

Education and Training

Racial Trauma and Unconscious Racial Bias: A Combined Teaching and Reflective Practice Intervention

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Differences in mental health outcomes for people from ethnic minority groups highlight the systemic barriers to accessing good-quality psychiatric care. Psychiatry trainees should understand the impact of structural inequalities and deliver equitable clinical care for all; this is in keeping with current curriculum requirements from the Royal College of Psychiatrists (RCPsych) in the United Kingdom.

To address this curriculum requirement, as well as to explore barriers that trainees faced to discussing unconscious racial bias, a combined racial trauma lecture and reflective practice session was organised as part of mandatory psychiatric postgraduate training in a regional training scheme in England. It was delivered to ten psychiatry trainees, six of whom anonymously filled in a feedback form before and after the session. This measured, using a five-point Linkert scale, trainees' self-reported understanding of racial trauma (improvement by 0.5 points) and their ability to integrate this into daily psychiatric practice (improvement of 1 point) before and after the session. It also revealed that trainees found the session useful, relevant, engaging, and appropriate for their level of training.

Feedback from a previous reflective practice session highlighted some of the emotions (fear, discomfort, anger, guilt, and sadness) and barriers (topic sensitivity, uncomfortable feelings, fear of judgement, and time constraints) that psychiatry trainees face when discussing unconscious racial bias and inequality. The combined session illustrated that some of these barriers can be overcome alongside improving trainees' confidence in understanding and applying concepts of racial trauma in clinical care. Furthermore, it emphasised the need to proactively create intersectional, anti-racist spaces where these issues can continue to be discussed, explored, and reflected upon.

INTRODUCTION

STRUCTURAL AND INSTITUTIONAL RACISM AND UNCONSCIOUS RACIAL BIAS

Structural and institutional racism are two interconnected concepts that describe systemic patterns of discrimination and inequality based on race. Structural racism refers to the ingrained societal practices that perpetuate racial disparities, often manifesting in economic, educational, and healthcare systems. It is deeply embedded in social structures, policies, and practices that disadvantage certain racial groups while benefiting others. On the other hand, institutional racism specifically highlights discriminatory

policies and practices within organisations and institutions, such as government bodies, and private or public institutions.¹

In 2020, the impact of structural and institutional racism was evident for the world to see in the racialised impact of the COVID-19 pandemic. Furthermore, the outrage sparked by the death of George Floyd in the United States of America (USA) and the subsequent revival of the Black Lives Matter movement highlighted a systemic problem that some have been trying to change for many years, with parallels in the United Kingdom (UK)² and other European countries.³

Racism is present in most aspects of our society, including healthcare. For instance, its pervasiveness is evident in the difference in COVID-19 health outcomes between mi-

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nority ethnic groups and the rest of the population, which could not be explained by social determinants of health such as housing, education, or income alone.⁴ Furthermore, a UK prospective study of adults from ethnic minority groups showed that if they perceive racial discrimination, they are more likely to experience poorer mental and physical health than those who do not.⁵ An independent review of the Mental Health Act 1983 was conducted in November 2018 and showed that profound inequalities exist for people of Black, Asian, and Minority Ethnic (BAME) backgrounds in access to psychiatric treatment, experiences of care, and outcomes.⁶

Unconscious racial bias refers to implicit forms of discrimination based on a person's ethnicity, which has a multitude of ramifications for people of BAME backgrounds. Some of these effects in medicine and psychiatry include being more likely to be perceived to have psychosis, to need antipsychotic medication, and to be non-compliant with medication when compared to white counterparts.⁷ The cumulative effects of unconscious racial bias and overt racial abuse result in racial trauma, which Comas-Diaz et al. (2019) describe as 'similar to posttraumatic stress disorder, [however,] racial trauma is unique in that it involves ongoing individual and collective injuries due to exposure and re-exposure to race-based stress'.⁸ The accumulation of sudden, unexpected, emotionally painful racial events results in hypervigilance, intrusive re-experiencing, and avoidance or numbing, which is analogous to the clinical presentation of post-traumatic stress disorder (PTSD).⁹

On the 3rd of September 2010, Olaseni Lewis was killed from cerebral hypoxia following prolonged physical restraint by eleven police officers at the Bethlem Royal Hospital in London. Subsequently, the Mental Health Units (Use of Force) Bill, also known as Seni's Law, was introduced. This requires that hospitals in the UK publish data on how and when physical force is used, and improve oversight and training on awareness of the risk of unconscious bias against minority groups receiving mental healthcare.¹⁰ The fact that a law needed to be created following the loss of a Black patient's life is a testament to the harsh reality that the systems we work within are permeated with racial trauma, and further highlights the importance of tackling racial bias.

