

Radical Healing Community-Based Participatory Research to Eliminate Health Disparities^Ψ

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Abstract

The health disparities experienced by Black older adults are associated with social determinants of health, all of which are inextricably linked to anti-Black racism. Research led by counseling psychologists has implications for promoting mental and physical health equity. We describe a new model, based on the integration of the radical healing framework and the community-based participatory research (CBPR) approach, for promoting mental and physical health and wellness among Black older adults. This model is called the radical healing CBPR model. Finally, we provide an example of a program informed by this model that helped improve the health outcomes and quality of life of Black older adults living in the low-income area of a city in the southeastern part of the United States. Notably, Black adults similar to the program participants, participated in the development and implementation of this program in ways that are consistent with the radical healing CBPR model.

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Keywords

health disparities, health equity, anti-Black racism, antiracism, CBPR

Significance of the Scholarship to the Public

Eliminating health disparities calls for research for, by, and about communities of Color that de-centers Whiteness in content and process. We propose a model for eliminating the health disparities that impact Black older adults that integrates the radical healing framework and the community-based participatory research (CBPR) approach—a model we call the radical healing CBPR model. We provide an example and suggestions for applying this model.

COVID-19 has disproportionately impacted Black older adults, who, by the time the pandemic hit, were already affected by several other health disparities (defined as, “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage”; [Office of Disease Prevention and Health Promotion, n.d.](#)). Black older adults are three times more likely to be hospitalized and twice as likely to die from COVID-19 than non-Hispanic White (NHW) older adults ([Centers for Disease Control and Prevention, 2022a](#)). Black older adults also have a disproportionate COVID-19 cumulative mortality burden ([Gawthrop, 2023](#)). Although Black Americans ages 65 to 74 years account for 10% of the people living in the United States, they represent 18% of COVID-19 deaths where race is known ([National Center for Health Statistics, 2023](#)).

Several explanations for the differential impact of COVID-19 exist. Although disparities in COVID-19 vaccination rates have narrowed over time, Black people are less likely to be vaccinated than their NHW counterparts ([Ndugga et al., 2022](#)). Among older adults, hesitancy to get a COVID vaccination is highest among Black Americans, who report mistrust of the vaccine infrastructure ([Shapiro et al., 2023](#)). Factors like racial residential segregation, poverty, and multigenerational households elevate Black older adults' risk for COVID-19 ([Chatters et al., 2020](#)). In addition, vulnerability to the coronavirus in Black older adults could be linked to their being more burdened by immunocompromising health conditions ([Hill Golden, 2020](#)), which are based on social and economic disadvantage that are exacerbated by “the virus of racism” ([Alvarez et al., 2016](#); [Hill Golden, 2020](#)). Indeed, racism often shares common characteristics of a virus, which include being invisible, having a detrimental effect such as corrupting systems (e.g., health care delivery systems), and being a common cause of disease (e.g., hypertension due to racism-related stress). As COVID-19 unfolds, counseling psychologists and the United States in

general are also reckoning with anti-Black racism and White supremacy (Wilcox, 2022).

The health disparities affecting Black older adults are entrenched in what liberation theologians and psychologists have referred to as *structural violence*, i.e., the “avoidable impairment of fundamental human needs” (Galtung, 1993, p. 106) that is historical and pervasive in that it is embedded in longstanding “ubiquitous social structures, normalized by stable institutions and regular experience” (Gilligan, 1997, p. 306). Racism and the exploitation of Black communities, both often the consequence of White supremacist ideologies, are intertwined to expose Black Americans to environmental hazards, insufficient funding for resources like education and recreation, limited food options, and poor access to health care that perpetuate their morbidity and their mortality (Sharif et al., 2022). This liberation theology and psychology framework is central to Black psychology and the radical healing framework (French et al., 2020). The radical healing framework serves as a solid conceptual foundation for research by and about communities of Color that resists structural violence and promotes health and wellness.

Eliminating the health disparities impacting Black Americans requires understanding and addressing the legacy of continued material and ideological colonization, exploitation, and domination that oppresses them (Azibo, 1994; Comas-Días & Torres Rivera, 2020). Counseling psychologists are increasingly taking on important roles in expanding work on racial trauma and how it impacts health outcomes, and in building a new health care infrastructure that is less racist (Hargons et al., 2017; Mosley et al., 2021). One avenue to build this new health and health care infrastructure is community-based participatory research (CBPR), which, based on the definition by the W. K. Kellogg Foundation (2009), “begins with a research topic of importance to the community with the aim of combining knowledge and action for social change to improve community health and eliminate health disparities” (An Effective Approach to Understanding Communities section, para. 1).

Literature Review

Health Disparities

The high prevalence among Black older adults of the most common health disparity diseases (e.g., hypertension) are just as intractable as the virus of racism in general and the virus of anti-Black racism in particular. In addition, Black older adults are likely to report fair or poor quality of life (Thorpe et al., 2012) and have higher rates of chronic health conditions than NHWs (Adomako, 2018; Hargrave, 2010).

Racism also has an impact on Black Americans’ quality of life (Carter, 2007; Pieterse et al., 2012) and mental health in general (Paradies et al., 2015;

Pieterse et al., 2012; Williams, 2018). For Black older adults, race-related stress accumulates over the lifespan and is relived with each experience of racism and/or discrimination (Adomako, 2018; Hargons et al., 2017). Exposure to racism increases rates of mental illness such as chronic anxiety and depression, and dementia (Adomako, 2018). Although research in this area is limited, mental health concerns among many Black older adults during COVID-19 were likely heightened because of social isolation, which was higher among Black older adults than their NHW counterparts (Chatters et al., 2020) and a primary driver of Black older adults' quality of life.

