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Pilot Intervention for Discrimination-related Coping Among HIV-Positive Black Sexual Minority Men

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Abstract

Objectives—Discrimination is associated with worse health. Although interventions have been developed to improve coping with general stressors and chronic illness, no literature to date has reported the development and testing of an intervention specifically to address coping with discrimination. We examined the feasibility, acceptability, and preliminary effects of *Still Climbin'*, a pilot intervention created to improve coping with discrimination experienced by HIV-positive Black sexual minority men, who face significant HIV-related disparities.

Methods—*Still Climbin'* was culturally tailored using community stakeholder input and formative qualitative research. *Still Climbin'* consists of 8 weekly group sessions and a graduation session, based on principles of cognitive behavior therapy. Sixty-four HIV-positive Black sexual minority men were recruited from community venues; 38 were randomized to the intervention and 26 to a wait-list control group. Participants completed assessments at baseline and 3- and 6-months post-baseline. Intervention participants completed post-session feedback forms.

Results—Repeated-measures regressions indicated significant intervention effects on improved coping in response to discrimination, including functional (problem-solving) coping [b (SE) = 0.39 (0.19), $p = 0.04$], humor [b (SE) = 0.48 (0.22), $p = 0.03$], and cognitive/emotional debriefing [b (SE) = 0.30 (0.14), $p = 0.04$], a culturally relevant form of coping that includes self-protective strategies (e.g., strategic avoidance of certain places or people). Intervention participants rated the sessions positively in response to closed- and open-ended questions.

Conclusions—*Still Climbin'* was feasible and acceptable to participants, and showed promise for improving coping with discrimination, which ultimately can lead to better health outcomes and reduced disparities.

Keywords

Black/African American; coping; discrimination; HIV; sexual minority

Racial/ethnic disparities persist in HIV diagnosis, care, and treatment. Black (versus White) Americans living with HIV are less likely to adhere to antiretroviral therapy and to be virally suppressed (Crepaz, Dong, Wang, Hernandez, & Hall, 2018; Simoni et al., 2012). Black individuals accounted for 45% of all HIV diagnoses in 2015; among those, 74% were men, and male-to-male sexual contact remains the primary transmission risk among Black men (Centers for Disease Control and Prevention, 2011, 2016).

HIV-related stigmas—from HIV and intersectional identities that co-occur with HIV—contribute to disparities among HIV-positive Black sexual minority men (Earnshaw, Bogart, Dovidio, & Williams, 2013). Black sexual minority men experience discrimination from multiple facets of their identity, including HIV-serostatus, minority race/ethnicity, and sexual minority status (Bogart, Landrine, Galvan, Wagner, & Klein, 2013; Stirratt, Meyer, Ouellette, & Gara, 2007), which contribute to worse health outcomes (Pascoe & Smart Richman, 2009). Among HIV-positive Black sexual minority men, experiences of racial discrimination have been associated with lower antiretroviral therapy adherence, increased depression symptoms, greater emergency department/room use, higher plasma HIV levels (a marker of treatment disengagement), and lower CD4 cell count (a marker of immune functioning), controlling for discrimination from HIV-serostatus and sexual minority status (Bogart, Wagner, Galvan, & Klein, 2010; Bogart et al., 2011; Bogart et al., 2013). HIV-related discrimination has been associated with lower adherence among people living with HIV, including Black men who have sex with men (MSM) (Bogart et al., 2011; Thrasher, Earp, Golin, & Zimmer, 2008). Sexual minority discrimination has been related to mental health symptoms, as well as less healthy behaviors, among MSM, including Black MSM (Hatzenbuehler, 2009; Meyer, 1995; O'Cleirigh et al., 2015; Wong, Schrager, Holloway, Meyer, & Kipke, 2014).

Biopsychosocial models posit that chronic discrimination affects health by increasing detrimental responses to stress (Brondolo, Rieppi, Kelly, & Gerin, 2003; Brondolo, Ver Halen, Pencille, Beatty, & Contrada, 2009; Clark, Anderson, Clark, & Williams, 1999; Landrine & Klonoff, 1996; Williams & Mohammed, 2009). Research has connected the use of specific coping strategies to positive or negative psychosocial functioning. A meta-analysis indicated that two avoidant coping strategies, behavioral disengagement and

substance use, are associated with worse mental and physical health among people living with HIV (Moskowitz, Hult, Bussolari, & Acree, 2009), whereas two active/approach coping strategies, direct action and positive reappraisal, are associated with better health (Moskowitz et al., 2009). Avoidant coping includes strategies such as behavioral disengagement (e.g., giving up trying to actively deal with a stressor) and cognitive escape (e.g., using substances and not having to think about a stressor). In the meta-analysis, use of avoidant strategies was associated with poor outcomes, including lower positive and higher negative affect, less healthy behaviors, and worse physical health. Further, active coping, such as cognitive flexibility (recognizing options and alternatives in a situation) and positive reframing/positive cognitive restructuring (e.g., reframing thoughts by making self-protective attributions) can minimize the negative effects of stress, including discrimination-based stress (Brewster, Moradi, DeBlaere, & Velez, 2013; Crocker, Major, & Steele, 1998; Goodkin et al., 1992). Similarly, social support-seeking can lead to better health outcomes, helping to regulate emotions and foster reframing, distraction (e.g., watching television), emotional expression, and problem-solving (Carter & Forsyth, 2010; S. Cohen, 1988; Mulder, Antoni, Duivenvoorden, Kauffmann, & Goodkin, 1995; Uchino, Cacioppo, & Kiecolt-Glaser, 1996). Improving coping self-efficacy—that is, confidence in one's ability to engage in adaptive coping such as problem-solving, positive reframing, and social support seeking—can lead to better mental health among people living with HIV (Chesney, Chambers, Taylor, Johnson, & Folkman, 2003).

Extant findings point to the importance of an empirical focus on whether, or how, increases in functional coping capabilities can improve health. Prior research indicates that cognitive behavior therapy (CBT) interventions can improve the mental health and immune functioning of people living with HIV (Crepaz et al., 2008). Literature has reported specifically on the effects of CBT stress management interventions (including relaxation skills training, cognitive restructuring, and social support-seeking) to improve coping, which can facilitate improvements in mental health and immune functioning (Scott-Sheldon, Kalichman, Carey, & Fielder, 2008). For example, randomized controlled trials (RCTs) have shown that group-based CBT stress-management programs increase active coping skills (e.g., positive reframing, acceptance of HIV, social support seeking) and reduce avoidant coping (i.e., denial) among HIV-positive MSM (Carrico et al., 2006; Lutgendorf et al., 1997).