Another key concept at play is white fragility, which refers to feelings of discomfort (e.g. guilt, fear, anger) that white people experience when they are involved in discussions around racial inequality and injustice. This discomfort can lead to the white person becoming defensive around discussions involving racial inequality and injustice, which may result in the denial of the disadvantage and discrimination people from BAME backgrounds regularly experience. This invalidates the traumatic and dehumanising experiences of BAME people which, in turn, promotes racism.¹¹

The UK is not an isolated case when it comes to the effects of unconscious bias and structural and institutional racism in psychiatric care. In January 2021, the American Psychiatric Association issued an apology to Black, Indigenous and People of Colour for its support of structural

racism in psychiatry.¹² The European Psychiatric Association has reviewed and published a policy statement paper on racism and mental health, which includes recommendations for clinicians, policymakers, and researchers.¹³

ADDRESSING STRUCTURAL AND SYSTEMIC RACIAL INEQUALITIES IN MEDICAL EDUCATION

In the UK, the Royal College of Psychiatrists (RCPsych) issued its Equality Action Plan to promote equality and equitable outcomes for College members, mental health staff, patients, and carers. It outlines 29 key actions to be rolled out until 2024.¹⁴ One of these actions focused on enhancing equality in training, which included the review of the psychiatric training curricula to ensure that they reflected the knowledge and skills necessary to deliver equitable clinical care, as well as for trainees to understand the impact of structural inequalities and power differences within mental health services.

The new UK curriculum for speciality training in Psychiatry includes several key capabilities that encourage reflective practice and emphasise the importance of addressing structural and systemic inequalities, as reported in the High-Level Outcomes for Professional Relationships and Standards, Communication, Health Promotion and Illness Prevention and Supervision.¹⁵

However, dialogues on race and ethnicity are difficult and can generate intense and powerful emotions. Anxiety, guilt, anger, and frustration can disrupt communication.¹⁶ This could limit one's ability to mentalise and observe one's emotions, which may, in turn, restrict one's openness and curiosity to discuss racial biases and how these might influence attitudes and behaviour.

The authors aimed to understand the barriers trainees faced exploring unconscious racial bias; to understand this in the context of racial trauma and how this intersects with clinical care; and to address RCPsych curriculum requirements of using reflective practice and providing equitable care by taking structural inequalities and power differences into account. To achieve this, a combined racial trauma lecture and reflective practice session was organised as part of mandatory psychiatric postgraduate training in a regional training scheme in England.

METHODS

REFLECTIVE PRACTICE SESSION ON UNCONSCIOUS RACIAL BIAS

Prior to organising the combined educational and reflective training session, the authors tried to organise a Race and Equality Reflective Group¹⁷ for doctors of any training grade working in psychiatry (this excluded consultant psychiatrists) to facilitate a space to discuss issues around unconscious racial bias. The session was cancelled as the authors received an insufficient number of registrations (two registrations out of over one hundred trainees invited). An anonymous feedback questionnaire was sent to all trainees via the Trust online platform Office365 Forms. This survey

aimed to explore the potential barriers to participation and asked the following questions:

1. Why do you think people did not register for this activity?
2. Would you be interested in a similar activity in the future?
3. Do you have any additional thoughts or comments?

DEVELOPING A TRAINING SESSION

Following the unsuccessfully organised reflective group and a discussion in a Balint group (please see [Box 1 – Balint Groups](#)), the authors proposed a training session to address topics of racial trauma and unconscious racial bias within mental health settings for core psychiatry trainees that would combine both educational materials as well as provide a space for reflection.

Box 1. Balint Groups

Balint Groups provide trainees with a space to reflect on clinical situations they have found emotionally challenging and are an integral part of core psychiatry training in the UK. These groups are based on a method developed by psychoanalyst Michael Balint and his wife, Enid Balint, who used psychodynamic theory to better understand the doctor-patient relationship, as illustrated in his seminal work 'The Doctor, his Patient and the Illness'.¹⁸ Balint Groups are a curriculum requirement for all UK psychiatry trainees in their first year of training.

