Healing Racial Trauma Initiative

A **Mindbridge** Initiative

2023 PROGRESS REPORT

MAY 2023 // PREPARED BY MINDBRIDGE

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Table of Contents

Healing is about taking the time to notice what gets in the way of feeling connected to your life, your community, and your sense of possibility. Healing, at its core, is about slowing down so that we can better listen, to ourselves and each other."

SUSAN RAFFO

INTRODUCTION:
THE HEALING RACIAL TRAUMA INITIATIVE

According to a 2015 study conducted by the American Psychological Association, approximately 86% of psychologists in the United States were white, while in contrast only 2% of psychologists nationwide were Black. This pattern is only exaggerated in Maine with only a handful of Black, Indigenous, and People of Color (BIPOC) identified psychologists and clinicians available within the state. This lack of diversity and representation creates not only a significant gap in experiences and understanding between practitioner and client, but leaves communities vulnerable to harm as BIPOC community members continue to experience the effects of racism and discrimination. While we acknowledge this, we also must acknowledge the BIPOC models of healing that highlight the cultural wisdom and practice inherent within a community. With that, the question becomes: How can we bridge the two? How can we increase the availability and accessibility of a racial trauma-informed therapeutic model that partners with and strengthens community-based approaches? How can traditional Western models of therapeutic intervention and healing be reimagined using somatic and traditional techniques?

The Healing Racial Trauma Initiative (HRTI) is an initiative designed for and by members of Maine's BIPOC community. Racism, whether subtle or direct, has long-term impacts on the mental and behavioral health of BIPOC communities. While COVID-19 and racial injustice protests may have brought on new trauma, years of systematic racism, discrimination, and microaggressions have forced Black & Brown communities to live in a constant state of high alert, causing traumatic stress. Traditional, therapeutic models situate the individual as the center of trauma healing and resilience. And while in some cases, this can be a positive and nurturing experience, it omits a crucial factor in the development of collective strength. Just as resilience is a source of healing and transformation from traumatic histories on an individual level, when communities engage in resilience-building, they promote their collective ability to cope and endure experiences of trauma. This in turn creates a feedback loop back to the community's individual members, creating an ever-strengthening cycle of collective strength and resilience. The key is engaging the community, not just the individual. For this reason, community wisdom and community-based methods of resiliency have been centered and closely partnered with all aspects of the Healing Racial Trauma Program.

This progress report provides an overview of work accomplished throughout 2021. In the pages that follow we present an overview of each aspect of the work, from initial ideas through until the completion of the Community Conversation Series. Currently, an analysis of all information gathered is underway with the final report of all findings and next steps released in December of this year.

Thank you for joining us on this journey. Onward.
Laura Ligouri
Executive Director, Mindbridge

ACKNOWLEDGMENTS

Mindbridge would like to thank the Maine Health Access Foundation (MeHAF) for funding the Healing Racial Trauma Initiative in 2021. It is not always easy taking a chance on a new idea or initiative. We are so grateful that MeHAF saw the possibilities present within the Healing Racial Trauma Initiative and for their ongoing support of racial trauma healing and mental health. It has been a joy working with Frank Martinez Nocito, Program Officer at MeHAF, whose support and enthusiasm for the work is utterly contagious. This work would not have been possible without their support.

We would like to extend our endless appreciation to Joy George whose expertise, insight, and efforts were paramount to the development of this initiative, and to our Summer '22 intern, Ella Caruso, whose keen eye, and sheer dedication to this work was an integral component of this process. Upon their arrival, Joy and Ella dove right into the work, contributing substantially to the early development of the project. We would also like to thank Mindbridge Administrative Manager for being the "Holder Of The Keys," and helping to bring the many moving pieces of this report together. Sheila, you are often the glue that keeps us together. Thank you for all that you do.

We would also like to take an opportunity to thank the numerous community members who have been helping to inform the program's direction, take part in the conversations, and help us imagine what racial healing looks like. We are deeply humbled by the passion and deep commitment here within Maine and count ourselves indescribably lucky to be able to work with you all. We hope that our efforts, in some small way, contribute to the healing and wellness of all.

Founding Advisory Committee

For Mindbridge, any work that sought to develop a community healing framework to address racial trauma had to be fundamentally grounded in the experience and input of those central to the work. We are forever indebted to the wisdom and dedication of our founding advisors listed below. Both Arabella and Keita reviewed our initial concept papers, provided critical insight, helped us to work through challenging questions, and were in all an integral component to the launching of this initiative.

Arabella Perez, LCSW, Ph.D. - Assistant Clinical Professor, School of Social Work, UNE

Dr. Perez, originally from Newark New Jersey, is a licensed clinical social worker and therapist of over 25 years. She holds a Master's Degree in Social Work and a Doctorate in Social Work from Tulane University in New Orleans. She is a native Spanish speaker and daughter of parents from Cuba and Puerto Rico. Prior to joining UNE, Dr. Perez was a system of care director from 2005-2015, leading three Substance Abuse Mental Health Services Administration (SAMHSA) grants for the state of Maine. During these years she founded THRIVE, a nonprofit technical assistance center for trauma-informed care. She is a certified cultural competency trainer and has presented and provided consultation extensively, both locally and nationally, on Trauma Systems Change, Organizational Healing and Resiliency, Cultural and Linguistic Competency issues, and Youth-Adult Partnerships.

Keita Whitten - THrive practitioner, BSW, MSW, LCSW, SEP, Kripalu Yoga Instructor

Keita identifies as an indigenous Black woman and THrive practitioner with 30+ years in the field of social work, art, community mental health, and education. Keita continues to train in embodied practices of trauma, racial equity, and communal racial healing.She presented and received several recognitions for her MSW graduate thesis, Dialogues in Diversity: Multicultural students sharing their realities in Portland Maine. Pedagogies of Diversity; Diversities of Pedagogy Conference on Diversity and Scholarship at the Turn of the 21st Century, USM. In 2012 Keita became involved with child welfare resiliency education following the ACEs study (Kaiser '97) championed by the works of Nadine Burke. In 2014 Keita opened a private practice and completed her Somatic Experiencing Practitioner (SEP) in 2015. She is the founder of the Mama Africa Show (WMPG Community Radio), Community Dialogues on Racism as a Public Health Crisis amid COVID-19, founder of The Harriet Tubman Movement Coalition, and creates community somatic liberation dance waves (Dance Church). Keita is a wife, an awesome grandmother, an astistá, writer, and small-time farmer in southern Western Maine.

UNDERSTANDING RACIAL TRAUMA

Introduction

The Healing Racial Trauma Initiative (HRTI) is a program rooted in community, research, and justice; seeking to shine a light on the conditions and methods necessary to transform the impacts of racism, colonialism, wealth inequality, and other structural forms of violence that harm the mental health and wellbeing of People of Color (POC).

In order to hold Black, Brown, and Indigenous communities over and against the interlocking systems of oppression, it is necessary to examine the emergence of racial trauma as it presents with the individual bodies and communities of POC.

Defining Racial Trauma

In 2000, the U.S. Surgeon General issued a report describing striking disparities in minority mental health as the result of racism (U.S. Department of Health & Human Services, 2000). A growing body of literature has begun to address the ways in which racial stress, or the experience of racial trauma, has profoundly impacted People of Color (POC).

Clinically, trauma is often defined by the diagnostic criteria used to identify Post-Traumatic Stress Disorder among clients (Carter & Pietrse, 2020). The criteria for PTSD include exposure to actual or perceived death, severe injury, or assault which results in persistent producing significant distress or functional impairment over the long term (lasting longer than one month).

Symptoms of PTSD fall into four categories including: *intrusion* – intrusive thoughts, involuntary memories or flashbacks, *avoidance* – avoiding specific places, people, activities, objects, or situations that may trigger the recurrence of distressing memories, alterations in cognition, *mood* – alterations in memory, feeling detached or estranged from others, inability to experience positive emotions, and alterations in arousal, and *reactivity* – irritability, hyperarousal, difficulties concentrating or sleeping (American Psychiatric Association, 2013).

The definition of racial trauma differs from standard diagnostic criteria in order to focus attention directly on the psychological and physiological effects of racism on People of Color and Indigenous individuals (POCI). Here racism is defined as the act of prejudice, discrimination, and violence against a subordinate racial group based on attitudes of perceived superiority by the dominant group (Williams, Printz, and DeLapp, 2018).

As a result, racial trauma, or race-based stress, refers to the individual as well as the collective experience of psychological distress and fear of harm that results from the cumulative effects of experiencing or witnessing discrimination, threats of harm, violence, and intimidation directed towards POCI (Chavez-Dueñas, et al., 2019).

The history of the United States is fraught with examples of victimization asserted by dominant populations. As the land that was once referred to as Turtle Island became what is known now as the United States, two groups stood most in the most vulnerable position relative to European settlers: Indigenous peoples and Africans who would become enslaved forced laborers. The violence asserted onto these two groups by European settlers is well documented, from the theft of Indigenous lands and disease wiping out millions of Indigenous peoples, to the horrors of the Trans Atlantic Slave Trade, and the rape, beating, and subjugation of enslaved Africans. The laws of this new colonial government were created specifically to create structures that would enshrine the supremacy of white settlers, as well as deny rights and agency to those deemed to be other.

These continued instances of intentional or unintentional, individualized or systemic forms of violence towards Indigenous people and African Americans begets what is known as racial trauma. **Racial trauma is defined as real and perceived danger, threats, witnessing harm, or humiliating and shaming events to ethno-racial individuals that may be sudden, beyond their control, emotionally overwhelming, and/or physically harmful**. We further add to this definition by naming the ways in which conditions for racial trauma are structurally perpetuated. Similarly, it must be highlighted that racial trauma is a particular challenge to individual identity formation as it is derived explicitly through a lens of historical and contemporary subjugation of their community.

The Healing Racial Trauma Initiative understands that there are a multitude of layers that contribute to the formation of racial trauma. As such, we examine the emergence of racial trauma through a psychological, somatic, sociological, historical, and political lens. It is as much a mediating presence as it is a response to an event, as much a world-bending influence as it is a force of destruction and adaptation.

Healing Racial Trauma

The healing of racial trauma is a particularly complex and challenging endeavor. The experience of racial stress occurs within a complex sociopolitical context where structures, policies, and practices continue to replicate inequitable if not hostile environments for POC. In addition, racial trauma is a cumulative experience, meaning that the factors leading to psychological wounding take place often continuously throughout the lifetime of the individual, potentially complicating the therapeutic process as harm may occur continuously throughout the time of treatment.

What is more, current definitions of trauma, traumatic stress, and PTSD are embedded within Western, Eurocentric perspectives (Hernandex-Wolfe, 2013), often excluding culturally informed understanding and experiences of trauma as experienced by Black communities. By way of illustration, Schnyder and colleagues (2016) investigated the degree to which therapists understood and integrated specific cultural aspects enhancing the meaning of both the patient's history and experience of trauma within their therapeutic practice.

Following examples from around the world, researchers found that not only did survivors not generally share their therapists' cultural perspectives, often impacting the client-therapist relationship and degree of success within the therapeutic process, but could spark cultural stereotyping by the therapist often negatively impacting client experience. Indeed, unaddressed personal biases and stereotypes can and will impact the therapeutic relationship and process, sometimes compounding harm experienced by the client (Hairston et al., 2019).

The healing of racial trauma is also particularly challenging because in many ways, it speaks to an expression of clinical intervention that has yet to come into being. Measures of racial trauma are still relatively new with few empirically supported clinical approaches established within the field. However, clinicians are faced with the limitations of their present field also lies the opportunity for innovation and potential advancement where new directions in the healing of racial trauma can be envisioned and tested. For the sake of brevity, we have chosen to address three clinical approaches to the healing of racial trauma to highlight.