Although research testing general stress management interventions is a valuable foundation for understanding ways to improve general coping skills, we could identify no literature reporting the development or testing of an intervention specifically to reduce discrimination's harmful effects through improved coping, or to address discrimination due to the intersectionality of multiple stigmatized identities—for any stigmatized group. One published case study described the development of an African-centered group intervention to help Black men cope with racism (Elligan & Utsey, 1999). In a pilot group of seven men, facilitators guided the group in restructuring ineffective coping responses (e.g., guilt) and determining effective coping responses (e.g., use of spirituality). Participants reported a decrease in anger and frustration from pre- to post-intervention, although there was no randomization or control group. *Many Men, Many Voices*, another intervention developed for Black MSM, has been shown to be effective in reducing risky sexual behaviors (Wilton

et al., 2009). Although the intervention includes discussions about how racism and homophobia are related to sexual risk and substance use, it does not focus explicitly on increasing coping skills for discrimination.

The goal of the present research was to use community stakeholder input and cultural adaptation to develop and pilot test a CBT intervention for Black sexual minority men that aimed to improve coping responses to discrimination. We used a group format because groups can provide a safe space to present one's identities and experience understanding and validation by similar peers. Although structural interventions are critical for reducing societal discrimination as a long-term strategy, individual-level interventions to reduce the psychological effects of discrimination are also necessary to assuage pain and negative health effects in the present (Brondolo et al., 2009). Individual-level interventions need to be conducted sensitively, to avoid implicitly blaming the discrimination target, and to empower individuals to leverage their innate resilience resources. In this paper, we present and discuss the findings from our pilot RCT of the intervention, *Still Climbin'*.

Methods

Setting

This study was conducted from July 2014 to September 2015 as a community-academic partnership among a medical school, a health research institute embedded in an LGBT-focused community health center, and a minority-focused HIV service organization. All procedures were conducted in compliance with the institutional review board of the research institute, which served as the institutional review board of record. All participants provided written informed consent prior to completing the baseline survey.

Intervention Development

Community engagement—The intervention was developed using an iterative community-engagement process, with input from two community advisory boards (one attached to an HIV research consortium and one from the LGBT research institute) and social service providers and clients at LGBT and HIV service organizations (Bogart et al., 2016). Community members on the team named the intervention *Still Climbin'* after a line (“I’se still climbin’...”) in the Langston Hughes poem “Mother to Son,” which emphasizes resilience in the face of hardship (Hughes, 1994).

Single-arm pilot process evaluation—Prior to conducting the pilot RCT, we refined the protocol through conducting a single-arm pilot test with one group of 14 HIV-positive Black sexual minority men (all of whom reported having sex with men). Debriefing exit interviews were conducted with all 14 participants post-intervention to assess feasibility and acceptability, a primary goal of intervention development research (Moore, Carter, Nietert, & Stewart, 2011). We asked participants open-ended questions about the overall intervention and its specific components, and elicited suggestions for improvement. To analyze the qualitative data, the team developed a codebook by reviewing exit interview transcripts and writing up summary notes capturing feedback and suggestions (Ryan & Bernard, 2011). Two coders marked areas of text pertaining to each code. Coder consistency, assessed on

four of the 16 interviews, was good (Cohen's Kappa = .78 across positive and negative feedback codes).(Cohen, 1960)

Inclusion Criteria and Randomization

Individuals were eligible if they were 18 or older, had a confirmed HIV diagnosis, were biologically male, identified as Black/African American, and reported having sex with men in their lifetime. Using blocked randomization (with permuted block size), 64 participants were randomized to one of two conditions: the *Still Climbin'* intervention group (n = 38) or a wait-list control group (n = 26). (Note that we did not control for attention in the wait-list control group, and wait-list control participants were not offered the intervention until completion of the final follow-up assessment for the evaluation.) We convened three intervention groups across different locations to reach a range of local participants: two in the LGBT-focused community health center (one at the main clinic site and another at a youth-focused satellite location) and one in the minority-serving HIV service organization. Given the limited resources available, we recruited more intervention than control participants to account for potential retention issues in the intervention sessions (i.e., to ensure that a sufficient number of participants would attend each group session). The assessor was blind to treatment assignment until after each participant completed the baseline assessment.

Participants

Fifty-six participants (88%) identified as Black or African American, six (9%) identified as Black/African American and Latino and two (3%) identified as multi-racial (Black/African American and another race). Fifty-seven (89%) completed high school, and 42 (66%) were stably housed. A total of 46 (72%) were not working and 36 (58%) had annual incomes below \$10,000. The average age was 46.3 (SD = 12.8). Forty-six (72%) were virally suppressed, and the majority had visited an HIV care provider in the last 6 months (96% of the control group and 87% of the intervention group). The intervention and control groups did not differ significantly on any socio-demographic or medical characteristics (see Table 1).

Intervention

Intervention content, structure, and counseling techniques—Table 2 shows the intervention content and structure. The intervention consisted of eight weekly two-hour sessions plus a brief ninth “graduation” session. Facilitators were trained to use a non-confrontational, non-judgmental style. Facilitators provided psychoeducation about disparities and discrimination, and discussed medical mistrust, e.g., by acknowledging historical and current discrimination, which can lead to the development of medical mistrust (Arkowitz, Miller, & Rollnick, 2015). To improve coping with discrimination, facilitators used principles of CBT, a widely used, evidence-based approach to behavior change that has shown promise when adapted to diverse U.S. populations (Bedoya, Dale, & Ehlinger, 2017; Pantalone, Iwamasa, & Martell, 2009). Using CBT techniques and assumptions from dialectical behavior therapy (DBT), facilitators also taught participants CBT coping skills

(chain analysis, mindfulness, cognitive restructuring, relaxation; Dimidjian & Linehan, 2009; Ellis, 2003; Ferguson & Sgambati, 2009; Linehan, 1993; Newman, 2004).

Facilitators helped participants to understand responses to discrimination in terms of the chain of events that led to the behavior (a functional/chain analysis) as well as the behavior's consequences (Rizvi & Ritschel, 2014). Participants were guided through a step-by-step, micro-level recounting of thoughts, behaviors, and emotions related to a specific discrimination event chain (i.e., distal vulnerability factors, proximal prompting events, immediate and longer-term consequences of coping strategies), and then learned how to identify problematic 'links' in the chain (Linehan, 1993). Facilitators elicited in-session skills practice (including role-plays) and assigned further practice between group meetings to encourage skills generalization (Heidt & Marx, 2004; O'Donohue, Fisher, & Hayes, 2004). CBT is usefully conducted in groups because antecedents or consequences of many problem behaviors are interpersonal, and because participants can learn skills by modeling the experiences of other group members (Bieling, McCabe, & Antony, 2006).

