Veterans has enrolled and completed the baseline assessment, the cohort will be randomized by the study statistician to either RBSTE or a Present-Centered Wellness Group (PCWG), a health promotion intervention based on Present-Centered Therapy. Although group randomization has disadvantages compared to individual randomization (e.g., lack of blinding of the final 1–2 groups), these can be managed and are outweighed by beginning groups more frequently. Groups will meet in weekly 90-min sessions for 8 weeks. Videoconferencing will be used by all participants to minimize barriers to participation, including transportation and public health concerns. The assessment battery will be repeated after the end of the final group. Participants will be compensated $50 for each assessment point for a total compensation of $100.

2.3. Interventions

Group facilitators will be VA mental health providers (licensed, privileged psychologists and/or doctoral-level psychology fellows under the supervision of licensed psychologists) who have completed a 4-h training in provision of culturally sensitive mental health care to a diverse military population. Training in the interventions and ongoing supervision will be provided by experts in each approach (C. Wang for RBSTE; A. J. Lang and S. Kelsven for PCWG). RBSTE and PCWG facilitators will review the manual in detail, co-facilitate a group with a previously trained facilitator (for PCWG this can be waived for individuals with experience with similar interventions), and receive session-by-session feedback about their first group. RBSTE facilitators will additionally attend monthly consultation calls with national experts in RBSTE. For each intervention, supervision will occur weekly for the duration of the first group. Thereafter, we will conduct monthly supervision and randomly select 20% of sessions for review by intervention experts. Written feedback will be provided to facilitators after session review and additional training will be provided as needed. Fidelity will be assessed using fidelity forms adapted from a previous trial [37]. Facilitators in both treatment groups will be drawn from the same pool and will identify as BIPOC. Studies on racial concordance/discordance among therapeutic dyads suggest that race-concordance has a small or inconsistent impact on therapy outcomes; however, BIPOC patients seem to prefer being treated by providers from their own ethnoracial background [11]. Although groups will likely be comprised of BIPOC of various ethnoracial backgrounds, the presence of BIPOC facilitators may help preserve the safety of the group environment, particularly given the challenging nature of group topics (e.g., White guilt, privilege).

RBSTE session-by-session modules are outlined in Table 1. RBSTE begins by normalizing experiences with race/ethnicity and reflecting on how one’s identity has been affected by positive and negative experiences with race. Each session includes psychoeducation about various forms of racism and their adverse mental and physical effects, based on Carter’s [14] race-based traumatic stress model. Skills from evidence-based psychotherapies (Cognitive Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT))

are included to restructure maladaptive beliefs, encourage values-based action, and promote active coping. This process creates a shared language for healthy communication and self-advocacy, combating experiences of helplessness and enhancing resilience. Cultural sharing is incorporated weekly to engender pride in one's racial/ethnic identity, counter negative messages, and promote positive cultural identification. A weekly Empowerment Process Journal is assigned as homework to further buffer against the oppressive effects of discrimination.

PCWG was developed as a control for nonspecific benefits of RBSTE [27]. Facilitators focus on current challenges in participants' lives; they do not teach specific skills but rather draw on the wisdom and experience of group members to address stressors. Common therapeutic techniques include mirroring participants' experiences and nondirective problem-solving. Homework involves keeping a daily record of stressful events to discuss in group.

2.4. Measures

The first aim of this study involves evaluating strategies for recruiting VOC. *Enrollment rate*, defined as the number of contacts per enrollment, will be used to optimize the future approach to accrual. Gathering information from Veterans and providers about reasons for declining participation or referral will be important in determining the representativeness of the sample. *Number of enrollments per month* will be viewed as successful if at least four individuals are enrolled per month as that level of recruitment represents a reasonable wait time (average 2–3 weeks) to begin a group. *Initiation rate* will be defined as the proportion of Veterans who initiate the intervention among all consented participants. This will help inform successful recruitment strategies and identify areas for improvement. As these behaviors are recorded prior to the first session, we do not expect group differences.