The first clinical approach is the **Racial Encounter Coping Appraisal and Socialization Theory** (RECAST, Anderson & Stevenson, 2019), which builds on the notion of racial socialization – the verbal and nonverbal racial communication between families and youth – to provide a proactive approach to the building of self-efficacy, confidence, and healing of racial trauma. The next approach is **Critical Consciousness of Anti-Black Racism** (CCABR, Mosley et al, 2021). This process situates the healing of racial trauma in a similar trajectory to that of RECAST, however rather than a focus on individualistic forms of healing, CCBR promotes the healing of racial trauma as a form of activism and liberation. Finally, the third approach is **Somatic or sensorimotor therapy**. This is a form of body-centered therapy that leverages the mind-body connection in a holistic approach to the treatment of trauma and psychological healing. In keeping with Damasio's somatic marker hypothesis (1996), where the recall of emotional memories elicits physiological states associated with the memory, somatic therapy seeks to access memory as stored within the "body-mind."

The treatment of racial trauma has before it a wealth of exciting opportunities and innovative potential to explore. Within that potential is our hope for the development of a measure of racial trauma that incorporates communal experiences of trauma and can capture both individualistic as well as community-based signs of healing and wellness over the long term. In addition, the field would benefit from evidence-based forms of assessment for the three therapeutic directions detailed above in order to capture what elements, and in what combination, most greatly benefit individuals and communities in their path toward healing. Indeed the greatest challenge may be in divergent concepts of what healing means and subsequently entails.

If healing is to be defined as the transcending of the limits of familial and community history that produces and passes forward insecurity and more trauma, it is essential that we foster nurturing conditions that produce earned secure attachment within the community and individuals. This happens through the intentional cultivation of methods that activate and validate the response of the parasympathetic nervous system. This is fostered through the reimagination of narratives of self-esteem, identity, and agency via empowerment methods, through the formation and maintenance of significantly secure relationships that alter the traumatized individual's assumptive beliefs, and increase their relationship to empathy. Another way is to discard tools that control and shame the marginalized/traumatized group. Yet another is to publicly acknowledge the legacy of harm and violence that has already occurred and vow to discontinue the sprawl of its progeny in the structure of society.

As Healing Racial Trauma is in the process of development, there exists room for further advancement, evolution, and expansion however in the meanwhile, "the more opportunities you practice, the better. But each one is important – and each can help mend your trauma, create more room for future generations, and heal the world" (Menakem, 2017, p. 306).

DEVELOPING THE **MAINE RACIAL EQUITY SOCIAL DETERMINANTS OF HEALTH**

Overview – Mindbridge worked to develop a Maine-based racial equity, social determinants of health in order to inform the way in which social and environmental conditions impact the experience of racial trauma.

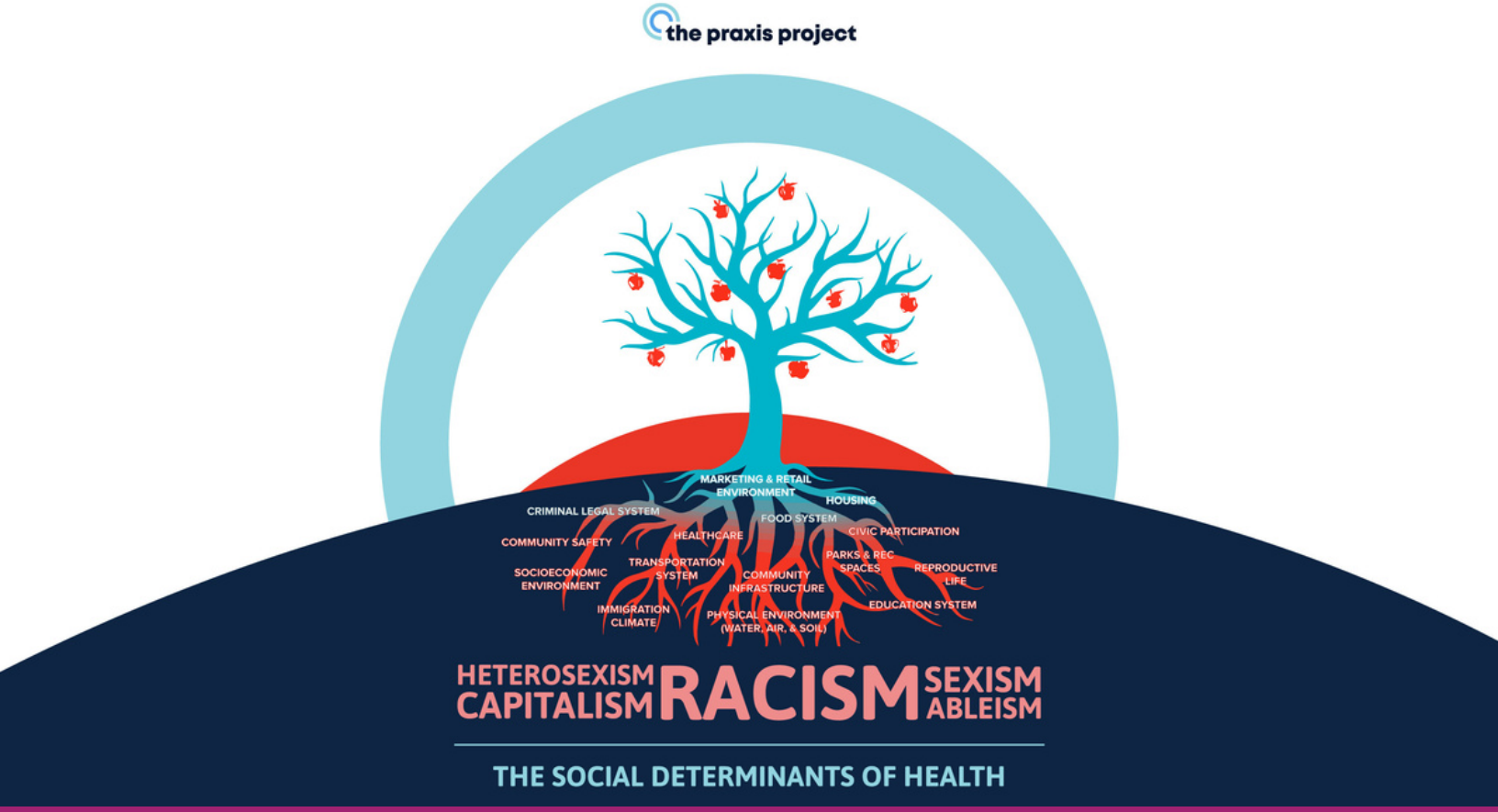
Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These circumstances (i.e., social determinants) are believed to drive many deep-rooted world health inequalities, such as lower life expectancy, higher rates of child mortality, and greater burden of disease among disadvantaged populations

Typically SDOH can be grouped into 5 domains:

Linking SDOH and Mental Health – An individual's mental health and many commonly experienced mental disorders are shaped by the social, economic, and physical environments operating at different stages of life. Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk. Marginalized and vulnerable communities tend to suffer disproportionately as compared to other members of the general population.

Designing a Maine Racial Equity – SDOH Model

The Praxis Project is a nonprofit organization dedicated to achieving health equity and justice for all communities. In 2020, following the disproportionate impact of COVID-19 on communities of color, the reemergence of the Black Lives Matter movement, and the ongoing experience of trauma within POC communities, the Praxis Project undertook the development of a re-imagined SDOH. According to their website, "Many traditional SDOH frameworks lack the explicit naming of systems of oppression that cause disparities in health determinants." The new Praxis SDOH sought to include the structural, systemic, and institutionalized policies that perpetuate health inequality as well as essential elements of community empowerment and resilience. (More on the Praxis Project and their SDOH can be found at: https://www.thepraxisproject.org/social-determinants-of-health)



From this foundation, Mindbridge reviewed both the traditional SDOHs and the newly revised Praxis SDOH in order to ascertain which determinants might immediately apply to POC-identifying individuals and communities within Maine. The following eighteen items were selected and modified for use within the HRTI. Three additional items were determined to be missing from the original lists and added on.

1. Injustice System
    a. Policing Programs
    b. Forms of Community-Based Prosecution
    c. Restorative Justice
    d. Community Justice Systems
    e. Knowledge of said systems
2. Education Systems
    a. Household Demographics
    b. K-12 relationship with DEIA
3. Hope and Efficacy (and Belonging)
4. Civic Participation
    a. Forms of civic engagement
    b. Dynamics of power
5. Community Infrastructure
    a. Community networks
    b. Gathering spaces
6. Community Safety
7. Connections with Neighbors
    a. Community networks
8. Economic Conditions
    a. Where are people working vs. where are people living
    b. Quality of work and work environment
9. Healthcare
    a. What forms of mental health are present within their communities?
    b. What forms of public outreach exist?
    c. Are any forms of cultural mental health available?
    d. Knowledge of mental health services
    e. Comfort in accessing mental health services
    f. Impact of COVID-19
    g. What is your understanding of healing?
    h. Community definitions of trauma?
10. Housing
    a. Population Density (POC/Wht)
11. Immigration Climate
12. Marketing and Retail Environment
13. Valued Cultures and Identities
    a. Experienced racism might be considered forms of social violence and/or exclusion
    b. Forms of honoring diverse cultures
    c. Personal Identity / Social Identity
    d. Beliefs in a wider community

Three Additional Factors:

1. Gentrification
2. Perspectives and experience regarding White Supremacy Culture
3. Length of time living in Maine (if applicable)

This new list was entitled the Maine **Racial Equity – Social Determinants of Health (Maine RE-SDOH).**

In order to understand the impact of the Maine RE-SDOH on the experience of racial trauma, Mindbridge began a research process dividing the list into three research directions:

1. Publicly available data
2. Survey data
3. Community conversation topics.

For some items, publicly available data exists and could be utilized in order to contribute to an understanding of that specific determinant. For example, statewide data on income (and income disparities) could be used to help inform the "economic conditions" RE-SDOH. Other determinants could be answered in part through survey methods. For example, the development of the Racial Trauma Survey (see that section on page 13 for a full discussion) included questions pertaining to the "Hope, Efficacy and Belonging" RE-SDOH. Finally, these as well as other determinants could be addressed during the Community Conversation Series (see that section on page 16). For example, while asking questions on a survey pertaining to hope and efficacy might be useful as it allows us to potentially access the opinions and experiences of a larger population, community conversations give a breadth and depth usually not possible through survey methods alone.

DEVELOPMENT OF THE **MAINE RACIAL TRAUMA SURVEY**

Over the last few years, several clinical tools have been released to assess symptoms related to racial trauma. Some are more clinical in nature and designed to be used by a clinician during face-to-face interviews. Others rely on self-assessment. Most attempt to integrate diagnostic criteria detailed within the Diagnostic Statistical Manual (DSM-5) with symptoms and lived realities specific to individuals and communities contending with racial trauma.

Mindbridge developed a measure, combining several validated and published surveys with questions and insight stemming from the immediate community. The result was the first Maine-based racial trauma survey. What follows are details as to the surveys used to inform the development of the Mindbridge survey.

ELEMENTS FROM THE **MAINE RACIAL TRAUMA SURVEY**

RACIAL TRAUMA

Components of the UCONN Racial Trauma Assessment (*Williams, Metzger, Leins, & DeLapp, 2018*) and the Race-Based Traumatic Stress Symptom Scale (*Carter et al., 2013*), or RBTSS, were used to measure racial trauma in adult members of the POC community. The UCONN Racial Trauma scale consists of interview questions typically used in clinical settings, with the "Racial Trauma Assessment" including 29 questions with yes or no answers. Adapted from this measure, the HRTI survey used 18 items from the UCONN assessment. Instead of yes/no questions, this section of the HRTI survey used a 5-point Likert scale where participants indicated their level of agreement with statements. An example item is "I avoid certain types of people because I worry they will behave in a racist way".

Additionally, parts of the 52-item RBTSS were also used to examine racial trauma (*Carter et al., 2013*). The HRTI survey used 11 items from this scale, an example item being: "When I describe the event, I feel nothing as if I'm not really there". Both the RBTSS and the HRTI used a 5-item agreement scale, with the RBTSS being 0-4 and the HRTI survey being 1-5.

