

# EMBRacing Racial Stress and Trauma: Preliminary Feasibility and Coping Responses of a Racial Socialization Intervention

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## Abstract

The goal of this article is to report initial feasibility and coping response data from a pilot study of a new five-session intervention (Engaging, Managing, and Bonding through Race [EMBRace]) for Black families utilizing racial socialization to address stress and trauma from racial encounters. Ten caregiver and youth dyads were enrolled and completed the EMBRace intervention. Feasibility was based on a closed-option survey for therapists as well as open-ended participant responses to program satisfaction post-intervention. Responses to stress management were assessed via repeated measures of self-reported coping strategies throughout the sessions. EMBRace was deemed to be acceptable by the majority of therapists and participants with regard to discussing racial encounters. Participant responses

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were categorized into five primary codes, including advice, clinician approach, program changes, likes, and dislikes. Participants' coping data throughout the intervention indicates changes in the hypothesized direction (e.g., increased attention to and identification of stressor and decreased stress). The pilot data indicate the desirability of the intervention as well as useful participant feedback for future iterations of EMBRace.

### **Keywords**

racial socialization, racial discrimination, families, intervention, coping, feasibility

Given the occurrence of negative discriminatory racial encounters during the life course of Black Americans (Harrell, 2000), race-based traumatic stress has been conceptualized as a unique stressor that yields specific challenges within this population (Carter et al., 2013). For Black youth and adults, the consequences of repeated exposure to racial discrimination are evident in psychological and physiological well-being as well as compromised stress appraisal and coping strategies (Outlaw, 1993). Accordingly, recent clinical psychology research has demonstrated that racial stress and trauma affects Black Americans at the time of the event and considerably after, lending credence to the trauma-oriented nature of some discriminatory racial encounters (Carter et al., 2013). Arguably, the unaddressed and prolonged stress that results from both in vivo and vicarious encounters may be one of the greatest threats to positive health outcomes for Black people (Kaholokula, 2016).

The dynamic interplay between stress, cognitive appraisal, and coping (e.g., Transactional Model of Stress and Coping [TMSC]; Lazarus & Folkman, 1984) underscores the way in which individuals generally have to meet demands with limited resources. Yet measures of general life stress, which typically do not include racial stress, do not account for the way in which discrimination as a stressor may affect Black people. Indeed, the multiple ways in which discrimination can be experienced (e.g., in vivo; Seaton, Yip, & Douglass, 2011, and vicarious; Jenkins & Baird, 2002) or perceived (e.g., overtly; Bennett, Merritt, Edwards, & Sollers, 2004, or ambiguously; Sue et al., 2007) can result in a range of health and coping challenges. Unlike the TMSC, in which a primary and secondary appraisal assessing the impact and potential resolution comes after the initial stressor, racial stress may compromise the recipient's ability to accurately appraise whether the stressor is present and how to best problem solve the experience (Stevenson, Reed, Bodison, & Bishop, 1997). Given the challenges in reducing the problematic

racial behaviors of others (e.g., problem-focused coping), targets of racism often rely on emotion-focused coping strategies (e.g., avoidance, denial, substances, etc.) when faced with racial incidents (Bennett et al., 2004). Thus, greater reports of internalizing (Anderson et al., 2015) and externalizing (Simons et al., 2002) problems, increased cardiovascular disease (Cuffee, Hargraves, & Allison, 2011; Neblett, Philip, Cogburn, & Sellers, 2006), and lower self-esteem (Utsey, Ponterotto, Reynolds, & Cancelli, 2000) are consequences of exposure to discriminatory racial encounters.

While the vast majority of Black adolescents and adults report frequent racial encounters (Helms, Nicolas, & Green, 2012), mental health advocates and treatment providers are underprepared to address and combat the effects of racial stress and trauma (Coard, Foy-Watson, Zimmer, & Wallace, 2007; Franklin, 1999). Furthermore, medical services and clinical programs have a history of racial misconduct which has led to skepticism among African Americans regarding the use of therapeutic services (Thornicroft, 2008; Washington, 2006). The confluence of discriminatory practices and historical distrust (Alvidrez, Snowden, & Kaiser, 2008) has hampered efforts at recruiting people of color and led to disparate retention rates in mental health care and clinical trials (Rodriguez, Cavaleri, Bannon, & McKay, 2008). Moreover, current clinical standards continue to underestimate the cumulative experiences of racial trauma as part of the posttraumatic stress disorder criterion, despite Black people experiencing greater prevalence and severity of racial conflict relative to their White peers (Terwilliger, Bach, Bryan, & Williams, 2013; Williams et al., 2014).