The authors planned to include this session on Racial Trauma in the Regional MRCPsych course. This is a preparatory course for the RCPsych membership examinations recommended by the college for all psychiatry trainees in the first half of training. The authors contacted a group analyst and principal psychotherapist working within the National Health Service (NHS) Trust, who was distinguished in the field of racial bias and trauma in psychiatric and forensic settings. They agreed to speak about these issues at an MRCPsych course teaching session. The session took place in June 2022.

In collaboration with the speaker, the authors designed the session. It involved a 45-minute lecture on Racial Trauma, followed by a 20-minute small group reflective activity in small groups and a 25-minute discussion as a larger group.

An online monitoring form was used to collect anonymous feedback using Office365 Forms. It was designed to measure knowledge before and after the session, as well as to collect feedback. It was developed using Kirkpatrick's Model of Training Evaluation.¹⁹ The outcome measures were trainees' self-rated confidence in understanding the concept of racial trauma and integrating it into daily psychiatric practice, calculated using a 5-point Likert scale (1 -

not confident at all; 5 - extremely confident). Median scores were calculated and compared pre- and post-session; the ranges were also collected. Quantitative feedback was collected after the session, which evaluated utility, relevance, quality of teaching methods used, and trainee engagement. Information about the attendees' subjective teaching experience was also collected in the feedback form. This included three open-ended questions:

1. Is there anything that could be done differently next time?
2. What is the single most important thing that you have taken from this session?
3. Any other thoughts, comments and reflections?

The authors confirmed with the local NHS Foundation Trust Research and Development department that this work was exempt from review by an Institutional Review Board (IRB). It was judged to be service evaluation rather than research because the data collected only included anonymised information that is routinely collected when conducting an educational session in the Trust.

RESULTS

REFLECTIVE PRACTICE SESSION ON UNCONSCIOUS RACIAL BIAS

Out of the doctors in training working in the Trust that were contacted (n=103), twelve trainees completed the questionnaire that explored the barriers to participation. Recurrent themes from the questionnaire included sensitivity around the topic, discomfort talking about the subject, and insufficient space in their timetable as the most prominent barriers to participation. The questionnaires were brought to be discussed at the weekly Balint group for further exploration. This was done as there was an overlap between trainee populations present at the Balint group and the doctors invited to attend the stand-alone reflective practice session.

BRINGING IT BACK TO BALINT GROUP

During the subsequent Balint group meeting, anger, guilt, and sadness were acknowledged. It was discussed how many trainees realised that while consciously they did not consider themselves racist, they did unconsciously hold racist attitudes and prejudices. However, the idea of saying something that might betray those biases, and having it noticed by others, was frightening for them.

Several members felt the need to justify why they did not sign up for the session, suggestive of a defensive position. Others were curious about why they had missed the details of the email and whether there could be some unconscious avoidance at play. A prominent theme which trainees had difficulties acknowledging was their unconscious barriers to having an open conversation about racial inequality. Furthermore, group members expressed fear of being misunderstood and judged if they voiced their thoughts or opinions.

Table 1. Median and range of scores of Outcome Measures

Question	Pre-session average Median (Range)	Post-session average Median (Range)
On a scale of 1-5, how confident do you feel in understanding the concept of racial trauma? *	3.0 (2-4)	3.5 (3-4)
On a scale of 1-5, how confident do you feel integrating this concept into daily psychiatric practice? *	2.0 (1-4)	3.0 (1-4)

*1 being not confident at all, 5 being extremely confident

Table 2. Frequency and percentage results of Quantitative Feedback

Question			Yes	Partially	No
Was this a useful learning opportunity for your level of training? n (%)			4 (67)	2 (33)	0
Was the content relevant? n (%)			5 (83)	1 (17)	0
Were the methods used helpful? n (%)			5 (83)	1 (17)	0
Was the session engaging? n (%)			4 (67)	2 (33)	0
Question	Excellent	Good	Average	Poor	Very poor
Overall, how would you rate this session? n (%)	1 (17)	4 (67)	1 (17)	0	0

The group reflected that not talking about race is a common theme within our society. However, there was an overwhelming sadness that we, as psychiatrists, could not tolerate the anxiety and discomfort of having this session. The group felt that this was a missed opportunity to learn and reflect with one another on a topic that is so important for both patient care and the well-being of our colleagues working in mental health services.