RACIAL IDENTITY

The HRTI survey racial identity section used 4 open-ended questions from the UCONN Racial Trauma Assessment. An example in this section is "What is the ethnic/racial environment of your place of work/school? How comfortable do you feel there as a person of your race/ethnicity?". Additionally, 3 open-ended questions on racial identity from the UCONN assessment were grammatically modified into statements for a 1-5 Likert scale of the agreement for the HRTI survey. An example from this section is "I have a lot of pride in my ethnic group and its accomplishments" (*Williams, Metzger, Leins, & DeLapp, 2018*).

Continued on next page.

ELEMENTS FROM THE **MAINE RACIAL TRAUMA SURVEY**

RESILIENCY

Measures of resilience and coping were adapted from parts of the Courage to Challenge Scale (*Smith & Gray, 2009*) and Brief Resilient Coping Scale (*Sinclair & Wallston, 2004*). While the Courage to Challenge scale was created for LGBTQIA+ individuals, many of the items in the measure are applicable to those who have been discriminated against on the basis of identity. The HRTI survey used 6 out of the 18 total items in the Courage to Challenge Scale, with an example being "Believing in myself helps me get through hard times". Of the 4 items in the Brief Resilient Coping Scale, the HRTI survey used 3. An example item from this survey is "I look for creative ways to alter difficult situations". These items used a 1-5 Likert scale of agreement.

RACIAL SOCIALIZATION

Finally, measures of racial socialization were adapted from the Racial Socialization Competency Scale (*Anderson, Jones, & Stevenson, 2020*). The HRTI survey grammatically-modified elements of the items to reflect participant self-confidence ("I feel un/comfortable") rather than parent/child interaction ("I do/not believe I can teach my child"). Of the 28 items in the Racial Socialization Competency Scale, the HRTI survey used 14 items. An example of item modification is: "Initiating a conversation about race with peers" instead of "Teach my child to initiate a conversation about race with peers" (*Anderson, Jones, & Stevenson, 2020*). This measure in the HRTI used a 1-5 Likert scale of comfort level in various scenarios, with 1 being very uncomfortable and 5 being very comfortable.

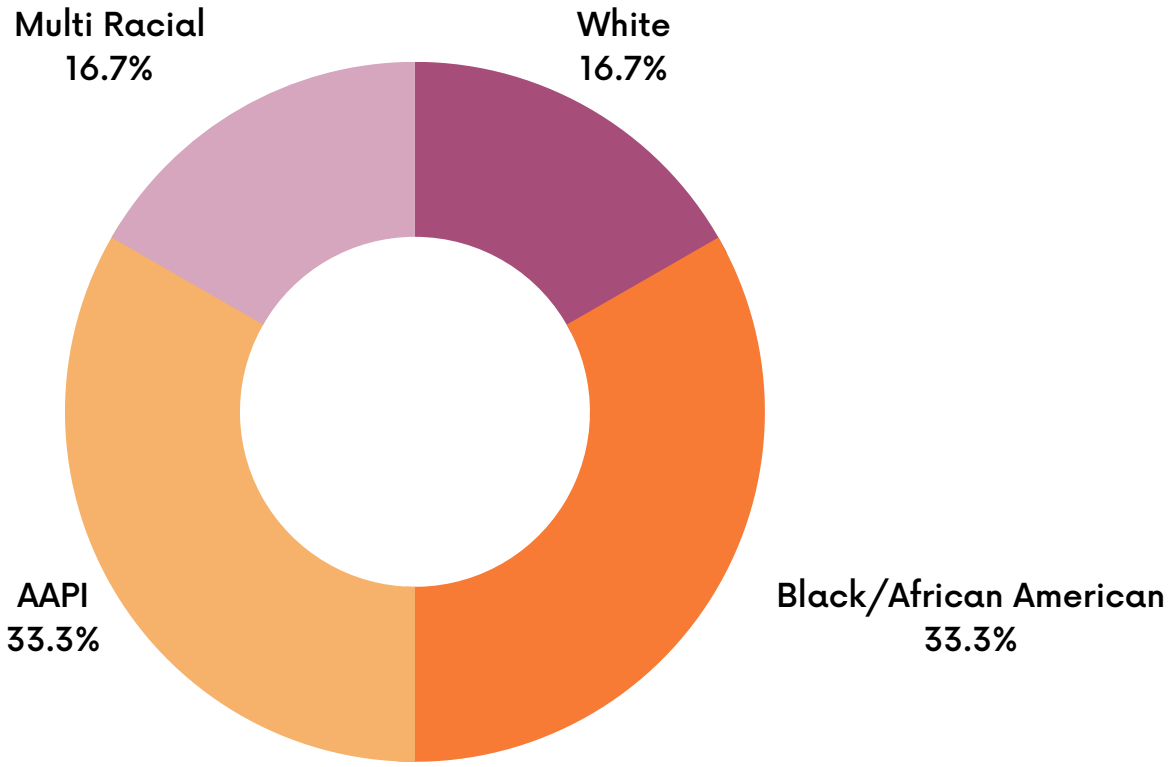
Findings (N = 7)

HRTI Community Conversation Series September 2022 Survey Results

Demographics

AGE
Average age was 33 years old, with a range from 26 to 50 years old

RACE AND ETHNICITY

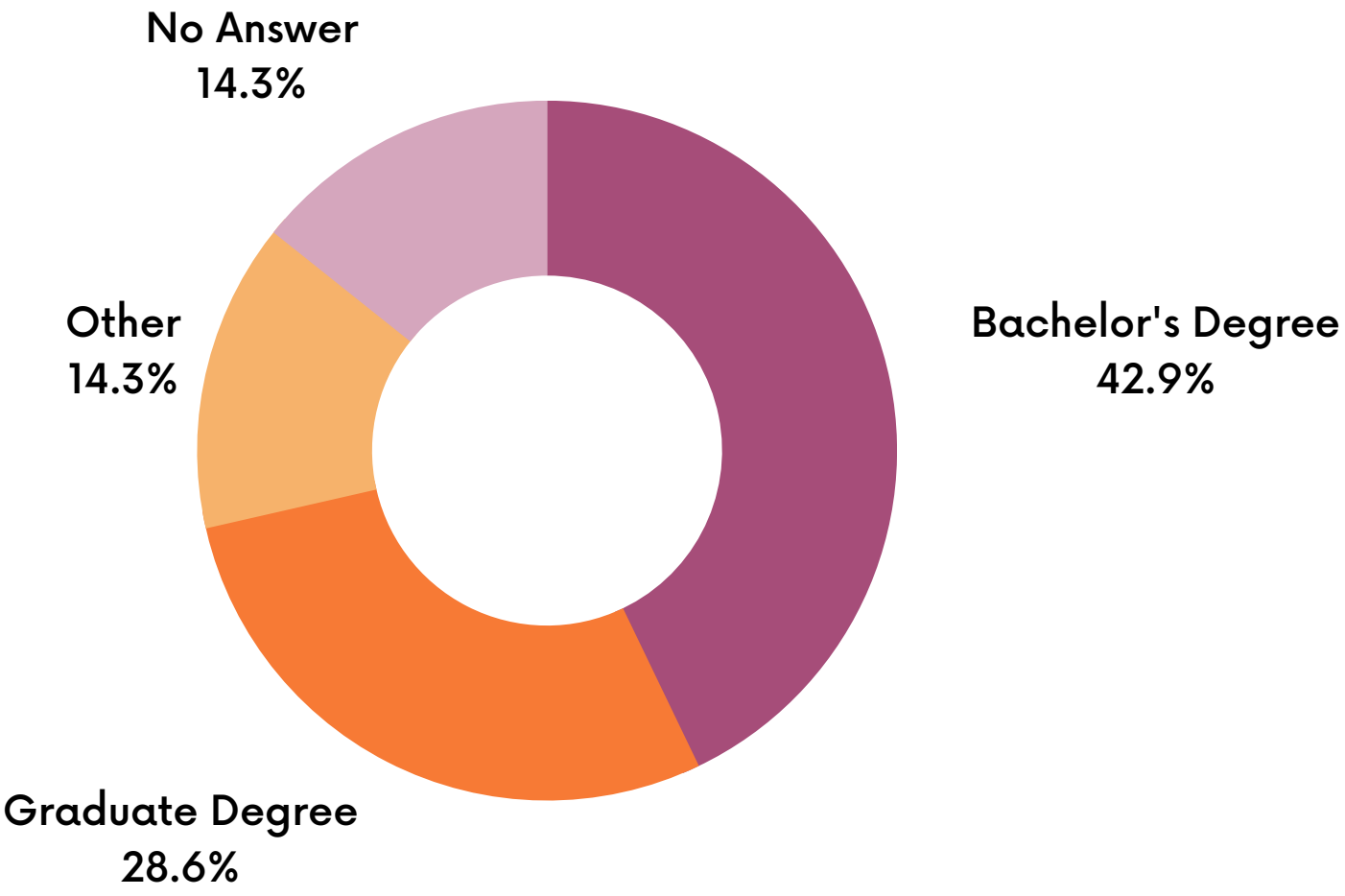


Demographics Continued

GENDER

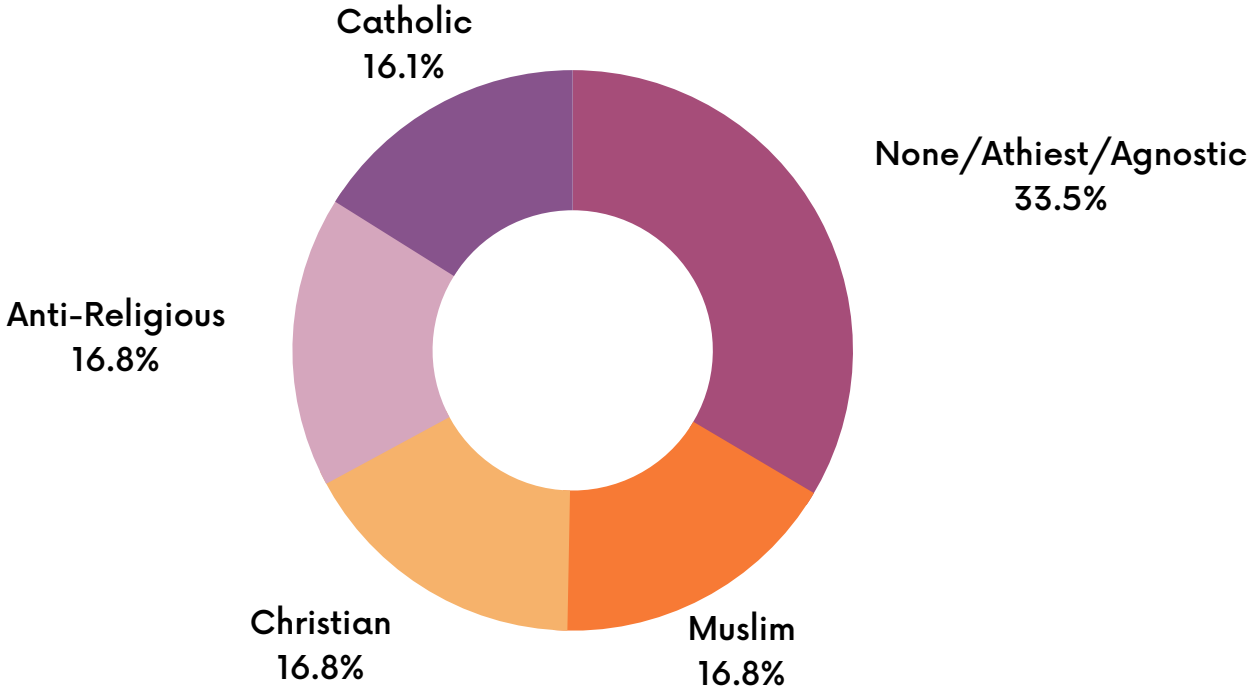
The sample had 2 Men, 2 Women, 1 Non-Binary Person, and 2 who did not disclose their gender