To protect their children from the negative emotional and physiological health outcomes associated with racial encounters, Black families have utilized racial socialization (RS). RS, or the verbal and nonverbal communication between families and youth regarding the importance of race, interactions, and identity (Lesane-Brown, 2006), is most frequently utilized as youth reach adolescence — a time of heightened racial exposure and understanding (Hughes et al., 2006). A primary reason for using RS is to negotiate racial encounters, prepare children for fight/flight/fright reactions, and to reduce racial stress and trauma when engaged in racially rejecting social interactions (Bentley, Adams, & Stevenson, 2008). The extant research on RS practices has focused mainly on its frequency and endorsement in retrospective accounts by Black parents or adolescents regarding parental communication as well as sociocultural demographics resulting in differences in these practices (e.g., gender; Gatson, 2011; McNeil Smith, Reynolds, Fincham, & Beach, 2016). However, little is known about how these practices can be improved upon over time to produce more effective coping skills and reduce parent and youth racial stress and trauma via intervention (Coard et al., 2007;

Coard, Wallace, Stevenson, & Brotman, 2004), particularly for in-the-moment and future racial encounters experienced by adolescents. Given the amplified social and mass media portrayal of racial chasms (Adams-Bass, Stevenson, & Kotzin, 2014), it is important to understand the malleability of RS processes which protect youth from the effects of past, current, and future racial rejection.

Although interventions have utilized RS elements in clinically oriented programs (e.g., Frabutt, Walker, & MacKinnon-Lewis, 2002; Robbins et al., 2007), very few are culturally grounded and steeped in the specifics of racial problem solving. One of the few published interventions to emphasize Black RS, or the Black Parents Strengths and Strategies program (Coard et al., 2007), targets parents of young children and is developmentally appropriate for a top-down approach. However, the Black Parents Strengths and Strategies program focuses less on the dyadic interplay of RS processes important in the parent-child relationship during adolescence (Smith-Bynum, Anderson, Davis, Franco, & English, 2016). Indeed, adolescents are more apt to challenge parental communication and authority as a way to learn (Baumrind, 2005) and prepare to identify, express reaction to, and seek to resolve racially stressful encounters relative to younger children (Quintana, 2007). Furthermore, an explicit focus on all RS strategies, including “proactive” (e.g., cultural socialization and preparation for bias; Stevenson, 1994), “reactive” (e.g., promotion of mistrust; Hughes & Chen, 1997), and “adaptive” (e.g., egalitarianism; Phinney & Chavira, 1995) components can help unearth maladaptive coping techniques evident in parental messaging and adolescent response to racial encounters (e.g., restricted breathing, communication challenges; Stevenson, 2014). Assessing the feasibility of a practical family intervention that improves coping techniques and builds evidence for the reduction of racial stress and trauma for adolescents and their families is a reasonable next step.

To address these needs, the Engaging, Managing, and Bonding through Race (EMBRace; Anderson & Stevenson, 2016) intervention was developed. EMBRace is a five-session RS intervention designed to reduce racial stress and trauma for both parent and youth. While traditional stress and coping theories identify appraisal as an initial step toward resolving one’s stressors (Lazarus & Folkman, 1987), racial stress and trauma in relationships is often difficult to appraise and thus resolve because youth and parents live in a culture of and are rewarded for avoidance (Bonilla-Silva, 2014). Thus, EMBRace relies on the culturally specific Racial Encounter Coping Appraisal and Socialization Theory (RECAST; Stevenson, 2014), which states that components of RS (e.g., racial pride and rejection-specific knowledge, racial mindfulness, and stress-reduction skills training) can prepare individuals to reduce

racial stress and trauma and use engaged (e.g., attending to intensity, concentration, communication, and relaxation) rather than avoidant coping strategies during racial encounters. Specifically, three core goals of RECAST's intervention recommendations for clinical practices include the competency development of racial encounter: (a) knowledge (racial self- and other-awareness), (b) management (racial stress appraisal and reappraisal), and (c) coping (racial engagement and resolution) skills.

Although research has begun to identify ways of improving upon health-related recruitment and retention strategies in ethnically diverse populations (Yancey, Ortega, & Kumanyika, 2006), less is known about the influence on culturally specific intervention trial outcomes (Breland-Noble, Bell, Nicolas, 2006; Muñoz & Mendelson, 2005). Therefore, the aims of the current study are to (a) apply an evaluation model for practitioners and participants of EMBRace assessing acceptability and (b) describe preliminary coping responses utilized by Black families throughout EMBRace. Although consensus does not exist regarding specific components of acceptability (see Sekhon, Cartwright, & Francis, 2017), we utilized an existing model of participant endorsement and addressing of intervention barriers to treatment (i.e., Kazak et al., 2006). We hypothesize for the first aim that participants and practitioners will favorably endorse acceptability. Regarding the second aim, participants are expected to show a response-shift bias (Howard, 1980) in coping, whereby an inflated score would be reported at the beginning of the intervention, a "corrected" or more self-aware score would be reported in the middle, and an improved score would be reported toward the end of the program.