Racism at the Root of Health Disparities

Structural factors shaping health and health outcomes, also known as "social determinants of health," are defined by the World Health Organization (2022) as the conditions in which people are born, grow, work, live, and age, and the wider set of economic policies and systems, development agendas, social norms and policies, and political systems that shape people's lives and influence their health outcomes. NHWs have historically controlled the policies that underlie these social determinants of health. The radical healing framework centers the fact that anti-Black racism is a major factor in the social determinants of health disproportionately leading to the higher prevalence of negative health outcomes among Black communities (American Public Health Association, 2021).

Systemic racism in health care is also a social determinant of health. Black older adults are more likely than NHWs to avoid healthcare due to cost (United Health Foundation, 2021) and to carry medical debt, which is linked to decreased use of health services (Perry et al., 2021). In addition, Black older adults are underdiagnosed and undertreated for mental health conditions that are largely a consequence of racism and other stressors (Taylor & Chatters, 2020).

Even when care is available and accessed, in their care, Black Americans often experience race-based traumatic stress or racial trauma, i.e., psychological, emotional, and physical injury from real and perceived racism (Bryant-Davis, 2007; Carter, 2007). In psychotherapy, a traditionally NHW space, anti-Black racism is often overlooked or, even worse, denied (Bartholomew et al., 2021; Wilcox, 2022). Interpersonal mistreatment by healthcare professionals (e.g., microaggressions and implicit bias) informs the quality of care received by many Black patients and whether they remain in treatment.

Among Black Americans, high levels of perceived racism are associated with delayed and missed care (Boyd et al., 2020). Older adults who experience racial discrimination have greater health care needs and are more prone to have feelings of social isolation, report material hardships, and be dissatisfied with their care than older adults who do not experience discrimination (Doty et al., 2022). Boyd et al. (2020) posited that "the solution to racial health

inequities is to address racism and its attendant harms and erect a new health care infrastructure that no longer profits from the persistence of inequitable disease” (para. 10). This new health care infrastructure would warrant Black Americans consistent access to the support they need to reach health and wellness more easily.

The Role of Counseling Psychologists in Community-Based Participatory Research

Counseling psychologists have been a bastion of resistance to anti-Black racism (Hargons et al., 2017) and are uniquely positioned to support what Nobel Laureate Amartya Sen called the “removal of major sources of unfreedom” (Sen, 1999, p. 1) to promote Black health and health equity broadly. Counseling psychologists are trained in multiple social justice areas, including developing and sustaining equitable, strength-based CBPR collaborations for the purpose of reducing and eventually eliminating health disparities, and promoting both physical and mental health (Nilsson et al., 2019; O’Leary Wiley, 2021; Tucker et al., 2019). The pervasive nature of anti-Black racism and its direct effect on the health of Black older adults make CBPR that is focused on reducing anti-Black racism and promoting health and/or health care justice a necessary endeavor for counseling psychologists. Yet, moving forward means grappling with the field’s own collective internalized White supremacist patriarchal capitalism as a profession (Wilcox, 2022).

Community Based Participatory Research as a Response to Racism in Research

Although research by counseling health psychologists and other health researchers has the potential to reduce health disparities and improve health in Black communities and other communities of Color, racism and cultural insensitivity in research undermine the participation of minority communities (American Psychological Association [APA], 2021). Manifestations of racism in research include: (a) not naming structural racism in the titles, abstracts, or body of health research (Boyd et al., 2020; Hardeman et al., 2018); (b) the exploitation of Black communities through “helicopter research” (i.e., researchers arriving, collecting data, and leaving); (c) using the deficit model research approach, which is using NHWs as the reference group for Black performance and noting group differences as “deficits” among Black Americans (Srinivasan & Williams, 2014); (d) failing to engage Black community members as research partners (Hawkins et al., 2022); (e) not adequately sharing grant funding with or disseminating results among community partners and target communities; (f) providing low or no compensation to Black community research participants and assistants (Nipp et al.,

2019; Whyte, 2021); (g) using research measures and tools focused on racial minorities that were developed using all or nearly all NHW samples; (h) not fostering sustainability of effective interventions for Black Americans; and (i) interpreting findings from studies focused on Black communities without input from members of these communities.

Multiple examples of racism in health research exist. An often-cited example is the Tuskegee Study conducted by the U.S. Public Health Service between 1930 and 1972 to track the full progression of syphilis. In this study, researchers provided no effective healthcare to the tracked Black participants with syphilis, who as a result suffered serious health problems, including blindness, mental health conditions, and even death (Center for Disease Control, 2022b). The Tuskegee Study has harbored mistrust of research and the healthcare system among Black Americans; yet, the study received support from researchers even in the 21st Century (Paul & Brookes, 2015; White, 2000). Even though the ethical failures of the Tuskegee Study resulted in the creation of Institutional Review Boards to protect participants in research, often such boards have had looser rules for research conducted in impoverished settings (Farmer, 2005).

When ethically executed and theoretically anchored, CBPR represents an avenue to eliminate racism from research. CBPR is a collective, reflective, and systematic inquiry in which scientific researchers and community stakeholders partner equitably, sharing their expertise and decision-making with the purpose of educating, improving practice, and/or bringing about social change (Jull et al., 2017; National Institute on Minority Health and Health Disparities, 2018; Tremblay et al., 2018; Tucker et al., 2017). Some key features of CBPR are that it (a) recognizes the community as a unit of identity; (b) capitalizes on the strengths and resources of the community; (c) promotes co-learning among academic, professional, and community member research partners; (d) balances research and actions to make them mutually beneficial to academics and the community; (e) emphasizes the relevance of problems as defined by the community; (f) adopts a cyclical and iterative process to initiate and sustain community research partnerships; (g) shares knowledge acquired from CBPR to any and all involved partners; and (h) requires a long-term commitment on the part of all partners (Israel et al., 2003). In this way, CBPR lies at the nexus of academia and activism (Collins et al., 2018), and incorporates strategies that build on existing individual and community strengths to promote resilience and well-being (French et al., 2019).