LEVEL OF COMPLETED EDUCATION

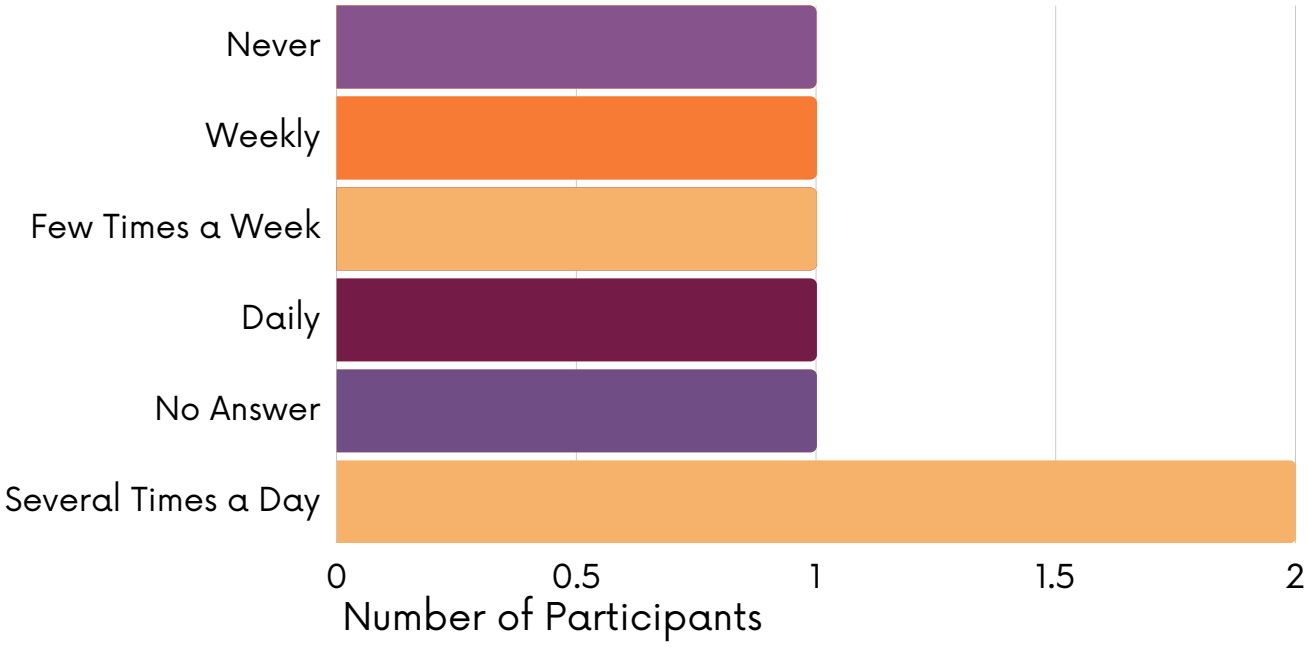


Demographics Continued

RELIGIOUS AFFILIATION

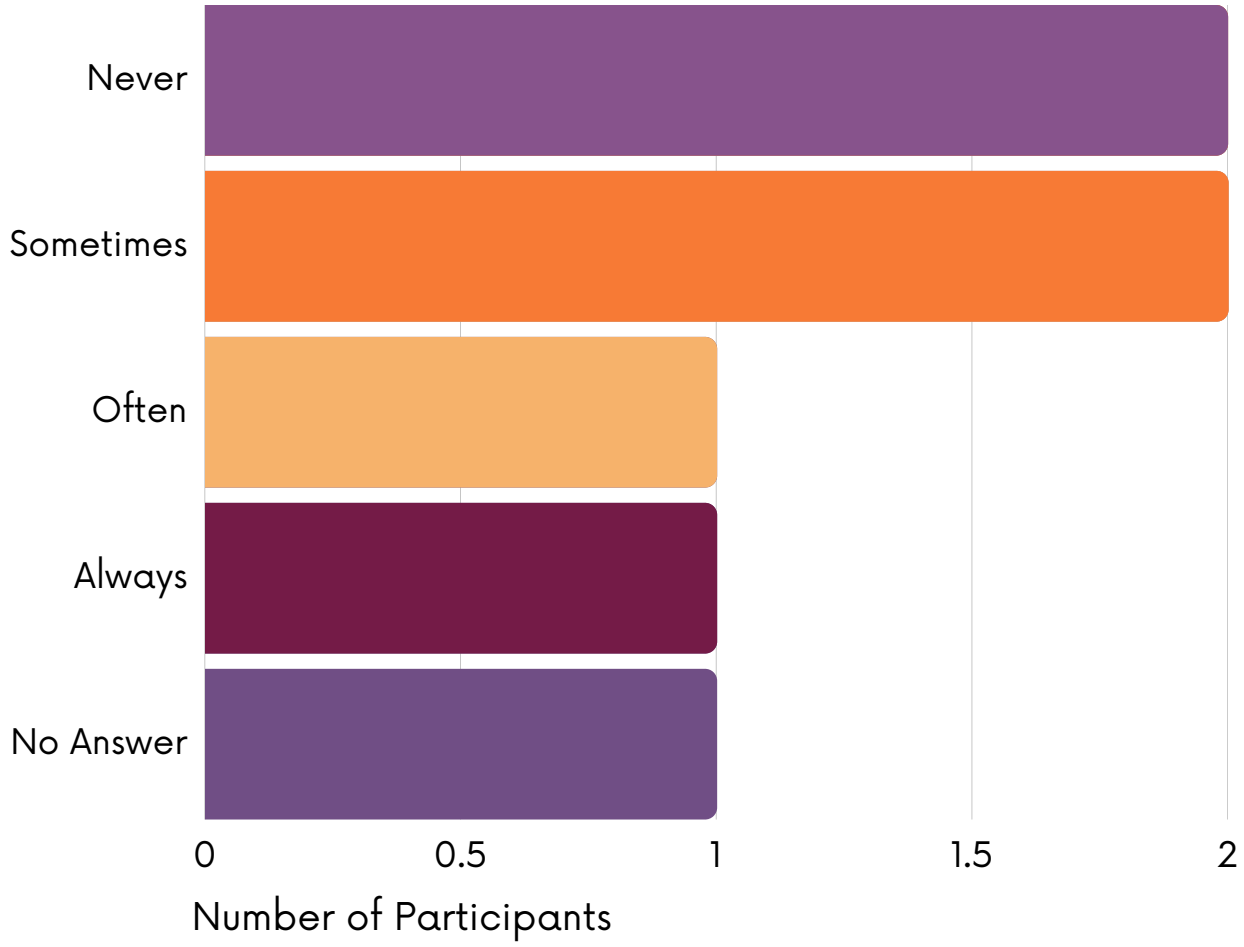


RELIGIOUS PRACTICE



Demographics Continued

TURNING TO RELIGION TO COPE WITH PROBLEMS IN LIFE



RACIAL TRAUMA INVENTORY AVERAGES

Re-Experiencing		
There are times when I feel and think as if the event is happening again	4.14	3.81
I can't seem to get the event(s) out of my mind even when I try	3.86	
I tend to stay away from people/places who remind me of the event	3.43	
Avoidance		
I avoid activities, places, things, or situations that remind me of the experience(s)	3.86	3.86
I avoid certain types of people because I worry they will behave in a racist way	3.86	
Dissociation and Distress		
These difficulties have been getting in the way of my everyday life	2.86	2.50
Everything seems rather unreal, dreamlike, distant, or distorted	2.71	
When I describe the event, I feel nothing, as if I'm not "really there"	2.29	
I feel detached from my body, disconnected from my sense of self, or like a robot	2.14	

***1-5 scale (strongly disagree → strongly agree)

RACIAL TRAUMA INVENTORY AVERAGES

Cognition and Mood		
I view others in a more negative way (e.g. "I can't trust white people")	3.71	3.08
I feel as the world is a dangerous place	3.71	
I found it difficult to work up the initiative to do things	3.57	
I find myself spending a lot of time at home and away from family or friends	3.29	
I feel detached, cut-off, or alienated from other people	3.14	
I view myself in a more negative way (e.g. "I should be a stronger person")	2.71	
I think I am no good at all	1.43	
Physical & Hypervigilance		
I experience tiredness and lack of energy	4.00	3.52
I find it difficult to relax	3.86	
I have been overly alert or on-guard	3.57	
I experience more headaches and stomachaches since the event	3.14	
I have used alcohol or other drugs to help me sleep or to make me forget the event	3.14	
I experience physical reactions when something reminds me of the event	2.71	

***1-5 scale (strongly disagree → strongly agree)

RACIAL IDENTITY AVERAGES

Racial Identity		
I have a lot of pride in my ethnic group and its accomplishments	4.57	3.71
I am active in groups that include mostly members of my own ethnic group	3.43	
I have a strong sense of belonging to my own ethnic group	3.14	

***1-5 scale (strongly disagree → strongly agree)

Time with Same Race/Ethnicity

28.5% said frequently/very often
28.5% said a 50/50 split
43% said not often
(reasons ranged from preferring alone time to not finding community)

Awareness of Race/Ethnicity

57% mentioned in childhood/primary school
29% mentioned since birth
14% did not mention a specific age

COPING AVERAGES

Racial Identity		
Believing in myself helps me get through hard times	4.50	3.98
I look for creative ways to alter difficult situations	4.33	
Getting through tough times prepares me for future challenges	4.33	
I guess I'm pretty tough because I've gotten through some hard times	4.17	
I'm determined to reach my goals in life	4.00	
Regardless of what happens to me, I believe I can control my reaction to it	3.83	
When I encounter people's hostile attitudes, I can control my reactions	3.83	
I believe I can grow in positive ways by dealing with difficult situations	3.67	
When people don't support me, it doesn't stop me from going ahead with my goals	3.17	

***1-5 scale (strongly disagree → strongly agree)

RACIAL SOCIALIZATION AVERAGES

Racial Socialization		
Openly share how I feel about my racial background	4.33	3.31
Speaking up if a peer uses a skin racial slur	4.00	
Correcting a peer/coworker's racial stereotyping of others	3.83	
Initiating a conversation about race with peers	3.67	
Speaking up if a stranger uses a racial color slur	3.67	
Sharing my emotions about my positive racial encounters in my life	3.33	
Correcting a stranger's racial stereotyping of others	3.33	
Asking for help when I am stressed from a negative racial encounter.	3.17	
Resolving a negative racial encounter with peers/coworkers	3.17	
Speaking up if I am racially mistreated by a non-authority person of the same race.	3.00	
Sharing my emotions about my experiences of negative racial encounters in my life	2.83	
Speaking up if I am racially mistreated by an authority figure of same race.	2.83	
Speaking up if I am racially mistreated by a non-authority person of the another race	2.67	
Speaking up if I am racially mistreated by an authority figure of another race.	2.50	

***1-5 scale (strongly disagree → strongly agree)

COMMUNITY CONVERSATION SERIES

Introduction:

The Healing Racial Trauma Initiative (HRTI), Community Conversation series served as an opportunity to gather and listen to the experiences of People of Color (POC) community members in Maine in order to understand the scope of racialized mental health challenges, the quality and range of current support systems in their communities, and the vision for improved wellness outcomes within the contexts in which these perspectives or experiences are situated. Four conversations were designed and facilitated online during the summer of 2022.

Guiding Questions

- What is the community consensus on the directives of a POC-driven mental health platform?
- How does local anecdotal data compare with national trends?
- What are the local mental health challenges and how can we provide targeted support through HRTI materials?

COMMUNITY CONVERSATION PROCESS:

Participants:

Close to forty individuals, nonprofit organizations, and mental health facilities were contacted and invited to participate in the Community Conversation Series. Stemming from findings from the Racial Equity Social Determinants of Health (RE-SDOH), efforts were concentrated within the Portland and Lewiston regions. In order to build trust and facilitate learning, individuals were asked to participate in all four sessions. Twenty individuals chose to participate in the series. Three additional individuals who could not make all four sessions were interviewed separately. 95% of all participants identified as POC.