## Method

This pilot trial of a five-session intervention aimed to prepare Black caregivers in their discussions on racial encounters with their child. As this was not a randomized clinical trial, all families participated in the same procedures, including pretest/posttest assessment, exposure to five manualized curriculum sessions of EMBRace, and parent-child interaction homework ("funwork") assignments. The present intervention was approved by the institutional review board at the university where the program was developed.

### *The Intervention*

EMBRace (Anderson & Stevenson, 2016) is a culturally relevant selective intervention developed by researchers and clinicians to help Black families address racial stress and trauma in their lives while promoting familial bonds

and positive coping strategies after racial encounters. Since internalized “burden” and trauma have been evident in studies investigating the challenges associated with racially socializing youth (Coard et al., 2004), a manualized curriculum eliciting trauma narratives from both the individual and the family unit was used to ameliorate some of the stressors involved in parenting Black children.

The EMBRace manual was developed by a multidisciplinary team of individuals with backgrounds in counseling, clinical psychology, education, and human development. The aim of the intervention is to promote more effective strategies for caregivers and children to discuss racial encounters in their lives and their larger communities to reduce racial stress and trauma as a family unit. The intervention incorporates skills for three major foci: RS content (e.g., cultural socialization, preparation for bias, promotion of distrust, and egalitarianism); racial coping (e.g., knowledge, stress management, and resolution); and delivery (e.g., affection, protection, correction, and connection). Therapeutic inclusion of role-playing, relaxation, debating, media, and art undergirds facilitation within the five sessions.

During the 90-minute sessions, facilitators incorporate skills across foci for the parent and child in parallel sessions first and then together as a family unit. Facilitators utilized the strengths of the families while simultaneously exploring the unique challenges described by participants. RS content, racial coping, and delivery were the techniques utilized to target improvements in personal and familial growth in psychological, physiological, and identity-related outcomes. The RS content included psychoeducation on the various constructs comprising RS, with a goal of improving familial awareness and knowledge about racial messaging common among Black families (Hughes et al., 2006). The specific objectives for RS include increasing cultural socialization messaging and behaviors (e.g., exploring their family histories, discussing pride within the race and culture), understanding the basis for techniques which prepare youth for a racially biased environment, exploring past and current trauma that may promote a sense of distrust in others, and promoting hope for equality in the future while coupling this hopefulness with current realities of inequality facing Black youth. The facilitators used the detailed manualized curriculum to guide the therapeutic process but also relied on their clinical acumen to tailor the content of the sessions to individual needs.

The second major task of the facilitators was to enhance the coping strategies available to the families in racially stressful encounters. Given the challenges in appraising the stressor and engaging in problem-focused coping, an emotion-focused technique of Calculate, Locate, Communicate – Breathe and Exhale (CLC-BE; Stevenson, unpublished data) was introduced to target

potential affective responses by families to “in-the-moment” racially perceived stimuli. Every session, individuals were asked to calculate on a scale of 0 to 10: how stressful that week’s stimuli was, scan the body for a location where they were experiencing the stress, communicate the self-talk that was being narrated about the stressful situation, and engage in deep breathing and exhaling after evaluating the stimuli. The facilitators utilized a vignette to introduce the coping skills during the pretest and reinforced the CLC-BE strategies at the start of each session.

### *Participants*

Inclusion criteria required target youth to be between ages 10 and 14 years and at least one of their parents to self-identify as “African American” (Note: ethnic and cultural differences exist within the spectrum of “Black” family socialization practices, thus, African American was specified for inclusion given the historical experiences often associated with multiple generations in the United States). No clinical cutoffs were evaluated for traumatic response or symptomatology.<sup>1</sup> Twenty families, consisting of one youth and one of their caregivers, enrolled in the pilot for a total of 40 initial participants. By the conclusion of the intervention, 10 families completed the posttest, yielding a total of 20 participants. Of the 10 youth participants who all self-identified as Black/African American, 5 identified as male and 5 identified as female. Of the 10 caregivers, 9 identified as biological mother to the target youth and 1 identified as biological father. Families were recruited from the middle school where one iteration of the intervention was held, as well as through community recruitment, scholarship listservs, churches, and community organizations throughout the city. Participants were compensated for their time with weekly dinners, a \$100 stipend for program completion, educational materials (e.g., books), and in-kind donations from community organizations (e.g., t-shirts, gift cards, etc.).

### *Procedure*

EMBRace was held at two sites: (a) a local charter middle school where youth were recruited and enrolled and (b) a university office in a major Mid-Atlantic urban city. The school was selected as the implementation site because of the partnership between the research collaborative and school administration, proximal location to where youth interact with others, and the availability of complimentary and ample space to host EMBRace. The university office was utilized, likewise, for proximal location and space. Participants were identified and referred by school social workers and staff at

partner organizations to receive an initial verbal overview. Following this overview, the EMBRace research team made contact with the family, confirmed interest and attendance, assessed eligibility, and scheduled them for a pretest session. If the caregiver reported having more than one eligible child, he or she was asked to choose one to participate in the program as the target child.