The intervention was developed from the perspective that different types of coping can serve distinct functions according to the nuances of a given situation and that, for some situations, such as racism from people in positions of power (e.g., law enforcement), there may be restricted coping options (Mellor, 2004). Thus, facilitators discussed with participants a range of different types of discrimination situations and various types of coping responses, rather than prescribing or proscribing the use of any particular coping strategies.

Facilitator training, supervision, and fidelity—Intervention groups were led by a trained facilitator (master's-level social worker who was a Black gay man with expertise in group therapy with Black sexual minority men) and a trained peer co-facilitator matched in identities with participants (HIV-positive, Black, and bisexual). At the close of each session, the facilitator and co-facilitator independently rated their fidelity to the protocol using standardized forms tailored to the content and goals of the session. Both facilitators received weekly individual supervision from a licensed, doctoral-level clinical psychologist, who listened to session audio-recordings and reviewed the protocol fidelity forms. The supervisor provided guidance about general therapy skills, group management, coping with discrimination, and the use of CBT techniques. Supervision focused on both content (protocol adherence) and process (group facilitation skills). As needed, facilitators were also provided with the opportunity to consult with a Black psychologist to further discuss group processes related to cultural factors (e.g., their roles as both facilitators and members of the participants' communities) and recent discrimination events (e.g., police brutality) that received significant media attention.

Assessment

Participants completed audio computer-assisted self-interviews at baseline and 3- and 6-months post-baseline.

Socio-demographic and medical characteristics—The survey assessed participant age, educational level (coded as less than high school versus high school graduate), income level (coded as less than or greater than or equal to \$10,000 annually), employment status

(coded as employed full- or part-time versus not employed full- or part-time), housing status (coded as stable [rent/own home, in subsidized housing] versus not stable [homeless, temporary/transitional housing, residential treatment facility, in a friend's/relative's home]), sexual minority identity (heterosexual versus gay, bisexual, not sure or in transition, something else), incarceration history (ever versus never), and relationship status (committed relationship versus not). Participants were also asked whether they were currently prescribed antiretroviral medications, if their viral load was undetectable or detectable, and the month and year of their HIV diagnosis.

Coping: Brief COPE—To assess coping with discrimination, participants completed the 28-item Brief COPE (Carver, 1997), consisting of 14 two-item subscales that assesses various coping strategies (i.e., active, planning, positive reframing, acceptance, humor, religion, using emotional support, using instrumental support, self-distraction, denial, venting, substance use, behavioral disengagement, and self-blame). The instructions were modified to direct participants to indicate the extent to which they had responded in each way “when faced with discrimination,” with response categories 1, *I haven't been doing this at all*; 2, *I've been doing this a little bit*; 3, *I've been doing this a medium amount*, and 4, *I've been doing this a lot*.

Prior research and guidance suggest that the factor structure of the Brief COPE depends on the context and population being studied and, thus, researchers have used exploratory factor analysis to identify subscales for their specific sample (Carver, 1997; Krägeloh, 2011; Rood, McConnell, & Pantalone, 2015). In our study, we conducted an exploratory factor analysis using varimax rotation and extracted eight factors with an eigenvalue >1 (Comrey & Lee, 2013; Kaiser, 1960). We determined item retention by using a factor loading cut-off of .60 (at least 36% overlapping variance), by ensuring that conceptually similar items were grouped together, and by eliminating one single-item factor. This process resulted in dropping two items and retaining seven factors, five of which matched the original Brief COPE subscales (denial, $\alpha = .66$; humor, $\alpha = .60$; religion, $\alpha = .76$; self-blame, $\alpha = .55$; substance use, $\alpha = .89$). The other two subscales were new configurations of items: functional coping, which includes items describing cognitions and behaviors to solve a problem, including positive reframing, acceptance, and active coping (i.e., “look for something good in what's happening,” “accepting the reality of the fact that it happened,” “learning to live with it,” and “taking action to make the situation better”; $\alpha = .86$); and social support/venting (“getting emotional support from others,” “getting comfort and understanding from someone,” “getting advice or help from other people,” and “I express my negative feelings”; $\alpha = .78$).

Coping: Africultural Coping Inventory—The Africultural Coping Inventory was developed to represent Black/African Americans' unique culture and history, which have led to reliance on culturally relevant resources for resilience in the face of stress (Utsey, Adams, & Bolden, 2000). It consists of four subscales: Cognitive/Emotional Debriefing (11 items; self-protective coping efforts driven by a survival instinct that evolved from historical and current racial oppression; combines positive reframing, increasing social support, and psychological and physical strategic avoidance of situations in which discrimination is

likely; e.g., “tried to remove myself from the situation,” “hoped that things would get better with time,” “sought out people I thought would make me laugh”; $\alpha = .75$); Spiritual-Centered Coping (8 items; connection with spiritual elements, e.g., “prayed that things would work themselves out,” and “went to church to get help from the group”; $\alpha = .84$); Collective Coping (8 items; reliance on others for emotional/informational support, e.g., “shared my feelings with a friend or family member,” “sought advice about how to handle the situation from an older person in my family or community”; $\alpha = .83$); and Ritual-Centered Coping (performing rituals, e.g., “lit a candle for strength or guidance in dealing with the problem”; $\alpha = .70$).

Post-session feedback forms—To assess intervention acceptability, intervention participants completed brief feedback forms after session. Feedback forms posited four closed-ended questions assessing whether participants liked the session, felt comfortable participating, learned new information or skills, and whether the facilitators helped to make the session a positive learning experience, with response options *strongly disagree* (1), *slightly disagree* (2), *slightly agree* (3), and *strongly agree* (4). Participants were also asked two open-ended questions assessing what they liked best and least about the session, and given a space for additional comments. The team coded and analyzed the open-ended responses using similar methods as the exit interviews. Interrater reliability was good (Kappa = .89 for positive feedback and .83 for negative feedback).

Incentives

Participants received a \$30 gift card for each study assessment (baseline and 3- and 6-month follow-ups), and \$10 for a brief check-in to update contact information. Intervention participants received a snack and \$5 for each of the first eight intervention sessions (excluding the ninth session, which was a graduation ceremony) to cover transportation costs. Intervention participants also had the opportunity to win a \$50 raffle at the graduation ceremony (with the number of entries per participant linked to the frequency of their attendance).