Session One: Grounding with Each Other and HRTI (2hrs)

Exploring our understanding of place – This discussion centered on providing a foundation for participants. A chance to get to know one another and perhaps, themselves. Here we invited participants to explore the geographical, historical, and social context of the place they call home.

Sample Questions:

- What is their relationship to the place they are currently living?
- What is their family's history and relationship with Maine?

Session Two: Personal and Interpersonal Experiences of Trauma (2hrs)

Session Two sought to establish a compassionate and supportive space to acknowledge and understand the roots of trauma. Participants were invited to explore in any way that felt right for them, the ways in which racial trauma has impacted their lives, family, and community as well as to explore the ways in which racial trauma has impacted society at large. Topics ranged from personal experiences of racialized discrimination and violence to poverty, struggle, resistance, and liberation.

Sample Questions:

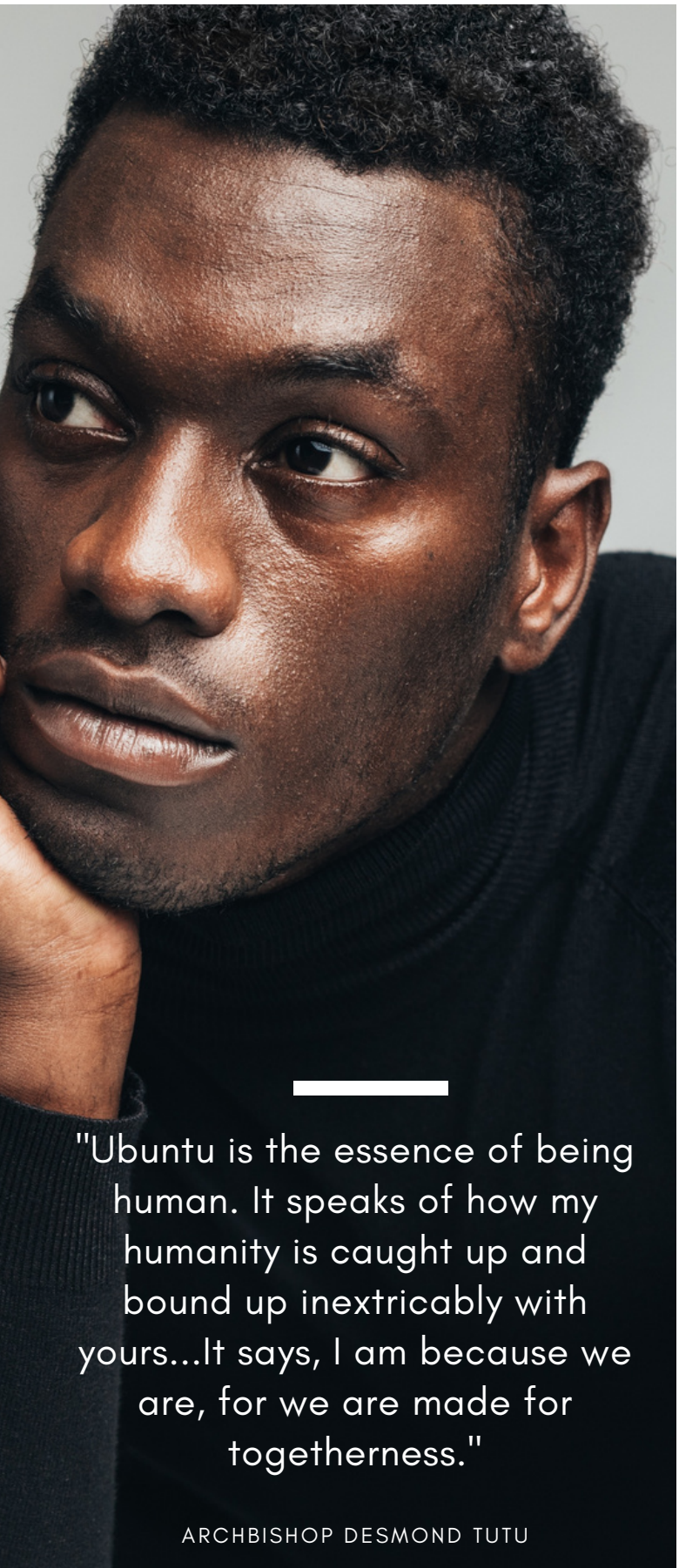
- Where are the points of stress in their lives?
- What are their body's reactions to the discrimination they face?
- How have they been taught to relate to these reactions?

Session Three: Personal and Interpersonal Experiences of Healing (2hrs)

The Praxis Project defines healing as, "community-centered love, connection, and restoration that cultivates communal power." This session invited participants to explore what healing looks like for them individually as well as how healing might be made manifest within our communities. In order to understand issues related to accessing mental health services or therapeutic forms of support, questions also included invitations to explore the ways in which these services show up in their lives.

Sample Questions:

- What trauma/stress-management strategies do they have access to?
- What strategies are practiced by their communities?
- What strategies are borrowed from other spaces?
- Who are the providers that you are aware of?



Session Four: Visioning for POC Futures (2hrs)

Our final circle invited participants to explore what a community-centered approach to racial trauma healing in Maine might look like. Participants expressed a deep desire for these sessions to continue and made plans to continue to meet after the four Community Conversations had been completed.

Sample Questions:

- What is needed?
- What comes to mind when you envision POC healing in community?
- What outcomes are important for the context of living in Maine?
- When thinking about resourcing a community with mental health support, who needs to be trained?
- What makes a practitioner or space accessible, safe & liberatory?

Method & Analysis

The Community Conversation Series resulted in over ten hours of recorded conversations. All conversations were transcribed using Otter.ai software and reviewed by the HRTI team for errors. All interviews and conversations were analyzed using a deductive coding process. Deductive coding is a method of qualitative data analysis that uses a predefined set of codes and assigns those codes where appropriate to points within the conversation.

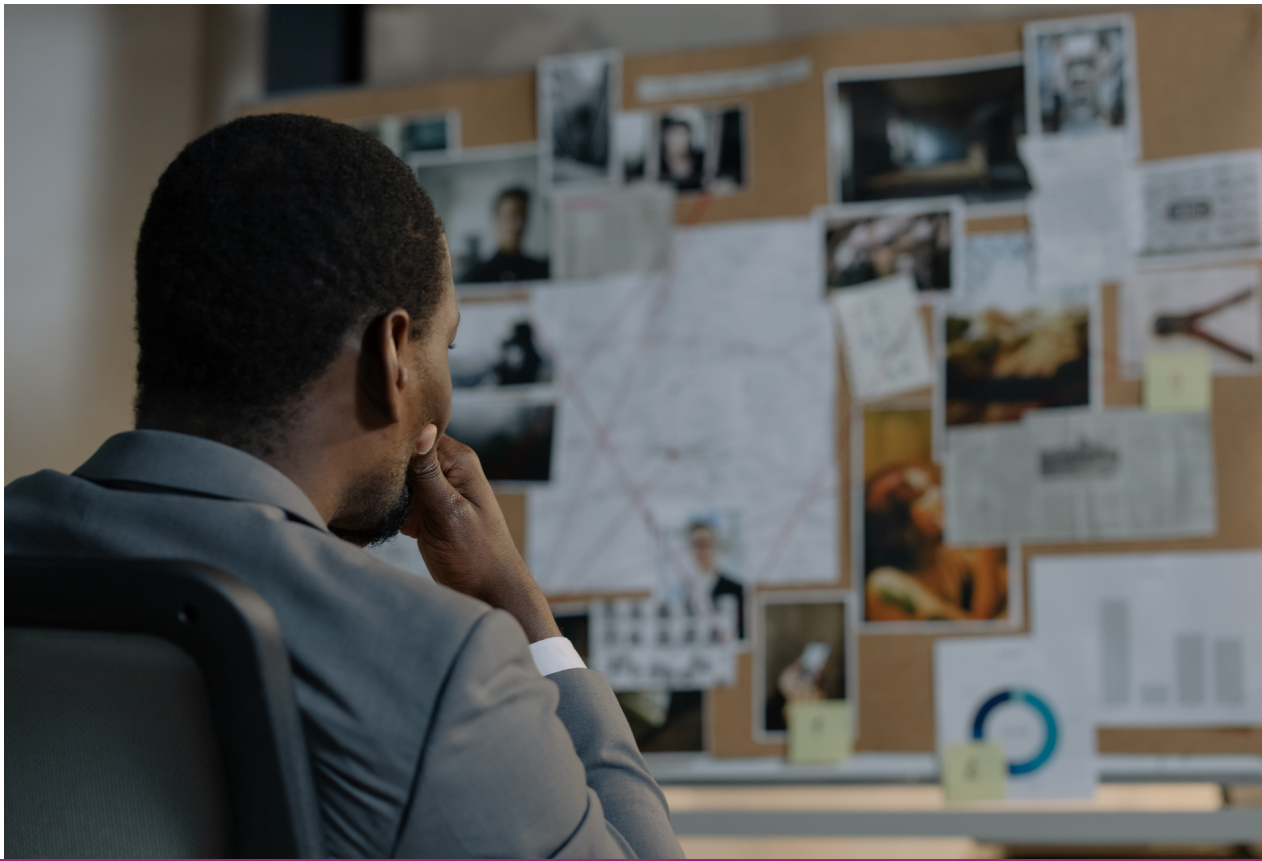
Description of Data Collection

A coding handbook was developed specifically to detect centrally important themes related to racial trauma. In addition to an extensive literature review (provided in part on pages 5-8), theoretical and empirical evidence from the Maine Racial Trauma Survey and the Maine Racial Equity Social Determinants of Health (ME-SDOH) were used to develop item generation for the coding handbook. Codes fall into one of four categories:

Personal level (e.g. feelings of being hopeful; personal identity markers)
Interpersonal level (e.g. references to family members; community experience of trauma)
Systemic implications (e.g. criminal justice system; economic impacts)
Reparations and healing (e.g. faith-based resources, liberation).

Research Design

The coding team consisted of five HRTI team members. Coders trained for approximately two months to reach adequate pre-study reliability (ICC > .60; Cicchetti & Sparrow, 1981). Training consisted of reading the scoring handbook, reviewing specific community conversation segments, and practicing scoring sessions. Once scoring commenced, each community conversation and interview was scored independently by no less than three individual coders. The results of these assessments were discussed in weekly meetings to prevent rater drift, or changes in rater behavior/coding across different transcripts. (Orwin & Vevea, 2009).



The Community Conversation Series included nearly 1,000 codes (see supplementary materials for coding list), which were broken down by code category and conversation transcript through a database system in order to develop a frequency distribution of codes (as shown in Tables 1-4). Simple descriptive analysis determined the most common codes per transcript, code category, as well as frequency of co-occurrence between codes (**betweenness**). Betweenness, therefore, is a strong way to determine which codes serve as a "bridge" to connect to other concepts. While it is mathematically complex, the importance of high betweeness is clear - it determines the flow of communication between ideas.

Simple descriptive analysis determined that the most common codes throughout all series included **SOL** (*solidarity as form of healing*), **IDE** (*personal identity markers*), **FAM** (*reference to a family member*), **RAC** (*reference to an experience of racism*), and **TRA** (*an event interpreted as trauma*).

In the first two Community Conversations, which were centered around self-reflection, 37% of all codes were of the "Systemic" Classification, followed by "Personal" (*28%*) and "Interpersonal" (*26%*). As this conversation primarily focused on grounding oneself and their understanding of "home" - **IDE**, **HOU**, **MENT**, and **FAM** made up nearly 40% of all codes from Community Conversation I. The second Community Conversation relied heavily on "Personal" and "Interpersonal" codes such as **TRA** (*8% of conversation*), **FAM** (*8% of conversation*), and **IDE** (*7% of conversation*).