Radical Healing to Address Health Disparities

Conceptual Foundation. The psychological framework of radical healing, introduced by French et al. in 2020, provides the conceptual foundation for a research approach by and about communities of Color that de-centers Whiteness

in content and process. Radical healing is rooted in health-promoting practices that combine components of liberation psychology, Black psychology, intersectionality, and ethnopological psychology. In this context, *radical* refers to getting to the root causes, such as racism, of particular phenomena, such as the health disparities experienced by Black older adults (Neville, 2022). Radical healing CBPR has the potential to improve the health of marginalized communities, e.g., Black older adults, in the context of systemic racism (French et al., 2020; Mosley et al., 2020; Neville & Cross, 2017).

Radical healing involves healing racial trauma, moving towards freedom and restoration, and becoming whole by resisting the oppressive conditions that caused these identity-based wounds (Adames et al., 2022; French et al., 2020; Ginwright, 2010; Mosley et al., 2020). Thus, the concept of radical healing refers to individuals and communities recognizing the structural barriers to their health and well-being and committing to a plan of action to fight oppression (Cross, 1971; Ginwright, 2010, 2018). Counseling psychologists can play an important role in supporting this fight for liberation and strengthening community resilience.

Key Elements. Radical healing has five critical components: (a) critical consciousness, (b) radical hope, (c) strength and resistance, (d) cultural authenticity and self-knowledge, and (e) collectivism. *Conscientização*, or critical consciousness, is a term conceived by Brazilian educator Paulo Freire in the 1960s (Freire, 1963). Critical consciousness refers to the dialectical process of (a) reaching an in-depth understanding (critical reflection) of the world and its oppressive forces as anchored in one's lived knowledge; and (b) taking individual collective action against these oppressive elements with a sense of political efficacy and hope for a new set of better possibilities, or *radical hope* (Comas-Días & Torres Rivera, 2020; Freire, 2000; Neville, 2022). The critical consciousness framework prepares people to target inequity, which is at the core of health disparities, rather than solely concentrating on symptoms of inequity (Jemal, 2018). For example, Black older adults may use critical consciousness to identify, understand, and challenge inequitable policies in the healthcare system and act to change them.

In line with the concept of radical hope, Czech dissident Václav Havel (Hvížďala & Havel, 1991) referred to hope as “an orientation of the spirit, an orientation of the heart; it transcends the world that is immediately experienced and is somewhere beyond its horizons” (p. 181). In more recent counseling psychology literature, radical hope has been defined as “the steadfast belief in the collective capacity contained within Communities of Color to heal and transform oppressive forces into a better future despite the overwhelming odds” (Mosley et al., 2020, p. 3). Radical hope is based on the belief that a better future is possible, and is fueled by seeing tangible change in

one's environment occur as a result of collective effort. This radical hope is a prerequisite to healing in the context of seemingly insurmountable challenges as it allows for the envisioning of new possibilities (Ginwright, 2011).

Healing occurs when Black individuals expand their critical consciousness and use their *strength* (individual and collective, ancestral and present) to act on the desire to live joy-filled lives and engage in active resistance to racial trauma (French et al., 2020). *Cultural authenticity and self-knowledge* build on the psychology of identity development and indigenous healing practices to reject colonized knowledge and practices and to center ancestral wisdom and ways of knowing (French et al., 2020). Black communities have ancestral knowledge and ways of knowing about health and healing; radical healing entails tapping into and honoring these ways to promote health and wellness (Neville, 2022). As an example, it is fairly normative for Black older adults to rely on faith-based institutions, instead of traditional therapy, for health support (Avent Harris, 2021; Siler et al., 2021). French et al. (2020) say, "Radical healing requires this sense of self-definition and cultural authenticity in which People of Color and Indigenous Individuals [POCI] are not defined by their oppressors" (p. 27).

Collectivism refers to the struggle for liberation as shared in and with the communities we belong to, what Ginwright called "common collective struggle" (2010, p. 63). For example, in the context of COVID-19, about half of Black respondents expressed a desire for more informal and formal social support in their lives (Randolph Cunningham et al., 2021); yet, many Black older adults were deeply affected by being homebound and having restricted access to digital ways of communicating (Ankuda et al., 2021; Roberts & Mehrotra, 2020). In times like COVID, which included isolation from losing a spouse or limited mobility, supporting efforts to sustain the collective among Black older adults is fundamental to their healing and well-being.

Purpose of This Paper

This paper has two purposes. One is to describe a new model for promoting mental and physical health and wellness among Black older adults that integrates the radical healing framework and the CBPR approach—a model called the radical healing CBPR model. The other purpose of this paper is to provide an example of a program (the Health-Smart Holistic Health Program for Black Seniors [HSHH]) that is informed by this new model and has helped improve the health and quality of life of Black older adults living in a low-income urban community. We do not report specifics on the results of this intervention in this paper as our focus is on the integration of radical healing and CBPR; results are published elsewhere (Tucker et al., 2022). The radical healing CBPR model enables intervention research by counseling psychologists that dismantles anti-Black racism and reduces health disparities by: (a)

naming the racism inherent in such research; (b) naming the anti-Black racism that underlies health disparities; (c) involving members of target Black communities as experts in this naming and in making the aforementioned intervention research responsive to anti-Black racism and cultural sensitivity (i.e., responsive to cultural preferences, promoting of comfort, trust and respect, and promoting of empowerment of others with limited power); (d) being holistic by taking into account the social factors and systems (e.g., no bus transportation, unsafe neighborhoods, racial trauma, sexual abuse trauma) that impact target health behaviors and research participation; and (e) empowering communities with the skills, knowledge, and support needed to obtain policy changes that address the social and systemic barriers (e.g., racism, health care injustice) to their health, wellbeing, and dignity.

Radical Healing CBPR

Integrating Radical Healing and CBPR

Radical healing and CBPR are a natural fit as they both recognize the community as a unit of identity (a collective) that is critically aware (conscious) of the issues that are most pressing to them. Thus, the radical healing CBPR model requires starting with the people (Martín-Baró et al., 1994). It pushes against the social dominance of Western, individualistic, person-level notions of healing to make room for a multisystemic focus on healing rooted in Black communities (French et al., 2020). Radical healing CBPR advances traditional CBPR by including aspects unique to the radical healing framework, specifically, healing of racial trauma, the decentering of Whiteness, and resisting systemic racism.