Intervention procedures included a 120-minute pretest, five 90-minute sessions, and a 120-minute posttest. Each of the five 90-minute intervention sessions included three components: 30-minute individual sessions when caregivers and youth worked separately with clinicians, a 15-minute break and dinner with parent and child (and other family members if present), and a 45-minute family session, when parent(s), their participating child, and the two clinicians from their individual sessions came together. Within sessions, clinicians used techniques like journaling, relaxation, debating, and reflection to engage parents and adolescents in activities that outlined a tenet of RS. In addition, some activities incorporated music, video, and visual arts. Sessions were scheduled around the parent's availability during weekday evenings and weekend afternoons. All participating parents were given written informed consent, while youth participants were given assent at pretest. Research assistants read and summarized consent and assent before soliciting signatures. Self-report data were collected from both parents and youth at pretest and posttest by research assistants via iPad in an effort to reduce participant's positive impression management. Qualitative measures were administered at pretest and posttest by research assistants.

Counseling psychology graduate students, a licensed social worker, and two postdoctoral fellows served as clinicians ( $N = 15$ ). Forty percent of clinicians identified as Black, 40% as White, and 20% as Asian. Forty percent of the clinicians identified as male. Clinicians and research assistants were recruited through the Counseling program within the author's research institution and through online solicitations via social media and counseling student listservs at two local universities. Clinicians were asked to complete a 3-hour theory of change, intervention rationale, and intervention decision-making training and were offered weekly supervision. Clinicians were guided in each session with a research-driven manual created by the program developers. Each session was audiotaped and video recorded when consent was given. Clinicians were required to complete weekly reflections after working with clients to assess their performance, reflect on participant engagement, and make suggestions for the future. EMBRace clinicians were assigned the same family for the entire 5-week program, however, in the event that a clinician was unable to be present for their scheduled session, another clinician would serve as a substitute.



## Measures

*Demographic Questionnaire.* Participants reported information on age, sex, race, and income. Participants could self-identify a range of racial/ethnic backgrounds, including Black race and African American, Hispanic, African, or Caribbean ethnicities, White, Biracial, or Multiracial races, or Hispanic ethnicity. The caregivers ranged in age from 32 to 54 years. Three out of the 10 families reported an annual income between \$0 and \$24,999, another three families reported annual incomes between \$25,000 and \$49,999, three additional families reported annual incomes between \$50,000 and \$74,999, and one family reported an annual income between \$75,000 and \$99,999. Parents within the sample had a range of educational attainment spanning from high school diploma to a Master's degree. The youth participants were enrolled in Grades 6 through 8.

*Coping Strategies.* The Stress Calculate, Locate, Communicate, Scale (SCLCS; Stevenson, unpublished data) was utilized to measure participant awareness of their emotional, physiological, and cognitive reactions during racially stressful encounters through the technique of CLC-BE. The four-item self-report measure was used to assess participants' ability to calculate stress levels, locate stress within the body, communicate that stress to one's self, and relax through breathing and exhaling. Items queried, "How well can you calculate how stressed you feel on a scale from 0 to 10?" "How well can you locate on your body where you feel stress?" "How well can you communicate or recall your self-talk when you are stressed?" and "How well can you relax (breathe and exhale) when you are stressed?" Each item was rated on a 5-point scale (1 = *not at all*; 5 = *very much*). The SCLCS was administered at the beginning of each individual session.

*Participant Evaluation Questionnaire.* The Participant Evaluation Questionnaire is a five-item qualitative measure utilized by the developers to assess the participants' satisfaction with the intervention. Participants were interviewed about what they liked, would foresee being helpful for other families in the future, and what they experienced throughout EMBRace. Questions assessing program satisfaction included "What did you like about EMBRace?" "What should we do differently next time?" and "What was it like to come to EMBRace every week?" The questionnaire also inquired about clinician preferences and satisfaction with the item, "What did you like or dislike about the therapist's style or approach?" Research assistants administered this questionnaire at posttest and responses were recorded via audiotapes.

*Clinician Evaluation Questionnaire.* The Clinician Evaluation Questionnaire (see Kazak et al., 2006) is a 12-item questionnaire utilized by the development

team to assess the therapists' level of satisfaction with the intervention and its perceived impact for participants. The questions in this measure also inquired about program materials and structure. Examples of items assessing familial impact included "The program will help more families in the future," "The program was helpful to the families," and "The topics were important." Items assessing program structure included "The five-session format worked well" and "The materials were easy to use." Three response options were offered for each question (Yes, Maybe, No). The questionnaire was administered to clinicians at the close of the intervention via anonymous electronic survey.

