

The Antiracism Learning Groups: A Mixed Methods Evaluation of an Interdisciplinary Antiracism Educational Program in an Academic Psychiatry Department

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Abstract

Background: Within medical education, emerging curricula focus on health equity, social and structural determinants of health, and anti-racism. To deepen anti-racism learning, experiential and longitudinal educational experiences are needed. To address this gap, we describe the implementation and evaluation of an anti-racism learning initiative delivered to psychiatry residents, psychology trainees, faculty, and staff within a large academic psychiatry department.

Methods: We outline the conception, development, and design of the Antiracism Learning Groups (ARLGs), highlighting key decisions made to enhance group learning and minimize power hierarchies among interdisciplinary groups. The ARLGs were subsequently evaluated through a mixed methods approach, including pre- and post-program surveys, and focus groups conducted with program participants. We used Welch's t-tests and Wilcoxon signed rank tests to analyze the pre and post surveys, and the constant comparison method to analyze the focus groups.

Results: Findings from the focus groups showed that participants' experiences in the ARLGs were overwhelmingly positive, with participants sharing important lessons learned, reflecting on how the group setting facilitated their learning, and describing the impact of the key text. Participants described that the ARLGs had lasting professional impacts on clinical work, advocacy, teaching, supervision, and leadership, along with effects beyond professional roles. Focus group findings also demonstrated the challenges of implementing the ARLGs, including sustainability, building community, and engaging participants beyond the formal conclusion of the ARLGs. Survey results showed significantly higher levels of self-reported critical consciousness and anti-racism behaviors at the post-program assessment compared to pre-program.

Conclusion: The Antiracism Learning Groups are a novel, interdisciplinary, longitudinal, and experiential anti-racist learning initiative that may be one tool to advance health equity and anti-racism learning within a large academic psychiatry department. This mixed methods analysis highlights important outcomes of the educational program, while describing the challenges faced in sustaining and scaling such programs.

Background

Mental health disparities in clinical training and practice are related to longstanding historical inequities in psychiatry and psychology that persist today (1). Research demonstrates clear and persistent racial disparities in mental health care access (2), psychiatric diagnoses—with overdiagnosis of conduct disorders and underdiagnosis of ADHD in Black youth (3), as one example, and mental health outcomes (4). The American Psychiatric Association and the American Psychological Association both acknowledged and apologized for their roles in supporting structural racism in psychiatry and psychology (5, 6).

Although these acknowledgements represent a critical first step in recognizing a legacy of racial disparities across healthcare and academic settings, there is an urgent need to address these issues in a way that tangibly improves behavioral health clinical training, practice, access, and outcomes on a population level. As Dr. Shim argues, institutions and faculty must move beyond “transient” measures and commit to ongoing and bold anti-racism education and unlearning of racist content (7).

In response to racism within medicine broadly, anti-racism curricula in undergraduate, graduate, and continuing medical education have been developed, which include stand-alone workshops (8–10), a quarterly case conference (11), learning modules (12), a series of classes (13), and a journal club (14). These curricula are emerging; a recent scoping review identified that 90% of anti-racism undergraduate medical education curricula were published in the five years leading up to the literature review (2018–2023) (15). Of the 20 anti-racism curricula included, 55% consisted of single sessions, while 45% included multiple learning sessions (15). Curricula included small-group case discussions (75%), lectures (50%), multimedia (30%), large-group discussions (25%), reflections (25%), role-play (10%), readings (10%), problem-based learning (10%), and team-based learning (5%) (15).

To address disparities specific to psychiatry's history and ongoing practice, several psychiatry residency training programs have developed longitudinal health equity curricula that include structural and scientific racism (16, 17). More broadly within medical education, emerging curricula are built around understanding systemic racism and social and structural determinants of health, and using frameworks such as structural competency, which is the capacity to recognize and respond to the sociopolitical and economic forces that impact health and illness (18). Other theoretical approaches to anti-racism curriculum are critical race theory (19, 20), a see-name-understand-act framework (21), and the Reflect, Educate, Assess, Call out, Treat (REACT) framework to modeling anti-racism in the clinical encounter (22).

Within anti-racism curricula, there is a recognition of the different learning needs and goals of white learners compared to learners of color (13). As Pieterse et al. note: “...the educational needs and training processes of White students and students of color can differ (Boatright-Horowitz, 2005; Miller & Garrahan, 2008). White students might need to learn about the nature of racism, whereas students of color might need to focus on how they are impacted by racism, and how to manage racism-related events.” (23) Although there are efforts to introduce curricula and trainings to address racism within psychiatry (16, 17), to our knowledge, there are no existing longitudinal anti-racism educational programs or curricula designed for interdisciplinary groups within academic medical centers that involve faculty, trainees, and staff, that also attend to the differential needs of white and non-white learners. Further, there is a need for experiential (24) and reflective learning practices that build community over time, rather than only modular or knowledge-based curricula. Sustainable changes in anti-racism learning and implementation require longitudinal programming that incorporates self-reflection, education (7), and relationship-building.

To address this gap in the literature, we describe the implementation and evaluation of an anti-racism learning initiative delivered to psychiatry residents, psychology trainees, faculty, and staff within a large academic psychiatry department. This initiative was delivered amidst an institutional, local, national, and international inflection point sparked by high profile police murders of Black men and women in the spring of 2020 (25). The national racial uprisings shifted institutional discussions around representation and activated receptivity and commitments to embed anti-racism in academic medical centers and related clinical training environments (26). Yet, justice, equity, diversity, and inclusion efforts had been long underfunded and understaffed (27). Black, Indigenous,

People of Color (BIPOC) faculty and trainees have faced a disproportionate ‘minority tax’ (28) and called upon white peers to step up into paying a ‘majority tax’ (29). In response to this national reckoning, there was a growing need and desire among many trainees and faculty to engage members of our psychiatry department to understand their own relationship with racism and equip them to move towards anti-racism.