The second aim is to evaluate the groups' acceptability, appropriateness, and feasibility. Participant behavior is one important marker of participants' perceptions of the project and their ability to comply with research procedures. *Retention rate* will be defined as the percent of enrolled sample completing both assessment time points; at least 80% retention rate will be considered successful. *Per protocol completion rate* will be defined as the proportion of subjects who attend 6 or more sessions among those who initiate an intervention; at least 90% completion rate will be considered successful. *Intent-to-treat completion rate* will be defined as the proportion of subjects who attend 6 or more intervention sessions among all randomized subjects; at least 80% is the target. *Compliance with homework* will be assessed as the proportion of subjects who "moderately" or "fully" complete assigned homework as rated by the facilitator, with a goal of at least 80%. After the completion of each group, Veterans will be queried about their experience and perceptions of their respective intervention using the *Acceptability of Intervention Measure (AIM), Intervention Appropriateness Measure (IAM)*, and *Feasibility of Intervention Measure (FIM*; [64]). The 4-item measures have strong content validity, test-retest reliability and sensitivity to change [64]. The psychotherapy version of the *Provider Rating Scales*, which were previously used to assess perceptions of VA mental health providers [57], will be adapted to assess Veterans' perceptions of the group leader.

We will employ a self-report assessment battery before and after the intervention to assess Veteran wellness and functioning. Veterans will complete the 21-item *Brief Personal Health Inventory (Brief PHI;* [21]). The Brief PHI includes 3 items of physical well-being, mental/emotional well-being, and daily life, which are rated from 1 (miserable) to 5 (great). Participants also complete ratings of one's current and ideal state from 1 (low) to 5 (high) for each of the nine areas in the VA Circle of Health: Moving the Body; Recharge; Food and Drink; Personal Development; Family, Friends, and Co-Workers; Spirit and Soul; Surroundings; Power of the Mind; Professional Care. The Brief PHI was originally designed for clinician use and currently has no published psychometric properties; however, a recent large-sample study of Veterans has indicated excellent internal reliability (Chu et al., under review). Participants also will complete the *21-item Depression Anxiety and Stress Scales (DASS-21;* [40]), which were developed to efficiently differentiate depression and anxiety in clinical and research settings and have well-established validity. Items are rated from 0 (did not apply to me at all) to 3 (applied to me very much, or most of the time) and reference symptoms over the past week. The DASS-21 shows consistency in means, internal consistency and factor structure across racial groups [50]. The 21-item *Trauma Symptoms of Discrimination Scale (TSDS;* [66]) will be used to measure anxiety-related trauma symptoms due to experiences of discrimination. Items are rated from 1 (never) to 4 (often), based on the amount of distress caused by discriminatory acts. It has excellent reliability and good concurrent and discriminant validity [66]. Coping will be measured using the 25-item *Coping with Discrimination Scale (CDS;* [63]). Participants respond to how much they use particular strategies to cope with experiences of discrimination and items are rated from 1 (never like me) to 6 (always like me). The CDS has good reliability and validity and is relatively invariant across racial/ethnic groups. The *Multigroup Ethnic Identity Measure – Revised* [10] is a 6-item measure with good psychometric properties and established invariance across multiple racial groups. It will be used to assess affiliation with one's racial group, which has been shown to moderate the relationship between discrimination and mental health ([74]). Items are rated from 1 (strongly disagree) to 5 (strongly agree). Insomnia severity over the past week will be assessed with the 7-item *Insomnia Severity Index (ISI;* [2]). Insomnia is a discrimination-related condition that disproportionally affects BIPOC [16]. Items are rated on Likert-type scales from 0 to 4, with higher values indicating more problems. The ISI has good internal consistency and reliability, and is sensitive to treatment response in clinical populations [2,46].

Allostatic load will be assessed within a week before and after the intervention by measuring 10 biomarkers of interest, specifically systolic and diastolic blood pressure (SBP, DBP) [cardiovascular]; hemoglobin (Hb) A1c, high density lipoprotein (HDL), and triglycerides [metabolic]; urine epinephrine (Epi) and norepinephrine (NE) and waking salivary cortisol [stress neuroendocrine]; and plasma interleukin (IL)-6 and hsCRP [inflammatory]. Venous blood will be drawn via venipuncture between 8 and 10 AM after overnight fasting at rest. The VA clinical chemistry lab will measure Hb A1c and the lipid panel (for HDL and triglycerides). Plasma from 5 mL of blood will be collected and frozen at −80C until assayed to measure IL-6 and hsCRP using electrochemiluminescence assay (Mesoscale Discovery). Spot urine will be collected for Epi and NE and frozen at −80C until assayed using ELISA-based immunoassay and adjusted for creatinine levels, which are well representative of