Concurrently to the authors carrying out this work, other trainees in the Trust were in the process of addressing issues of bullying, harassment, and undermining. The authors collaborated with these trainees and together set up a broader trainee project called “Hear My Voice”, which was supervised by a consultant psychiatrist in medical psychotherapy. This was used as a means of implementing these recommendations as well as tackling other challenges in the wider system.

COMBINED TEACHING AND REFLECTIVE PRACTICE INTERVENTION

Out of the ten psychiatry trainees who attended the session as part of their MRCPsych course, six completed the online monitoring form just before and immediately after the session. The average self-rated scores of the outcome measures (i.e. understanding and integrating racial trauma into daily practice) improved after the session, as displayed in [Table 1](#). The quantitative feedback from the attendees about the session was positive overall in terms of utility, relevance, quality of teaching methods used, trainee engagement, and overall quality of the session. This is illustrated in further detail in [Table 2](#). Statistical comparisons were not made due to the small sample size, which limits conclusions which can be drawn from this data.

With regards to the qualitative feedback, trainees highlighted the importance of raising awareness on the topic. They also commented on the subjective experience of racial

trauma, bias, and the impact these have on the lives of patients and staff alike. One trainee spoke of “the importance of thinking about people’s experiences of racial trauma and how it has impacted upon their lives” and also “reflecting on my own experiences [and] practice”, while another of “the importance of awareness, reporting and supporting colleagues who experience racial trauma”. Additionally, attendees reflected on how racial trauma and bias can be conceptualised systemically and structurally. One trainee wrote: “I think the emphasis on thinking systemically rather than individually as is often the focus in psychiatric practice is particularly helpful”.

Trainees also provided feedback on what could be improved in future sessions. They suggested that it would be helpful to clarify the context of the session from the outset and to be given more practical examples of how to address racial trauma and bias in clinical practice within the NHS. One trainee wrote: “I think more time to consider issues more specific to British psychiatric practice around engagement of minority ethnic communities and ethnic disparities in access to care and how care is provided would be useful”, while another said that it “would have been helpful to brainstorm further possible strategies of managing the situation, even though options were suggested”.

Similarly, the small group reflective activity was appraised as helpful, but attendees suggested that having facilitators present would have improved the learning experience. One trainee fed back that it would have been helpful “having facilitators for the breakout groups [and] focusing more on how to integrate discussions about racial trauma into clinical practice.” Another trainee said that “the session helped to give a good understanding of what racial trauma is. However, I think it is a shame that it did not focus more on how the effects of racial trauma are important for us as doctors. For example, how should we be thinking about the impact of racial trauma when we are assessing

patients/ formulating management plans? How [and] when should we be having conversations about racial trauma with patients?”

The experience of developing a session to combine elements of medical education and reflective practice was helpful as a new way of bringing complex topics into existing medical postgraduate educational spaces. The session has been incorporated into the syllabus of the regional MRCPsych course and it will be accessed by every psychiatry doctor in this region's postgraduate training. This ensures the sustainability and longevity of the project. Suggestions for improvement were taken on board by the 'Hear My Voice' initiative, which is planning to liaise with other clinicians and academics in the NHS Trust to provide more targeted and experiential training opportunities for doctors.

DISCUSSION

This intervention suggested an improvement in trainees' self-reported confidence in understanding racial trauma and integrating this concept into clinical practice in a subset of trainees who completed pre and post-intervention questionnaires. However, this paper is unable to examine the statistical significance of this change. What this paper does show is that a mixed educational and reflective session is well received by psychiatric trainees in terms of utility and relevance, whilst being helpful and engaging.

This project highlights the barriers that trainees face when collectively reflecting on unconscious racial bias in clinical practice. This paper also opens the possibility of addressing these challenges through a mixed educational and reflective session. Education and reflection can be helpful tools to improve understanding of racial trauma, and this knowledge may be implemented into clinical practice. While this was supported by the qualitative and quantitative feedback that was collected, it is difficult to draw robust conclusions based on the small sample size and limited data.

The process of organising this intervention has highlighted the profound barriers and challenges that trainees face to engage with the subject. White fragility is likely to have been at play in the avoidance of engaging with the subject matter. It is highly unlikely that this intervention will result in meaningful change in isolation; rather, it is a small part of a wider process towards addressing unconscious racial bias and racial trauma among psychiatry trainees. Integrating interventions like this into standard teaching programmes for clinicians are more likely to be effective than targeted one-off sessions. An example of this is the Seni Lewis Training Programme that has been introduced by South London and Maudsley NHS Foundation Trust.²⁰ The subjective feedback received suggested that trainees wanted more from the session in terms of material and application. This may reflect a desire among trainees to have similar educational and reflective opportunities beyond a single session.