Practices and policies that positively impact the health of communities of Color must be informed and generated by relevant research that actively engages members of these communities in sharing their knowledge from shared, direct experiences (APA, 2021; Avent Harris, 2021; Martín-Baró et al., 1994). In this way, CBPR is in line with radical healing's element of cultural authenticity and self-knowledge. Freire (1974) said,

No pedagogy which is truly liberating can remain distant from the oppressed by treating them as unfortunates and by presenting for their emulation models from among the oppressors. The oppressed must be their own example in the struggle for their redemption (p. 197).

CBPR engages community members as subject matter experts, promotes social justice, and emphasizes the need for research that is directly connected to positive social change (Avent Harris, 2021; Tucker et al., 2017); these values are in direct line with radical healing tenets.

The radical healing CBPR model entails a paradigm shift in the content and process of CBPR research in that it: (a) operates from a strength-based approach; (b) adopts a multisystem level focus; (c) includes action that targets and dismantles the root causes of the “wound” (oppression) in the process of healing; (d) promotes healing both at the individual and community level; and (e) is culturally relevant and centers Black, Indigenous, and people of Color (BIPOC) as experts in their own experience and needs (Neville, 2022). The radical healing CBPR model must be anchored in what Prilleltensky (2003) called *psychopolitical validity*; that is, it must integrate, (a) knowledge regarding the multidisciplinary and multilevel sources, experiences, and outcomes of oppression; and (b) effective strategies for promoting psychopolitical liberation.

The radical healing CBPR model offers the promise of individual and collective physical and emotional healing in a culturally relevant manner. Yet, more guidance is needed on the development and evaluation of interventions based on the psychology of radical healing (Neville, 2022). In the next section, we present an example of a radical healing CBPR program designed by counseling and clinical health-focused psychologists to promote healthy weight and engagement in health-promoting behaviors among Black older adults. We hope that this example program will inspire other health promotion programs that are anchored in the radical healing CBPR model and aim to reduce the health disparities that negatively affect Black communities (Figure 1).

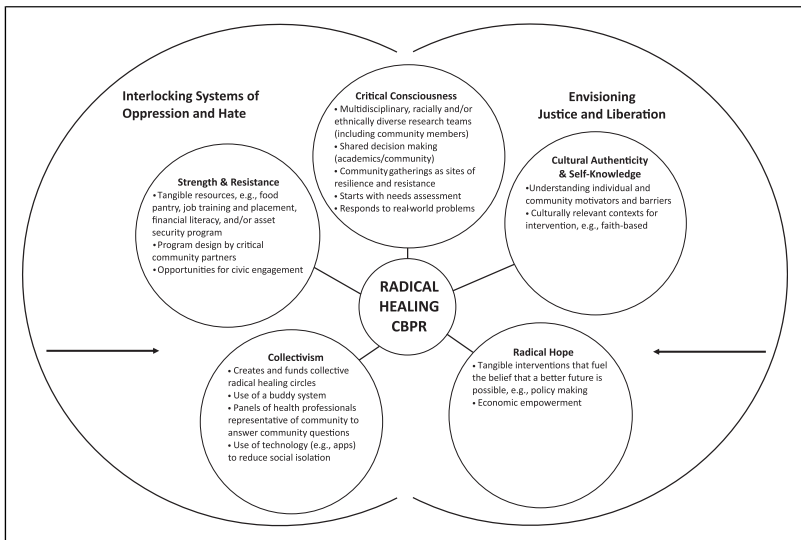


Figure 1. Radical Healing CBPR Model.

Note. (adapted from Radical Healing Model by French et al., 2020).

An Example Radical Healing Community Based Participatory Research Program—The Health-Smart Holistic Health Program for Black Older Adults

In the context of the disparities affecting Black older adults and the poor results of common “one-size-fits-all” health interventions to reduce them (Wippold et al., 2021), the HSHH Program emerges as a novel culturally relevant intervention to promote the physical and mental health of Black older adults, with the institutional and social-structural context in mind (French et al., 2020). The HSHH Program began in 2019 in Jacksonville, Florida and is most intentionally focused on program sustainability in its fourth year of implementation (2023). The criteria for program participation includes being Black; 55 years or older; food insecure and/or socially isolated; and living in a low-income area of this city, called Health-Zone 1, which is 81% non-Hispanic Black and has the highest rates of poverty and chronic disease of all health zones in this city. The HSHH Program was developed before the radical healing framework was published (French et al., 2020), but with the same vision to advance beyond individual-level approaches to coping with racial trauma to promote health equity. In this section, we briefly describe the HSHH Program and how it is informed by the five earlier described components of radical healing: (a) critical consciousness, (b) radical hope, (c) strength and resilience, (d) cultural authenticity and self-knowledge, and (e) collectivism.

The HSHH Program (a) showcases the integration of the CBPR approach and the radical healing framework; (b) is culturally sensitive; (c) fosters individual and community health empowerment; (d) includes a focus on social skills and promotion of healthy eating, physical activity, and management of stress and depression. More recently, it incorporates policy and system changes for reducing health disparities and ensuring program sustainability. The HSHH Program also utilizes the historical strengths in the Black community by (a) including the use of collective mental and physical health promotion approaches, such as group discussion of ways to integrate taught health promotion knowledge and skills into their daily lives; (b) validating traditional beliefs regarding the power of prayer for fostering emotional and physical healing and well-being as well as overcoming stress, depression and racism; (c) fostering hope through knowledge and empowerment; (d) involving the Black church as an intervention research partner; and (e) sharing of knowledge regarding the roles of racism in inequities so as to deter personal and imposed self-blame for these inequities.

