Addressing the Impact of Racism on Veterans of Color: A Race-Based Stress and Trauma Intervention

Marie Carlson
University of Texas at Austin

Maurice Endlsey
Edward Hines Jr. Veterans Affairs Medical Care System, Hines, IL

Darnell Motley
University of Chicago

Lamise N. Shawahin
Governors State University

Monnica T. Williams
University of Connecticut

Objective: Veterans of color represent a unique intersection of individuals at risk of experiencing racialized discrimination during their military service and of developing negative mental health outcomes. At the same time, there has been little guidance for Department of Veterans Affairs (VA) health-care providers in how to address these clinical issues in a culturally competent manner. This article describes a group-based intervention targeting race-based stress and trauma among veterans implemented at 4 different sites. Method: The authors describe the development and application of this intervention, including information about development of the group and general aims as well as the process of implementing the group across settings. Results: The authors address broad factors to consider when implementing the group, including navigating diversity dimensions within the group and addressing provider cultural competence and identity. Finally, the authors review recommendations for future directions for implementing the group within and outside of a VA setting, seeking institutional support for the group, and developing measures to assess the efficacy of the group. Conclusions: The intervention described in this article has the potential to serve as a model for development of similar interventions both within VA health-care centers and non-VA health-care settings.

Keywords: race-based stress, racism, veterans, group therapy, trauma, ethnic minorities

Supplemental materials: http://dx.doi.org/10.1037/vio0000221.supp

Military veterans of color are at risk of developing adverse psychological outcomes at higher rates than their White counterparts. For example, in the National Vietnam Veterans Readjustment Survey, rates of posttraumatic stress disorder (PTSD) were higher among African American (27%) and Hispanic (20%) veterans than among White veterans (13.7%; Kulka et al., 1990). There has not been a similar survey conducted with post 9/11 veterans. However, in a smaller scale nationwide sample, veterans of color had a higher prevalence of mental health diagnoses (Koo, Hebenstreit, Madden, Seal, & Maguen, 2015). There are a number of reasons why these discrepancies may be present, including veterans of color experiencing increased exposure to conflict (Beals et al., 2002; Kulka et al., 1990) and traumatic brain injury (Dismuke, Gebregziabher, Yeager, & Egede, 2015) and increased exposure to stressors upon returning to civilian life (Polusny et al., 2011). Even when controlling for severity of war zone and post-deployment stressors, racial and ethnic minorities still experience higher rates of PTSD than their White counterparts, suggesting unique experiences (e.g., racial/ethnic discrimination) associated with being a racial or ethnic minority may play a prominent role (Dohrenwend, Turner, Turse, Lewis-Fernandez, & Yager, 2008). The association between PTSD and racism is best understood through a holistic framework that integrates an understanding of culturally relevant factors such as intergenerational transmission of trauma and minority stress (Coleman, 2016). Race-based traumatic stress (Bryant-Davis, 2007; Curter, 2007) provides a theoretical framework through which to understand how stressors experienced as racial minorities may cause or worsen symptoms of PTSD.
The Need for a Novel Intervention

Experiences of racial/ethnic discrimination may be even more detrimental in the military, an environment where individuals work closely together and demonstrate loyalty toward one another and where interdependence is required for safety and well-being (Hall, 2011). At the same time, there is limited research examining the short- and long-term impact of experiences of discrimination in the military. Racially motivated mistreatment of people of color can lead to a breach of trust and lack of safety between service members that can have long-term detrimental effects, given the strong emphasis on group cohesion (Foynes, Smith, & Shipherd, 2015). Moreover, a sense of preserving group cohesion may actually serve as a barrier to disclosing or formally reporting instances of racial/ethnic discrimination (Foynes, Shipherd, & Harrington, 2013). In addition, these instances may be ignored when reported or may lead to negative outcomes for the victim, such as demotion, being forced out of military, or being ostracized from their unit. This is especially concerning in combat, as an individual may not feel safe with their own unit. There is evidence to suggest that the military may promote color-evasion, a domain of colorblind racial ideology (Neville, Awad, Brooks, Flores, & Bluemel, 2013) that denies racial differences by emphasizing sameness to its service members through slogans such as “we are all green” (Gilodi, 2017). Slogans such as this may instill the notion that racial differences are not important in the military, which may make experiences of racial/ethnic discrimination more difficult to report. Finally, because service members live and work together and are legally bound to complete their term of service, they may experience more chronic exposure to racial/ethnic discrimination and feelings of helplessness associated with being unable to escape or remedy the problem (Foynes et al., 2015). Military veterans of color may experience racial/ethnic discrimination in circumstances that can make it more intense than their civilian counterparts.

Despite the significant need for services among veterans of color, several studies have demonstrated that veterans of color underutilize mental health care within the U.S. Department of Veterans Affairs 2016 (VA) facilities (Lu, Duckart, O’Malley, & Dobscha, 2011). Spoont, Nelson, van Ryn, and Alegria (2017) found that veterans of color are more likely than their White counterparts to discontinue mental health treatment, and that their decision to discontinue is largely related to provider dissatisfaction. This finding is consistent with other research that suggests veterans of color with substance abuse disorders have more negative experiences with access to care and poorer interpersonal experiences with providers within primary care mental health (Jones et al., 2016). Veterans of color are also at risk of experiencing discrimination within the VA health-care system (Rickles, Domínguez, & Amaro, 2010). Thus, it is critical that VA hospitals adopt programming to specifically and competently address experiences of race-based stress and trauma (RBST) for veterans of color.

In the following sections, we describe a group intervention to address RBST that was developed for use with veterans of color and implemented in four VA health-care centers with a predominately Black veteran population. We first discuss the specific ways in which veterans have experienced race-based traumatic stressors and limitations to current trauma treatment protocols, with case examples. Finally, we review the RBST group intervention.

RBST Among People of Color

Racism can be defined as individual and systemic prejudice, discrimination, and violence against a subordinate racial group based on attitudes of superiority by the dominant group (Winant, 1998). Some examples of experiences of racism reported to us by veterans include an incident where a veteran’s White shipmates were actively planning to throw him overboard and made him aware of their plan to intimidate him; a veteran’s shipmates conspired against him, exposing him to white phosphorous, a deadly chemical weapon, resulting in 6 days of incapacitation due to full-body burns all over his skin, medical evacuation to a navy hospital, and medical discharge; and a veteran witnessed the deliberate killing of a Black service member. Experiences like these can cause deep emotional wounds that continue to cause distress for a lifetime. Furthermore, the impact of racially motivated violence often reverberates beyond the individual target, promoting a climate of fear, distress, and helplessness among other veterans of color within the unit who may witness or otherwise learn of these events. The severity, visibility, and unaccountability that characterize these events also imply a broader climate of racial hostility that, to date, few veterans have had the opportunity to process within a clinical VA setting.

Experiences of racial discrimination can lead to myriad mental and physical health consequences, including depression and anxiety (Harada et al., 2002), PTSD (Loo, Fairbank, & Chentob, 2005), and poor overall health status (Williams, Neighbors, & Jackson, 2003), among veterans of color. Carter (2007) provided a theoretical framework through which to understand elevated levels of PTSD among people of color. He argued that experiences of race-based stressors such as discriminatory harassment are best understood as a traumatic stressor for people of color and, like other traumatic stressors, can lead to the development of PTSD symptoms. In a sample of Asian American military veterans, race-related stress was found to contribute uniquely to PTSD symptoms and generalized psychiatric distress (Loo et al., 2001).

In a meta-analysis conducted on a nonveteran sample of Black Americans, the researchers found evidence to support conceptualizing experiences of racism as trauma, as psychological responses to racial discrimination shared many of the same features typically associated with trauma (Pieterse, Todd, Neville, & Carter, 2012). Polanco-Roman, Danies, and Anglin (2016) found evidence for racial discrimination elicitng symptoms comparable with PTSD in a nonveteran sample. These results converge to suggest that race-based stressors are associated with myriad mental and physical health outcomes and seem to potentiate the traumatization process for people of color. Increasingly, scholars are calling for greater focus on trauma resulting from experiences of racism (Butts, 2002; Helms, Nicolas, & Green, 2012; Holmes, Facemire, & DaFonseca, 2016).