To that end, we created Antiracism Learning Groups (ARLGs) for interested trainees, faculty, and staff in the department, in which participants would unpack their own individual and collective participation in white supremacy. Through the ARLGs, participants would deepen anti-racism learning and build a community of individuals in different positionalities across the department committed to promoting sustainable anti-racism practices. To understand the impact on group participants and inform future efforts of anti-racism learning programming we sought to evaluate the pilot groups through a mixed-methods approach consisting of qualitative focus groups and analysis of pre-program and post-program survey findings.

Methods

Antiracism Learning Groups

Setting

The Antiracism Learning Groups, and their subsequent qualitative and quantitative evaluation outlined below, occurred within a department of psychiatry in a large academic medical center in the Western United States. In our department, although trainees and faculty had led anti-racism efforts for decades, many of these efforts were stymied by limited representation of BIPOC faculty and trainees, lack of funding, and longstanding structural racism within academia. In particular, BIPOC faculty and faculty involved in anti-racism, health equity, and social justice work experienced marginalization and grappled with significant minority tax (27).

The initial conception of the ARLGs occurred in June 2020. Design and planning continued throughout the summer and fall of 2020, and the first groups launched in January 2021. Groups ran in the winter and spring of 2021 and again in the winter and spring of 2022. In the year one pilot, 53 individuals participated within eight groups. In year two, 35 individuals participated within six groups. See Table 1 for more details.

Table 1
Participants in the Year 1 and Year 2 ARLGs

	Year	
	2021	2022
Number of groups	8	6
Number of sessions	16	13
Number of participants at the start of the groups	53	35
Number of groups that met beyond group conclusion	1	4

Development

The initial conception of the group was led by a resident [initials blinded] with a background in designing and teaching anti-racism education. The resident’s initial goal was to create a group for fellow psychiatry residents. Through consultation with faculty leaders it became clear that there was a need to expand the groups to include the range of constituents (faculty, staff, and psychology trainees) in the department. Faculty with senior leadership roles in education and administration championed and sponsored the groups’ expansion and implementation. This included securing executive sponsorship from the Department’s chair and executive leadership cabinet. Faculty provided feedback to refine the group design, connected other interested department members who became involved in group leadership, provided administrative support, and shepherded the announcement of the groups through meetings with department leaders to achieve executive sponsorship and buy-in.

Text

The ARLGs were guided by the book *Me and White Supremacy* by Layla F. Saad (30). This book is divided into twenty-eight topics organized into four themes. The first theme includes foundational topics such as white privilege and white silence. The second focuses on racism towards Black women, men, and children, and other racist stereotypes. The third week covers optical allyship and white saviorism. The book concludes with a focus on moving towards action: engaging with family and friends, defining values, and making commitments. The section for each topic introduces and explains the concept, provides personal examples, and ends with reflection questions.

The text focuses on anti-Black racism and white supremacy. Other than one topic, there is not an inclusion of material on other forms of racism. The focus on anti-Black racism was intentional in the design of the ARLGs. We believed that a specific understanding of anti-Black racism and white supremacy as motivating forces throughout the nation’s history is foundational to understanding other forms of racism and is critical for authentic and meaningful engagement in anti-racism efforts.

The book was also chosen due to its accessibility of topics, reflective prompts, length, language, and complexity. The book includes foundational topics core to an understanding of racism and anti-racism, with a focus on topics relevant for people who experience white privilege. The prompts at the end of each

section were key to the ARLGs, as they formed the basis for individuals' reflective journaling and group discussion (see examples below).

Group Design

Invitations to voluntarily participate in the ARLGs were distributed electronically to department members via email. Those who signed up to participate were organized into groups consisting of between five and eight members. Groups were organized by scheduling preferences and professional position (e.g., faculty, trainees, staff) to minimize power hierarchies. In addition, workplace-specific groups were offered based on participants' expressed interest in participating in the program with colleagues within their workplace. A group for BIPOC participants was also added in year two to attend to the particular learning and community building needs of BIPOC. As the text focuses on individuals who experience white privilege, a BIPOC specific space allowed participants to engage differently with the text and reflection prompts.

Groups met virtually for ninety minutes weekly, across sixteen weeks in year one and twelve weeks in year two. Each group typically met on a consistent weekday evening chosen by members; time was not set aside in the day for faculty or trainees to meet. In year two, a longer weekend session was added based on feedback to reduce the total number of weekly sessions and to create more opportunities for community-building. This longer session was designed to be in-person and occur near the start of the groups to enhance relationship-building. Flexibility shaped the evolution of scheduling, as groups were encouraged to modify scheduling and meeting times to fit their group needs while maintaining adherence to the aims of the group. For example, one group divided the longer weekend session into several weekday sessions and one group met for three hours every other week rather than ninety minutes weekly.

Individual Process

Individuals were expected to attend each session having completed the assigned reading topics and personal reflection prompts from the text. Example reflection questions from the first topic, white privilege, include: "What negative experiences has your white privilege protected you from throughout your life?" "What positive experiences has your white privilege granted you throughout your life (that BIPOC generally do not have)?" "What have you learned about your white privilege that makes you uncomfortable?" Participants were encouraged to engage in honest, vulnerable, and thoughtful self-reflection while journaling about these prompts. Approximately every four weeks, reflection questions guided participants to think critically about what they had learned in the groups and through individual processing, encouraging them to build cross-topic connections and develop deeper awareness of their in-session learnings.