Statistical Analysis

To assess *Still Climbin*'s effects on coping, we conducted an intent-to-treat-analysis using linear repeated measures regressions on the coping subscales, using as predictors the intervention condition, timepoint (baseline versus 3-month and 6-month follow-up combined), and the intervention $\times$ timepoint interaction; the interaction tested whether the change from baseline to follow-up was different for the intervention versus control condition. We also conducted a set of secondary, as-treated regression analyses that tested the association between number of sessions attended and the coping outcomes among intervention participants only. (Note that none of the analyses tested for whether differences changed from 3-months to 6-months, which was not hypothesized, and for which there was insufficient power to test.) Because the randomization was successful and the groups were balanced on socio-demographic and medical characteristics (Table 1), we did not include covariates in any analyses.

Missing data were imputed using the mean within timepoint and condition and thus, each of the 64 participants contributed three records (baseline, 3-month follow-up, and 6-month follow-up). Numbers of missing values for coping scales, including both unit and item nonresponse, ranged from 0–1 at baseline and 7–8 at 3-month follow-up, and equaled 10 at 6-month follow-up.

Results

Single-Arm Process Evaluation

Exit interviews of the initial 14-person group (that was not included in the pilot RCT) indicated that participants felt very positively about the intervention, with all but one saying that they would recommend the group to other HIV-positive Black sexual minority men. For example, one participant felt that the content was relevant to all minority individuals, not only Black men:

“I would recommend to all men, all Black men living with HIV. I would even offer this to all Black men in general because the experiences and topics that were brought up weren’t just related particularly to gay men or HIV... I would recommend it to like, everybody... every person that’s a minority.”

Participants who recommended the group also said that the group made them more aware of discrimination and how to cope effectively. As expressed by one participant:

“I took a lot out of this group... A lot of positive stuff to carry on for the rest of my life... this was one of the greatest experiences for a group. We all bonded... The group really taught us to think in the moment... And think of the best, positive, most effective solution to come across a problem.”

Several participants said that learning coping skills, especially to counteract anger, was a valuable part of the program. As one participant said:

“ ‘Do unto others as you would have other do unto you’ ... we covered that a great deal. That’s how we need to live our lives, is treat your neighbors kind, and try to be the best person you can possibly be, even if you’re not feeling so well. And that’s where the test comes in—is when you’re having a bad day, and everything seems to be going wrong, it’s hard to try and stay cheerful... You have to have some kind of buffer in place—a safety net that can catch you—in a time when you’re getting ready to face a crisis, and by crisis I mean being on the edge and exploding on somebody and yelling and screaming and losing your temper.”

The facilitators were viewed very positively, as “kind,” “knowledgeable,” “skillful,” and “trustworthy,” and participants noted that the intervention felt culturally sensitive to them, in part because participants were matched in their identities with each other, as well as with the facilitators. In speaking about the facilitators, one participant said, “you can bond with the person more because they know what we’re going through... Because your facilitators are very different than the regular group because they were Black, they was more open. Most groups are White.”

Participants especially liked the “Identity Pie” activity (Adams, Bell, & Griffin, 2007), in which they were asked to divide a circle into different slices based on how big or important each identity was to them:

“The Pie is very good... I like that no one was the same. You might’ve had the same similarities, but everyone was an individual on the percentage on how big of the piece of the pie you filled stuff in. Everyone had African American. Everybody had HIV, or maybe bisexual. But then other things that you had to deal with. That pie is what I liked the most.”

Participants expressed disappointment when the group sessions ended (“because we all got along, it was very sad when we left... it was like a little family”). Several expressed that the group should have lasted longer.

Although participants saw the value of the take-home activities, some had difficulty understanding the take-home activities and, as a result, did not complete them regularly. To help with the understanding of the take-home activities, some participants suggested providing take-home handouts with summaries of each session’s key content and terminology. A handful of participants found the group less useful because they said they were already coping effectively, or they did not experience discrimination themselves.

Three participants did not attend any of the group sessions: Two expressed a desire to attend but were unable to do so because of circumstances beyond their control: One was hospitalized, one had a prior commitment at the same time, and the third had confidentiality concerns because he had only disclosed his HIV-positive serostatus to his romantic partner. One participant only attended two sessions due to health issues, and another only attended five due to a family emergency that resulted in his relocation.

These qualitative data, which showed intervention feasibility and acceptability, were used to refine the intervention for the pilot RCT. In response to participants requesting more information and clarification regarding the take-home activities, the team developed handouts for participants to take home that included key points and definitions from each session (e.g., a list of coping strategies); these handouts were used in the pilot RCT. The team also worked to minimize didactic content and maximize interactive activities and role plays.

Pilot Randomized Controlled Trial

Participant flow—Of the 64 participants recruited, 38 were randomized to the intervention and 26 to the wait-list control group. Of the 64 total participants, all provided baseline data, 58 (91%) provided survey data at 3-month follow, and 56 (88%) provided survey data at 6-month follow-up. The majority (55%) of intervention participants attended at least half of the eight content-based sessions, and the average number of sessions attended was 3.8. Eleven participants did not attend any sessions, but were included in the intent-to-treat analysis. Known reasons for missed sessions included transportation and housing issues. Consistent with CONSORT guidelines, Figure 1 shows participant flow through the intervention and control conditions, and assessments (Schulz, Altman, & Moher, 2010). (Note that, because intervention sessions for the wait-list control group were conducted

several months after control participants had completed the study, only two individuals on the wait-list were interested in and available for participation in the sessions.)

Feedback forms—Overall, participants rated the intervention session positively on feedback forms. On a scale of 1 to 4, in which 4 indicated “strongly agree,” average ratings were very high in terms of liking the session overall [M (SD) = 3.8 (0.6)], feeling comfortable participating in the session [M (SD) = 3.7 (0.6)], thinking that they learned new information and skills [M (SD) = 3.6 (0.6)], and rating the facilitators as helpful at making the session a positive learning experience [M (SD) = 3.8 (0.5)].

Open-ended responses were similarly positive, with enthusiastic feedback about the activities (e.g., the Identity Pie), the discussions (“Intersectionality discussion was very enlightening and helpful”), and the education about coping and the CBT model (“I appreciated the critical linking segment”). Several participants reflected on how they benefitted from the group: “I been using in my daily routine, how to use my emotions, thoughts to better my behavior”; “Now I have sense of awareness and responsibility for my action”; and “Being in the world daily, it is a great feeling knowing we could have a space to be ourselves and make sense out of chaos, preparing us for another day.” When asked what they liked the least, most participants said “nothing” or that they “liked everything.”