Although a single life-threatening event motivated by racism qualifies as a Criterion A event, expressions of racism tend to be less extreme and more frequent than events traditionally conceptualized as traumatic. Thus, most cases of racial or race-based trauma are the result of repeated events, not unlike traumatization resulting from ongoing sexual harassment or bullying (Bryant-Davis & Ocampo, 2005). In these cases, chronic interpersonal events of a distressing nature occur with enough frequency that the individual begins to worry about future distressing events, result-
Victims may respond to incidents of racial discrimination with disbelief, shock, or dissociation, which can prevent them from responding to the event in an adaptive manner (Williams, Metzger, Leins, & DeLapp, 2018). The victim may then feel shame about their inability to respond or defend themselves, which may in turn lead to low self-esteem and maladaptive coping behaviors (Borrell et al., 2010; Krieger, Smith, Naishadham, Hartman, & Barbeau, 2005; Landrine & Klonoff, 2000; Yoo, Gee, Lowthrop, & Robertson, 2010). Like other individuals impacted by PTSD, people of color subjected to race-based trauma may try to avoid thinking about the experiences and avoid reminders of the racially charged events (Bryant-Davis, 2007; Carter, Forsyth, Mazzula, & Williams, 2005). Due to shame over being mistreated and/or about difficulty coping, victims may avoid conversations about the events and their subsequent difficulties, preventing adaptive social processing of the experience (Williams in press). Furthermore, there are often social costs for sharing personal experiences of racial discrimination, which include being perceived as less likable, as a complainer, and/or as attempting to avoid personal responsibility (Garcia, Reser, Amo, Redersdorff, & Branscombe, 2005; Stangor, Swim, Van Allen, & Sechrist, 2002). Therefore, people of color may experience dissonance between their own lived reality of racial discrimination and conflicting social messages that indicate such experiences are not a valid explanation for their distress (Delapp & Williams, 2015). For veterans of color seeking care, this dissonance could be compounded when medical providers fail to recognize and address historical events that contribute to mistrust among people of color toward health-care professionals (Suite, La Bril, Primm, & Harrison-Ross, 2007). Further, everyday racism, often in the form of microaggressions (Pierce, 1970; Sue et al., 2007), can reshape individuals’ perceptions of themselves, their ethnic group, and the benevolence of the world, leading to low self-esteem, psychological distress, and even suicidal ideation (O’Keefe, Wingate, Cole, Hollingsworth, & Tucker, 2015; Williams et al., 2003). These may be potentiated by the cumulative effects of cultural trauma, which can be inherited through social or even epigenetic mechanisms (Bierer et al., 2014; Kira, 2010).

Limitations in Current Trauma Treatment Protocols

The VA hospital system has a strong emphasis on evidence-based interventions and empirically supported treatments for trauma, with a culturally appropriate and patient-centered approach (Perlin, Kolodner, & Roswell, 2004). To date, there has been inadequate attention on traumatization stemming from race-based stress, within the military or otherwise. Veterans may experience a ubiquity of triggers, including daily microaggressions, media coverage of violence against people of color, and incidents that evoke memories of racial discrimination experienced during service. Given the particularity of this context, current treatment protocols and approaches to trauma treatment have several critical limitations, if intended to maximally benefit veterans of color. A strict focus on the experiences that qualify as Criterion A events, which may not colloquially or clinically be interpreted to include experiences of racial discrimination, may prevent clinicians from recognizing that traumatization has occurred (Holmes et al., 2016; Malcoun, Williams, & Bahojb-Nouri, 2015). For example, one veteran experienced retaliation when passing on a report made by a subordinate about racial harassment perpetrated by a supervisor. After he refused to destroy the report, this veteran faced a hostile work environment, which led him to request to transfer units. His request was accepted and as he was preparing to assume a high-level engineering position, human resources was informed about the report filed at his previous position. Consequently, his offer was rescinded and he was relegated to a position of a low-skilled correctional officer, a clear mismatch for his education, performance record, and training. This veteran made three separate attempts to report retaliation events to his superiors, but on each occasion, he was dismissed. These injustices resulted in depression, feelings of helplessness, isolation, social alienation, hypervigilance, panic attacks, disillusionment, sadness, humiliation, shame, and generalized anxiety. To cope he engaged in extreme cognitive avoidance of the events that transpired, including denial and minimization. It would not be until over 20 years later, with a restored sense of safety and security among his peers in the RBST group, that he was able to revisit his file and complete a request for correction of his military records. Under current protocols for PTSD, the traumatization and ongoing impact resulting from this event would not be recognized.

Cognitive–behavioral protocols (e.g., cognitive processing therapy and prolonged exposure; Williams et al., 2014; Williams, Cahill, & Foa, 2010) may not be equipped to address trauma related to race, as these protocols were initially developed with a minimal consideration of diversity and as a result many omit needed components for some ethnic minority patients, especially surrounding experiences of racism (Comas-Díaz, 2016; Williams et al., 2014). These protocols lack psychoeducation on race-based stressors, and as such would require the patient or therapist to advance the traumatizing impact of racial events. Many providers can be uncomfortable (Sue, Rivera, Capodilupo, Lin, & Torino, 2010; Wade, 2005) with racial dialogues, and as such may not be equipped to address racialized aspects of traumatic experiences that meet Criterion A (Williams et al., 2018). For example, a veteran recounted an event in which White soldiers, stationed on a hill overlooking a valley where the Black soldiers were stationed, would fire into the valley simply for sport. The Black soldiers assumed this was enemy fire but later discovered that it was from their own troops. Although this experience would qualify as a Criterion A trauma, current protocols are not designed to address the impact of the systemic culture of White supremacy and racism that enabled events of this caliber to transpire without recourse.

As such, providers using standardized protocols are often ill-equipped to intervene regarding issues of systemic racial oppression, persecution, and discrimination (Sue et al., 2010). For competent administration of these protocols, providers need the ability to accurately determine unhelpful thoughts and behaviors. Ignorance of the challenges faced by people of color can lead to inappropriate challenging of protective and accurate thoughts and behaviors, resulting in rupture of the therapeutic relationship, further harm to the client, and/or early termination of therapy (Miller, Williams, Wetterneck, Kanter, & Tsai, 2015).

With regard to basic cultural competence, standard treatment manuals are often based on White middle-class identity and norms (often presented as race-neutral) and lack guidance regarding engagement of other intersecting racial/ethnic and socioeconomic
identities, such as views on disclosure of personal information, healthy cultural mistrust, or differing perceptions of mental health (Whaley & Davis, 2007). Further, these protocols often are developed with an individualistic focus and specific cultural frame of reference for coping with traumatic experiences and the associated designations of which thematic thoughts and behaviors are pathological and therefore should be addressed (Williams et al., 2014). There are some scholarly recommendations on how to address racial trauma therapeutically (Comas-Diaz, 2016); however, none of these protocols is empirically supported and none is specific to veterans. The RBST intervention was developed to meet the critical need of providing space for veterans to address the impact of racism that has had on their lives.

The RBST Intervention

Although programming has been developed at a number of VA medical centers targeting the unique needs of some veterans with marginalized identities (e.g., lesbian, gay, bisexual, transgender support group and peer hospital escort service for women), there remains no mandate within the VA system to address RBST in the veteran population. However, the Department of Veterans Affairs and Department of Defense (2017) website for PTSD makes several assertions that racial minority veterans are underserved and calls for more efforts to better serve veterans of color, including the need for novel interventions. The first and last authors responded to this limitation by collaboratively developing the initial RBST group. The intervention was based on suggestions found in the literature and the last author’s years of experience treating PTSD, working with people of color, and training clinicians in culturally informed treatment approaches and lived experience as a person of color. The first and second author and a veteran peer support specialist then implemented this treatment plan and refined it based on feedback from participants. Further refinements came about based on the other authors’ subsequent experiences in implementing the group and their input, as it was ultimately administered at six VA medical centers in a variety of settings, with grant support to expand this intervention to more VAs.