Community Conversation III shifted themes to center more around the concept of healing. Here, analysis of qualitative data determines that nearly 40% of all codes from this session were classified under "Reparations and Healing". The most common codes in this conversation were **SOL** (*17% of conversation*), **BOD** (*8% of conversation*), and **HEA** (*7% of conversation*). Similarly, Community Conversation IV included the following top codes: **SOL** (*15% of codes*), **BOD** (*9% of codes*), and **CULT** (*8% of codes*).

TABLE 1
FREQUENCY OF PERSONAL CODES

Personal Codes	Totals code	CC 1	CC 2	CC 3	CC 4	Interview	Survey
HOP	5	2	2				1
IDE	64	23	16	7	2	2	14
SELP	4		1	1			2
SELN	10	1	8				1
HEA	31	5	9	14	2	1	
SOMA	9	1	5	1	2		
WEA	19	3	2	7	1	5	1
PSY	5			2	2	1	
TRA	42	4	19	7	2	10	
PERT	8	1	6				1
HIS	5	1	1	1	1		1
RPASS	9		8	1			
SCS	1		1				
GENS	1	1					
BELS	13	6	3	2			2
COPP	12	4		7			1
COPN	8	2	1	5			
PE	4		1	3			
Totals collection method	250	54	83	58	12	19	24

TABLE 2
FREQUENCY OF INTERPERSONAL CODES

Interpersonal Codes	Totals code	CC 1	CC 2	CC 3	CC 4	Interview	Survey
COMT	11	5	2	2	1	1	
COMB	19	9	5			2	3
EPI	13	3	9	1			
FAM	52	13	18	8	3	5	5
FREN	21	6	2	8	5		
IN	6		4	2			
INGT	14	3	9			2	1
INHT	0						
SOCI	22	11	2	5	3	1	
Totals collection method	158	50	51	26	12	11	8

TABLE 3
FREQUENCY OF SYSTEMIC CODES

Systemic Codes	Totals code	CC 1	CC 2	CC 3	CC 4	Interview	Survey
COMI	20	9	2	2	7		
COMS	19	5	7	4	3		
ECO	31	13	3	5	4	6	
EDU	24	5		5	5	7	2
HOU	28	17	5	2	1	3	
IM	14		7	2	2	2	1
JUS	2					1	1
MENT	35	15	5	6	6	3	
PR	4		2	2			
RAC	44	3	14	3	3	8	13
SETC	30	5	11	2	1	6	5
SY	19		11	2	5	1	
VL	16		15				1
WS	29		8	3	6	4	8
Totals collection method	315	72	90	38	43	41	31

TABLE 4

FREQUENCY OF REPARATIONS & HEALING CODES

R&H Codes	Totals code	CC 1	CC 2	CC 3	CC 4	Interview	Survey
APO	0						
ART	3			1	2		
BOD	25			15	10		
CULT	19	3	2	1	9	2	2
FAIT	6		1	5			
GAP	30	8	3	6	2	9	2
LIB	15		1	5	4	2	3
REP	0						
RS	9		1	7	1		
SOL	78	5	6	34	18	10	5
TRAI	9	2		1	4	2	
Totals collection method	194	18	14	75	50	25	12

As elaborated on in the "Key Takeaways", there is a clear distinction between the codes related to oppression (ie: White Supremacy/WS) and negative self-image (SELN). Through the analysis of the coded conversations, the SELN code encompassed the second highest level of betweenness, suggesting significant overlap between this concept and other codes within the conversations. Further, SELN was coded a total of ten times.

In the latter Community Conversation Series, topics surrounding solidarity (SOL) and various modalities of healing were explored in great detail in relation to experiences of racism and poor mental health. Solidarity in particular was a powerful item, coded a total of 78 times, and was the highest coded item throughout all of the conversations. The idea of healing as a collective process was significant in these coded sections, such as "_____" (QUOTE?).

Additionally, the second-highest frequency code, IDE, was a salient connecting concept that bridged other relevant codes within the discussions. These self-reflected markers of identity were crucial in describing instances of racial trauma and connecting to the importance of community-based healing methodology. The IDE code also had a relatively high score of betweenness, reinforcing its importance as a "bridge" between participants' reflections on experiencing racism and collective healing. For more discussion on the concept of betweenness, please see page 19.

Network analysis of code co-occurrences While the coding scheme covers a multitude of attitudes, behaviors, and experiences related to racial trauma it also enables analysis of the underlying patterns of association that arise from conversations, interviews, and qualitative data that were captured in this project. The total counts of codes and proportions that are reported above tell one story of degree and scale, essentially who talked about what and when? But, to understand the associations that were made when participants were answering questions or prompts we used attitudinal network analysis (ANA) to tease apart the structures and associations that are key to understanding the landscape of patterns related to community healing and resilience.

Here we developed a model for investigating the core research questions by building attitudinal network analysis models based on the work of causal attitudinal network analysis (Dalege et al., 2017a, 2017b). Network analysis of attitudes has been used in a variety of research projects to understand the structure of attitudes and other epistemic elements and how they relate to various behaviors and decisions such as community healing, voting patterns, and behavioral change programs in general. For the purpose of this report, "attitudes" references the psychological concept related to one's perception of the world (Greenwald, 2014). By this definition, attitudes are rooted in object appraisal (the lens through which we make judgments about the world), social adjustment (which provides schemas, or cognitive frameworks), and externalization (how we project the judgment through behavior or decision-making).

By predicting both the extent to which individuals base their attitudes on their pre-existing experiences or ideas about community healing and the extent to which an attitude element influences decisions and other behavior relevant to an attitude network measure can elucidate various structural patterns to underlying attitudinal pathways leading to behaviors in ways that other methods cannot (e.g. regression, modeling).

Additionally, attitudinal connectivity can help inform how effective programmatic interventions can target various attitudes to ameliorate problematic behaviors or encourage healing activities. Measures of attitudinal centrality (degree and betweenness) can further inform the effectiveness of targeting specific attitude elements, as addressing a central or embedded attitude element is probably more likely to affect outcomes than changing a peripheral attitude element.

We employed the coding scheme and transcript analysis to develop a model for code co-occurrence that enabled us to examine these underlying structures of the conversations and qualitative data gathered. Diagram 1 displays the co-occurrence of links between codes that appear in a row of transcript which was generally a complete answer to a prompt or question. A link between two codes is created when they co-occur or are coded in the same row of transcript which means there is an association between the two codes in what a participant is talking about or referring to in the discussions or answers to questions. Each code node is sized based on the betweenness score for each code. Betweenness centrality measures how many times an element, or in this case a code, lies on the shortest path between two other codes. In general, codes with high betweenness have more control over the flow of information and act as key bridges within the network. They can also be potential single points of failure. We interpret codes with high betweenness to be key attitudes or themes that are connecting or related to many other codes and are thus important in both how we understand racial trauma and healing and how best to build programming around community healing initiatives.

In table 5 we report on the degree and betweenness centrality for each code. Degree centrality is the simplest of the network centrality metrics, counting the number of connections a code has in the network. In this case, the number of co-occurrences that code has in the transcript analysis. In general, elements with high degrees are local connectors or hubs but aren't necessarily the best connected to the wider network. Here we are interested in codes that might outperform in betweenness based on where they rank in degree centrality.

DIAGRAM 1:
NETWORK GRAPH OF CODE CO-OCCURRENCE

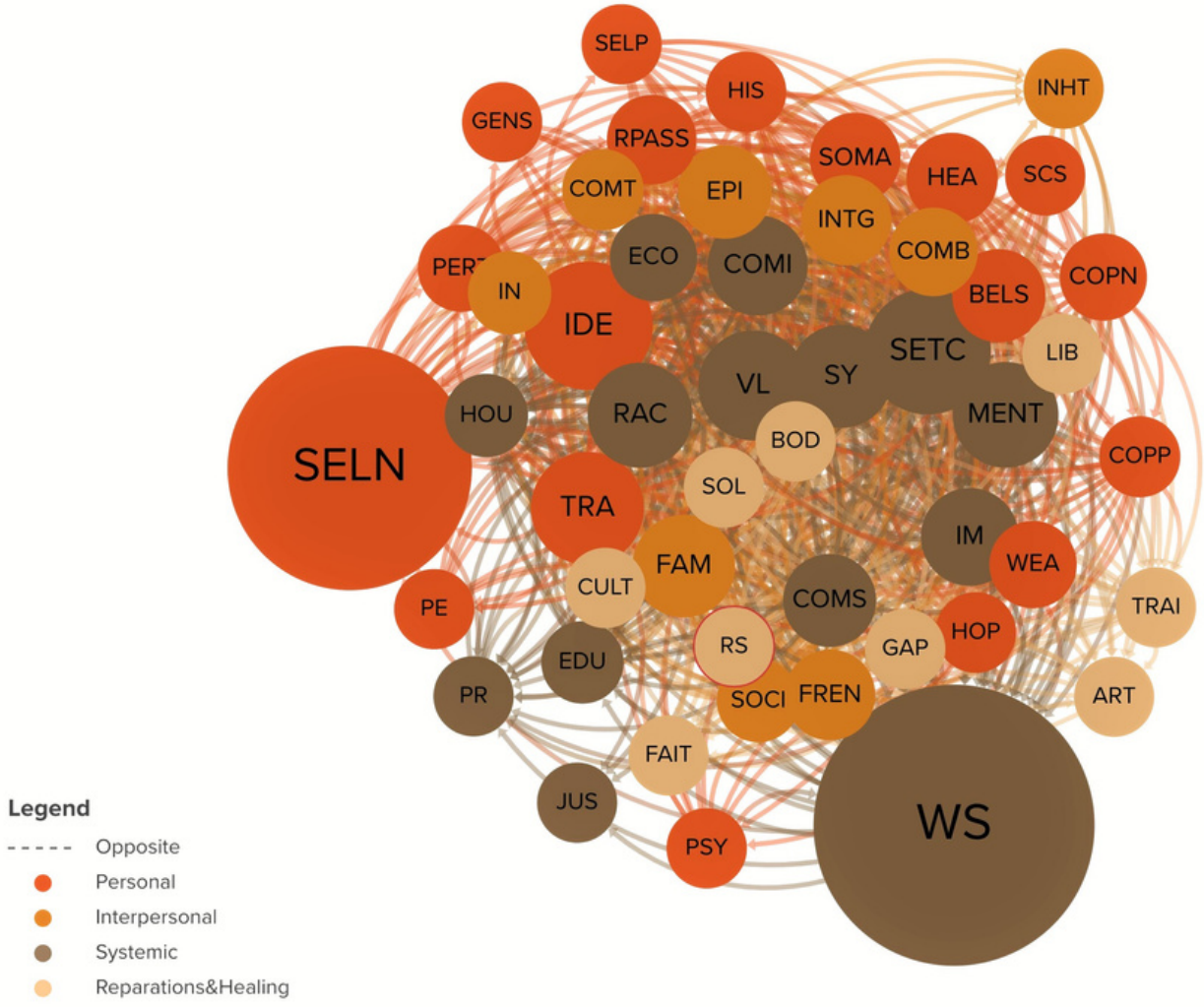


TABLE 5

CODE CO-OCCURRENCE DEGREE AND BETWEENNESS SCORES AND RANKINGS

Degree Rank	Code	Degree	Between Rank	Code	Betweennes s	Degree Rank	Code	Degree	Between Rank	Code
#1	WS	56	#1	WS	0.31	#26	HEA	32	#26	COPN
#2	RAC	54	#2	SELN	0.254	#27	PERT	32	#27	ECO
#3	SETC	51	#3	IDE	0.074	#28	IN	31	#28	PERT
#4	TRA	50	#4	SETC	0.071	#29	RPASS	30	#29	CULT
#5	SY	50	#5	TRA	0.051	#30	COMT	30	#30	GAP
#6	SOL	50	#6	VL	0.046	#31	WEA	29	#31	LIB
#7	FAM	49	#7	MENT	0.039	#32	EDU	26	#32	HOU
#8	MENT	49	#8	RAC	0.038	#33	BOD	26	#33	IN
#9	COMS	48	#9	SY	0.035	#34	LIB	26	#34	SOCI
#10	IDE	47	#10	FAM	0.034	#35	HOP	24	#35	EDU
#11	IM	44	#11	COMI	0.031	#36	RS	23	#36	TRAI
#12	ECO	43	#12	SOL	0.028	#37	TRAI	23	#37	COMT
#13	VL	43	#13	IM	0.027	#38	COPP	22	#38	RS
#14	INTG	42	#14	EPI	0.021	#39	HIS	21	#39	COPP
#15	COM B	41	#15	ART	0.021	#40	PR	20	#40	FAIT
#16	EPI	40	#16	BELS	0.02	#41	COPN	19	#41	HIS
#17	COMI	40	#17	COMS	0.02	#42	ART	16	#42	HOP
#18	HOU	40	#18	BOD	0.018	#43	SCS	15	#43	PSY
#19	BELS	37	#19	HEA	0.017	#44	SELP	13	#44	PE
#20	FREN	37	#20	SOMA	0.016	#45	PSY	12	#45	PR
#21	SOMA	36	#21	FREN	0.016	#46	FAIT	12	#46	SELP
#22	SOCI	36	#22	INTG	0.015	#47	PE	11	#47	SCS
#23	CULT	36	#23	RPASS	0.015	#48	INHT	10	#48	GENS
Totals collection method	250	54	83	58	12	19				24