general sympathetic output of an individual. Salivary cortisol levels will be measured in saliva collected the morning of the blood draw visit upon wakening. Saliva samples will be frozen at −80C until assayed using immunoassay (Salimetrics). Both pre- and post-samples from a given participant will be assayed together using reagents from a single lot number by one technician who is blinded to the condition. The intra- and inter-assay coefficients of variability of these proposed markers are generally <10%. Seated SBP and DBP will be measured after a 5-min of rest, and the average from 3 readings will be used. The *AL index (ALI)* for each participant will be calculated by assigning 1 to the highest quartile values vs. the rest 0 for each marker and summing them [53]. Thus, a possible range of 0 to 10 will emerge, indicating the lowest to highest ALI. There are differing ways for ALI calculation; our proposed methods and markers are based on the best consensus from several studies and reviews that also demonstrated evidence of AL reflecting chronic stress and eventual health outcomes including all-cause mortality [23,29,33].

3. Data analysis plan

3.1. Sample size

The sample size was determined based upon the primary feasibility aim. To evaluate projected rates of enrollment and retention, we assessed the precision of these estimates using various sample sizes. For example, the width of the two-sided 95% binomial exact confidence interval (CI) for a 0.80 initiation rate would be 0.266 for a sample size of 40 and 0.237 for a sample size of 50. We plan to enroll approximately 48 Veterans, for 8 groups (4 groups of each intervention) with approximately 6 Veterans (range of 4–10) in each group. We additionally evaluated the effect size for outcome measures of interest that could be detected with this intended sample size with 80% power and a two-sided type I error of 0.05. Paired *t*-test estimates for change from pre- to post-intervention indicated that medium effects of 0.41 and 0.60 could be detected for the sample sizes of 24 per intervention and 48 total, respectively. To compare the outcome change between the RBSTE and PCWG groups, we could detect an effect size of 0.83 for the difference with 24 subjects per group. The sample size assessment was conducted using R [52].

3.2. Feasibility indicators and clinical outcomes

All analyses will use a two-sided test of hypotheses, with a significance level of 0.05. Study variables will be examined for outliers and missing data and summarized using descriptive statistics. Outliers will be determined if any data is erroneous by summary statistics and data cleaning visualization methods. Missing data will be handled according to the procedure recommended by Little and Rubin [39], including that subjects with missing data will be compared to those without on primary outcomes. Effectiveness of randomization will be tested using Wilcoxon rank sum test and Fisher's exact test to compare baseline demographic and clinical variables for participants between the two conditions. Baseline variables that are significantly associated with the outcome or significantly different between intervention conditions ($p < 0.15$) will be considered as potential confounders and included in the analysis plans as appropriate. Backward elimination will be used to remove insignificant covariates in a model, starting by removing the variable with the largest p-value, ultimately retaining variables with $p < 0.10$ in the final model.

Primary feasibility will be determined by estimating 95% binomial exact CIs for rates of enrollment and retention indicators for the overall sample and by each intervention condition. Fisher's exact test will be used to compare rates across intervention conditions and logistic regression will be used to examine differences in rates between intervention conditions. Acceptability and appropriateness ratings (AIM, IAM, FIM and Provider Rating Scales) will be estimated by means, standard deviations, and 95% CIs, and the difference in these ratings between intervention groups will be compared by Wilcoxon rank sum test. Linear regression will be used to model differences in acceptability and appropriateness between intervention groups.

Within-group change will be assessed separately by intervention group on psychosocial outcomes and AL markers, by estimating the effect size (mean and standard deviation) for pre- to post-intervention change. The pre to post-intervention change in AL markers and psychosocial outcomes will be compared between intervention groups using linear random effect model. The mixed effects model allows for inclusion of subjects with missing data, including those who terminated before study completion, without relying on data imputation. To enhance feasibility of future trials, we intend to identify a subset of baseline AL markers that are significantly associated with psychosocial outcome measures, as administering measures for a narrower set of markers would reduce burden. The association between each baseline AL marker and the change in psychosocial outcome will be pre-screened first, and we will include those with p-value <0.15 in the multivariable model. Backward elimination will be used for variable selection. A sensitivity analysis using Least Absolute Shrinkage and Selection Operator (LASSO) regression will be conducted to assist in variable selection through the elimination of irrelevant parameters.