Effects of *Still Climbin'* on coping—Compared to control participants, intervention participants showed higher levels of several different types of coping strategy use at follow-up, as indicated by significant intervention $\times$ timepoint interactions for the functional coping subscale (i.e., using cognitions and behaviors to solve a problem) and the humor-based coping strategy subscale from the Brief COPE, and the Cognitive/Emotional Debriefing subscale from the Africultural Coping Inventory (which combines positive reframing, increasing social support, and psychological and physical strategic avoidance; see Table 3). None of the as-treated regressions showed significant effects of number of sessions on coping among intervention participants.

Discussion

Still Climbin' is, to our knowledge, the first systematically evaluated intervention developed specifically to address coping with discrimination from multiple intersectional identities. Although the present study was only a pilot, *Still Climbin'* showed promise in being both feasible and highly acceptable (as evidenced by overwhelmingly positive participant feedback) and improving coping among HIV-positive Black sexual minority men. The intervention was created with extensive input from community stakeholders, including HIV-positive Black sexual minority men and healthcare and social service providers who work with that population, ensuring high acceptability and relevance to the men.

Still Climbin' led to improved functional coping, as well as self-protective coping strategies, including affiliation with others, strategic avoidance of discrimination, and positive reframing—coping strategies that are hypothesized to have been developed by Black/African American individuals in response to centuries of racial oppression (Utsey et al., 2000). The intervention did not affect culturally relevant coping strategies related to collective coping

(e.g., relying on family members for emotional support) or religious coping (e.g., going to church, religious rituals). Such forms of coping may be less available to Black/African American individuals with intersectional identities related to being HIV-positive and engaging in same-sex sexual behaviors, which may be stigmatized by family members, friends, or within religious communities.

Still Climbin' included psychoeducation about the CBT model and skills training in traditional CBT and DBT strategies (O'Donohue et al., 2004; Pantalone et al., 2009), such as behavioral analysis, self-monitoring, cognitive restructuring, in vivo rehearsal, and planning for skills generalization into the natural environment, uniquely applied to past and imagined future experiences of coping with discrimination. In a closed group format, cohorts of participants explored their identities together, confided in each other about the discrimination experiences they faced and those that they feared—and provided support, validation, and coaching for how they could cope better in the future—while acknowledging the injustice of how they should not have to be learning to cope with such experiences in the first place. One of the strengths of this intervention in terms of scalability is the use of standard CBT strategies, which are well-known to clinicians and taught routinely in mental health training programs.

Some of the strategies improved by the intervention included psychological and physical strategic avoidance (e.g., not thinking about the event, using humor as a distraction, physical avoidance of places and people anticipated to be discriminatory). Although avoidant coping strategies can lead to worse mental health outcomes (Moskowitz et al., 2009), avoidant strategies may be adaptive when used strategically, such as when behaviors are constrained by situations in which there is a power imbalance and a high probability of potentially negative consequences. For example, when individuals experience discrimination by people of higher status and power (such as employers, landlords, or law enforcement officers), their safety or life stability may be at risk—and actively addressing the situation when they are highly distressed may not be prudent. Prior qualitative research with Black MSM has uncovered stories of discrimination (e.g., physical abuse) by police and by prison guards (Bogart et al., 2016), situations in which resistance in a given moment could have harmful long-term effects. Thus, rather than teaching participants strict decision rules, or that only specific coping strategies should be used, our intervention aimed to teach a flexible and contextual approach to coping skill selection, so that participants could learn how to distinguish situations in which active behaviors might be less adaptive than avoidance to maintain self-preservation.

When interpreting the present study's results, it is important to take into account the larger societal context during which this study was conducted. The first group was conducted in the summer of 2014, shortly after a widely circulated video showed the death of Eric Garner, a Black man who died after being put in a chokehold by the police in Staten Island, NY (Goldstein & Scheweber, July 19, 2014). Although the medical examiner ruled his death a homicide, and the NY Police Department prohibits the use of chokeholds, the police officer was not indicted, leading to national protests. Other similar, high-profile videos of police killings of Black men around the U.S. surfaced during the study, and more protests ensued. As a result, intervention group discussions tended to focus on racism (both within the men's

own lives and in terms of processing the impact of these national events) more than on discrimination due to other stigmatized identities, including HIV or sexual minority status. Because discrimination based on different identities may lead to distinct forms of coping (Bogart et al., 2016), the results of this study may have been different if the groups had primarily focused on coping with discrimination from their HIV-serostatus or sexual minority status, or if the study occurred in a different sociopolitical context.

Other limitations of this study should be recognized. Although our pilot showed feasibility of recruitment, randomization, and follow-up assessments, retention was relatively low in the group sessions, and participants did not consistently complete the take-home activities. Competing life demands and structural issues, including health, transportation, and housing issues, made group attendance difficult for some of the men. Future research should investigate the potential for alternate intervention structures (e.g., fewer group meetings, online or phone-based meetings) that would allow participants to benefit from group camaraderie and support without requiring as large an in-person commitment; in addition, text messages and check-in calls with staff might help men remain engaged in the intervention and increase the focus on take-home activities between sessions. In addition, although the intervention affected coping responses that have been associated with health outcomes (Moskowitz et al., 2009), we did not have the resources in this trial to assess the longer-term duration of the coping effects or the intervention's effects on markers of physical health and functioning. Further, the majority of men in the study were virally suppressed at baseline which, combined with the small sample size, would have limited our ability to determine effects on viral suppression. Future research could test whether the observed effects on coping are sustained over time and whether effects on coping, in turn, lead to mental and physical health improvements. For example, discrimination has been associated with HIV medication nonadherence in prior research (Bogart et al., 2010) and, thus, improving coping with discrimination may also improve adherence. Finally, we only tested the intervention with HIV-positive Black sexual minority men, although the intervention has the potential for adaptation to other groups who experience discrimination from intersecting identities, including Black sexual minority men who are HIV-negative. The intervention could be introduced as part of an array of interventions for Black men regardless of HIV status, as unhelpful coping with discrimination may affect health outcomes via risky sexual behaviors as well as treatment nonadherence.