Group Participants

The groups delivered in the RBST group included 75 total veterans at six VA medical centers ranging in size from four to 13 participants each. In all, 93% were male and over 90% identified as African American. Although the intervention was designed to address race-based stress for people of color, including those with intersecting marginalized identities (e.g., women of color), the veterans who presented to the group tended to be predominantly Black men. The groups were conducted in Illinois, Texas, California, Oregon, and Missouri. Within the groups, veterans experienced combat deployments across several eras, including from the Second World War, Korea, Vietnam, Desert Storm, Iraq, and Afghanistan. Veterans presented with a wide range of mental health diagnoses, including PTSD, bipolar disorder, psychotic spectrum disorders, depressive disorders, anxiety disorders, and adjustment disorders. At the same time, many veterans were naive to mental health treatment or had been lost to follow-up.

Theoretical Mechanism of Action

The RBST group is designed to alleviate symptoms associated with experiencing RBST and is intended to be used independently of or in conjunction with evidence-based practices for treatment of psychopathology (e.g., depression and PTSD). When considering the modality of the protocol, the group format may be especially well-suited to addressing the impact of RBST. Shame is posited as a key barrier to overcoming race-based trauma, as it prevents veterans from sharing experiences with others and an opportunity for verbal processing and exposure (Williams et al., 2014, 2018). In a study examining PTSD treatment for African American veterans (Jones, Brazel, Peskind, Morelli, & Raskind, 2000), the authors noted that these veterans felt the need to “wear a mask” in White majority groups and found themselves keeping their inner thoughts, feelings, and beliefs private. Although processing traumatic memories was not an explicit focus of the group intervention, the safety that veterans felt within the company of peers who had also experienced RBST enabled them to share encounters and events that had remained unexpressed, often for fear that others would not believe them. In the course of these discussions, veterans noted that they were “crazy or making things up” or “using the race card,” or simply not understand. The ability to speak freely about race-based trauma and triggers suggested by exposure to distressing memories that are typically avoided, allowing exposure and beneficial mental and emotional processing of traumatic events (Williams et al., 2010). In several cases, veterans opened up about these experiences for the first time or had told very few others, including individual therapists. Most had previously avoided trauma treatment for their experiences, but some veterans later opted to engage in individual mental health care for their traumas, after taking part in the group.

Cognitive restructuring surrounding the trauma occurred, as members were able to make sense of their experiences by placing them within their proper sociocultural context. Ongoing discussion within the group, with guidance as needed from facilitators, helped to slowly reshape maladaptive beliefs that maintained trauma-related distress, such as self-blame, hopelessness, and internalized stigma. In concert with psychoeducation about racism in the American society, members learned that they did not cause their exposure to racial discrimination or race-based trauma but that it was primarily a function of systemic racism, rather than any flaw or deficiency on their part. These realizations provided an explanation for events that were not rooted in personal failure or something unique to them as a person, which reduces internalization of events, mitigating the psychological and physical health consequences of traumatic experiences. Feelings of shame were further attenuated through empathetic feedback from supportive and understanding group members, all of whom had also experienced the pain of RBST as stigmatized minorities.

Veterans were encouraged to consistently discuss their methods of coping with their experiences with racial discrimination and associated consequences of their coping methods. After receiving psychoeducation on the impact of racism and discrimination, sev-
eral veterans commented on how these experiences influenced unhealthy coping strategies, such as substance abuse, anger directed at loved ones, and isolating oneself. The goal of discussing coping strategies used was to increase coping tools available to veterans, both by listening to other veterans’ approaches and introducing new skills (e.g., cognitive restructuring, mindfulness, and advocacy), and to minimize unhealthy coping attempts. Increasing availability of approaches to coping allowed veterans to make better value-based decisions, thereby limiting regret and shame related to their own reactions. For example, a veteran expressed pride and feeling less shame regarding how he handled a discussion regarding the inclusion of the confederate flag in a veteran event. This veteran highlighted the use of knowledge and coping strategies he garnered from his participation in the group. Finally, the group addressed feelings of hopelessness as members brainstormed and supported proactive solutions to ongoing race-related difficulties. Participants felt greater empowerment, as they were able to implement adaptive, value-driven responses to future experiences of racism. These changes were positively reinforced by other group members, who helped to celebrate victories, small and large. As individuals succeeded, the group provided an opportunity to make meaning of painful experiences through “giving back” both within the group and outside of it. Examples of giving back outside of the group have included veterans getting together to form a local chapter of the National Association of Black Veterans, exhibiting one’s series of paintings of Black civil rights leaders at multiple art galleries nationwide, aligning with other veterans and prominent city officials to oppose inclusion of the confederate flag in the veterans day parade, redressing municipal neglect stemming from Jim Crow-era segregation, and other community empowerment and civic engagement activities.

Content and Structure of the RBST Group

Although the delivery of the RBST group varies based on the clinic in which the group is held, the underlying material and content remained similar across the different settings. The group structure varied based on changes made based on veteran input (e.g., inclusion of music) and the specific clinic within which the group was conducted. Within the VA setting, oftentimes, the clinic may determine appropriate length, frequency (such as weekly vs. twice per month), targets, and patient population for services within that clinic. A group in primary care mental health integration (PCMHI) clinics may be shorter in length, as the PCMHI model encourages the number of sessions to be six or fewer compared with a general mental health clinic. A group in a health promotion and disease prevention (HPDP) clinic may place more emphasis on health-related impacts of discrimination and associated coping responses and includes more information on ways to improve health to combat health disparities. The application of this intervention is discussed in more detail later. Despite the adjustments made to match the clinic demands, the overall content of the group intervention is broadly consistent across the different clinics and is presented in Table 1.

Group themes center on fostering an understanding and exploring one’s own racial identity development (Helms, 1990) and the impact of interpersonal and systemic racism experienced within and outside of military experiences. Facilitators provide psychoeducation on interpersonal and structural racism, internalized racism, racial identity development, power, and White privilege to create a common language with which to explore personal experiences (Williams et al., 2018). Facilitators reviewed the phenomenon of overt racism, as well as theories that attempt to explain the development of racist or prejudiced perspectives by others (Feagin & Elias, 2013; Kanter et al., 2017).

Early in the process, facilitators engaged participants in discussion about their early experiences of racism and their racial identity development. Racial identity development is a process that people of color must navigate as they come to understand their stigmatized status in society’s socioracial hierarchy (Cokley, 2005; Sue & Sue, 2003). In the early stages of this process, people of

Table 1

<table>
<thead>
<tr>
<th>Theme</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introductions and establishing a safe space</td>
<td>Exploring first experiences with racism</td>
</tr>
<tr>
<td></td>
<td>Racial identity development</td>
</tr>
<tr>
<td>2. Interpersonal, intrapersonal, and systemic racism</td>
<td>Exploring witnessed and experienced instances of racism, including White supremacy, power, and privilege</td>
</tr>
<tr>
<td>3. Physical and psychological toll of chronic exposure to race-based stressors</td>
<td>Psychoeducation on common physical and psychological responses to chronic exposure to race-based stressors</td>
</tr>
<tr>
<td></td>
<td>Development of strategies to maximize resilience from CBT, DBT, and ACT</td>
</tr>
<tr>
<td>4. Race-based stressors and mental health</td>
<td>Psychoeducation on natural alarm system and mental health correlates of race-based stress, with an emphasis on traumatization</td>
</tr>
<tr>
<td>5. Race-based stressors and physical health</td>
<td>Psychoeducation on physical health correlates of experiencing race-based stress</td>
</tr>
<tr>
<td>6. Race-based stressors and military experiences</td>
<td>Processing the uniquely stressful intersection of confronting both enemy combatants and military personnel</td>
</tr>
<tr>
<td>7. Challenges to addressing the emotional impact of racism with providers</td>
<td>Processing historical breaches of trust and the impact on difficulties disclosing race-based stressors with providers</td>
</tr>
<tr>
<td></td>
<td>Evaluation of different behavioral responses to determine optimal course of action from a holistic standpoint</td>
</tr>
<tr>
<td>8. Resilience and empowerment</td>
<td>Psychoeducation on resilience and strengths-based approaches found in individuals and communities</td>
</tr>
<tr>
<td></td>
<td>Sharing of a source of strength/empowerment/pride in relation to one’s racial/ethnic identity</td>
</tr>
</tbody>
</table>