As a result of this project, the following recommendations were agreed upon by the authors and presented to the NHS Foundation Trust's Medical Education Department:

1. To incorporate discussions about unconscious racial bias in already established reflective spaces;
2. To create new reflective and educational opportunities focusing on unconscious racial bias, inequality, and inclusion;
3. To encourage trainees to join staff networks and special interest groups with a focus on equality and inclusion;
4. To further develop the local training curriculum to facilitate trainees to meet this national curriculum requirement;
5. To support trainers and supervisors to feel confident in discussing these topics with trainees. This might include further training or access to reflective groups for trainers.

Previous studies with medical students and doctors have shown that educational activities might improve reflection and confidence in reducing the racism experiences of patients. In a trial conducted by Ruben and Saks, they tested a three-part implicit bias training programme that included visits to an art museum, a lecture on medical anthropology, and an interactive sociological discussion about bias in medical research. Medical students struggled to recognise their own racial biases, but the students in the experimental group had a greater capacity to reflect on these biases than those in the control group.²¹ The results of this paper are similar to those found by White-Davis et al. They reported that a workshop helped to improve confidence in reducing racism in patient care among family medicine doctors. They also recommend that curricula be further developed to “effectively incorporate the discussion of racism in the education of health professionals”.²² Pacheco et al. argued that including teaching material that is anti-racist and anti-discriminatory in medical education curricula is a way of addressing structural racism that psychiatric trainees from ethnic minority backgrounds face.²³

The main limitation of this project is the small sample size, which limits the generalisability of its findings. Furthermore, out of the ten trainees who attended the session, only six completed the feedback questionnaire, which could mean that the results are not representative of all attendees. It is possible that these results are subject to selection bias, and therefore larger studies are warranted to confirm these results. It is possible that those with more positive reactions to the session self-selected by filling in the anonymous feedback form, which would mean that other views may have been missed. The authors hope this will be possible as the session will be repeated each year as part of the regional MRCPsych course, which forms part of the mandatory teaching curriculum required to complete psychiatric training. Furthermore, not being able to gather demographic information such as trainee gender and ethnicity limits the interpretation of the data collected.

Another limitation is that this study could not examine the effects of unconscious racial bias and racial trauma on members of staff (including trainees) who come from BAME backgrounds, who may be in positions of power to BAME patients in psychiatric institutions that may be structurally racist. It was also not possible to explore trainee expe-

periences of witnessing racial violence in the workplace, as well as the effects of working with racial trauma between themselves, among their multidisciplinary teams, and in clinical scenarios. Moreover, the effects of white fragility on trainees were not captured in the measures used. More studies exploring these dynamics could result in the creation of novel interventions to contribute to the ongoing fight for racial equality in psychiatry. Future work could include sharing testimonies from local service users from BAME backgrounds about their lived experience with psychiatric services.

This study has shed light on the complexity faced with exploring and overcoming barriers for psychiatry trainees reflecting upon and talking about their own unconscious racial bias, as well as institutional and structural racist inequalities that permeate society as a whole, including their workplace. This is especially the case given the stark power imbalances in psychiatry, where patients are routinely detained in hospital against their will under the Mental Health Act and equivalent legislation in other UK nations. The intersection of power, racism, and the racial trauma that patients from BAME communities carry with them results in a situation where not reflecting on one's own unconscious racial bias and white fragility (as individuals, as collective mental health professionals, and as members of institutions) and not adopting an intentionally anti-racist approach to patient care can have catastrophic consequences.

CONCLUSION

This process has revealed some of the emotions and barriers that psychiatry trainees face when discussing unconscious racial bias, which is essential to improving the quality of holistic patient care and the well-being of mental

health staff members. This may be achieved by creating safe and trusting environments in the form of facilitated educational and reflective spaces that promote sharing, reflection, and discussions which are proactively anti-racist.

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DECLARATION OF INTEREST

None. The views expressed here are those of the authors and not necessarily those of the National Health Service.

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AUTHOR CONTRIBUTIONS

Both authors contributed equally at every project stage, including conceptualisation and project design, methodology, writing, and editing.

AUTHOR AGREEMENT

All authors have approved the final version of the manuscript.

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SUPPLEMENTARY MATERIALS

Supplementary Material

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