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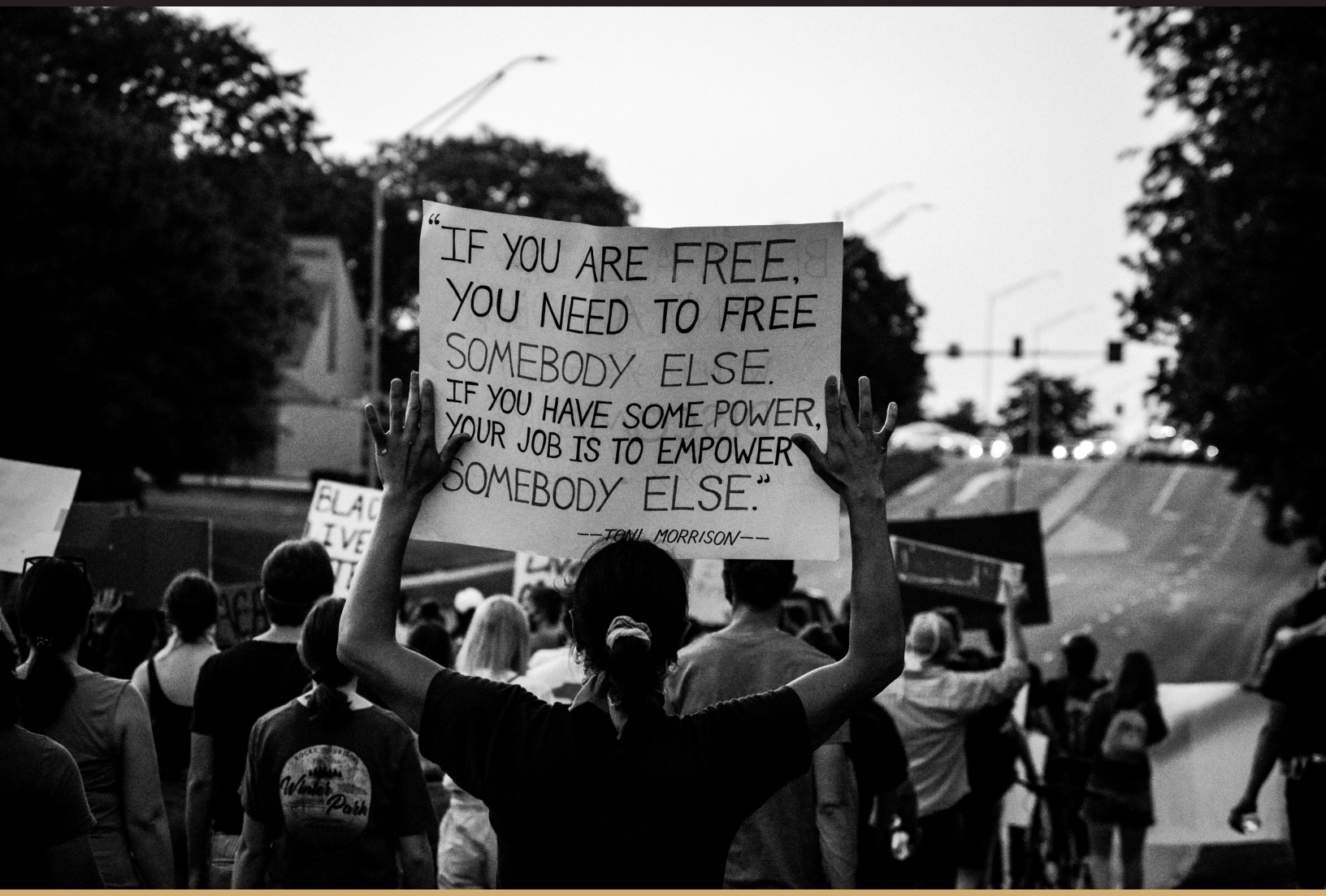
Understanding & Dismantling Privilege



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I Committed a Racial Microaggression, Now What? An Introduction to CPR: The Racial Microaggressions Reparative Response Model

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Abstract

Researchers, educators, counselors, and other service providers use microaggression frameworks to describe the subtle, individual, verbal, and non-verbal messages that are intentionally or unintentionally communicated to marginalized individuals, such as Black, Brown, Indigenous (BIB), lesbian, gay, bisexual, and queer communities (LGBQ), and transgender people. As research into the phenomenon of microaggressions continues to expand, there is a growing need for effective tools and interventions to decrease the likelihood of committing a microaggression, and foster repair to promote healing and reduce ongoing harm. The following article includes a brief review of the racial microaggressions literature, an account of ongoing barriers to reducing racial microaggressions and introduces the foundational components of a newly developed tool – a microaggression response model called "CPR: The Racial Microaggressions Reparative Response Model" (the CPR model).

Keywords: racism, anti-racism, microaggressions, reparative response model

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Overview of Racial Microaggressions in the U.S.

Racism is defined as a system of oppression meant to racially oppress only people of color through individual, institutional, and cultural policies and practices via white supremacy (Bonilla-Silva, 2015). The United States' history of racism is well-documented, having been founded on the genocide and colonization of Indigenous peoples and the enslavement and torture of peoples from the African Diaspora. Summarizing that history is beyond the scope of this manuscript; however, it is important to note that this history has baked racism into the systems, institutions, and traditions that make up the U.S., and influence individuals' biases in both conscious and unconscious ways. Systemic racism has led to the creation and enforcement of racially-oppressive laws and practices throughout the history of the U.S. (Omi & Winant, 2015).