4. Discussion

There is compelling evidence that stress due to racism and discrimination contributes to adverse physical and mental health outcomes among BIPOC [51]. Systemic changes must ultimately occur to stop the perpetuation and reverse the impact of racism, but there is also a need for individual health promotion interventions to mitigate the impact of living in an unjust society. RBSTE is a novel intervention for VOC that combats the negative effects of racism through psychoeducation, skills development, and empowerment. Although there is growing VA implementation of this program, there have not been any controlled trials examining its effectiveness. This pilot study will begin to address that need.

This study has several strengths. While general stress management interventions exist, the focus on racism-related stress in RBSTE is novel and fills a gap in services for VOC. This will be increasingly important as the Veteran population becomes more diverse; recent projections estimate that the ethnoracial minority Veteran population will increase from 25.5% in 2020 to 35.3% in 2040 ([47]). There is also a significant gap in research focused on ethnoracial minority health. Despite the National Institutes of Health (NIH) mandate requiring the inclusion of women and minorities in clinical research [48], BIPOC continue to be underrepresented in medical research [22,34,55]. This not only limits generalizability of clinical findings but also prevents communities of color – who often have disproportionate disease burden – from potentially benefiting from the results of research.

Our study is the first of its kind to be funded within VA, representing an important step in addressing equity in research.

There are potential challenges and limitations to this study. BIPOC have historically been under-engaged in research, in part due to distrust fostered by a history of exploitation, current public health violations, and ongoing discrimination in medicine [19]. Assessing recruitment feasibility and acceptability of the intervention will be crucial and may inform more culturally competent strategies for recruitment in future clinical trials. Additionally, as a feasibility study, our sample size does not allow enough power for comparing psychosocial and biological outcomes across the intervention groups. All findings will be preliminary and may support justification for future, larger trials.

RBSTE represents an important innovation in addressing the health of VOC. As one of the nation's largest integrated healthcare systems, VA provides an opportunity for this intervention to have a widespread impact. RBSTE may serve as a model for future interventions targeting identity-specific stressors. This study also provides the opportunity to assess and address barriers to BIPOC engagement in research. We hope this study will inform other clinical trials and contribute to growing efforts to advance equity for underserved minoritized populations.

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Data availability

No data was used for the research described in the article.

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Table 1

Content of RBSTE Sessions.

Session	Description
1	"Establishing the Space": orientation to group structure, history, and purpose; establish ground rules; group member introductions and community-building activity; communal sharing of experiences with racism ("Conocimento"); introduce mindfulness, weekly cultural sharing exercise, and empowerment process journal.
2	"How Do We Begin to Address Race?": discuss and acknowledge race and racism; explore common barriers; introduce values-congruent strategies for communication with White and cross-racial providers.
3	"Resistance to Learning About Race/Racism": view video excerpts from Jane Elliot's "blue eye/brown eye exercise;" discuss experiences of resistance; define and discuss concepts of privilege, White guilt, and White shame.
4	"Overt Racism and Microaggressions": define overt vs covert racism (microaggressions); discuss impact of microaggressions; review empowering strategies for responding to microaggressions.
5	"Aversive Racism, Institutional racism, and White Privilege": Define aversive racism; explore the impact of unconscious bias and white privilege within institutions; discuss and normalize common emotional reactions to racism.
6	"Validating and Depathologizing the Impact of Race-Based Traumatic Experiences": introduce the ABC model of cognitive behavioral therapy and apply to experiences of race-based stress; define race-based traumatic stress; discuss experiences of race-based traumatic stress in context of law enforcement encounters, current events, and more; discuss self-care strategies.
7	"Stress, Anxiety, and the Alarm System": introduce general adaptation syndrome (GAS) and relevance to race-based stress; discuss long-term health impacts of race-based stress; use cognitive model to introduce coping strategies for cognitive, affective, and behavioral impacts of race-based stress.
8	"Resilience and Empowerment": define and reinforce resilience and empowerment in the context of race-based stress; reflect on personal/familial/community strengths; group feedback, take-aways, and commitments to future action.