### ***Data Analysis***

The current study examined self-report data and qualitative interviews to assess program feasibility and preliminary coping responses. Given the small sample size, quantitative data were aggregated and treated at the trend level rather than evaluated through statistical software. Participant feedback was coded through the use of NVivo 11.0 software (Richards, 2016) to allow for multiple types of searches of the data corpus. The aim of the qualitative analysis was to describe the participants' experiences and compare and contrast responses with grounded inquiries.

### **Results**

The small sample size did not allow the performance of inferential statistics, yet provided information with regard to program trends and staffing feedback. Program evaluation was conducted via open response items with participants, as well as closed-ended response options with clinicians. Participant coping was also evaluated with regard to responses provided via the SCLCS and are depicted graphically.

### ***Acceptability***

Feedback was largely positive from the intervention clinicians and supervisors with regard to EMBRace facilitation. Weekly meetings of both the content and process of implementation allowed for opportunities to improve both therapeutic techniques and procedural practices within the manual (e.g., the development of general check-in questions to attend to participant needs prior to the start of programmatic procedures). Given the focus on acceptability and initial feasibility, fidelity was not conducted nor evaluated during this initial pilot.

*Participants.* Five evaluative coding schemes were utilized to assess the interviews (e.g., advice, clinician approach, changes to EMBRace, and

EMBRace likes and dislikes). Participants advised the next set of families to be truthful and prioritize engagement through time commitment. As an example, one 13-year-old girl noted, “Just make sure they tell you everything they got on they chest . . . make sure they don’t hold nothing back.” Participants also indicated the importance of the therapist’s rapport, including personality, creating a comfortable setting, and self-disclosing. A 32-year-old mother, indicated that her clinicians “. . . didn’t get off like they were better than you or anything like that. They was open and talked to you and helped you guide through things . . . wonderful.” Another mother, age 54, shared that clinicians “. . . were engaging! They were definitely engaging and um they seemed genuinely concerned and they both um appreciated meeting us and also what they learned from us.” Participants also provided various suggestions for improvements related to program length, session length, follow-up, and scheduling. One mother noted that, “. . . some kind of newsletter or something that’ll keep us connected” would be useful after the conclusion of EMBRace. Additional interview questions assessed the program likes (e.g., content, clinician relationship, personal growth, and applied lessons) and dislikes (e.g., food, time conflict, program site, and clinician continuity). With regard to what participants liked about EMBRace, several youth indicated that the space was safe to share intimate feelings. One youth, an 11-year-old boy, noted that, “. . . it felt good cuz like, we can talk about, like, what we seen. So like, we won’t have anger built up inside of us.” Likewise, another youth, a 12-year-old girl, said that, “Getting to get stuff off my chest about how I feel about White people and racial experiences” was useful for expressing unresolved emotions. One participant, a 12-year-old boy, echoed these sentiments by stating, “It helped me be able to get the feelings out. Because if I didn’t, it would have a negative impact on [my] character and morals.” And, while one mother, age 32 years, indicated having a busy schedule as a challenge, she stated that “I wouldn’t mind coming . . . they [the clinicians] listened to everything from me to [my child] and they helped us try to communicate together.” Similarly, another caregiver, a 50-year-old mother, acknowledged some travel barriers to participation but maintained interest throughout the seven weeks by stating,

But at the end, I mean I was still excited but I was like okay I got to deal with traffic, okay now [public transportation service] is not running, and I had to get him out of school early . . . that rushing back and forth. But, um, I would do it again. Yep, I would do it again.

*Clinicians.* Responses from clinicians were positive, indicating their overall satisfaction with serving as facilitators of the program. Each of the 15 total clinicians who interfaced with clients positively asserted that EMBRace session

**Table 1.** Clinician Feedback.

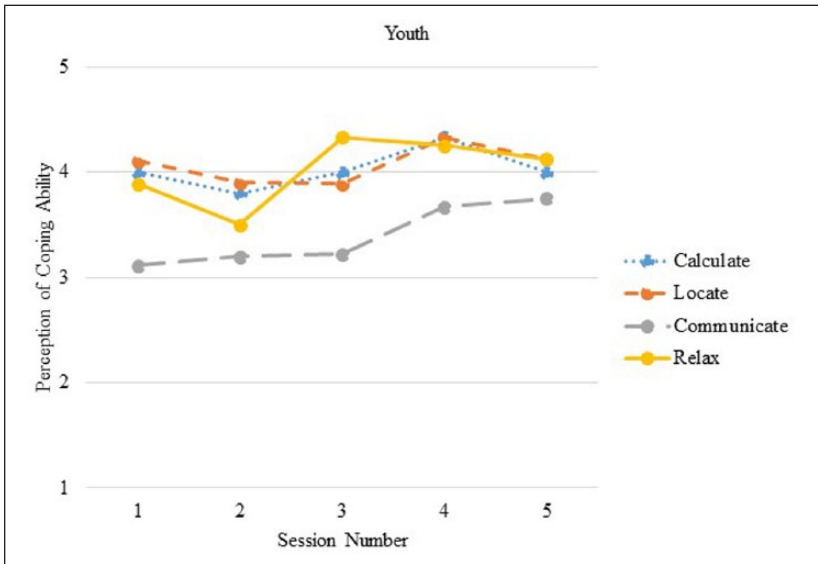
	Clinicians (N = 15)		
	Yes	Maybe	No
The timing of this program was appropriate.	13	2	
I empowered the family to help each other.	11	4	
The program will help more families in the future.	13	2	
I was attentive to the needs of the family.	13	2	
The program helped me think differently about how race affects families.	13	2	
The program was interesting.	15		
The program was helpful to the family.	12	3	
The topics were important.	15		
I learned a different way of working with families.	13	1	1
The materials were easy to use.	10	5	
The five-session format worked well.	12	2	1