Circle Way Process

Within the group, individuals shared their personal reflections and engaged in discussions. The group process was adapted from the Circle Way, a framework for creating equitable, dynamic discussion groups (31). The Circle Way was chosen as it is recommended by Layla Saad for the adaptation of *Me and White Supremacy* to a group learning format. Its emphasis on leadership rotation and shared responsibility leads to a reduction of power dynamics that could recreate white supremacy in action.

The Circle Way relies on three principles: rotation of leadership, sharing of responsibility, and reliance on wholeness. It uses three practices: speaking with intention, listening with attention, and tending to the well-being of the circle. In this process, the groups open by setting a center point, repeating group intentions, checking in with individuals, continuing with the core discussion of material, rotating between members, and concluding through check outs at the end of the session. There are three roles: host, guardian, and scribe, which were adapted to the ARLGs. In most groups the host welcomed and centered the group, the guardian monitored time and group dynamics, intervening when needed, and the scribe was used to record key insights, resources, or points to which the discussion could return. As with the group schedule, organizers encouraged flexibility in how the Circle Way, and particularly the roles, were adapted in each group.

Supervision and Meta-guardians

In addition to the three Circle Way roles in the ARLGs, another role was added: "meta-guardian," a term we created while designing the groups. This *meta-guardian* attended weekly supervision and communicated with the ARLG organizers, serving as a liaison between the central organizers and the many groups. Additionally, the meta-guardians were able to serve as backup guardians, as they had a deeper understanding of the group process given their positionality. In year one, the *meta-guardians* were identified by the key faculty and resident leaders as individuals known in the department to be interested in anti-racism work and were invited to participate in this role. In year two, all participants were asked at the time of signing up for the ARLGs if they would like to be a *meta-guardian*. In both years, the role was voluntary, with no compensation.

The supervision group was created with one *meta-guardian* from each ARLG, the supervisor, and key faculty. This supervision group met weekly with the supervisor and senior faculty throughout the length of the ARLGs. An individual with expertise in equity and racial healing outside of the department was chosen as the supervisor to reduce any preexisting or ongoing professional relationships with ARLG participants and to minimize power hierarchies. During supervision, *meta-guardians* sought to share challenges and triumphs that emerged during the weekly sessions in a non-judgmental, de-identified manner. The weekly supervision became a space to collectively troubleshoot, process, and develop strategies to support the group process and safety. Shared experiences and insights in the first year of the supervision group also helped leaders design adaptations for the second year of the ARLGs.

Evaluation

We utilized a mixed-methods approach to evaluating the learning groups, including qualitative analysis of focus groups and quantitative analysis of survey data. The focus group component was deemed exempt by the [institution masked for blind review] Institutional Review Board (IRB), and secondary analysis of the pre- and post-group surveys were approved by the [specific institution masked for blind review] IRB.

Focus Groups

Participants

Following the completion of the ARLG pilot, participants were invited to give feedback about their experiences in the focus groups. We chose to conduct focus groups so that participants could freely share about their personal experiences, opinions, and recommendations for improving the groups in the future (32). We conducted three 1–2 hour focus groups with ten ARLG participants from December 2021 to January 2022 using Zoom. The participants consisted of those who took part in the ARLG that year, including psychology and psychiatry faculty, staff, and trainees. Because the evaluation presented minimal risk, a waiver of written informed consent was approved for the focus groups by the [institution masked for blind review] IRB. A focus group written information sheet was read out loud at the start of the focus groups and verbal informed consent was obtained. All focus group participants were provided a written copy of this information sheet.

Recruitment

Administrative staff invited participants to take part in focus groups over Zoom via email invitations. Participants were informed that participation was voluntary, and they were also given the option of participating in an individual interview instead of a focus group based on their preference. Of the 53 pilot group participants invited to participate in the focus groups, 10 volunteered to participate, consisting of five trainees, four faculty, and one staff. All 10 participants chose to take part in focus groups rather than individual interviews.

Approach

The semi-structured interview guide for the focus groups was developed collaboratively by the year one *meta-guardians* and the ARLG leadership team. The facilitators used the guide to inquire about the participants' experiences in the ARLGs broadly and about the impact the ARLGs had on participants beyond the conclusion of the groups. Participants were also asked to reflect on how closely the groups met the organizers' aims and the individuals' personal intentions. Participants were prompted to discuss what they liked and disliked about the group process and were asked for recommendations on how to improve the ARLGs.

The focus groups were organized by professional positions to minimize power hierarchies, with groups offered separately to trainees. Additionally, the option of participating in a separate focus group was offered to participants who held minoritized racial and ethnic identities, although these individuals elected to join the other groups. The facilitators for the focus groups were program evaluation team members trained in conducting qualitative focus groups [initials blinded], and consisted of an attending psychiatrist, attending psychologist, and resident. Facilitators were assigned to groups in a manner that strove to minimize power dynamics or any existing relationship with the facilitator in service of reducing group inhibition around sharing authentic feedback. For example, a non-core faculty member was assigned to a trainee focus group, and white facilitators were assigned to groups primarily made up of individuals who did not hold racially or ethnically marginalized identities. A Black trainee was assigned to facilitate a potential group of individuals with minoritized identities, although this distinct group was not held, since these individuals chose to join other groups. All focus groups were audio-recorded and transcribed by an independent outside agency. All participants were reimbursed for their time with a \$20 gift card.

Qualitative Analysis

The focus group transcripts were initially reviewed independently by three members of the program evaluation team [initials blinded] to identify preliminary themes. Codes were discussed iteratively among the three team members and a codebook was developed by one team member [initials blinded] with feedback and testing from the other two team members. Codes were discussed, collapsed, and expanded until they were mutually agreeable. The transcripts were coded by two team members [initials blinded] using qualitative software Dedoose (33). Any discrepancies in the codes or excerpts were resolved in discussions between the three team members. The constant comparison method was used to identify main themes among the focus group transcripts (34).