In conclusion, our pilot group therapy intervention showed feasibility and acceptability, and favorable effects on coping among Black sexual minority men living with HIV, a group highly affected by health disparities. Despite our promising results, individual-level interventions are insufficient in tackling the myriad ways that discrimination affects health. Complementary structural-level interventions are needed in tandem that address social determinants of health disparities such as inequitable treatment in health care, residential racial segregation, and income inequality.

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References

- Adams M, Bell LA, Griffin P. Teaching for diversity and social justice. 2. New York: Routledge; 2007.
- Arkowitz H, Miller WR, Rollnick S. Motivational interviewing in the treatment of psychological problems. Guilford Publications; 2015.
- Bedoya CA, Dale SK, Ehlinger PP. Cultural competence within behavioral medicine: Culturally competent CBT with diverse medical populations The Massachusetts General Hospital handbook of behavioral medicine. Springer; 2017. 321–334.
- Bieling PJ, McCabe RE, Antony MM. Cognitive-behavioral therapy in groups. Guilford Press; New York: 2006.
- Bogart LM, Wagner GJ, Galvan FH, Klein DJ. Longitudinal relationships between antiretroviral treatment adherence and discrimination due to HIV-serostatus, race, and sexual orientation among African-American men with HIV. *Annals of Behavioral Medicine*. 2010; 40(2):184–190. DOI: 10.1007/s12160-010-9200-x [PubMed: 20552416]
- Bogart LM, Wagner GJ, Galvan FH, Landrine H, Klein DJ, Sticklor LA. Perceived discrimination and mental health symptoms among Black men with HIV. *Diversity and Ethnic Minority Psychology*. 2011; 17(3):295–302. DOI: 10.1037/a0024056
- Bogart LM, Landrine H, Galvan FH, Wagner GJ, Klein DJ. Perceived discrimination and physical health among HIV-positive Black and Latino men who have sex with men. *AIDS and Behavior*. 2013; 17(4):1431–1441. DOI: 10.1007/s10461-012-0397-5 [PubMed: 23297084]
- Bogart LM, Dale SK, Christian J, Patel K, Daffin GK, Mayer KH, Pantalone DW. Coping with discrimination among HIV-positive Black men who have sex with men. *Culture, Health & Sexuality*. 2016; 19(7):723–737.
- Brewster ME, Moradi B, DeBlaere C, Velez BL. Navigating the borderlands: The roles of minority stressors, bicultural self-efficacy, and cognitive flexibility in the mental health of bisexual individuals. *Journal of Counseling Psychology*. 2013; 60(4):543. [PubMed: 23815628]
- Brondolo Rieppi R, Kelly KP, Gerin W. Perceived racism and blood pressure: A review of the literature and conceptual and methodological critique. *Annals of Behavioral Medicine*. 2003; 25(1):55–65. DOI: 10.1207/s15324796abm2501_08 [PubMed: 12581937]
- Brondolo, Ver Halen NB, Pencille M, Beatty D, Contrada RJ. Coping with racism: A selective review of the literature and a theoretical and methodological critique. *Journal of Behavioral Medicine*. 2009; 32(1):64–88. DOI: 10.1007/s10865-008-9193-0 [PubMed: 19127420]
- Carrico AW, Antoni MH, Durán RE, Ironson G, Penedo F, Fletcher MA, Schneiderman N. Reductions in depressed mood and denial coping during cognitive behavioral stress management with hiv-positive gay men treated with HAART. *Annals of Behavioral Medicine*. 2006; 31(2):155–164. [PubMed: 16542130]
- Carter RT, Forsyth J. Reactions to racial discrimination: Emotional stress and help-seeking behaviors. *Psychological Trauma: Theory, Research, Practice, and Policy*. 2010; 2(3):183.
- Carver CS. You want to measure coping but your protocol is too long: Consider the Brief COPE. *International Journal of Behavioral Medicine*. 1997; 4(1):92. [PubMed: 16250744]
- Centers for Disease Control and Prevention. HIV surveillance report, 2009. 2011. Retrieved from http://www.cdc.gov/hiv/pdf/statistics_2009_hiv_surveillance_report_vol_21.pdf
- Centers for Disease Control and Prevention. HIV surveillance report, 2015. 2016. Retrieved from <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>
- Chesney MA, Chambers DB, Taylor JM, Johnson LM, Folkman S. Coping effectiveness training for men living with HIV: Results from a randomized clinical trial testing a group-based intervention. *Psychosomatic Medicine*. 2003; 65(6):1038–1046. [PubMed: 14645783]
- Clark R, Anderson NB, Clark VR, Williams DR. Racism as a stressor for African Americans: A biopsychosocial model. *American Psychologist*. 1999; 54(10):805–816. DOI: 10.1037/0003-066X.54.10.805 [PubMed: 10540593]
- Cohen J. A coefficient of agreement for nominal scales. *Educational and Psychological Measurement*. 1960; 20(1):37–46. DOI: 10.1177/001316446002000104
- Cohen S. Psychosocial models of the role of social support in the etiology of physical disease. *Health Psychology*. 1988; 7(3):269–297. [PubMed: 3289916]