topics were important and the program was interesting (see Table 1). Twelve out of 15 clinicians (80%;  $n = 12$ ) agreed that the five-session format worked well and the program was helpful to the families with whom they worked. The vast majority of clinicians agreed that (a) the timing of the program was appropriate (86.7%), (b) they learned a different way of working with families (86.7%), (c) EMBRace helped them think differently about how race affects families (86.7%), and (d) the program will help more families in the future (86.7%). There was greater variation in responses regarding whether clinicians empowered their families to help each other (e.g., 73.3% = Yes; 26.7% = No).

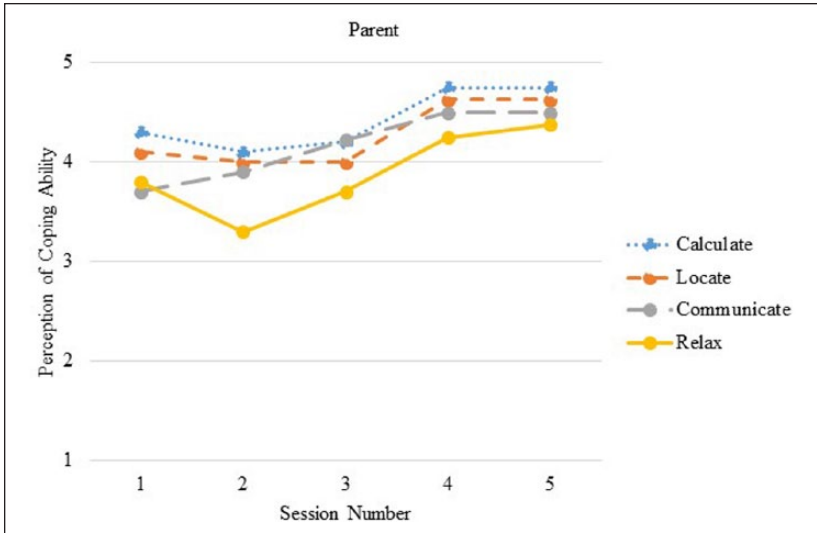
**Recruitment and Retention.** Although recruitment efforts were centralized within a school, retention was still challenging for the invited participants. While we maintained a broad range of partnership efforts throughout the year, recruitment was ultimately between one school and one partner organization. Through these methods of recruitment, staff initially identified 30 interested families, with 20 agreeing to participate and 10 indicating nonprogram-related barriers to participation (e.g., hospitalization, school transfer, scheduling conflicts). Over the course of the intervention, attrition was evident throughout the weeks of pretest ( $n = 5$ ), Session 1 ( $n = 4$ ), and Session 2 ( $n = 1$ ). Reasons for program departure included apprehension with the topic in the school setting, work/school changes, family circumstances, the reception of additional therapeutic services, and adverse life events, in addition to nonresponses. Our final sample of 10 families represented a participation rate of 50% from the enrolled families.

### Preliminary Responses to Intervention

**Coping.** For each of the four programmatic components of coping with racial encounters (i.e., ability to calculate, locate, communicate, and relax), it was hypothesized that participants would overinflate their ability at the beginning of the program, identify challenges throughout the program (e.g., score lower), and then improve throughout and toward the end of the program (i.e., response-shift bias; Howard, 1980). Youth responses followed these expectations in session one regarding their ability to relax ( $M = 3.89, SD = 1.15$ ); calculate ( $M = 4.00, SD = 0.82$ ); and locate ( $M = 4.11, SD = 1.10$ ) their stress relative to session two ( $M = 3.50, SD = 1.43$ ;  $M = 3.80, SD = 1.32$ ;  $M = 3.90, SD = 0.99$ , respectively). Following Session 2, youth reported a slight increase in their ability to calculate, communicate, and relax, with a slight reported decrease in the ability to locate their stress (see Figure 1). In Sessions 3 through 5, youth participants reported an increase in three out of the four coping strategies (calculate, communicate, and relax) and finished session five higher than their initial session in their perceived ability to calculate ( $M = 4.0, SD = 1.41$ ); communicate ( $M = 3.75, SD = 1.16$ ); and relax ( $M = 4.13, SD = 1.46$ ).