Pre- and Post- Group Surveys

Surveys were distributed to group participants prior to the start of the ARLGs and following the conclusion of the final ARLG session. Surveys included questions about demographic characteristics (pre-group survey only; Appendix A) and six previously published measures on anti-racism and related constructs (pre-group and post-group surveys; see *Survey Measures* section for further information and citations). Surveys were securely administered in English via Qualtrics. For year one, pre- and post- program surveys were distributed, respectively, in December 2020-January 2021 and October-November 2021. For year two, these surveys were sent in March 2022 and June-July 2022. Completion of the surveys were voluntary and included no reimbursements or incentives.

Participants & Recruitment

All participants of the ARLGs were invited to participate in the surveys, including psychiatry and psychology trainees, faculty, and staff. Staff invited all ARLG participants from both years to participate in the surveys via email. Seventy-three participants across the two years completed the demographic items.

Survey Measures

The survey instrument included seven components: one section of demographic items and a compilation of six scales published elsewhere. We used these six published measures to assess participant changes in attitudes towards racism before and after engaging in the Antiracism Learning Groups. The measures employed were: Critical Conscious Inventory (CCI) (35); Color-blind Racial Attitude Scale (CoBRAS) (36); Psychosocial Costs of Racism to Whites Scale (PCRW) (37); Social Dominance Ordinance Scale (SDOS) (38); System Justification Scale (SJS) (39); and Anti-Racism Behavioral Inventory (ARBI) (23). Each measure assesses different aspects of participants' cognitive beliefs, attitudes, and/or actions towards racisms and systems of inequity that perpetuate racism in our society.

The CCI survey is a 9-item scale that measures a person's critical consciousness, defined as a person's ability to perceive social, political, and economic injustice and take action against inequity (35). The CCI has demonstrated good psychometric properties in prior research (35). Critical consciousness is divided into pre-critical, beginning critical, critical, and post-critical stages. To obtain estimates of which stage of critical consciousness participants were at in each time point, we calculated a mean score (see Thomas et al., 2014). Higher scores on the CCI survey correlate with higher levels of critical consciousness.

The CoBRAS survey is a 20 item 6-point Likert scale survey that measures color-blind racial attitudes in participants (36). Each item on this scale measures the degree to which participants deny the existence of institutionalized racism, and higher scores indicate higher levels of color-blind racial attitudes. The CoBRAS scale can be examined as a Total Score with all items (for this sample, $\alpha = .70$), or three subscales: 1) unawareness of racial privilege (Factor 1), 2) unawareness of institutional discrimination (Factor 2) and 3) unawareness of blatant racial issues (Factor 3). The CoBRAS is widely used to assess color-blind racial ideology and has shown robust reliability across diverse populations (36). During programming of the survey for the ARLG, a 5-point Likert scale was used in error, so comparisons between CoBRAS scores from this evaluation with other published CoBRAS scores should be made with caution.

The PCRW survey is a 16-item 6-point Likert scale survey that assesses the negative impacts of racism on white individuals (37). It uses three subscales (Factors 1 to 3) which measure "White empathic reactions toward racism" (Factor 1), "White guilt" (Factor 2), and "White fear of others" (Factor 3). Higher scores indicate a greater negative impact of racism on the psychosocial health of whites. Higher PCRW scores have also been associated with greater awareness of racism and openness to anti-racism engagement (37).

The SDOS survey is a 16-item, 7-point Likert scale survey that measures one's desire for their in-group to dominate, or be superior to other groups (38). Higher scores on the SDOS scale are correlated with higher levels of anti-Black racism (for this sample, $\alpha = .92$). Elevated SDOS scores reliably correlate with racial prejudice and endorsement of group-based hierarchy (38).

The SJS survey measures the participants perception of the justifiability, reasonableness, fairness, and legitimacy of our current social system (39). It is an 8-item, 9-point Likert scale survey. Higher scores on the SJS survey indicate increased levels of system justification, and lower scores indicate lower levels of justification (for this sample, $\alpha = .78$). Higher SJS scores have been linked to reduced recognition of inequality and lower support for structural change (39).

Lastly, the ARBI scale is a 21-item, 5-point Likert scale that measures anti-racism behavior (23). Higher scores indicate more engagement in anti-racism behavior while lower scores indicate lower participation in anti-racism behavior. The ARBI focuses on observable anti-racism behaviors, providing a useful complement to belief-based measures (23). For all surveys, items were summed to obtain the total score for each participant (for this sample, $\alpha = .81$), as well as subscale scores for Individual Advocacy, Awareness of Racism, and Institutional Advocacy. For this evaluation, one item was dropped at the time of survey creation, so comparisons between ARBI scores from this evaluation with other published ARBI scores should be made with caution.

Quantitative Analytic Plan

Data from the pre- and post-program surveys from years one and two were combined for data analysis. For the PCRW, data was analyzed based on whether the respondent identified as "white" or does not identify as "white," a question that immediately preceded the PCRW survey items.

We conducted Welch's t-tests on all 17 outcome measures and their component factors to compare scores pre- and post-program in the full sample of respondents. Despite the exploratory nature of the quantitative analysis for this newly developed, innovative program, due to the large number of tests conducted, we include *p*-values adjusted for multiple comparisons using the Benjamini-Hochberg method.

Results

Qualitative Findings

Experiences were overwhelmingly positive

The overwhelming majority of participants (nine out of ten in focus groups) described notably positive experiences in the group. Many described they recommended it to others or wished all their colleagues participated in the ARLGs. One focus group participant described their learning in the groups as "very transformative." Although most responses were positive, one participant in the focus groups described an overall negative experience. This participant found that a lack of open critique of the book and an emphasis on disclosure of personal racism in the group created a culture of rigid thinking about racism, which led them to disengage from their group and not participate in anti-racism efforts outside of the group.