FINDINGS

EXECUTIVE SUMMARY

The main findings of these community conversations emphasize the cause-and-effect relationship between overt and covert experiences of racism, and poor mental health outcomes and care for People of Color. From the data, it is evident that there is a clear correlation between the systemic and the personal. The greater societal systems that People of Color (POC) attempt to navigate often negatively impact the relationships that they are able to form with themselves. This ripples out to influence how they are able to interact with their personal relation systems and societal responsibilities.

The highly interpersonal nature of these findings emphasizes the need to move away from individualized methods of care and instead pivot toward collective, somatic, and culturally affirming strategies of healing.

Ultimately, this data presents a profound look at the interlocking systems of domination and oppression, and how it impacts mental health outcomes and care. These findings help form an understanding of how the different experiences of racial harm are functioning simultaneously in the lives of individuals. This will allow individuals to understand oppression and domination as a collection of nuances that can hinder the mental health and well-being of People of Color. It is a reminder of how systemic constructs deeply impact social and personal relationships, as well as authentic identity formation. In addition, we are also able to gain perspective as to what the gaps are for healing racial trauma. Throughout the findings, solidarity, belonging, and safe spaces were identified as some of the pathways toward establishing greater personal resilience and manifesting more collective joy.

Key Takeaways

1. Cause and effect relationship between domination, oppression, and poor mental health outcomes

From the workplace to schools, social settings, the home, and the body, we are seeing how the nuances of white supremacy are creating a powerful barrier for People of Color to access a full quality of life. These findings were previously supported in the analysis section where codes of white supremacy (WS) and negative self-image (SELN) appeared with frequent and consistent overlap.

The threat of deadly harm and devaluation of Black and Brown life permeating from a dominant culture of white supremacy has created conditions where People of Color are finding themselves in a perpetual state of fight or flight. Increased feelings of hypervigilance, depression, anxiety, and low self-worth are a direct result of living within the confines of a white supremacist society. The real and perceived threats of violence impact the ability to feel trust and safety within predominantly white spaces. This includes attempting to access the field of mental health care that has a racist history of harm toward POC.

Key Takeaways Cont.:

In addition, POC often develop a **double consciousness** as coined by W.E.B Du Bois (1897), about the value of their identity and place in society. This causes POC to have less access to forming positive relationships with themselves, which in turn ripples out to all other facets of navigating life and forming secure relationships with others and the self.

I have to just be able to move fast, and adapt and be more like a chameleon. And I think those properties are what makes me 'safe' in my community

I tried to define trauma as hurt. And the way that we hold our hurt, and how that ripples out to impact others around us and ourselves. I'm thinking of the fragments of stories that I've heard from my parents growing up and the hard ways that they grew up

I think it's interesting to see how past traumas relate to the oppression and racism in the US.... So finding [a therapist] who can embrace all of that and provide care in a way that makes sense... is hard.

I just felt like, people started to interrogate my blackness

I'm thinking about the ways in which trauma impacts me and my family, it's through war and through imperialism, and colonialism, and patriarchy, and misogyny, and state violence, and how that how those things get recreated on like interpersonal level, and in our relationships

2. Prioritizing Community Approaches

Throughout the community conversations, the highly interpersonal nature of this work is abundantly clear, as previously discussed in the analysis, solidarity (SOL) appeared within the data more than any other code. This emphasizes the importance of approaching healing as a collective process. People of Color are persistently interacting with harm and healing on a collective level. There is a great sense of personal harm that comes from witnessing violence toward individuals who share similar racial and social marginalization as well as a greater sense of relief from coming together with the community to find healing.

I view communal healing, as like a house ... maybe some people are cooking, or maybe some people are sleeping, or maybe some people are drawing or things like that ... we can all heal individually, but together .. we also don't all heal in the same ways..

I just believe in the power of human connection and healing that comes through good emotional connection with people and with ourselves and with our world. And I think therapy can be a tool for that.

Throughout the findings, solidarity, belonging, and safe spaces were identified as some of the pathways toward establishing greater personal resilience and manifesting more collective joy.

As we move away from individualized approaches to mental health care, we are able to pivot toward what comes as an Afrocentric understanding of healing. In the book, "Understanding an Afrocentric Worldview: Introduction to an Optimal Psychology" (1993) Dr. Linda James Myers explains,

...we get an African concept of self that is multi-dimensional and consistent with the proposed model...The individual cannot and does not exist alone, but owes his/her very existence to other members of the "tribe, including the ancestors and yet unborn. According to the Afrocentrists, the concept of self may be described as follows: I am, because we are; and because we are, therefore, I am. It is the individual and the infinite whole. We is the individual and collective manifestation of all that is. Self includes all ancestors, the yet unborn, the entire community, and all of nature. In my being is my worth, because I am not a separate, finite, limited being, but an extension of-and one with-all that is.

Within this framework, we are able to strategize therapeutic models which honor the process of healing as collective. By centering Afrocentric and Indigenous worldviews at the heart of patient care, HRTI seeks to alleviate cultural barriers to mental health care and provide direct access to therapeutic practices and resources that are intentionally designed to mitigate racial trauma.

3. Decolonizing Black & Brown bodies

Here we examine the body as a sight for trauma, reclamation, healing, and liberation. By exploring the somatics of creating safety, this initiative will provide access to an essential personal foundation required to access a full quality of life. As previously discussed in the analysis, identity (IDE) shows up as the second-highest frequency code and was a salient connecting concept that bridged other relevant codes within the discussions. These self-reflected markers of identity were crucial in describing instances of racial trauma and connecting to the importance of community-based healing methodology. Using identity as a bridge we are able to understand how identity, the body, and racial trauma calcify into an unabating experience of emotional and physical suffering.

In order to mitigate the cycles of harm that are constantly present in the lives of People of Color, we have coined sustained healing integration (2023) as a concept that can help POC increase and prolong experiences of healthy regulation, ease, and wellbeing. .

Sustained healing integration is defined as the ability to find momentum and resilience in emotional ease by incorporating grounding and self-affirming healing strategies as a lifestyle/daily practice and as a way of being, and relating.

From the data, we were able to identify some of the ways individuals are responding to systemic oppression within their physical bodies. Two participants describe below how healing interacts with what individuals have identified as a perpetual state of nervous system arousal

> *I feel like I have a nervous system that is so inflamed, that it that most of the time is spent trying to survive*

> *It feels like healing is…striving for that…sort of soothing, that is able to take place when the body can rest and not be always, always so on edge*

An identification of **soothing** and **rest** as strategies to mitigate the flight or fight response is important data that we have identified as a direct strategy for healing. Once rest strategies have been implemented, individuals are able to be present within their own bodies and can process the world with greater clarity.

In addition, this research has identified how although participants strive for a greater feeling of calm, there is still a necessity to remain in a state of hyper-vigilance as the reality and possibility of experiencing racial violence in society comes in direct conflict with opportunities for safety. The dual necessity for maintaining healthy threat assessment and ability to soothe an overactive nervous system is a pivotal intersection that requires careful consideration. Without sustained healing integration, attempting to practice discernment about threats in the world can be an immense challenge.

There's this autonomic response, you know, this desire to heal and for the immune system to fight.

Providing support to POC in all areas of society has surfaced as a necessity for mitigating the burden of racial harm and alleviating the unavoidable pressures that unduly burden POC.

...and so it almost feels now that... I understand that I'm not invincible, that the amount of trauma and pain that a person can feel actually has a limit.

An additional strategy that has been developed to address decolonizing Black and Brown bodies is somatic abolition, coined by therapist Resmaa Menakem (2023). Somatic abolition is described as:

A living embodied Anti-Racism practice and culture building that requires endurance, agility, resource cultivation, stamina, discernment, self and communal discipline cultivation, embodied racial literacy and humility. These can be built, day by day, through reps. These communal life and invitational reps will temper and condition your body, your mind, and your soul to hold the charge of race.

4. Identity and Belonging Here we look at how the co-occurrences between feeling seen, mental health, and how social setting impacts experiences of harm, belonging, and potential for healing. As we discussed in Key Takeaway 3 and in the analysis of the data above, identity (IDE) emerged as a pivotal entry point and bridge for understanding multiple interactions of racial harm.

Identifying how individuals interact with their environment and identity is a powerful entryway into establishing healthy foundations for long-term confidence, feelings of belonging, and resilience. Here, the interdependence between social setting, family, and identity forms an important trinity of care.

POC typically gravitate towards spaces where they will not find themselves as the only individual of color and be directly exposed to tokenism.

I definitely had a lot of anxieties about moving to a very white state, having come from another very white state. But I feel very fortunate that I have encountered people and opportunities that have made me feel very much at home now in the way that I haven't.

There's so much unknown that is specifically very white...maybe [some white communities] have never even seen a person of color....I think our states....need some understanding and story sharing without a tokenized fetishism... [of] one person of color who's coming tell their story....there has to be some sort of sort of community connection in order to create empathy. In order for there to be growth in the ultimate feeling of not feeling uncomfortable....Because that starts with really exposure...and a willingness to learn.

It is also evident through the research that the family systems of POC largely do not have a positive relationship with mental health care if they have one at all.

Mental Health in my native language, that word does not exist. The names for depression, anxiety, things like that don't exist. In fact, if you try to match it with a word, the closest that that comes to is shame.

From these findings we are able to understand how all of the varied pressures that rest on People of Color additionally create a barrier to accessing mental healthcare. Day to day focus is often so much within survival mode that individuals can rarely find time to incorporate strategies for self care.

I think part of living in a country that's not safe for a long time, is that you're on the hierarchy of needs, you can only see so much. So you don't have that luxury or time to think about, you know, what else is? You don't really explore other places of yourself.

In order to create a greater sense of belonging, it is pivotal that People of Color have a safe environment to be witnessed wholeheartedly in their pain and in their joy.

NEXT STEPS

1. The HRTI team will contact participants from the community conversation to share the findings presented within this report. By sharing the findings of this report, we will foster a sense of trust and transparency within our community. We hope that individuals who participated in the conversation series will gain a deeper understanding of the process and will share in the ownership of this project together with us. Our team is interested in launching this initiative as a program that is for the people and by the people. This process would be impossible without their vulnerability and dedication to transforming racial trauma.
2. We anticipate launching a Healing Racial Trauma pilot program that will encapsulate an Afrocentric and Indigenous-centered therapeutic programming series during the Fall of 2023. Consisting of 6-10 meetings in a single series, we aim to offer the series in 4-6 locations throughout Maine with the possibility to hold meetings virtually. Each series will include roughly 10-15 participants. It is incredibly important to us that we are responsible and considerate in our approach to healing racial trauma, taking all necessary precautions not to re-traumatize community members while being able to supply a program that is grounded in community-based practices.

   a. Healing racial trauma is approached through a nonlinear, iterative therapeutic process that will be measured through a reduction of mental and somatic symptoms over time. Collecting data about the program's progress will be done using consent and following strict confidentiality protocols. By analyzing post-session practitioner notes with assessments of the issues and progress, we will be able to assess a client's development and the overall success of the program. In addition, surveys will be provided at the end of each of our therapeutic series in order to obtain feedback from participants as to their experiences.