**Figure 1.** Youth responses to coping strategies through the duration of EMBRace. Note: EMBRace = Engaging, Managing, and Bonding through Race.



**Figure 2.** Parent responses to coping strategies through the duration of EMBRace. Note: EMBRace = Engaging, Managing, and Bonding through Race.

Parents' responses to perceptions of their coping ability also aligned with the hypothesized pattern (see Figure 2). Caregivers reported relatively high scores in their ability to calculate ( $M = 4.3$ ,  $SD = 0.82$ ), locate ( $M = 4.1$ ,  $SD = 0.88$ ), and relax ( $M = 3.8$ ,  $SD = 1.14$ ) in their initial session, with a slight decrease in this perceived ability by session two ( $M = 4.1$ ,  $SD = 0.99$ ;  $M = 4.0$ ,  $SD = 0.94$ ;  $M = 3.3$ ,  $SD = 1.06$ , respectively). On the other hand, communication scores increased from Sessions 1 ( $M = 3.7$ ,  $SD = 1.06$ ) to 2 ( $M = 3.9$ ,  $SD = 0.82$ ). Between Sessions 2 and 3, all caregivers reported an increase in the ability to locate, communicate, and relax, with a slight decrease in the perceived ability to locate stress. During Sessions 3, 4, and 5, each of the coping strategies (calculate, locate, communicate, and relax) improved and by Session 5, resulted in a higher mean score than the first session ( $M = 4.75$ ,  $SD = 0.46$ ;  $M = 4.63$ ,  $SD = 0.52$ ;  $M = 4.5$ ,  $SD = 0.53$ ;  $M = 4.38$ ,  $SD = 0.74$ , respectively).

## Discussion

We hypothesized that (1) participants and practitioners would favorably endorse acceptability and (2) participants would show a response-shift bias in coping, whereby an inflated score would be reported at the

beginning of the intervention, a “corrected” or more self-aware score would be reported in the middle and an improved score would be reported toward the end of the program. Evidence from this small pilot study suggests that EMBRace is promising for clinicians and participants and may support a pattern of coping changes anticipated by program developers (Anderson & Stevenson, 2016). By conceptualizing racial experiences as stressful, the developers of EMBRace were able to utilize a framework of a racially specific stress and coping theory (i.e., RECAST; Stevenson, 2014) to encourage coping improvement for participants. Although the sample size of this study was too small to analyze quantitatively, both qualitative and survey data trends help underscore the importance of this intervention, particularly during the racially charged climate reported by Black participants and community members throughout the intervention. Preliminary data yield evidence from clinicians and participants as to the clinical utility of the EMBRace intervention.

Participants responded favorably to the structure and likability of EMBRace within their posttest assessments. Five codes emerged as particularly relevant to participants’ experiences, including advice, clinician approach, changes, program likes, and program dislikes. Although certain elements were indicated as displeasing (e.g., the food selection), the vast majority of responses evaluating core intervention elements (e.g., content, length, clinician factors) were affirmed. Additionally, advice generated for the program and for future participants will be useful as we incorporate feedback into the next version of the manual and implementation.

Clinicians, by and large, agreed that EMBRace was a timely, relevant, and helpful intervention for participants. Although generally positive, various clinical-level factors (e.g., helping families work better with each other and learning new perspectives on race) showed more variability in response. The most variable response regarded EMBRace material use and the clinician’s perceived ability to empower the families with whom they worked. Given the ecologically relevant nature of the pilot, feedback regarding ease of material use and training-specific components are especially useful and will aid to subsequent iterations of EMBRace implementation. Of importance, training was offered in-person as well as via electronic viewing; however, not all of the facilitators elected to receive the training or weekly supervision. Thus, implementing a mandatory training and weekly supervision will likely streamline elements of the program (e.g., skills, philosophy, manual use, etc.) and generate more feedback regarding how to make improvements prior to the next round of implementation. It should also be noted that the variation of the clinicians’ ability to empower families may be explained by the range of clinicians within various years of formal training.

Participants indicated that their ability to cope with various stressors were session specific and followed the patterns hypothesized by program developers. Since the coping methods of calculation and relaxation had the most variability from sessions one to three in the hypothesized pattern, that is, initially high, a decline, and recovery, it may be particularly helpful to attend to those coping needs for future participants. Hypothesized patterns support research indicating an initial inflated sense of self-efficacy with regard to coping strategies (Bandura, 1993). Youth responses also appeared more variable throughout the sessions, particularly in the last three sessions. Thus, ensuring that youth thoroughly understand the coping methods and reinforcing this coping task will be crucial in future implementations. Generally, youth participants followed the hypothesized pattern for three out of the four coping strategies, save communication, in which improvement continued after the first session. An attempt to reduce socially desirable responding (Abrams & Trusty, 2004) and positive impression management (Peebles & Moore, 1998) was employed by providing participants with an iPad rather than having them verbally respond to inquiries of their coping strategies. Thus, coping skills following similar patterns between participants are likely an indication of the content and process of the intervention rather than spurious or socially desirable responding/positive impression management effects. While the hypothesized pattern was evident in both youth and parents throughout the study, conclusions cannot be drawn regarding EMBRace effects given the small sample size. However, it was evident from most participants that additional support may be needed between Sessions 1 and 2 due to either the lower or “corrected” scores in various domains of coping ability.