Note. This table represents the overarching themes of the race-based stress and trauma groups taking place across general mental health care and posttraumatic stress disorder, primary care mental health integration, health promotion and disease prevention, and psychosocial rehabilitation and recovery settings. CBT = cognitive behavioral therapy; DBT = Dialectic behavioral therapy; ACT = Acceptance and commitment therapy.
color accept the values of the majority culture without critical analysis (Atkinson, Morten, & Sue, 1998; Cross, 1995; Sue & Sue, 2003). As such, they may believe it is better to be White and have underlying negative emotions toward the self as a person of color or have minimal identity associated with race (Atkinson et al., 1998; Cross, 1995; Sue & Sue, 2003). Over time, individuals begin to acknowledge the personal impact of racism when a triggering event causes the person to question and examine their own assumptions and beliefs. They become more aware of racism and experience confusion and conflict toward the dominant cultural system (Atkinson et al., 1998; Cross, 1995). As a result, they may actively reject the dominant culture and feel hostility toward White people in this stage. If they continue to grow in this process, the person of color will start to question the values of both his or her own ethnic group and the dominant group, eventually developing a cultural identity based on both minority and dominant cultural values, where they feel comfortable with themselves and their own identity as a person of color in a multicultural society (Atkinson et al., 1998; Cross, 1995; Sue & Sue, 2003). Over the course of the group, the veterans shared more nuanced perceptions of their racial identity, including how they may identify within differing dimensions of their race, which is in line with multidimensional models of racial identity, such as the multidimensional model of racial identity (Sellers, Smith, Shelton, Rowley, & Chavous, 1998). This may become especially salient as group members make statements that resemble the ideologies within the multidimensional model of racial identity, such as nationalist, humanist, assimilationist, and oppressed minority statuses (Sellers et al., 1998). Veterans are encouraged to explore their racial identity through group discussion with other veterans and the presentation of alternative views or ideologies. Veterans then come to better understand their approaches to coping in light of their beliefs and are able to bring their coping responses to be more consistent with their values as a result of this discussion.

Participants were provided with psychoeducation on stress response, reactions to trauma, and cognitive appraisal. Participants received information on the psychological impact of more subtle forms of racism, including aversive racism and microaggressions (Gaertner & Dovidio, 2005; Nadal, Griffin, Wong, Davidoff, & Davis, 2017) and resulting internalized racism. In addition, facilitators review interpersonal and systemic racism (Feagin & Bennefield, 2014; Wolfe, 2016), stress response (Berger & Sarnyai, 2015), and allostatic load processes that lead to poorer health (Legato, 2010; McEwen & Wingfield, 2003).

Group facilitators reviewed cognitive and behavioral strategies to address race-based traumatic stress, and participants were able to practice and implement skills/strategies in between sessions. Facilitators incorporated cognitive–behavioral and culturally informed mindfulness techniques (Hill, 2017) into the groups to assist with adaptive coping skills and processing emotional reactions to experiences of racism and related triggers, with a focus on empowerment.

Initial sessions focused on facilitator and veteran introductions and rapport building, establishing a sense of hope and collective ownership of the group, learning about what drew each veteran to the group and what they hoped to get out of it, and addressing initial questions or concerns. As new members joined the group, they were given the opportunity to share similar information and to be welcomed by the group. The groups were guided by predetermined topics but were flexible to incorporate major events (e.g., police shootings, hate crimes, or other news that may serve as triggering reminders of previous race-related traumas) into the discussion or to become the focus of the session, as needed. Subsequent sessions were structured to review any remaining topics from the previous week that needed further discussion, followed by introduction of the weekly topic with subsequent discussion of experiences and coping approaches. At the end of each session, veterans were introduced to a new mindfulness or relaxation activity and they provided a brief reflection of their experience of the activity.

Implementation Across Service Areas

The RBST group was developed to address a needed area of care for ethnic and racial minority veterans, with a focus on an open and safe environment for veterans to discuss their experiences with racism and the resulting stress and trauma. To our knowledge, this clinical need has not been addressed within the VA health-care system. The group has been implemented as an ongoing open group (e.g., general mental health clinic) or as a closed, time-limited group (e.g., primary care mental health clinic). Typical session lengths are 60–90 min, and the typical group size is between six and 12 veterans. These groups were conducted in different clinics at different VA health-care locations nationwide. They provided validation of veterans’ experiences with race-based oppression, discrimination, and trauma, while simultaneously enhancing their ability to use values-based action to respond to these types of stressors in the future. Moreover, the groups promoted empowerment, resilience, and community engagement.

Although this intervention is intended to supplement current available treatments and to fill a clinical need where there is a lack of clinical services, it is important that veterans’ treatment needs for mental health concerns are adequately addressed. This may mean interfacing with other mental health-care providers, such as helping a veteran make connections with PTSD programs or other mental health and social services when necessary. An additional goal of the RBST group in this setting is to help veterans maximize the utilization of resources available to them, when needed.

Although the various versions of this intervention have overlapping goals and include similar techniques, the session length, open/closed status, as well as some of the didactic information varied, due to the clinic and providers located in the clinic. It is important to note that each program (general mental health, PC-MHI, HPDP, and psychosocial rehabilitation and recovery) has individual aims and serves specific populations. Due to these differences, alterations to programming were made to match fit within these clinics.

General mental health and PTSD clinic. The RBST group was initially created for use within a mental health clinic. This group was started in early 2015 and continues to run in an open format. At the maximum, this group had approximately 13–15 regular participants, all African American, except two members who identified as biracial (Latinx and Black, and White and Black) and one Asian American woman. The group was largely male with four female participants over the course of the group. The ages of the participants ranged from late 20s to 90s and included members who experienced combat in several eras, including the Second World War, Vietnam, and Iraq/Afghanistan. This group was facil-
ilitated by two African American men (psychology intern and a peer support specialist) and a White woman (psychology practicum student). The current group is facilitated by an African American male psychologist. The program underwent iterative changes throughout its development and implementation. Veteran input contributed substantially to the changes to better address their needs and to remain consistent with the spirit of empowerment, prioritizing veterans' voice, appreciation of diverse perspectives, resilience, and a core objective of the group to be peer-driven and collaborative. A menu of themes was presented to the group, and each theme was addressed for the duration of group interest and therapeutic benefit. Each session included individual check-ins, brief psychoeducation on the specific session topic/theme, group discussion of topic and experiences, and review of veterans coping approaches and their utility and closed with a mindfulness/wellness activity. Interventions included cognitive behavioral therapy (e.g., reviewing the cognitive model and self-monitoring form tailored to microaggressions), acceptance and commitment therapy (e.g., practicing mindfulness and values-directed behavior in responding to and coping with RBST), dialectic behavioral therapy (e.g., emotion regulation and communication strategies), and positive psychology principles (e.g., strengths and empowerment focused and sharing a source of pride/empowerment in relation to racial identity). These components were organically interwoven and adapted to promote the core group objectives and productive discussion of themes, acknowledging the strengths and shortcomings of each approach as relevant and emphasizing core values of resilience, empowerment, and community engagement.

A recent mental health and PTSD clinic group was also started at another VA in Oregon in 2018, which uses an eight-session closed model. Their single cohort, ages 30 to late 60s, consisted of African American men and one veteran who identified as Asian/Pacific Islander. Participants' service experiences included Vietnam, Desert Storm, and Iraq/Afghanistan.

**Primary care mental health integration.** A group was held within a PCMI clinic and consisted of eight 90-min, once weekly, initially open group meetings. This group had approximately three cohorts at one location in the Midwest, beginning in 2016, and has been conducted by a variety of psychology postdocs and interns, a social worker, and one peer support specialist. One of the authors who participated in the initial (general mental health) group adapted it to a four-session model highlighting the most salient topics based on veteran input from the initial group. This was later expanded into a closed eight-session model by two of the authors during the second cohort. The cohorts in this clinic modality were African American/Black and predominantly male, ranging in age from 20 to 70 years. The initial cohort had four participants, and the most recent cohort has 15 members. Modules focused on depathologizing experiences of racism and the resulting emotional and physical sequelae. Veterans were referred to the group most often by their primary care physicians after potential participants mentioned experiences of racial discrimination to their providers. This group centered empowerment (Hawxhurst & Morrow, 1984) and resilience throughout the group, emphasizing the importance of individual and community focus on strengths. Moreover, the group emphasized on the facilitation of practical skills, including effective communication with cross-racial primary care providers, navigating the hospital system as a person of color, and self-advocacy.