- Comrey AL, Lee HB. A first course in factor analysis. Psychology Press; 2013.
- Crepaz N, Passin WF, Herbst JH, Rama SM, Malow RM, Purcell DW, Wolitski RJ. Meta-analysis of cognitive-behavioral interventions on HIV-positive persons' mental health and immune functioning. *Health Psychology*. 2008; 27(1):4–14. DOI: 10.1037/0278-6133.27.1.4 [PubMed: 18230008]
- Crepaz N, Dong X, Wang X, Hernandez AL, Hall HI. Racial and ethnic disparities in sustained viral suppression and transmission risk potential among persons receiving HIV care—United States, 2014. *Morbidity and Mortality Weekly Report*. 2018; 67(4):113. [PubMed: 29389918]
- Crocker J, Major B, Steele C. Social stigma. In: Gilbert DT, Fiske ST, Lindzey G, editors *Handbook of social psychology*. 4th ed. Vol. 1. New York: McGraw-Hill; 1998. 504–553.
- Dimidjian S, Linehan MM. Mindfulness practice. General principles and empirically supported techniques of cognitive behavior therapy. 2009:425.
- Earnshaw VA, Bogart LM, Dovidio JF, Williams DR. Stigma and racial/ethnic HIV disparities: Moving toward resilience. *American Psychologist*. 2013; 68(4):225–236. DOI: 10.1037/a0032705 [PubMed: 23688090]
- Elligan D, Utsey S. Utility of an African-centered support group for African men confronting societal racism and oppression. *Cultural Diversity and Ethnic Minority Psychology*. 1999; 5(2):156–165. DOI: 10.1037/1099-9809.5.2.156 [PubMed: 15605685]
- Ellis A. Cognitive restructuring of the disputing of irrational beliefs. *Cognitive behavior therapy: Applying empirically supported techniques in your practice*. 2003:79–83.
- Ferguson KE, Sgambati RE. 54 relaxation. *Cognitive Behavior Therapy*. 2009:434.
- Goldstein J, Scheweber N. Man's death after chokehold raises old issue for the police. Vol. 7. *The New York Times*; Jul 19, 2014 18
- Goodkin K, Blaney NT, Feaster D, Fletcher MA, Baum MK, Mantero-Atienza E, Eisdorfer C. Active coping style is associated with natural killer cell cytotoxicity in asymptomatic HIV-1 seropositive homosexual men. *Journal of Psychosomatic Research*. 1992; 36(7):635–650. [PubMed: 1403998]
- Hatzenbuehler ML. How does sexual minority stigma “get under the skin”? A psychological mediation framework. *Psychological Bulletin*. 2009; 135(5):707. [PubMed: 19702379]
- Heidt JM, Marx BP. 53 self-monitoring as a treatment vehicle. *Cognitive behavior therapy: Applying empirically supported techniques in your practice*. 2004:361.
- Hughes L. Mother to son. In: Rampersad A, Roessel D, editors *The collected poems of Langston Hughes*. New York: Alfred A. Knopf, Inc; 1994.
- Kaiser HF. The application of electronic computers to factor analysis. *Educational and Psychological Measurement*. 1960; 20(1):141–151.
- Krägeloh CU. A systematic review of studies using the Brief COPE: Religious coping in factor analyses. *Religions*. 2011; 2(3):216–246.
- Landrine H, Klonoff EA. The schedule of racist events: A measure of racial discrimination and a study of its negative physical and mental health consequences. *Journal of Black Psychology*. 1996; 22(2):144–168. DOI: 10.1177/00957984960222002
- Linehan MM. *Skills training manual for treating borderline personality disorder*. Guilford Press; New York: 1993.
- Lutgendorf SK, Antoni MH, Ironson G, Klimas N, Kumar M, Starr K, Schneiderman N. Cognitive-behavioral stress management decreases dysphoric mood and herpes simplex virus-type 2 antibody titers in symptomatic HIV-seropositive gay men. *Journal of Consulting and Clinical Psychology*. 1997; 65(1):31. [PubMed: 9103732]
- Mellor D. Responses to racism: A taxonomy of coping styles used by Aboriginal Australians. *American Journal of Orthopsychiatry*. 2004; 74(1):56. [PubMed: 14769109]
- Meyer IH. Minority stress and mental health in gay men. *Journal of Health and Social Behavior*. 1995; 36(1):38–56. DOI: 10.2307/2137286 [PubMed: 7738327]
- Moore CG, Carter RE, Nietert PJ, Stewart PW. Recommendations for planning pilot studies in clinical and translational research. *Clinical and translational science*. 2011; 4(5):332–337. [PubMed: 22029804]

- Moskowitz JT, Hult JR, Bussolari C, Acree M. What works in coping with HIV? A meta-analysis with implications for coping with serious illness. *Psychological Bulletin*. 2009; 135(1):121–141. DOI: 10.1037/a0014210 [PubMed: 19210056]
- Mulder C, Antoni M, Duivenvoorden H, Kauffmann R, Goodkin K. Active confrontational coping predicts decreased clinical progression over a one-year period in HIV-infected homosexual men. *Journal of Psychosomatic Research*. 1995; 39(8):957–965. [PubMed: 8926605]
- Newman CF. Cognitive restructuring: Identifying and modifying maladaptive schemas. *Cognitive behavior therapy: Applying empirically supported techniques in your practice*. 2004:89.
- O’Cleirigh C, Dale SK, Elsesser S, Pantalone DW, Mayer KH, Bradford JB, Safren SA. Sexual minority specific and related traumatic experiences are associated with increased risk for smoking among gay and bisexual men. *Journal of Psychosomatic Research*. 2015; 78(5):472–477. [PubMed: 25754971]
- O’Donohue WT, Fisher JE, Hayes SC. *Cognitive behavior therapy: Applying empirically supported techniques in your practice*. Hoboken, NJ: John Wiley & Sons; 2004.
- Pantalone DW, Iwamasa GY, Martell CR. Cognitive-behavioral therapy with diverse populations. *Handbook of cognitive-behavioral therapies*. 2009:445–464.
- Pascoe EA, Smart Richman L. Perceived discrimination and health: A meta-analytic review. *Psychological Bulletin*. 2009; 135(4):531–554. DOI: 10.1037/a0016059 [PubMed: 19586161]
- Rizvi SL, Ritschel LA. Mastering the art of chain analysis in dialectical behavior therapy. *Cognitive and Behavioral Practice*. 2014; 21(3):335–349. DOI: 10.1016/j.cbpra.2013.09.002
- Rood BA, McConnell EA, Pantalone DW. Distinct coping combinations are associated with depression and support service utilization in men who have sex with men living with HIV. *Psychology of Sexual Orientation and Gender Diversity*. 2015; 2(1):96. [PubMed: 26042226]
- Ryan GW, Bernard R. Data management and analysis methods. In: Denzin NK, Lincoln YS, editors *Handbook of qualitative research*. 4 ed. Thousand Oaks, CA: Sage Publications; 2011. 796–802.
- Schulz KF, Altman DG, Moher D. Consort 2010 statement: Updated guidelines for reporting parallel group randomised trials. *BMC Medicine*. 2010; 8(1):18. [PubMed: 20334633]
- Scott-Sheldon LAJ, Kalichman SC, Carey MP, Fielder RL. Stress management interventions for HIV+ adults: A meta-analysis of randomized controlled trials, 1989 to 2006. *Health Psychology*. 2008; 27(2):129–139. DOI: 10.1037/0278-6133.27.2.129 [PubMed: 18377131]
- Simoni JM, Huh D, Wilson IB, Shen J, Goggin K, Reynolds NR, Liu H. Racial/ethnic disparities in ART adherence in the United States: Findings from the MACH14 study. *Journal of Acquired Immune Deficiency Syndromes*. 2012; 60(5):466–472. DOI: 10.1097/QAI.0b013e31825db0bd [PubMed: 22595873]
- Stirratt MJ, Meyer IH, Ouellette SC, Gara MA. Measuring identity multiplicity and intersectionality: Hierarchical classes analysis (HICLAS) of sexual, racial, and gender identities. *Self and Identity*. 2007; 7(1):89–111. DOI: 10.1080/15298860701252203
- Thrasher AD, Earp JAL, Golin CE, Zimmer CR. Discrimination, distrust, and racial/ethnic disparities in antiretroviral therapy adherence among a national sample of HIV-infected patients. *Journal of Acquired Immune Deficiency Syndromes*. 2008; 49(1):84–93. DOI: 10.1097/QAI.0b013e3181845589 [PubMed: 18667919]
- Uchino BN, Cacioppo JT, Kiecolt-Glaser JK. The relationship between social support and physiological processes: A review with emphasis on underlying mechanisms and implications for health. *Psychological Bulletin*. 1996; 119(3):488–531. [PubMed: 8668748]
- Utsey SO, Adams EP, Bolden M. Development and initial validation of the Africultural Coping Systems Inventory. *Journal of Black Psychology*. 2000; 26(2):194–215.
- Williams DR, Mohammed SA. Discrimination and racial disparities in health: Evidence and needed research. *Journal of Behavioral Medicine*. 32(1):20–47. DOI: 10.1007/s10865-008-9185-0
- Wilton L, Herbst JH, Coury-Doniger P, Painter TM, English G, Alvarez ME, Carey JW. Efficacy of an HIV/STI prevention intervention for Black men who have sex with men: Findings from the Many Men, Many Voices (3mv) project. *AIDS and Behavior*. 2009; 13(3):532–544. DOI: 10.1007/s10461-009-9529-y [PubMed: 19267264]