The impetus for this site was the findings in the 2019 Jacksonville Community Health Needs Assessment that included the needs of the residents of Health Zone 1. Notably, of the six health zones in Jacksonville, Health Zone 1 had the highest rates of poverty and chronic disease. Additionally, in the

aforementioned health needs assessment, the top priorities highlighted by citizens in Health Zone 1 were the need for obesity intervention programs and resources to promote healthy lifestyles and mental health, better transportation, safe housing, and access to healthy food and quality health care. These findings informed the planned focus of the HSHH Program—a focus that was expanded based on the loneliness and social isolation as well as the exacerbated food insecurity that came near the end of the first year of this program in association with the onset of COVID-19. The content of the HSHH Program was solidified based on input from elders hired to implement the program, who were called health empowerment coaches, during their training. Additionally, meetings with pastors and members of three churches in Health Zone 1 regarding the program resulted in more discussion of the need for transportation to the only food store in Health Zone 1, and the need for food pantries as well as better access to healthy food at the food distribution center in Jacksonville.

The second author of this paper was asked to spearhead the HSHH Program for three reasons: (a) she was the only Black health disparities researcher near Jacksonville; and (b) she was trusted by the members of the Health Zone 1 as a result of her serving as the co-host and guest psychologist of a widely viewed television program in Jacksonville called [Name of Show], which provided an opportunity for viewers to call in and ask their physical health and mental health questions. The second author was also asked by the first-ever Black CEO of [Large Health System]— Jacksonville to write a grant to develop and implement the HSHH Program in light of the findings from the earlier mentioned Jacksonville Community Health Needs Assessment. This grant was funded by the Humana Foundation. The target outcomes of the HSHH Program as specified in the grant are intrapersonal (e.g., loneliness, obesity, physical and psychological quality of life), interpersonal (e.g., social isolation), and systemic (e.g., food insecurity). Program participants to date include older adults (age 55 years and older) in Health Zone 1 of Jacksonville, Florida over 4 years (Year 1: $n = 600$, Year 2: $n = 500$, Year 3: $n = 300$, and Year 4: $n = 150$).

The core components of the HSHH Program are: (a) the Health-Smart Behavior Program™ (or Health Smart); (b) a food pantry program; (c) a web-based, smartphone accessible Social Connection and Food Security (SCFS) App; (d) a 10-member Community Transportation Alliance; (e) a Community Advisory Board that includes community members and business leaders; and (f) a job training and placement, financial literacy, and asset security program. Health Smart was created by the second author and is implemented in groups of 5 to 10 seniors, each facilitated by a Health Empowerment Coach (HEC). Health Smart involves teaching and learning from each other ways to engage in nationally recommended health-smart behaviors (i.e., healthy eating, physical activity, and depression- and stress-

management) included in a culturally sensitive Health-Smart Resource Guide, which was adapted to promote food security and social connection among older adults. The Health-Smart Resource Guide includes bible scriptures that are relevant to each health-smart behavior. The HEC-facilitated group sessions that focus on each health-smart behavior include a focus on: (a) the structural racism designed to deter these behaviors, like the targeting of fast food and soda commercials to Black communities; and (b) culture-based food selections and preparations that are high in salt and fat and ways to cook these foods in healthier ways.

A free, healthy food pantry program was implemented at 20 churches in the target community. Moreover, the SCFS App was developed for this program so as to reduce social isolation and enable participants to ask and get answers to their health and well-being questions, in particular in the context of COVID-19. Further, the 10-member Community Transportation Alliance solicited input from 150 residents in the area regarding needed changes in transportation access. The Community Advisory Board includes community members and business leaders. Finally, the Job Training and Placement, Financial Literacy, and Asset Security Program (an HSHH program component)—for family members who provided some financial support to the participating older adults—was included only in Years 1 and 2 of the program because of low participation by the target family members.

Participants in the HSHH Program are also granted free, walk-in access to two community health centers that served as “clearing houses” by checking participants’ blood pressure and glucose numbers. Participants who need additional healthcare can get services from a free Total Care Clinic, led by a Black physician (who is a Co-I for the HSHH Program).

Community members, called Community Scientists, obtained consent from program participants and administered questionnaires to evaluate the impact of the HSHH Program. These Community Scientists also conducted telephone-based prescreening to be sure that participants lived in the target community, were at least 55 years old, and were lonely, socially isolated, and/or food insecure. Additionally, a brief suicide risk measure was administered via telephone, and those few persons (0 to 3 per year) who scored in the suicide risk range indicating a need for help were referred to a pro bono mental health provider. Community Scientists underwent all required training by the [University]’s Institutional Review Board and consequently were called unaffiliated investigators by the Board.

Detailed results of the HSHH Program have been published elsewhere (Tucker et al., 2022) and show that the program was successful at improving participants’ Body Mass Index, loneliness, physical health-related quality of life, and psychological quality of life from preintervention to immediate postintervention. These changes were maintained 3 months after the end of the program. Food insecurity did not show a significant change over the 10 weeks

of the intervention; however, there was a significant decrease between the start of the program and 3 months after the end of the program. In addition, the work of the program's Community Transportation Alliance resulted in changes in transportation policies in Jacksonville, which now include easily accessible bus transportation and \$2.00 car transportation to the only food store and pharmacy in the target community's health zone. The pastor and pantry coordinators of the earlier mentioned food pantries and the academic and community member research team worked in partnership to get food for these pantries actually delivered to the pantries rather than vice versa, as was the case in Year 1 of the program.

In Year 4 of the HSHH Program (2023), there was an added focus on sustainability. The program sustainability plan included: partnering with the American Heart Association and Silver Sneakers Program to provide free healthy eating classes and physical activity sessions, respectively, in Health Zone 1; having each church commit to having a HEC that they pay to implement a Health-Smart session of their choice at least every 3 months; assisting the participating churches with starting a garden at their church; and applying to the Florida Department of Elderly Services to have the HSHH Program become one of its funded providers of services to senior citizens in Jacksonville, Florida, including in Health Zone 1.