**Health promotion and disease prevention.** A group was held within an HPDP clinic and consisted of eight modules, with once weekly, 60-min, open group meetings similar to the PCMI clinic. The two cohorts, each 13 members in size, began in 2017 when one of the authors moved from a PCMI clinic to an HPDP clinic at another VA location. One cohort was facilitated by an African American male psychologist and a Taiwanese American female psychologist. The other cohort was facilitated by the same African American male psychologist but included an African American female psychologist. Both cohorts were predominately male and African American. Four female African American veterans and one Hispanic male veteran participated between the two cohorts. This group had an additional goal of counteracting the development or worsening of chronic disease hastened by exposure to racial discrimination and race-based trauma (Chae et al., 2015) through health behavior education and promoting healthier coping strategies. Links between mental and physical health may be discussed in more depth than in other programs. This ensures that the group fits with the overall mission of HPDP programming within the VA. This group is ongoing in a closed eight-session model format with the planned addition of a monthly booster group for completers of the eight-session model.

**Psychosocial rehabilitation and recovery center.** A group was held within the psychosocial rehabilitation and recovery center (PRRC) and consisted of weekly 90-min sessions in an ongoing format. PRRCs serve veterans with serious mental illnesses (e.g., psychotic spectrum illness) on an intensive outpatient basis with a mission that is recovery-oriented and strengths-based focusing on empowerment, personal goal attainment, and community engagement, within a predominantly group-based format. As such, this was a natural fit for the RBST group, which we structured and implemented similarly to the group within the general mental health clinic. The group at this site was launched in 2017 with a cohort of eight regular participants who were all African American and male, consistent with the smaller size and lower female-to-male ratio within this specialty clinic compared with other VA clinics. Participant ages ranged from early 30s to late 60s and included members from war eras of Vietnam and Iraq/Afghanistan. This group was facilitated by a White woman (psychology intern; one of the facilitators from the initial general mental health group) and supervised by a Latinx psychologist with expertise in culturally competent adaptations of cognitive behavioral therapy within a PRRC setting, and who resumed as facilitator after the intern’s departure. Some of the unique aspects of conducting the group within this clinic included the incorporation of psychoeducation on minority status as a unique risk factor for psychosis and exploring the overlap, distinctions, and gray areas among paranoia, rational fear, and PTSD-related hypervigilance, and the relevance of historical context. In addition, given the physical health side effects of many antipsychotic medications, this group also placed an increased emphasis on health and wellness practices, including meditation.

**Obstacles to implementation.** There were several obstacles to implementing these groups that merit mention. One problem encountered is that many clinicians are unfamiliar with the potential for racial discrimination to be traumatic; there was not always immediate support for starting such a group by medical leadership within the VA system. Providing education to leadership on health disparities, the impact of race-based traumatic stress on veterans,
examples of their experiences, and other relevant topics may be helpful. Moreover, support from diversity officers or equal employment opportunity committees can help make a strong case for starting such a group. The RBST group faced similar challenges that other new programs have with regard to recruitment. Change can be slow moving in VA systems when new programming is initiated. The authors found success in connecting with primary care providers, program managers, and peer support specialists, along with use of flyers distributed throughout the hospital, and veteran word-of-mouth. VA medical centers employ patient advocates who serve as an interface between patients and the hospital system to resolve any concerns or disputes. Connecting with patient advocates and requesting they inform veterans who are reporting issues of racial/ethnic discrimination within the hospital system can serve as a powerful recruitment tool and provide veterans with a space in which to process more recent experiences of discrimination.

Cultural Competence and Diversity: Important Considerations for Facilitators

Attention to facilitator diversity and identity is critical, as group members may react to the racial/ethnic composition of the facilitators differently based on their worldview and experiences with RBST. Actively addressing and processing veterans’ reactions to providers’ intersecting identities (e.g., race, gender, and class) early in the process and revisiting as needed was important (Fuertes, Mueller, Chauhan, Walker, & Ladany, 2002). For example, when one of the authors, a White woman, facilitated the group, several members remarked that they were surprised that someone who was not a person of color cared about discrimination. In implementing a group like this, it is particularly important to acknowledge that there may be initial discomfort between group members and facilitators of a different racial/ethnic background, as they may not be given the same level of ascribed credibility (Meyer, Zane, & Cho, 2011; Sue & Zane, 1987). This early engagement of the conversation is intended to avoid group members feeling hesitant to disclose information or directly challenge perspectives and to promote discussions about racial differences, which has been shown to be beneficial (Arreondo, 1999; Cardemil & Battle, 2003; Fuertes et al., 2002). One significant challenge for creating these groups in many areas is the lack of availability of providers of color, as the wide majority of the psychology workforce is White (American Psychological Association, 2015). Accordingly, to adequately meet the need for these services, some facilitators will necessarily be White. This can also be an opportunity to show participants that many White people do care about addressing experiences of racism (Miller et al., 2015).

As race-based stress, resilience, and trauma is the focus of these groups, it is pertinent to address cross-racial facilitator–client considerations, particularly as it relates to whiteness. This is a critical consideration, given the central role of White power structures, institutions, and privilege in creating and perpetuating systems of oppression. It is important for White facilitators to appreciate the healthy mistrust that group members are likely to feel toward them and to be as open and transparent as possible (Sue et al., 2010). People of color are often met with resistance and denial when they disclose experiences of racism (Sue & Zane, 1987). Thus, they may be hesitant to discuss race and racism even in a group context designed for this purpose. For example, one group member disclosed that he was uncomfortable sharing his experiences because he was concerned he would offend a White provider. Conversely, participants may challenge or test facilitators to see how they respond before trusting them. Thus, at the beginning of the group, providers were intentional about discussing their own identities and how they came to be interested in facilitating this group.

Clinicians should engage in mindfulness of history, culturally competent consultation, and ongoing self-reflection. This includes a critical examination of one’s own racial identity, positionality, intersecting identities, implicit biases, and explicit attitudes about race. This work can be challenging, as clinicians must be willing to tolerate feelings of discomfort, admit to ignorance, and acknowledge one’s whiteness—including the benefits conferred by White privilege (Sue et al., 2010). Provider competence and sensitivity to diversity issues become even more salient, due to the lack of ascribed credibility regarding racial minority experiences. It is important that providers have the knowledge, skills, and awareness to address the difficult experiences to ensure that veterans of color feel heard and validated. These factors contribute to cultural competence, which has a significant impact on client satisfaction (Constantine, 2002; Meyer et al., 2011; Sue & Sue, 2003). All providers should review and challenge their own areas of privilege to avoid invalidating experiences and recreating the systems of oppression group participants experience in their daily lives (Miller et al., 2015). Furthermore, it is important that providers are able to help group members develop shared language to describe their experiences and make sense of these experiences and that group members feel that they resonate. To do this, it is important to have a firm knowledge of discrimination, racism, White supremacy, and privilege and to be able to translate these concepts in ways that veterans can use in their daily lives.

Dimensions of Diversity Within the Veteran Group

One of the most challenging yet enriching aspects of the RBST groups has been the navigation of various dimensions of diversity within the group. Skilful navigation posed some of the greatest challenges at the outset, as veterans were still getting acquainted with one another and forming impressions about fit and facilitators were seeking to establish rapport and instill a sense of relevance and hope about the group. Facilitators sought to ensure an inclusive space for all members and to anticipate and address issues that might arise from differences within the group to ensure that all members’ intersecting identities (e.g., gender, sexual orientation, multiracial status, age, war era, and language) were afforded respect and appreciation.