NEXT STEPS CONTINUED

3. In addition, we will establish a community-based advisory committee that meets monthly to share information, insights, discuss research, and make recommendations on programming. This will bring together local mental health practitioners, healers, and social justice advocates from community organizations.

From this research, HRTI intends to implement **prioritizing community approaches** to care as well as **decolonizing the body** as an alternative care strategy to mitigating racial trauma. These approaches identify how an iterative, collective, and somatic understanding of care is able to connect with the needs of POC and will be key in defining and informing the development and implementation of pilot programs.

The lack of diversity and representation within the field of mental health care creates a significant gap in experiences and understanding between practitioner and client while leaving communities vulnerable to harm. By centering Afrocentric and Indigenous worldviews at the heart of patient care, HRTI seeks to alleviate cultural barriers to mental health care and provide direct access to therapeutic practices and resources that are intentionally designed to mitigate racial trauma.

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FUTURE DIRECTIONS

While data gathered over the course of this year is still being analyzed, preliminary analyses point to four necessary elements to be implemented in 2023:

(1) Establish an HRTI Director: As previously stated, the healing of racial trauma is a particularly complex and challenging endeavor. The experience of racial stress occurs within a complex sociopolitical context where structures, policies, and practices continue to replicate inequitable, if not hostile, environments for POC. Racial trauma is experienced both in an individualized context as well as within collective or community-based experiences. In addition, there exists an extensive body of psychological literature applying the latest research in the healing of racial trauma while there simultaneously exists a wealth of community-based knowledge. Whether the two come into useful conversation with one another is often dependent upon the leader of that respective movement.

Having the expertise necessary to hold this very complex experience with the compassion and care needed to successfully partner with community members is of utmost importance. We will seek an HRTI Director with training in racial trauma and liberation psychology to help lead this effort. Emphasis will be placed on identifying a director who shares the race/ethnicity of those with whom we seek to support. Conversations are currently underway with potential candidates.

(2) Launch of Pilot Programs: This effort seeks to establish a permanent source of community-based psychological support in the healing of racial trauma within the state of Maine. As the analysis continues, details as to what that program could or should look like will begin to emerge. Emphasis will be placed on centering information and experiences gathered during the Community Conversation Series with additional information from the RE-SDOH and findings from Racial Trauma Survey informing program design.

It is incredibly important to us that we are responsible and considerate in our approach to healing racial trauma, taking all necessary precautions not to re-traumatize community members, and are able to supply a program with the greatest benefit for everyone involved. This often takes a period of time to test program design, refine the process, and update the materials. Therefore, we seek to launch a series of HRTI pilot programs in 2024 in order to test program design, gain feedback from participants, and make necessary improvements before a full roll-out in 2025.

(3) Maine Racial Equity – Social Determinants of Health & Racial Trauma Survey Update & Expansion: This year represented our first pass at developing a Maine Racial Equity – Social Determinants of Health (RE-SDOH) as well as an initial process in collecting data to understand how RE-SDOH impacts the experience and healing of racial trauma. In addition, this year also represented our first attempt at building a Maine-specific measure of racial trauma. Developing a survey is an incredibly complex process, a process made all the more complex given the topic of racial trauma and our desire to understand both the individual as well as community-based experience. Here we would seek to both update the RE-SDOH and racial trauma survey as well as expand upon both processes.

For the RE-SDOH we would work towards the development of a system when racial equity social determinants could be tracked regularly on a 3-5 cycle. This would greatly help to inform health equity in the state and provide the information for bolstering existing systems as well as ways to explore the establishment of new ones.

We would also seek to further develop the racial equity survey, refining the process and aligning survey elements further to Maine-specific experiences. In addition, we would like to distribute the survey state-wide to gain a more comprehensive understanding of the experience of racial trauma in Maine. Information gained through a state-wide survey could be used to support school-based efforts, enhance mental health services, and support the development of city and municipality efforts.

(4) Support for an Ongoing Community-Based Advisory Committee: This work would be nothing without our community. Center their voices and experiences throughout the program is a critical component of HRTI success. We seek funding to support participation in an ongoing community-advisory committee to help offset travel, child care, or other necessary expenses.

"rarely, if ever, are any of us healed in isolation. Healing is an act of communion."

bell hooks

THE HRTI & RESEARCH TEAM

Arianna Bow - Healing Racial Trauma Intern
Arianna was born and raised on the island of O'ahu in Kō Hawai'i Pae'āina, the Kingdom of Hawai'i, where she learned to climb trees and roll in mud. She currently studies Dance and Psychology at Bowdoin College on the land of the Wabanaki Confederacy. Her passions lie in movement, radical joy, and somatic healing, and she believes that connecting to our bodies and communities is key to repairing our world.

Scott Byrd - Data Statistician and Research Scientist. Scott received his Ph.D. in Sociology from the University of California, Irvine. His early research examined the efforts of marginalized communities and social justice movements to build consensus through framing and organizational strategies that influenced international climate change negotiations. He is currently a Co-PI on a project that will co-design and research culturally sustaining STEM programs across three states that incorporate indigenous knowledge through storytelling with local science phenomena. He has also worked with the National Science Foundation to build better strategies for inclusion and community engagement in developing innovative, community-based technologies. At Mindbridge Scott blends cognitive and socio-cultural approaches to applied research in order to support Mindbridge programming.

Joy George – HRTI Fellow. Joy George, born and raised in the Bronx, NY as the daughter of Nigerian diaspora, has found herself at the intersections of human rights, transformative, healing and restorative justice, and social change in her work and activism. A recent graduate of Swarthmore College, she actively centers the livelihoods of marginalized peoples and seeks to bring together stakeholders in her community to transform the climate into one of intentional collective care. Joy is a facilitant of the YES! Education Transformation Jam and is currently serving as the Community Engagement Coordinator with Mindbridge. She also is working excitedly to expand Communities of Care to bring much-needed conversation to the transformation and restoration ecosystem with the the state of Maine.

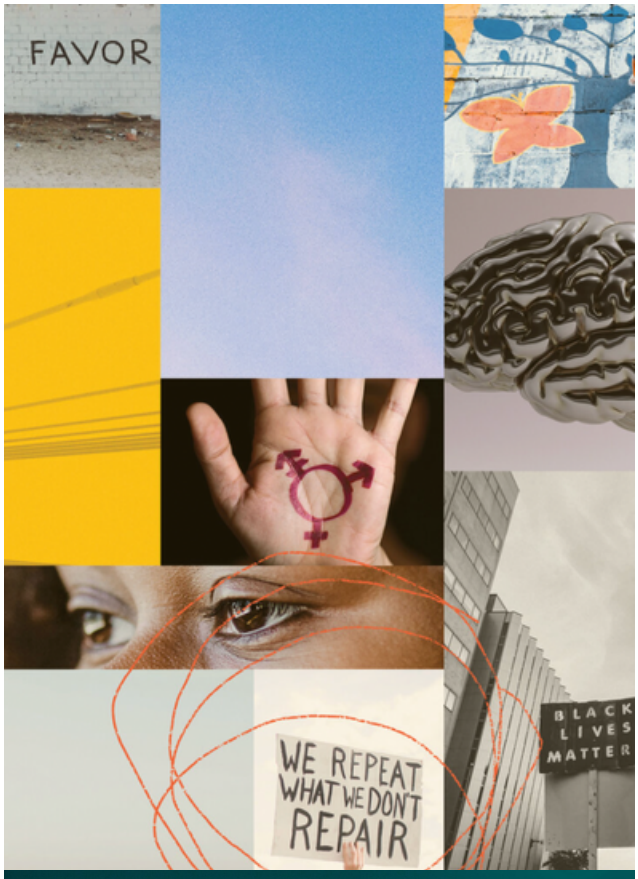
Laura Ligouri, ED, Mindbridge (Program Lead). Born in Waldwick, New Jersey to Puerto Rican and Sicilian parents, Laura founded Mindbridge in Maine six years ago, a nonprofit organization seeking to transform human rights through the integration of neuropsychological science. Her interest in the intersection of neuroscience and human rights emerged while at the Saxelab Social Cognitive Neuroscience Laboratory at MIT, where neurobiological research often sought to understand the biological underpinnings of implicit bias, inter-ethnic social conflict, violence and conversely collective empowerment and change. Currently, Laura teaches neuroscience at the University of Southern Maine and is working to complete her Ph.D. in Clinical Psychology.

THE HRTI TEAM

Kaina Martinez - Healing Racial Trauma Intern
Kaina Martinez is the eldest of Georgia Alvarez's three living children, and a loving sister to several other paternal siblings. She grew up in southern Belize in the small Garifuna village of Seine Bight. She considered herself an advocate for changes and therefore lived her life in such a manner. She is the founder for Kaina Martinez Track and Field Games-and Travel-In Wellness Specialist.

Kholiswa Mendes Pepani - Assistant Director - HRTI
Kholiswa was born in Pretoria, South Africa, and is part of the post-Apartheid generation known as 'the born-free'. With a Bachelor's degree in Social Justice and Creative Writing, Kholiswa is committed to transforming narratives that perpetuate inequity, violence, and disease. When she's not at Mindbridge, Kholiswa is assisting research in psychosis at Massachusetts General Hospital/Harvard Medical School Center for Psychosocial and Systemic Research/Disparities Research Unit. An experienced writer, her work appears in the Anti-Racism Daily, LIBER: A Feminist Review, Amjambo Africa, and Hobart.

Emily Williams - Research Assistant. Emily received her Bachelor's in Psychology from the University of New England with academic minors in Education and Women's and Gender Studies. Her current research interests align with DEI (Diversity, Equity, and Inclusion) from within the lens of social psychology, strengthened by her time as an intern in the Office of Community, Equity, and Diversity (CED) at the University of New England. Emily also has experience as a research assistant in the Self and Close Relationships Lab at the University of New England, where she presented findings at both local and regional conferences. Most recently, Emily was involved with research involving areas of relational resiliency in LGBTQIA+ college students who have experienced discrimination.



ABOUT MINDBRIDGE

Implied in Mindbridge's name is the principle of connection originating from the Founder's nearly two-decades of work linking scientific inquiry to human rights. The last few years have seen an unprecedented rise in human rights abuses world-wide as millions of human beings continue to be the victims of varied forms of racism, racial discrimination, anti-Semitism, xenophobia and related intolerance. The last few years have also seen remarkable advances in psychological and neurobiological research where investigators unlock the unconscious and often implicit drivers underlying intergroup conflict. Connection and "bridging" is essential to long-lasting, effective change. For human rights defenders to find ways to eliminate racist rhetoric and extremist ideology, human rights-based methods historically steeped in policy and reporting must take a different approach. By linking the psychological and neurobiological to efforts deeply invested in structural and institutional forms of change, we acknowledge and can now access the vast ways in which our values, our beliefs and our biology ultimately influence and shape our behavior. **It is through the integration of science with human rights that we build more effective interventions.** And it is ultimately through our understanding of how the brain gives rise to the mind that **we no longer work to simply combat human rights abuses in an endless cycle of violence, but guide the psyche towards the strengthening of society built upon the tenets of human rights itself.**

Mindbridge is a nonprofit organization that is dedicated to generating and harnessing psychological and neurobiological science in service of human rights efforts worldwide. Our mission is to link data to application where psychology and neuroscience is used to build knowledge, generate new realization, and promote actionable real-world solutions for human rights defenders and the communities they support.

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