The recruitment and retention of participants is an important aspect of any research, especially interventions. However, several barriers exist for the recruitment of Black families in particular (e.g., distrust; Thornicroft, 2008). Although the retention rate for the study was 50%, the families who continued to participate were agreeable to our methods and provided valuable recommendations for additional recruitment strategies (e.g., snowball sampling, door-to-door advertisements, etc.). Additionally, we will prioritize meeting with interested participants face-to-face to bolster our recruitment and retention efforts and increase our point of contact in community settings. Taken together, EMBRace’s presence relevant programmatic and recruitment aspects addressing the contextual and racial politics specific to Black children and families (e.g., community partners and race-based curriculum) may lead to the improvement of strategies related to enrollment of hard-to-engage Black populations (e.g., Yancey et al., 2006).

The intervention approach established by EMBRace showed promise. The work undertaken by parents and children in their individual sessions may



advance our understanding of RS interventions, particularly with regard to the conceptualization of racialized experiences as trauma needing to be treated individually in youth and caregivers (Franklin, Boyd-Franklin, & Kelly, 2006; Helms et al., 2012). While group-level interventions may be effective at promoting a sense of community and accountability (Coard et al., 2007), one-on-one sessions may help unearth triggering and traumatic experiences for individuals (Roberts, 2005). Furthermore, the dynamics between parent and child in the family sessions offer a number of anecdotal lessons for program improvement and hypothesis testing. Namely, the interaction *between* parent and child is crucial to our understanding of RS practices (e.g., Smith-Bynum et al., 2016). EMBRace's five-session approach allowed for the development of RS practices over time, a concept often missed from the largely cross-sectional studies within the literature. Thus, a focus on the transmission, rather than the declaration of messages, allows for better understanding ecologically valid, family systems-based, and developmentally appropriate familial practices.

There are several notable limitations evident within the current study. Of greatest importance is the small sample size and absence of a control group. These factors precluded the ability to statistically analyze data to show the effect of EMBRace on participants. Furthermore, program retention and completion rates were hampered by the unfulfilled school partnership originally secured for implementation — families were unable to both enroll in and complete treatment in the allotted time for clinician availability. Additionally, the results are difficult to generalize beyond African American mothers, given that only one father completed the intervention. In the future, greater emphasis will be placed on the recruitment of fathers. Finally, some stress data collected on the iPads, although preferable to verbal response, were dubious and thus not included within this study. An item assessing participants' stress level on a scale of 0 to 10 was not utilized because the response item was depicted as a "sliding scale." If participants did not move the scale, the data point of "0" could be interpreted as a nonresponse or lack of understanding for how to move the slider. Given the high number of ambiguous responses, this crucial item was excluded from analysis yet provides a critical point of research assistant and participant training in our subsequent iterations.

The nature of our limitations yielded several important future directions from this pilot study. Namely, participants either verbally or electronically indicated their varying stress levels throughout the sessions, so physiological measures that assess real-time cortisol or heart-rate levels will be important to assess active rates of stress moving forward. Additionally, CLC-BE assessments at the beginning and end of a session

might provide feedback for the stressfulness of a particular session rather than the dynamics of a given week or family. Families also indicated that schools were racialized spaces where they prefer not to discuss their experiences with race, thus, testing site effects (e.g., clinics, religious, and community spaces) in future iterations is of great interest. Moreover, considering in what ways EMBRace can be used for groups, children of varying ages, and delivered by lay-facilitators are important aspects of scaling this intervention for greater reach. Finally, continued engagement with the community to both address the current racial climate and maintain recruitment and retention efforts to yield a larger sample for statistically powered empirical analyses will prove most compelling in subsequent trials of EMBRace.

In summary, this study of the EMBRace pilot provides preliminary evidence for the improved coping skills of Black parents and children as well as the satisfactory nature of the intervention for both families and clinicians. It is our aim that continued research will help identify how the skills facilitated in EMBRace are used to reduce the impact of racial stress and trauma in Black families and in what ways the dissemination of this research can best prepare clinicians to contribute to Black familial stress reduction.

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### **Note**

1. Race-based trauma is not recognized by the *Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition* as a feature of posttraumatic stress disorder—please see introduction for commentary.

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