One approach that proved helpful involved an investment of planning and effort at the outset (e.g., individual telephone calls with prospective members) to promote a collaborative culture that valued open-mindedness and strove to embrace diversity within the group as an opportunity for learning and dialogue—indeed one of the key benefits afforded by the group format. In addition, facilitators encouraged group members (though participation was voluntary) to reserve part or all of a session to share a source of strength, achievement, and pride in relation to their racial/ethnic identity. For example, one veteran performed a Langston Hughes poem, *The Negro Mother*, which was par-
ticularly meaningful to him, as it reflected the women in his life who served as a source of strength. Another veteran shared a series of his oil paintings celebrating civil rights pioneers and other inspirational Black leaders and noted artists. Another veteran shared a book he authored as an Afrocentric guide to self-help. Others shared empowering quotes and passages from revered Black leaders and intellectuals, family photos, blog posts, articles, framed correspondence from President Barack Obama, journal entries, songs, and poems. Facilitators approached this activity with varying levels of structure (e.g., members signing up to reserve all or part of a session in advance or members briefly sharing a source of inspiration during check-in). This component proved to be a highly popular aspect of the group that fostered a culture of curiosity, mutual respect, and appreciation of individual differences and strengths. This in turn reinforced an atmosphere of acceptance and tolerance. As this culture gained footing, it appeared to serve as a natural mechanism for embracing new forms of diversity and intersecting identities.

We now elaborate on some of the more salient aspects of diversity that arose from our experiences, including recruitment; the prospect of intraracial tensions, including the discriminatory views of other races or minimization of other racial/ethnic group members’ individual or collective histories of discrimination; intergenerational differences; war era and sociopolitical differences at time of service; socioeconomic status (SES); and diversity and racial identity among facilitators.

Racial/ethnic diversity. Although all groups have been open to veterans of color broadly, the racial composition of our groups to date has been predominantly African American. One reason for this may be related to the unique history of Black oppression in the United States stemming from slavery to mass incarceration resulting in historical conflicts and oppression being viewed as strictly Black/White. That being said, African Americans also experience greater racial discrimination than other major minority groups (Chou, Asnaani, & Hofmann, 2012) and, thus, may be more prone to racial traumatization. Another contributor could be the timing of the groups, as the first one launched in February 2015, coinciding with the onslaught of high-profile media coverage and imagery of police killings of Black men and boys. In addition, veterans themselves were among the most effective recruiters of new group members, and the shared experience of Black struggles may have inspired members of the group to reach out to other Black veterans in particular.

Yet, a further possibility may relate to ethnic differences in perceptions of what constitutes race-based trauma or discrimination. Although our groups have been predominantly African American, most have also included a small number of veterans from other racial and ethnic minority backgrounds as well. As such, it is important that facilitators are prepared to address and appropriately resolve challenging interracial dynamics within the group. For example, ethnocultural stereotypes and prejudice may be expressed by group members about another racial group. Providers must be prepared to address these remarks as they arise to ensure a safe space is maintained for everyone. In our experience, this most commonly arose within the context of what were initially perceived as seemingly benign stereotypes (e.g., model minority stereotypes in relation to Asian Americans) or minimizing the pain of other racial/ethnic groups. Providers used these occasions to provide additional psychoeducation and relevant historical context, challenge stereotypes, and facilitate further reflection on the ways in which seemingly benign stereotypes can be harmful and micro-aggressive as well.

To aid in competent and productive intervention, we found it helpful for facilitators to have an understanding of the history of interracial dynamics and/or conflict related to their specific region or practice. Veterans were able to identify parallels and areas of common ground within their own experiences with discrimination that facilitated empathic understanding and respect for others’ experiences. With awareness of one’s own positionality, privilege, and racial or ethnic identity, facilitators can aid in modeling effective communication across differences. For example, one author and facilitator is a Palestinian American woman who shared her perspective on the complex relationship between African Americans and Palestinian refugees/migrants in the region in which the group was held. Facilitators can also share examples highlighting group content (e.g., experiences of racism) while incorporating a range of ethnocultural identities. This allowed facilitators to place experiences of oppression, discrimination, and race-based trauma within the appropriate sociocultural contexts.

Gender diversity. Consistent with the veteran population more broadly, the composition of the RBST group has been predominantly male. As a result, male perspectives and experiences were more prominent among these groups than those from female veterans or transgender veterans. Consequently, veterans from these backgrounds may feel less inclined to express themselves for fear of dismissal, rejection, or invalidation of a perspective that may not be shared among the other members of the group. Thus, recruiting female veterans is challenging and, even if initially interested in attending to address race-based stress, a male-dominated group may lead to loss of interest if a safe and inclusive environment is not maintained. This is a pertinent consideration within the VA setting in particular, as an estimated one in every four female veterans has experienced military sexual trauma (MST) during their time in the service (Department of Veteran Affairs, 2015). Moreover, male veterans may also suffer from MST (Hoyt, Klosterman Rielage, & Williams, 2011) and may likewise have difficulty engaging in a predominantly male group if safety and inclusivity are not maintained, given that masculine gender role stress may make race-based MST (or any experience of MST) more difficult to disclose and discuss (Juan, Nunnink, Butler, & Allard, 2017).

Intergenerational differences. Although most veterans who participated in the RBST groups tended to be late 50s and older, some groups had a wider range in ages. Older veterans, such as those from the Second World War era, described experiencing different forms of discrimination and racism than their younger peers, both in intensity and frequency. Younger veterans tended to view more elder veterans with respect and acknowledgment of their elder status. Even though facilitators may have felt unease when older veterans seemed to be minimizing or chiding those of a younger generation, this message was typically not perceived negatively by younger veterans. However, it is possible that some younger veterans may have felt as though the older veterans did not understand their experiences and challenges. As a result, it will be important in future iterations of this group that facilitators are judicious in intervening as veterans navigate this intergenerational difference. Care will need to be taken to honor cultural practices
around elder respect while also ensuring that each individual in the group is respected as well.

Sociopolitical changes influence the way that veterans of color have been treated in the military. For example, some older veterans served during a time when units were segregated by race and so had difficulties understanding that although younger veterans served in integrated units, some of the same problems persisted (e.g., service members of color being given more dangerous assignments or fragmenting). In addition, many older veterans had been drafted into the military and had difficulties understanding that while the draft is not currently in place, military recruiters disproportionately target low-income communities of color. As with most group therapies, one challenge encountered was exercising clinical judgment with regard to redirecting group members to the theme at hand versus allowing open processing of intergenerational differences to occur.

Because group members from different generations experienced different forms of racism, education on all the various forms of racism and racial discrimination helped group members to share a common language and recognize the impact of experiences different from their own. Nonetheless, at times, it has been necessary to remind the group members that each person has different experiences and their experience of psychological pain may differ based on their experiences. Furthermore, emphasizing veterans’ various reactions and emotions to experiences of discrimination can help to facilitate bonding around similar experiences and appreciation of differing reactions and ways of coping.

**Socioeconomic status differences.** SES (defined here to include income, residence, occupation, and education) is likely to have a significant impact on the types, quantity, and quality of experiences with discrimination, leading to differential impact on all areas of life. The intersection of racial/ethnic minority status and SES can compound discrimination at both the interpersonal and the institutional level in unique ways at different points along the SES continuum. One of the domains in which the intersection of race and SES, in particular, is most salient is in the enforcement of drug laws and discriminatory drug policies in the war on drugs that have disproportionately targeted and stigmatized low-income communities of color and driven mass incarceration (Alexander, 2012), and this is true despite overwhelming data showing that drug possession, use, and sales are comparable if not slightly greater among White individuals relative to Black and Latinx individuals (Beckett, Nyrop, & Pfingst, 2006; Mitchell & Caudy, 2017). The higher prevalence of law enforcement patrolling lower income communities of color coincides with greater incidence of racial profiling and prevalence of police abuse and misconduct (Beckett et al., 2006), making stress and trauma experiences in these domains particularly salient among these groups, though still certainly relevant for people of color across the spectrum of SES as well.

**Educational attainment differences.** Differences in educational attainment may necessitate that facilitators present complex information in various formats and present concepts clearly and free of unnecessary jargon to engage a range of learning differences. However, assumptions of capability and comprehension should not be made solely on the basis of formal educational attainment. It was often our experience that veterans across a range of formal education levels appreciated when extra primary source materials (e.g., journal articles) were made available for further reading on a topic of interest.

**Experiences of incarceration.** The disparities that stem from discriminatory practices including disproportionate stops, detain, and overpatrolling of Black and Brown communities have led to a disproportionate number of people of color in prison (Alexander, 2012). These disparities continue at each juncture of the justice system from arrest, prohibitively expensive bail, coercive plea deal terms, prosecutorial discretion on whether to prosecute, number of charges, and quality of legal representation, to jury conviction rates, sentencing length, and legalized discrimination following release (Alexander, 2012). Given that racial discrimination is prevalent at all stages of the criminal justice system, there are unique considerations in working with veterans whose histories include inequitable encounters within this system.