Book and group structure were useful

Participants found the book useful for its teachings on foundational concepts and terminology. They found value in learning and building community with group members. Fellow participants shared varying perspectives, experiences, and resources. As one faculty member reflected:

This is actually a really great resource in terms of having a community of people who are interested in furthering anti-racism, who work in similar domains, or move in similar capacity to me, and that part of it became the most... valuable to me, with just like having the sounding board and having kind of people sharing their experience... We just could strengthen each other in terms of the awareness, or knowledge, or resources, or experiences that people had had...

One faculty participant noted the importance of participating in the ARLGs with professional colleagues, with whom they could strategize about specific situations:

...it was nice being with work colleagues. I've done a lot of this work personally and I haven't done it at work, and so it was really a unique experience to be able to say, "This popped up," and ... be able to kind of troubleshoot together and to stop and use the awareness we learned... So being able to process that during the group, I think we were applying it in vivo.

Important lessons learned

Participants described key lessons they learned throughout the groups. One important lesson identified across the focus groups was a recognition of participants' own racist thoughts and behaviors, for example, as one trainee said, *"I was scared of admitting that ... I do have racist thoughts and beliefs ... and I think it really helped me be able to recognize and be okay saying that."* Other key lessons included recognizing the ubiquity of racism in society and an appreciation of one's own responsibility to work against racism. As a faculty participant described: *"...white supremacy is something that we all are part of and it surrounds all of us in our culture, so we all have to have a part in working to fix it."* Participants shared that by viewing and discussing the pervasiveness of racism in our nation and their own participation in racist systems, they were able to reduce their own shame and guilt and move towards becoming actively anti-racist.

Participation had lasting professional impacts

Participants described that learning in the ARLGs had lasting impacts on participants' anti-racism skills within their multitude of professional roles as clinician, supervisor, teacher, clinic leader, colleague, and researcher.

Better equipped in clinical work

Participants described feeling better equipped to address racism in clinical settings by talking to their BIPOC patients about their experiences of racism, acknowledging their own racial identity and lens, and partnering with patients. Participants also gained a more nuanced and informed perspective on the structural barriers confronted by patients of color, as one trainee reflected:

Many of the patients are Black or not white, and it definitely... shifted a little bit... the way I perceived my work with them in a way where I think the parts of me that might have [thought] "Oh, these people keep coming in, revolving door, like resource[s]," and then it shifted ... more towards thinking about how much the system is built up against them.

Increased involvement in discussions, advocacy, and direct interventions

Participants described that their experiences in the groups equipped and motivated them to change policies at work, to attend more meetings related to anti-racism advocacy, and to be more vocal in efforts to make the healthcare system more equitable. They explained having increased comfort discussing topics of racism and anti-racism with colleagues and applicants, as one trainee described:

"Like before, I remember before if a BIPOC resident would mention racism I would just freeze and I would not know what to say, and now while it still makes me uncomfortable because I don't know if I am saying the right thing ever, I feel more comfortable engaging in the conversation, at least like acknowledging what they said and supporting them."

In addition to increased comfort with speaking about racism at work, participants described feeling an increased ability to intervene when racism occurs at work, as one faculty shared: *"I felt like I was more prepared in the group, and the people in my group also felt more prepared or equipped...just kind of reducing the barriers to speaking up or...making moves about it."*

Enhanced leadership as supervisor and clinic director

One participant detailed how they felt "emboldened" by their experiences in the group to lead more overt anti-racism work in their role as a supervisor and clinic leader. They described developing didactics by inviting speakers with relevant lived experiences and knowledge, discussing racism and anti-racism in individual supervision, including discussions of racism in psychiatric diagnoses, making positionality statements, and creating a reflective and informed culture to encourage trainees to share their own experiences and to critique them if they perpetuate racism in clinical practice. One faculty member described:

Thinking about the importance of my role in furthering the anti-racism mission of our clinic, or of ... modeling what it looks like to be a supervisor who incorporates that in ... has... been on the forefront for me, and the group ... definitely emboldened me to be like, "This is appropriate, this is something [the institution] is aligned with, and even if it wasn't it's something that I guess we should be doing more," but it gave me more of that feeling [that] I can... be a little bit more overt and intentional about these practices because they fit right in with the training goals... We are the people who are training the future ... We are the ones, if we want to see change, that we can start the change and not wait for it to come from the top... I think that was something that I felt more strongly about having been in the group.

Additional individual and department-wide impacts

Participants noted impacts in other domains of work: hiring staff, designing research protocols, approaching community participants, teaching medical students, applying for an anti-racism-related grant, and participating in recruitment efforts of applicants underrepresented in medicine. There was also a recognition among participants that the groups contributed to a significant shift in the department in which more non-Black and non-Latinx trainees are involved in anti-racism work, as one trainee reflected:

I think that a lot of transformative changes happened because of these groups. There's much more energy and desire to actually work as allies, rather than leaving all the labor to largely the Black and Latinx residents in our departments... That's a huge cultural and paradigm shift in how the residency is actually approaching anti-racism or anti-racism labor.

Generalized impacts within and outside of professional roles

Outside of the professional sphere, participants described an increased comfort with discussing issues of anti-racism/racism and new involvement in organizations involved in reparations. One trainee participant described an understanding of experiences of BIPOC that opened more compassion and curiosity in their interactions with others:

I feel like just when I consider the life of a patient, or a colleague, a friend, a neighbor, anybody, there's just a little more resolution to what their experience might be, and more little doors for compassion and for curiosity in just understanding the complexity of somebody else's experience, because ... they could have experienced a world that I was not open to, or like cognizant of, and so I found that to be helpful...I think that the group, by asking some of the questions that it did... was helpful in ... the direct, personal experience I have of interacting with people who are not white... by really considering those kinds of experiences as we did in the class [group], so that was a benefit.