Critical Consciousness. Critical consciousness, i.e., awareness of pressing issues and their underpinnings, is a prerequisite of resistance and liberation (Mosley et al., 2021). Developing critical consciousness among the broader community, academics, and policymakers about the structural barriers anchored in systemic racism that were most pressing to the target community (as determined by the needs assessment) was a primary goal of the HSHH Program. This program aligns with critical consciousness through empowerment of Black older adults to take charge of their health without complete reliance on an unjust healthcare system.

The eight-member core research team that developed the program consisted of nearly an equal number of academic researchers and community members, all Black but one, and led by a Black woman Principle Investigator (PI) (the second author of this study). The total program research and implementation team consisted of the eight core research team members; 20 church-based pantry coordinators (pastors and church members) who recruited the senior program participants; four community scientists; and 10 HECs, most of whom were from among the 20 participating churches for the purpose of enabling program sustainability at these churches; and six culturally diverse [University] student researchers enrolled in the PI's health disparities and health promotion research internship who assisted with all aspects of the program as needed, including participation in weekly program planning meetings.

A community member of the research and implementation team spearheaded the 10-member Community Transportation Alliance and its data collection to inform the pursued transportation policy changes. Another community member of this team spearheaded the program's Community Advisory Board, which assisted with finding needed program resources, such as a team of professionals to answer questions posted on the SCFS App. All program research and implementation team members were required to participate in a cultural sensitivity and humility training conducted by the Program PI, and all of the team members except the undergraduate research interns (who received course credits) were paid to execute their roles from funds awarded via the program grant from Humana Foundation.

Cultural Authenticity and Self-Knowledge. The Health Smart portion of the HSHH Program incorporated culturally syntonc approaches to healing aimed at promoting liberation and pride (Neville, 2022). This portion included the following components, led by the HECs: (a) assessment of participants' motivators and barriers to engagement in health-smart behaviors; (b) use by coaches of the assessed motivators and barriers to facilitate individual goal-setting for engagement in health behaviors and to identify culturally relevant strategies to achieve the set goals; (c) nine weekly group sessions where participants discussed different segments of the Health-Smart DVD and the accompanying Health-Smart Behavior Resource Guide that included relevant scriptures that participants can read on their own; (d) implementation of a buddy system in which older adults were paired to motivate each other to attend sessions, exercise, and reach their goals; and (e) Health-Smart Panel sessions at which participants could ask anonymous or direct health-related questions to a panel of health professionals (e.g., dietitians, physical fitness experts, pharmacists, mental health providers) and Black community members who have made positive lifestyle changes. These components included prayer and meditation and the teaching and learning of positive cultural traditions, e.g., ways to keep valued traditional foods in one's diet, such as through cooking them with less fat than did Black ancestors, to address stress and promote racial pride.

The Health Smart group sessions and other meetings with the HECs represented culturally relevant sites of resilience and resistance within the program, as processing the direct experience of bearing witness to anti-Black racism can have a system-focused liberatory effect (Mosley et al., 2021; Neville, 2022). These group sessions promoted intimacy and relational coping experiences with others with key shared identities (i.e., other Black older adults) and with Black community leaders that are needed for the establishment of resilience and resistance against the racist forces that have destructive outcomes on Black older adults' health. These components of the program empowered participants to expand their critical

consciousness in a culturally relevant context through recognizing the systemic variables (e.g., racism, fast food television commercials targeting Black audiences) that contribute to obesity and make reaching and sustaining health difficult (i.e., impact their lived experience). They also supported participants in embracing that they have the right to the “highest attainable standard of [physical and mental] health” (World Health Organization, 2017), that they can do something to make a change (i.e., political efficacy), and that direct action translates to desired change (Neville, 2022).

Radical Hope. The Health Smart components of the HSHH Program aimed to foster participants’ radical hope, and their confidence and ability to act in culturally authentic ways when making individual and collective decisions that promote engagement in health behaviors and liberation. Health behaviors are salient pathways linking racism and health outcomes (Williams & Mohammed, 2013). The individual participant meeting with the HECs for the assessment of motivators and barriers and goal setting and the group meetings to discuss the DVD and Resource Guide scaffolded participants’ further understanding of the factors, such as racism and poverty, that impact health in Black older adults. From a Freirian lens (Freire, 1974), this understanding and the identification of manageable strategies to cope with them is a starting point for the development of radical hope to resist some of the processes whereby negative social circumstances become embodied.

The changes in policies that resulted from this program, such as the transportation policy changes that were brought about by the Community Transportation Alliance, formed and supported by the research partners (i.e., a tangible change), promoted radical hope among participants. In addition, the HSHH Program offered participants access to high-quality, culturally responsive, and affordable mental and physical healthcare, resources like a living wage for community leadership as part of the program, and leadership roles (e.g., on the research team, as manuscript coauthors), which also promoted radical hope for representation.

Collectivism. One of the primary aims of the HSHH Program is to reduce social isolation among Black older adults, especially during COVID times. For this purpose, the HSHH Program creates and funds collective radical healing circles. Grills et al. (2016) spoke to the need for Emotional Emancipation Circles (EECs), where Black people can share their stories, deepen their understanding of their circumstances and the forces driving these circumstances, and set the foundation to be stronger, healthier, and safer. In the Health-Smart group sessions, participants simultaneously take the roles of both learners and teachers, and sit in circles that affirm their identities and healing. HECs in these meetings call attention to sections of the resource guide

and DVD to discuss and facilitate group discussion of relevant topics, making sure that there is discussion of the impact of racism on the health behaviors and outcomes of Black Americans in general and older Black Americans in particular. In addition, panels serve as educational forums to make contributions, share struggles, and challenge existing (cultural) norms regarding health behaviors, like eating and physical activity, and to imagine alternative ways of being (i.e., to resist the status quo). Both of these spaces (meetings and panels), as well as other spaces in the program, aim to promote self-care and leisure, which are not typically fostered in programming developed for Black Americans. The use of the buddy system to promote attainment of individual physical activity goals and to support attendance to Health-Smart group sessions was also an individual and collective effort to change the current conditions based on critical insight. Finally, the SCFS App was used to help participants connect with other community members (i.e., to reduce social isolation). The HECs were trained to teach and then taught participants to use the SCFS App.