Although veterans experience lower rates of incarceration than the general population (i.e., 0.85% vs. 0.96%; Bronson, Carson, Noonan, & Berzofsky, 2015), in our clinical experience, there were a number of veterans participating in the group who were formerly incarcerated, thus warranting attention. Among individuals who have spent time in jail or prison, depending on the duration of time incarcerated, duration since release, and the security level of the facility, there can be unique considerations pertaining to comfort level within a racially and ethnically diverse group. Because racial tensions are common within the prison system, the mistrust and animosity toward other racial or ethnic groups may naturally persist for some. This is a necessary consideration for facilitators, as part of their role is to help foster safety especially in a culturally diverse group. In some cases, depending on an individual veteran’s experience within the criminal justice system, law enforcement figures (e.g., police, prison guards, security guards, and Transportation Security Administration (TSA) workers) may themselves be a trigger for posttraumatic stress, and this can be helpful to process in a supportive and safe space.

**Experiences of housing insecurity.** Although veterans’ VA benefits (e.g., vocational assistance and housing assistance) can help mitigate challenges associated with structural and interpersonal discrimination, homelessness remains more prevalent among veterans of color than their White counterparts (Moore, Johnson, & Washington, 2011). In addition, facilitators must also take into account the emotional toll of housing insecurity and homelessness as well as the manifestations of trauma that may accompany them (Hamilton, Poza & Washington & 2011; Rosenheck & Fontana, 1994). Facilitators must recognize and recommend adjunctive VA services as relevant to ensure that veterans have support in attaining housing needs, as well as a space to process the ways in which experiences with homelessness are related to trauma.

**Effectiveness of the RBST Group Intervention**

In the interest of building trust and establishing engagement and retention of veterans, the authors suspended initial plans to collect data using conventional measures. Many examples of medical and psychological misconduct and human rights violations have been documented against people of color, particularly African American and Native individuals, leading to mistrust among these communities (Suite et al., 2007). Mistrust and skepticism are natural consequences of historical and contemporary violations of trust. Consideration of this history would require special care in provid-
ing a thorough and transparent rationale for each measure, its purpose, and relevance to the group, which at this stage in establishing engagement could send the message that our interest in data collection took priority over addressing race-based stress. Each of the authors has had experience with veterans of color reporting feeling “experimented on” by providers at the VA. Consequently, with a mindfulness toward this history and in the interest of building trust and establishing engagement and retention of veterans, the authors suspended initial plans to collect conventional data. However, as the group continues to evolve and trust is built around this intervention, it will be useful to measure RBST (e.g., Race-Based Traumatic Stress Symptom Scale; Carter et al., 2013) and track symptoms using coping inventories (e.g., COPE Inventory; Carver, Scheier, & Weintraub, 1989), symptom inventories (e.g., Outcome Questionnaire 45; Lambert et al., 1996), and clinical interviews (UConn Racial/Ethnic Stress and Trauma Survey; Williams et al., 2018). In addition, it is important to note that limitations within the VA system prohibited more extensive data collection especially during time-limited appointments such as internships and postdoctoral fellowships. Thus, data were collected at only one of the VA sites in the general mental health care clinic, and the authors adopted an approach of introspective reflection and continual adaptation according to group member feedback from ongoing dialogue. In lieu of standard clinical outcome measures, the authors provided alternative indicators of efficacy from three domains: (a) optional feedback forms submitted after the Session 4–6 mark, (b) excerpts from group-initiated written narratives, and (c) behavioral examples of empowerment that arose over the course of the group and were attributed, in some form, to the impact of the group. Each of these domains is described in further detail next.

At the outset of one of the RBST group cohorts, veterans were provided with feedback forms that included a comprehensive list of questions seeking feedback on the group and input as to what was going well and what could be improved. Veterans were informed that all feedback was optional and that they could pick and choose to respond to as many or as few of the questions as they saw fit. Table 2 includes a summary of the responses collected from 11 veterans who completed and returned feedback after the Session 4–6 mark (a complete table of the feedback can be referenced in Tables A.1a and A.1b of the supplemental online material.) Veterans noted the group offered them a new way to think about their experiences. For example, one group member noted, “Racism and white privilege—it’s designed to affect your inner dialogue—what you say to yourself on your own time. This has helped me address that.”

### Narrative Feedback

Five narrative responses were collected during the course of one cohort. Collecting these data was not planned a priori but starting around the 10-month mark, there seemed to be a noted influx of events and examples that veterans would share with the group, which they attributed it in some part to the impact of the group. These responses centered on feelings of empowerment, the development of new skills, and hopes that such interventions would be made available to other veterans. They noted the group empowered them to address racism in a way that felt authentic. One veteran noted, “I gave away my power along with my self-respect, even when I should have challenged offensiveness. I gave away my voice. RBST empowered me to find my voice and speak my truth, unapologetically from proud Black skin.” Veterans noted the group provided them with coping strategies to address daily experiences of racism. One veteran explained, “Learning about microaggressions and how it is closely related to white privilege has been a source of healing for me. . . . I am sometimes better able to deal with microaggressions when [they] actually occur in my life.”

Finally, veterans expressed hope that other VA locations would adopt a similar group. One veteran stated, “I am not certain where this group is headed next, but I think that being part of this group is good medicine and I hope that it continues and spreads to every VA hospital in every state in America.”

#### Behavioral manifestations of empowerment

One of the by-products of increased empowerment was action. Veterans made efforts to seek fairness for past injustices. One veteran pursued correction of his military records subsequent to a chain of race-based retaliatory events after 20 years. He had avoided addressing this issue due to anxiety and traumatic memories evoked by the process. Another veteran garnered support from his neighbors and sought litigation against his hometown over environmental racism involving funneling excess rainwater to the historically Black side of the neighborhood. Veterans noted following the RBST group, they assertively addressed racism in contrast to previous more passive reactions. These behavioral changes lead to enhanced self-esteem and an overall sense of control. For example, one veteran led an effort to hold a veterans organization accountable for use of the confederate flag in a parade. He engaged in attempts to change the behavior of the group and ultimately rescinded his group’s participation in the parade, which led to a primary vendor also withdrawing their plans to provide food at the parade and the city’s mayor to boycott it as well (a more complete table of examples can be referenced in Table A.3 of the supplemental online material). This veteran noted he would not have been able

### Table 2: Summary of Written Feedback From Veterans Regarding the RBST Group

<table>
<thead>
<tr>
<th>Theme</th>
<th>Veteran responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive aspects of group</td>
<td>Didactic aspects of the group including new information and coping strategies</td>
</tr>
<tr>
<td></td>
<td>Sense of comradery stemming from connecting with other veterans</td>
</tr>
<tr>
<td></td>
<td>Space to express thoughts and feelings related to experiences of racism</td>
</tr>
<tr>
<td>Impact of group on veterans</td>
<td>Increased sense of self efficacy at coping with experiences of racism</td>
</tr>
<tr>
<td></td>
<td>Decreased emotional liability</td>
</tr>
<tr>
<td></td>
<td>Increased use of adaptive coping strategies</td>
</tr>
</tbody>
</table>

Note. N = 11 veterans collected in the RBST group conducted in a general mental health care setting. RBST = race-based stress and trauma.
to do this advocacy before “without exploding with anger or bursting into tears.”

Conclusion

Many notable improvements were observed across critical mental health domains among participants. Nonetheless, future work is needed to continue to refine this approach, quantify benefits, and isolate mechanisms of change. To that end, new measures are necessary to help capture the range of experiences and resulting distress caused by racism perpetrated against service members of color without compromising the therapeutic relationship. The development of such measures is still in its infancy, and very few existing measures for RBST are focused on the military experience (Loo et al., 2001). Thus, more tools for the valid and reliable measurement of RBST in a military veteran population is an important next step.

There remains a need for increased access to interventions to address racial trauma. We have described how the RBST group is potentially useful for veterans when offered alone or in conjunction with other treatments. At the same time, there are a wide range of potential applications for this type of group, both within and outside of the VA. The RBST group could be offered in other veteran-centric spaces (e.g., Veterans Centers). Veterans of color in many different settings experience RBST and would benefit from the opportunity to receive support and healing in a safe and affirming environment.