Challenges and recommendations

Participants described several challenges in designing and implementing the ARLGs. Focus group participants provided valuable recommendations to improve the groups in the future.

Sustainability

In the first year of the groups, participants explained that there was not a clear direction on future programming or resources after the groups ended. Participants requested more guidance on what comes next following the conclusion of the groups, for example one faculty sought “...the pragmatic, “What next?” piece, ... we are looking for that... in our continuation of our anti-racism journey.” They recommended potential solutions, including creating spaces for groups to continue discussions, such as journal clubs, lecture series, or social events.

Increasing involvement

Another set of challenges identified among focus group participants was encouraging more people to participate in the groups and supporting group members to attend more consistently. Participants noted that the most motivated participants self-selected to join. As one faculty participant stated, “I felt like a lot of transformative change could happen if it was more widespread and in a way that was incentivized for people who might not self-select in to participate.” In addition, a minority of participants described difficulty consistently attending group meetings.

To address these paired challenges, participants noted that the program would benefit from increasing incentives and reducing barriers to participate in the groups. Groups occurred during uncompensated, evening hours after the workday had concluded. Recommendations included scheduling the groups during work hours, such as during protected didactic time for trainees, and/or compensating the time spent in group after the workday. Another participant stated that some form of acknowledging members who are participating in the group, as is done for those participating in mentoring activities, would encourage participation. Another participant suggested building the groups into the onboarding process for new department hires to increase participation broadly across the department.

Building community

The ARLGs ran individually in parallel without larger intergroup sessions, with the exception of an end of program voluntary social gathering. This allowed for smaller group trust- and relationship-building, but came at a cost of not expanding community across groups. Participants identified that knowing who participated in other groups would have built more cross-group community. As one faculty participant described:

I know..., the people who are in our group and I know of some other people from other groups, but... I think there is a sense of community that could've been expanded even further. Although, I don't know how you could do that while maintaining that privacy that may have been important for some people to join and share the way they did...

Quantitative Findings

Seventy-three participants across the two years completed the demographic items of the pre-program survey (see Table 2 for details). The mean measure scores from the pre- and post- program surveys are shown in Table 3. The results of Welch's *t*-tests indicated a significant difference in mean CCI score at the pre-program assessment compared to post-program ($t(93.19) = -3.45, p < 0.001$, adjusted $p = 0.01$), indicating that respondents at post-program reported higher levels of critical consciousness than respondents at pre-program. There were also significant pre-/post-differences for ARBI Factor 1 (Individual Advocacy) score ($t(100.78) = -2.70, p = 0.008$, adjusted $p = .046$), Factor 3 (Institutional Advocacy) score ($t(82.21) = -2.59, p = 0.01$, adjusted $p = .048$), and

Total score ($t(-2.75) = 86.97, p = 0.007$, adjusted $p = .046$), indicating increased engagement in anti-racism behavior after the learning group. Statistically significant differences were not found for pre-/post-program responses on other variables examined (p range .146 – .986).

Table 2
Demographics of participants who completed the pre-program survey (N = 73)

Age	n	%
25–34	29	39.73
35–44	18	24.66
45–54	15	20.55
55 +	11	15.07
Gender Identity		
Cis female	49	68.06
Cis male	23	31.94
Sexual Orientation		
Heterosexual	59	80.82
Other ^a	14	19.18
Race/Ethnicity		
White	46	63.01
Minoritized racial/ethnic groups ^a	27	36.99
Position at [institution masked for blind review]		
Faculty	34	46.58
Psychiatry Resident/Fellow; Psychology Post-doc/Trainee	25	34.25
Staff	14	19.18
Household Income		
less than \$25,000 - \$75,000	8	10.96
\$75,000 - \$125,000	11	15.07
\$125,000 - \$175,000	7	9.59
\$175,000 +	47	64.38
^a Given the small sample size, to protect confidentiality, detailed sexual orientation and racial/ethnic breakdowns are not presented.		

Table 3
Participant characteristics at pre- and post-program

Measure	Pre		Post	
	n	Mean (SD)	n	Mean (SD)
CCI	71	3.34 (.28)	47	3.53 (.31)
CRAS				
Factor 1: Unawareness of Racial Privilege	71	10.35 (2.59)	47	10.36 (3.10)
Factor 2: Unawareness of Institutional Discrimination	71	11.89 (3.19)	47	11.45 (4.40)
Factor 3: Unawareness of Blatant Racial Issues	71	7.00 (1.54)	47	7.06 (1.79)
Total Score	71	29.24 (5.58)	47	28.87 (8.03)
PCRW (for those who identified as white)				
Factor 1: White Empathic Reactions Toward Racism	54	5.27 (.44)	39	5.15 (.50)
Factor 2: White Guilt	54	3.96 (.86)	39	3.94 (.87)
Factor 3: White Fear of Others	54	2.24 (.70)	39	2.21 (.74)
PCRW (for those who did not identify as white)				
Factor 1: White Empathic Reactions Toward Racism	16	5.13 (.34)	7	5.19 (.55)
Factor 2: White Guilt	16	2.78 (1.05)	7	2.46 (1.09)
Factor 3: White Fear of Others	16	2.31 (.54)	7	1.97 (.51)
SDOS	69	1.49 (.70)	46	1.44 (.73)
SJS	67	3.08 (1.02)	45	2.83 (.79)
ARBI				
Factor 1: Individual Advocacy	67	33.90 (4.88)	45	36.29 (4.41)
Factor 2: Awareness of Racism	67	25.64 (3.11)	45	26.13 (3.67)
Factor 3: Institutional Advocacy	67	11.73 (3.47)	45	13.69 (4.19)
Total Score	67	71.27 (8.50)	45	76.11 (9.54)
CCI: Critical Consciousness Inventory. Higher scores indicate higher levels of critical consciousness.				
CRAS: Color-Blind Racial Attitudes Scale. Higher scores indicate greater levels of color-blind racial attitudes and beliefs.				
PCRW: Psychosocial Costs of Racism to Whites Scale. Lower scores indicate a lower experience of the psychosocial costs of racism.				
SDOS: Social Dominance Orientation Scale. Lower scores indicate a lower social dominance orientation.				
SJS: System Justification Scale. Lower scores indicate lower levels of system justification.				
ARBI: Anti Racism Behavioral Inventory. Higher scores indicate more engagement in anti-racism behavior.				