Strength and Resistance. The HSHH Program strengthened individual and collective resilience to promote health. In addition to participating in Health Smart, older adults in the HSHH Program have access to food pantries that are implemented at 20 churches in [CITY]'s Health Zone 1. Church is the "most important institute in the Black community" (Davis, 2010, p.4); thus, Black churches are an important mediator within the context of the radical healing CBPR model for effecting change in health and engagement in the health behavior of participants (Avent Harris, 2021). Finally, some participants had family members who enrolled in a job training and placement, financial literacy, and asset security program. The program intended to promote financial security in adults who are contributors to the older adults' financial stability.

With the exception of the HSHH Program, the existing health interventions for Black older adults have generally been developed without input from Black community members who are living with poor health (Tucker et al., 2021). At the start of the pandemic, the HSHH Program was modified to meet stay-at-home and social distancing recommendations. These modifications included a drive-through pantry program and the delivery of Health Smart via Zoom. In line with radical healing, these program modifications were developed and executed by critical community partners (Mosley et al., 2020).

Beyond providing input on the program, community members are also granted opportunities for civic engagement. As part of the program, a Community Transportation Alliance was created with community members as leaders. Alliance members surveyed the community to capture their (little) satisfaction with the transportation system in Health Zone 1. As a function of the work conducted by the Alliance, three transportation and/or food access

policies recommended were adopted: (a) the \$2 ready-ride program was expanded to Health Zone 1, (b) a bus route was established that goes from communities in Health Zone 1 to a food store where participants can get their food and medications, and (c) delivery of food from the local food distribution center to specified churches in our program rather than requiring that church members go to the food distribution center as had been required in the past.

Conclusion

The syndemics of COVID-19 and racism call for a creative approach to health interventions that is congruent with the values and needs of the community, such as the radical healing CBPR model. The HSHH Program is clearly anchored in the radical healing CBPR model. The HSHH Program limitations, such as the lack of a control group (out of respect for the wishes of community members who decided to not have a control group) and the exclusive use of self-report measures (that could in future iterations of the program be supplemented by semistructured interviews, which are culturally sensitive individual data collection approaches; Burnette et al., 2014). Yet, the evidence of the effectiveness of this program in promoting targeted health among Black older adults living in a Black low-income urban community provides support for using the radical healing CBPR model in similar intervention research to address health disparities and related health disparities that plague Black communities.

The HSHH Program is consistent with the radical healing CBPR model in that it entails interventions at the individual, group, community, and societal level (Neville, 2022). At the individual level, it promotes critical consciousness, racial pride, and self-care. At the group level, it offers opportunities and support for advocacy and coalition building. At the community level, it offers a forum to share struggles and partake in resistance and civic engagement, and heal in culturally meaningful ways. Finally, at the societal level, it promotes economic opportunity and positive representation of Black Americans in spaces where they have been historically underrepresented. In sum, the HSHH Program has built-in strategies that address the root causes of health disparities and builds on the resilience and culture-specific practices of Black older adults.

Radical healing CBPR model supports counseling psychologists in doing what they do best: challenge the notion that social justice-oriented practice, advocacy, and research are stand-alone roles that are in competition for precedence over other roles. Counseling psychologists can and must develop research and intervention models for addressing the underlying causes of mental and physical health problems among Black Americans, including anti-Black racism, poverty, limited political power, and acculturation into the valuing of individualism.

Even at the dawn of the 21st century, racism and the structures that emerged from and now sustain racism remain intractable—resistant to change. The calls for radical healing and the Black Lives Matter Movement are at the beginning of the revolution needed for Black Americans and other disenfranchised people to achieve equity in all domains of life. In her 2020 Society of Counseling Psychology Presidential Address, amidst the COVID-19 pandemic and global uprisings against anti-Black racism, Anneliese Singh (Singh, 2020) reminded us: “Now, more than ever, we have the opportunity to build a counseling psychology of liberation that centers Black liberation with every breath we take, because in working for Black liberation, we all get free” (p. 1112).

Implications for Practice, Advocacy, Education and Training, and Research

Implications for Practice. An important implication of the radical healing CBPR model is that counseling and clinical psychologists must expand their roles, venues, and counseling frameworks for providing counseling services to Black Americans, particularly those who are older and living in low-income communities. At present in psychotherapy, anti-Black racism is often overlooked or denied (Bartholomew et al., 2021; Wilcox, 2022). An alternative to such therapy is to empower community members to provide basic counseling and related interventions to their peer community members and serve as liaisons to psychologists. These *wounded healers* (or individuals with a personal understanding of anti-Black racism and its health consequences) can empathize, connect, understand, and help heal community members struggling with similar stressors (Mosley et al., 2021). This empowerment by counseling psychologists addresses the mental health of Black Americans in ways that are responsive to the lack of trust of the mostly NHW mental health providers.

It is also important that individual and group counseling venues move from university counseling centers and private practices in NHW neighborhoods to community sites (Gone, 2004), in this case, in Black communities. Because of the value of collectivism in Black culture, group counseling co-facilitated by a member of the target community is a great strategy for culturally sensitive counseling. Such counseling fosters equity in relation to mental health in that it provides access to counseling and conveys a valuing of Black community members as counseling partners with knowledge that most counseling psychologists do not have.