References


Gildon, A. (2017). “We are all green and we all bleed red”: Stories of inter-ethnic relations among Hispanic U.S. military personnel in San Antonio, TX (Master’s thesis).


Helms, J. E., Nicolas, G., & Green, C. E. (2012). Racism and ethnoviolence as trauma: Enhancing professional and research training. Traumatology, 18, 65–74. http://dx.doi.org/10.1175/1534765610396728


Received January 3, 2018
Revision received August 8, 2018
Accepted August 14, 2018

---

**E-Mail Notification of Your Latest Issue Online!**

Would you like to know when the next issue of your favorite APA journal will be available online? This service is now available to you. Sign up at https://my.apa.org/portal/alerts/ and you will be notified by e-mail when issues of interest to you become available!
Table 1a. Veteran feedback from optional questionnaire seeking early impressions on group.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Veteran Responses (written)</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is going well?</td>
<td>&quot;Vets who share similar race-related incidents.&quot;</td>
</tr>
<tr>
<td></td>
<td>&quot;Just being able to be surrounded by fellow Vets.&quot;</td>
</tr>
<tr>
<td></td>
<td>&quot;Able to express my thoughts and feelings.&quot;</td>
</tr>
<tr>
<td></td>
<td>&quot;I learn something new each week that helps me cope with discrimination.&quot;</td>
</tr>
<tr>
<td></td>
<td>&quot;Veterans are continuing to come to the group - excellent!&quot;</td>
</tr>
<tr>
<td>Have you noticed anything useful or not useful?</td>
<td>&quot;Being able to hear that other people have gone through similar experiences - I think, 'yeah I can adjust and adapt, I can make it.'&quot;</td>
</tr>
<tr>
<td></td>
<td>&quot;I do not explode as quick about discrimination issues as before.&quot;</td>
</tr>
<tr>
<td></td>
<td>&quot;I have been able to deal with race issues more positive than prior to group.&quot;</td>
</tr>
<tr>
<td>What sorts of things do you like or not like about group?</td>
<td>&quot;Ease of being surrounded by others of the same background.&quot;</td>
</tr>
<tr>
<td>Do you feel comfortable sharing in group?</td>
<td>&quot;Yes, because race-based stress and trauma is real!&quot;</td>
</tr>
<tr>
<td>What's helpful?</td>
<td>&quot;Openness, able to talk about race issues that I have not talked about before.&quot;</td>
</tr>
<tr>
<td></td>
<td>&quot;I've been able to talk about things I've never shared before because I didn't think anybody would believe me - or they'd think I was crazy.&quot;</td>
</tr>
</tbody>
</table>

Note. $N=11$ group members.

Table 1b. Veteran feedback relayed verbally during course of group

<table>
<thead>
<tr>
<th>Context</th>
<th>Veteran Reports (verbal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veteran’s response after disclosing his experience with a close family member verbally rejecting him because of his success.</td>
<td>&quot;I have never shared that before and gotten head nods - I've always gotten, ohhhhhh that is sooooooo terrible!&quot;</td>
</tr>
<tr>
<td>A Veteran sharing with a new group member what he has found helpful about group.</td>
<td>&quot;Racism and white privilege - it's designed to affect your inner dialogue - what you say to yourself on your own time. This has helped me address that.&quot;</td>
</tr>
<tr>
<td>A Veteran’s reaction after his first time attending group.</td>
<td>&quot;I didn't know Black people still had this underbelly, but we do, we still have it after all this time - you guys have restored my hope.&quot;</td>
</tr>
<tr>
<td>Input on how / in what way has group been useful or helpful</td>
<td>“Extraction of solutions from shared experiences”</td>
</tr>
<tr>
<td></td>
<td>“I’m learning how not to be an asshole.”</td>
</tr>
<tr>
<td></td>
<td>• [and] “be the spiritual person that I really am.”</td>
</tr>
<tr>
<td></td>
<td>• Regarding female friends, “I can like them from a distance, not have to have them.”</td>
</tr>
<tr>
<td></td>
<td>• “You [group facilitators] give us a chance to voice who we are.”</td>
</tr>
<tr>
<td></td>
<td>• “…When I have no choice but to look at myself. This class allows me to breathe and live.”</td>
</tr>
</tbody>
</table>
### Table 2. Behavioral Manifestations of Empowerment

<table>
<thead>
<tr>
<th>Examples of Empowerment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pursued correction of his military records subsequent to a chain of race-based retaliatory events that followed from his refusal to breech protocol and withdraw a complaint reported by his subordinate documenting racially derogatory harassment made by a supervisor. Veteran had been unable to complete the process of changing his record for over 20 years due to the anxiety and traumatic memories that the process stirred about his past mistreatment.</td>
</tr>
<tr>
<td>Canvassed neighborhood collecting signatures and then proceeded to take his hometown to court over a discriminatory man-made drainage system constructed during Jim Crow that continued to the present, funneling excess rain water into the black side of town.</td>
</tr>
<tr>
<td>Departed early from a Bed and Breakfast following poor treatment, and finding somewhere else to stay rather than “being polite and just dealing with it and enduring poor treatment, like I would have in the past.”</td>
</tr>
<tr>
<td>Withdrew participation from a costume event due to the costume attire only accommodating white/light skin.</td>
</tr>
<tr>
<td>Emailed the leader of a community group to address the impact of an offensive joke that she told about Bob Marley’s dreadlocks. In this email, Veteran explained why the comment was hurtful and provided some historical context so that the woman could fully understand why her comment was racially offensive. The woman responded thoughtfully with profuse apologies, embarrassment, and regret and thanked Veteran for reaching out to her with this feedback.</td>
</tr>
<tr>
<td>Having the courage and composure to take a stand and maintain his cool as he expressed his opposition, in front of a predominantly white audience, to the confederate flag being allowed in the Veteran’s day parade.</td>
</tr>
<tr>
<td>And relatedly, pulling his organization from participation in the Veteran’s day parade in objection to the committees allowing the marching of Veterans with confederate flags. Following his lead, one of the primary vendors who had previously planned to provide food and supplies, withdrew their participation as well.</td>
</tr>
<tr>
<td>Approached the head of the confederate flag group to engage in dialogue and share the perspective of what that flag represents to black Americans; an action that this Veteran had noted he would not have been able to do before without exploding with anger or bursting into tears.</td>
</tr>
<tr>
<td>Initiated an Austin chapter of National Association of Black Veterans (NABVETS).</td>
</tr>
<tr>
<td>Veteran’s paintings depicting black civil rights leaders/heroes were selected for national exhibit, including a show featured in Times Square and select Veterans museums across the nation (this wasn’t so much a function of the group per se but rather, his success in this domain and sharing his work with the group, helped to foster a culture of inspiration, pride, and momentum).</td>
</tr>
<tr>
<td>Veteran was able to paint a tribute that included a white military Veteran in one of his paintings. This was a big step and marker of healing, as this Veteran endured extensive racial discrimination and terrorism during his time in the military and white military men had been quite triggering for him.</td>
</tr>
<tr>
<td>Inspired to make a new edition of his book targeting white allies in addition to black audiences. And after several years break, this Veteran resumed travel in relation to his book and broader work towards the empowerment of young black people through an Afrocentric lens and an empowering, more comprehensive, understanding of black history rooted back to ancient Egypt.</td>
</tr>
<tr>
<td>After ten dissatisfying years, one Veteran, arrived at the decision to move from his current neighborhood. With the help and support of the group members (who, being local to the area, were familiar with the history of his neighborhood as a destination of white flight following the abolishment of Jim Crow laws) this Veteran was able to recognize that the problems he had been encountering and internalizing over the previous ten years, particularly as it pertained to social interaction, were not specific to him or his character, but rather the community and culture surrounding him. Veteran’s ivy league credentials and business casual attire were no match for the invisibility, suspicion, and scorn, that he routinely encountered due to his dark skin.</td>
</tr>
</tbody>
</table>

**Note.** Behavioral manifestations of empowerment. One of the byproducts of increased empowerment appeared to be action. Though not exhaustive, the following list includes concrete actions that were attributed, in some part, to increased empowerment that stemmed from the group / group related growth.