Discussion

Despite significant research demonstrating the pernicious effects of structural racism in medicine, there is still a dearth of anti-racism education programming for trainees and faculty as well as a number of barriers to implementing initiatives at an institutional level (40). In this paper, we describe the implementation and mixed-methods evaluation of novel Antiracism Learning Groups within a large psychiatry department. In summary, most participants described positive experiences in the ARLGs, where they built community, learned foundational concepts and terminology, and developed key insights about white supremacy and anti-racism. They identified a multitude of positive professional impacts from participating in the groups, including impacts on teaching, supervision, patient care, and involvement in anti-racism activism within the department as well as positive impacts outside of their professional roles. They described a shifted perspective on the impact of racism on their patients and a sense of feeling empowered to align their clinical practice and leadership more directly with anti-racism principles. Participants identified challenges in the pilot year and offered recommendations for future iterations on how to continue anti-racism learning and community formation beyond the conclusion of the groups, how to encourage more people to participate in the groups and participate consistently, and how to build intergroup community while protecting the privacy of group members.

At the most foundational level, participants described becoming more aware of the pervasiveness of racism and white supremacy throughout society, including how it permeates clinical and educational settings and their own views. This impact of the ARLGs on participants' own lives was also reflected in the survey results, as post-program scores on critical consciousness were significantly higher than pre-program scores. Furthermore, participants experienced lasting impacts outside of and beyond the conclusion of the ARLGs on their professional work and interpersonal relationships. This was reflected not only in participants' qualitative responses, but also in survey responses indicating higher engagement in anti-racism behaviors, such as

engagement in institutional advocacy, at post-program than pre-program. These findings are promising, particularly among the faculty, given concerns that faculty are not adequately trained to support anti-racism initiatives or navigate challenges that may arise in the educational or clinical setting and may harm trainees if not properly prepared for these conversations (7, 40). Furthermore, due to power dynamics and positionality, faculty participation is critical, as their buy-in and institutional advocacy impacts the development and sustainability of programs. It was also promising that more white participants felt equipped to handle issues of racism, including within the clinical setting, offering a possible antidote to the 'minority tax' that often arises in institutions (29).

Notably, one group from the pilot year and four groups from the second year continued to meet beyond the original planned conclusion of the groups. This ongoing commitment reflects the continued impact of the ARLGs on experiential learnings that led to community building for a number of participants, beyond the end of the formal groups. This is particularly important given the aim of the ARLGs to support ongoing community building beyond knowledge-based learning alone and aligns with calls from experts that anti-racism learning initiatives should be ongoing (7). However, it's notable that these groups that continued to meet did so on their own without institutional support or protected time, as discussed below. This echoes findings from other anti-racism initiatives of a need for institutional investment and time to take part in initiatives. Indeed, Fatahi and colleagues' survey of anti-racism curricula among US Academic Health Centers similarly found a lack of time to implement curricula or that the work was considered less important (40).

Several recommendations were identified by the pilot year participants, some of which were implemented in year two. In response to feedback that participants lacked direction on how to continue their work following the conclusion of the groups, a resource guide was created and distributed to second-year participants as they completed the groups. This guide encouraged participation in existing anti-racism and equity advocacy committees within the institution and recommended anti-racism books, articles, movies, poetry, and other resources. Groups were encouraged to continue meeting. A social gathering was held for all participants in years one and two of the groups, with a focus on celebrating the end of the second-year groups and supporting ongoing community building across the individuals who participated.

A further contribution of this mixed methods evaluation is assessing changed behaviors related to the ARLGs. Prior anti-racism educational programs have been assessed through program evaluation surveys (8, 9, 11) and pre- and post- program self-reported efficacy and knowledge related to anti-racism and clinical care (12, 14). Focus groups have been used to assess participant experiences in anti-racism trainings (10) and classes (13). In a recent scoping review of anti-racism curricula in U.S. undergraduate medical education, curriculum evaluation was completed through surveys (90%), focus groups (20%), and direct observations (5%) (15).

When assessing impacts of educational programs, there is a need to evaluate not only changed attitudes or knowledge, but also actual changed behaviors, an identified gap in existing assessments of anti-racism curricula (15, 23). A robust finding in the focus groups was the multiple ways participants reported changed behaviors, in several professional and personal domains: their abilities to communicate about racism/anti-racism, intervene when racism occurs, teach about racism/anti-racism, include awareness of racism/anti-racism in clinical supervision, and approach patients, colleagues, and others with more compassion. Positive and significant changes occurred in the pre- and post-group Anti-racism Behavioral Inventory, cataloguing changed personal behaviors.