Powell et al. (Wizdom Powell et al., 2021) remind us that “disproportionate COVID-19 response efforts and racialized violence [have exacerbated] longstanding mistrust of healthcare systems among BIPOC” (p. 2). Therefore, it is important that counseling psychologists abandon the use of common

counseling frameworks developed by NHWs to understand and treat mental health issues presented by Black clients and instead use conceptual and theoretical frameworks that are responsive to the historical and current racism and oppression that underlie mental health issues (Gone, 2004; Torres Rivera & Torres Fernandez, 2015). To this effect, Grills et al. (2016) advocated for addressing the dehumanization of Black individuals, including the lie of Black inferiority and its damaging implications, as a promising intervention for Black health.

Consistent with the radical healing CBPR model, counseling interventions and related research must acknowledge the roles of racism, oppression, and discrimination in problematic mental and physical health behaviors and outcomes, and utilize the strengths and resources in Black communities and families to help address these behaviors, outcomes, and underlying causes (e.g., structural racism). Clients can be empowered to share their traumas (e.g., of burying loved ones during COVID-19 or struggling with racism while trying to access adequate care) and related feelings through expressive mediums such as drawings of their families, collages, songs, and poems. Using the term “healing” in counseling acknowledges emotional and psychological pain. Healing resources and interventions include but are not limited to strong ties with a church, spirituality, flexible family roles, extended families, and surrogate family ties (Danzer, 2012), and discussion of clients’ personal strengths.

Use of the radical healing CBPR model requires that counseling psychologists become knowledgeable about past and present institutional racism and oppression so that they can be authentic in addressing these issues in counseling (Gone, 2004). It also requires that counseling psychologists actually visit African American churches, attend Black history and other events in African American communities, and find their courage to speak about racism without fear of persecution.

Implications for Advocacy

There are three important implications of the radical healing CBPR model for advocacy by counseling psychologists. First, counseling psychologists must advocate for community members to be trained as researchers and paraprofessional counselors and for a curriculum that prepares them for these roles. This advocacy is important because there are not enough psychologists of any race/ethnicity to address the mental health needs in Black communities.

Second, there needs to be advocacy for lay and professional members of Black communities, including Black older adults, to be on all boards and committees within the APA that set policies regarding research, counseling, and health promotion interventions to address the syndemic of COVID-19, racism, and behavioral health issues. It is also important that funding is made

available for lay members of such boards and committees to be paid for their contributions to these groups.

Third, counseling psychologists must engage in advocacy at the community level that is informed by the assessed views of their target; BIPOC community members regarding policy changes desired to overcome structural barriers to their mental and physical health (French et al., 2020; Vera & Speight, 2003). Such advocacy must be community-specific and requires forming of long-term partnerships with community organizations with the goal of them being active advocacy partners.

Implications for Education and Training

The radical healing CBPR model implies that education and training of counseling psychology students, professionals, and staff must include the history of African Americans prior to their shackled enslavement by NHW Americans as well as the post-shackled enslavement period that lasts until this date in the form of structural racism and oppression. It is the plight of Africans, which have historically been left out of the American history, that will bring awareness of and sensitivity to the soul wounds and traumas as well as the ongoing oppression and anti-Black racism that underlie the behaviors of African Americans/Black Americans and their relationships with non-Black Americans. It has been asserted that bearing witness to anti-Black racism can have a system-focused liberatory effect (Mosley et al., 2021; Neville, 2022).

Teaching student and veteran counseling psychology researchers and interventionists about Africans before their enslavement in America will promote awareness of the strengths and resourcefulness within African American communities and reveal strategies for conducting culturally sensitive research and interventions in African American communities. These strategies will clearly involve community member empowerment, equitable academic-community partnerships, collective research and intervention approaches, and viewing community members as the experts in every aspect of research and interventions to promote health and healing. Radical healing entails tapping into and honoring the expertise of Black older adults, on ancestral ways to promote their health and well-being (Neville, 2022).

Another implication of the radical healing CBPR model is that research and interventions in Black communities must include members of these communities as research partners, including those who are over age 55 years. Failing to engage Black community members as research partners is a manifestation of racism (Hawkins et al., 2022). Black community members can also serve as trainers and teachers in research, intervention research courses, and in practice. Doing this will ensure the cultural sensitivity needed to address health disparities and related health disparities that most negatively impact Black communities.

Implications for Research

Given the cultural insensitivity and mistrust of researchers and the structural racism and oppression experienced by members of Black communities (Boyd et al., 2020), particularly Black older adults, it is important that research teams who aim to conduct health disparities research and other research in Black communities use the radical healing CBPR model to do so. This view is consistent with the acknowledgement by the American Psychological Association (APA) that racism and cultural insensitivity in research undermine the participation of minority communities (APA, 2021). There are four important implications of this model, with one being that research teams should include Black researchers and community members among the team leaders. It is also important that these Black team members are not acculturated into the majority culture such that they cannot acknowledge and address the oppression, structural racism, and policies that impede research participation and success in Black communities. Being Black alone does not make a researcher culturally sensitive or a valuable member of a research team.

A second implication is that researchers who aim to address health disparities that affect any BIPOC communities must necessarily recognize and utilize the strengths and resources in these communities. In African American communities these strengths and resources typically include the Black church, which is typically a great research site, and their pastors, community organizations and leaders. Other strengths and resources include Black newspapers, family members of research participants, and Black and other political leaders. Utilizing these strengths is consistent with CBPR, which includes building on existing individual and community strengths to promote resilience and well-being in Black communities (French et al., 2019).

A third implication is that health disparities-focused researchers as well as other researchers who work in BIPOC communities must be prepared to work in partnership with individuals and groups/organizations, and politicians involved with these communities to bring about system-level policy changes needed to remove barriers to research participation, health, and/or health care in these communities. It is important that such researchers are willing to invest the time and work required to bring about such policy changes and avoid helicopter research.

The fourth implication of the radical healing CBPR model is that researchers who conduct research in African American communities must find the courage to acknowledge structural racism and oppression and their past or present roles in both. It is only then that these researchers can authentically engage in research and related interventions with members of African communities that will help heal the soul wounds and diseases inextricably linked to intractable racism and oppression.

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