Wong CF, Schrager SM, Holloway IW, Meyer IH, Kipke MD. Minority stress experiences and psychological well-being: The impact of support from and connection to social networks within the Los Angeles house and ball communities. *Prevention Science*. 2014; 15(1):44–55. DOI: 10.1007/s11121-012-0348-4 [PubMed: 23412944]

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Figure 1.
CONSORT Flow Diagram of *Still Climbin'* Pilot Intervention Test

Table 1

Participant Socio-demographic and Medical Characteristics by Intervention Group (N = 64)

	Control n = 26	Intervention n = 38
Socio-Demographic Characteristics		
Age [M(SD)]	46.3 (13.3)	46.2 (12.6)
Low education (HS grad) (%)	12%	11%
Employed (full- or part-time) (%)	31%	26%
Low income (< \$10,000 annually) (%)	56%	59%
Stable housing (%)	65%	66%
Ever incarcerated (%)	50%	47%
In committed relationship (%)	21%	21%
Heterosexual (%)	0%	5%
Medical Characteristics		
Ever received HIV care	96%	89%
Received HIV care in last 6 months	96%	87%
Viral load undetectable (%)	73%	71%
Currently taking antiretroviral medications (%)	81%	87%
Years since HIV diagnosis [M(SD)]	18.9 (15.1)	16.5 (9.6)

Note: The intervention and control groups did not significantly differ on any socio-demographic or medical characteristics, based on Fisher's Exact test for dichotomous characteristics or t-tests for continuous characteristics (all p-values > 0.20).

Table 2*Still Climbin' Intervention Content*

Session	Goalse	Take-Home Activity
1. Orientation to the Group, Identity Pie Activity, and Discussion about Discrimination	<ul style="list-style-type: none"> • Orient group members to group/ground rules • Build group cohesion • Discuss how discrimination affects group members' lives • Describe most important identities 	<u>Tracking Discrimination</u> : Describe any discrimination experiences from race/ethnicity, sexual orientation, and/or HIV-serostatus
2. Discussion of Multiple Identities & Coping with Discrimination	<ul style="list-style-type: none"> • Discuss men's experiences living with multiple stigmatized identities • Evaluate coping as effective or ineffective 	<u>Tracking Discrimination</u> : Same as prior week, and also describe coping responses
3. Introduction to Ways to Understand Discrimination and Coping with Discrimination I	<ul style="list-style-type: none"> • Introduce group members to the CBT model • Discuss how to apply CBT model (and chain analysis) to discrimination 	<u>Tracking Discrimination</u> : Same as prior week
4. Ways to Understand Discrimination and Coping with Discrimination II	<ul style="list-style-type: none"> • Gain further knowledge and experience on understanding discrimination experiences • Define and identify critical links and vulnerability and resilience factors 	<u>Tracking Discrimination</u> : Same as prior week, and add identification of vulnerability and resilience factors
5. Ways to Understand Discrimination and Coping with Discrimination III	<ul style="list-style-type: none"> • Identify barriers to effectively coping with discrimination experiences (e.g., internalized stigma and power differentials with perpetrators, such as law enforcement) • Brainstorm and learn strategies for overcoming those barriers 	<u>Tracking Discrimination</u> : Same as prior week
6. Investigating Medical Mistrust	<ul style="list-style-type: none"> • Orient group members to mistrust as an expectable consequence of discrimination 	<u>Tracking Discrimination</u> : Same as prior week and describe role of mistrust
7. Getting the Social Support You Need	<ul style="list-style-type: none"> • Describe support that group members have • Strategize about how to get support for whole self, across identities 	<u>Tracking Discrimination</u> : Same as prior week
8. Addressing Structural Discrimination and Review	<ul style="list-style-type: none"> • Discuss ways to take action and advocate for change through changing societal structures • Review progress 	<u>Prepare for Graduation</u> : Reflect on what was learned, what changes were made, and what will be remembered
9. Graduation	<ul style="list-style-type: none"> • Describe how to practice after group ends 	N/A

Table 3

Linear Repeated Measures Regressions Testing Effects of *Still Climbin'* on Coping from Baseline to 3- and 6-Month Follow-Up (N = 64; 38 intervention and 26 control)

Coping Measure	b (SE)	p-value
Africultural Coping		
Cognitive/Emotional Debriefing	0.30 (0.14)	0.04
Collective	0.22 (0.15)	0.13
Ritual-Centered	0.24 (0.19)	0.21
Spiritual-Centered	0.18 (0.13)	0.19
Brief COPE		
Denial	−0.12 (0.21)	0.56
Functional coping	0.39 (0.19)	0.04
Humor	0.48 (0.22)	0.03
Religion	0.02 (0.21)	0.92
Self-blame	0.19 (0.24)	0.43
Social support/venting	0.04 (0.19)	0.81
Substance use	−0.18 (0.22)	0.41