Limitations

There were a number of limitations to the ARLG's and their mixed-methods evaluation. The Antiracism Learning Groups and the focus groups were held remotely via Zoom due to the COVID-19 pandemic, potentially impacting intergroup dynamics. The focus group facilitators were involved in the ARLGs in various ways, one as a participant, another as a *meta-guardian*, and another as the lead creator and organizer. Focus group participants may have self-censored their critiques of the groups in front of facilitators, as focus group leaders held a dual role in both the ARLGs and the focus groups. Additionally, there was likely volunteer bias in who offered to participate in the focus groups. There were ten focus group participants out of fifty-three participants in the pilot year, thus these perspectives may not reflect the full range of experiences among all that participated in the focus groups. Despite this limitation, focus group participants did represent a range of trainees, staff, and faculty. Regarding the quantitative analysis, the sample size was small, resulting in reduced statistical power to detect results. Furthermore, pre- and post-program responses were not able to be matched, reducing our ability to examine individual pre- to post-program change. Finally, changed behavior findings in the focus groups and Anti-racism Behavioral Inventory rely on self-report.

Implications and Lessons Learned for Implementation

The Antiracism Learning Groups serve as a model that can be adapted at other institutions and in other departments beyond psychiatry. These groups rely on two publicly available resources, a core text and an established group process, which can be adapted and used in other settings.

Those seeking to replicate these groups in other settings should consider what institutional resources are available and whether leadership is willing to commit to the ARLGs. As other leaders in anti-racism have pointed out, it is imperative that leadership make structural commitments to achieve transformative anti-racism changes in medical education curriculum and culture (41).

Resources at our institution were provided from the departmental Office of Inclusive Excellence. This included administrative assistance, funding for an outside supervisor, books for each participant, and gift cards for focus group participants. Supplemental funding by a departmental pilot grant and partial clinic credit for the resident leader who developed the ARLG groups were key to operationalizing the development and evaluation of the groups. Resources not available at our institution were protected time during the workday to participate, compensation or work credit for group participation, or compensation for program leaders.

If the groups meet in the evenings, only those without evening commitments or those with resources or other support for evening child or elder care will be able to participate. Without substantial commitment from a department in the form of protected time, compensation, or other type of work credit, the ARLGs

could become a tokenistic intervention, led by highly motivated, under compensated faculty and residents. If both participation and leadership fall on faculty, staff, and trainees of color, the ARLGs could create additional ‘minority tax’ (28).

For ARLGs to be implemented in a sustainable manner, they require substantial institutional support. Departments will need to invest in making these efforts part of their curriculum, such that individuals are able to engage in these activities within their normal workdays as a part of their professional activities. Additionally, ongoing learning and development opportunities following group participation will need to be thoughtfully integrated into these programs to promote sustainability in service of lasting institutional changes. Institutional sustainability requires executive sponsorship and participation from senior faculty to shoulder advancing learning and community of practice. This will help create a culture that aligns value, mission, and practice. Additionally, administrative support is key, and departments need to underwrite this as part of core infrastructure.

In our evaluation, we report on the immediate impacts of the ARLGs on participants. However, more long-term research is needed to determine if these impacts are long-lasting, not just at the individual level, but at the departmental and institutional levels. Future research measuring the impact of anti-racism programming may consider analysis of long-term systemic changes, such as shifts in hiring practices, patients served, and trainee outcomes. Finally, these groups were initiated at a time when academic medical centers and health systems were being held accountable for racial inequities and structural racism in medicine. Now, at this time when diversity programming is being threatened and programs are engaging in self-censorship, it is up to faculty and leadership to continue to call for these educational initiatives in the pursuit of racial justice.

Declarations

Ethics approval and consent to participate:

The focus group evaluation of the Antiracism Learning Groups has been certified as exempt by the [specific institution masked for blind review] Institutional Review Board (IRB) per 45 CFR 46.104 categories 1 and 2, IRB number 21–000692. Secondary analysis of the pre- and post- group surveys were approved by the [specific institution masked for blind review] IRB, number IRB-26-0171. The study was conducted in accordance with relevant guidelines such as the Declaration of Helsinki.

Consent for publication:

Not applicable.

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Authors’ contributions: ACD contributed to conceptualization, data curation, formal analysis, funding acquisition, investigation, methodology, and writing. For some sections, ACD wrote the original draft. For other manuscript sections, ACD reviewed and edited. NH, AW, and RIM contributed to the formal analysis of data and manuscript writing (original draft and review and editing). AK contributed to data curation and writing (original draft and review and editing). YA contributed to data curation, formal analysis, literature review, and writing (original draft and review and editing). AS contributed to data curation, formal analysis, visualization through manuscript tables, and review and editing. GEP supervised JR, who helped with project administration and methodology, and contributed to manuscript writing (review and editing). JR supported the administrative coordination of project activities and manuscript writing (review and editing). MN led administrative coordination of project activities and manuscript writing (review and editing). EB contributed to conceptualization, funding acquisition, investigation, project administration, resources, supervision, and writing (original draft and review and editing).

Author Contribution

ACD contributed to conceptualization, data curation, formal analysis, funding acquisition, investigation, methodology, and writing. For some sections, ACD wrote the original draft. For other manuscript sections, ACD reviewed and edited. NH, AW, and RIM contributed to the formal analysis of data and manuscript writing (original draft and review and editing). AK contributed to data curation and writing (original draft and review and editing). YA contributed to data curation, formal analysis, literature review, and writing (original draft and review and editing). AS contributed to data curation, formal analysis, visualization through manuscript tables, and review and editing. GEP supervised JR, who helped with project administration and methodology, and contributed to manuscript writing (review and editing). JR supported the administrative coordination of project activities and manuscript writing (review and editing). MN led administrative coordination of project activities and manuscript writing (review and editing). EB contributed to conceptualization, funding acquisition, investigation, project administration, resources, supervision, and writing (original draft and review and editing).

Data Availability

The datasets used in the current study are available from the corresponding author on reasonable request.

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