The Civil Rights Act was passed in 1964 in response to "Jim Crow" laws, which allowed legal segregation and discrimination. While the Civil Rights Act made most explicit forms of state-sanctioned racism and white supremacy illegal, racism and white supremacy continue to pervade U.S. culture – oppressing Black, Brown, and Indigenous (BBI) folx while privileging white folx with more access to housing, healthcare, education, employment, and wealth (Hahn, Truman, & Williams, 2018). Critical race scholars have argued for decades about the systemic barriers to racial equity and justice, and have had difficulty establishing the need for discussion and intervention; racial discrimination is, in fact, illegal. Because systems of racial oppression have evolved to become more insidious and less explicit, it is imperative to be able to detect, decode, and demystify instances of racism, and intervene in ways that support the safety and success of BBI in the post-Civil Rights Act-era in the U.S.

In response, researchers and scholars have formulated the *racial microaggressions framework* to qualitatively and quantitatively capture the seemingly subtle instances of racism that greatly impact BBI people and communities. Racial microaggressions are the harmful, often stereotypical messages specifically about BBI people and communities and are defined as: brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color (Sue et al., 2007).

Racial microaggressions stem from racism, white supremacy, and living in a racist culture, and while they can be committed by both white and BBI people, it is only BBI people who are harmed by them. Most often, white microaggressors commit microaggressions out of ignorance, internalized domination, white fragility, and white solidarity; however, when BBI folx commit racial microaggressions against another people from BBI communities, it most typically stems from interfacing with a white supremacist culture that leads to biases against other people of color, such as colorism and internalized racism. Because microaggressions refer to harmful messages about people and communities facing systemic oppression, white folx cannot be the object of racial microaggressions, although they may be the object of other forms of microaggressions (such as those based on gender or ability) that are outside the scope of this manuscript.

Microaggressions and Intentionality

There are three types of microaggressions that describe different levels of intention: microassault, microinsult, and microinvalidation. Microassaults are characterized as "conscious and deliberate," and there is usually little doubt that the microaggressor intended to communicate a racist message – e.g., college parties with white students in blackface and "jokes" about different racial and ethnic groups. Some researchers and scholars use the term *macroaggression* and microassault interchangeably to communicate severity, but the prefix "micro" in microaggression does not mean "small." Rather, it refers to *subtle,* which does not equate to a decrease in harm. In fact, research shows that experiencing microaggressions may lead to more psychological harm than experiencing more explicit forms of racial bias because of the cognitive labor required to identify covert racist messaging (Sue et al., 2007).

Microinsults are characterized as unintentional and most typically occur when someone is attempting to compliment another person, but the compliment stems from ignorance and racism – e.g., touching a BBI person's body or hair and/or commenting in a surprised way on how well they speak. Though unintentional, microinsults can have deep psychological and physiological impacts that result in minority stress (Sue et al., 2007), a specific type of stress a person with an oppressed identity may experience because of how others treat them.

The third type of microaggression, the microinvalidation, is characterized by messages that "exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality" of BBI folx, and can occur as a response to being called out on a microaggression (Sue et al., 2007). In other words, after a microaggressor touches a BBI person's hair and is told not to, the microaggressor then commits a microinvalidation by nullifying the BBI person's boundary and making statements such as "It's not a big deal" or "You're being too sensitive." A common misconception about microaggressions is that they happen one-at-a-time, but in any given social exchange microaggressions can start happening and possibly never stop. One clumsy, insensitive remark gives rise to embarrassment and defensiveness and, ironically, triggers yet more microaggressions as the perpetrator attempts to minimize or defend the original conduct.

Implicit Racial Bias

A bias is generally described as a preference for or against something. Explicit bias is the conscious and controlled way in which people act on beliefs in favor of or against something or someone, whereas implicit bias refers to the unconscious, automatic beliefs, attitudes, and values that inform a person's behavior (Adams, Devos, Rivera, Smith, & Vega, 2014). Most implicit bias researchers agree that:

1) Everyone has implicit biases that are informed by their cultural worldview and life experiences;
2) Implicit bias functions on unconscious levels of the mind;
3) Implicit biases do not necessarily align with a person's explicit beliefs, attitudes, and values; and
4) Implicit bias powerfully informs decision making and behavior.

Implicit racial bias is one of the main foundations of the racial microaggressions

framework. People of all races hold implicit biases; however, implicit racial biases cause systemic and individual harm to BBI people. These internal cognitions support and maintain white racial privilege through intentional and unintentional subjugation of BBI communities (Dovidio, Gaertner, Kawakami, & Hodson, 2002). Implicit racial bias research findings have indicated that even people who are committed to racial justice and whose explicit values are centered around racial equity can possess strong implicit racial biases favoring white groups (Dovidio, Gaertner, Kawakami, & Hodson, 2002). This research demonstrates that white people who grew up learning that explicit racism was harmful often believe themselves to be non-racist and are often unaware of how their implicit racial biases inform their beliefs and behavior.

Microaggressions and Traumatic Stress

While everyone in life experiences some type of stress, people with marginalized identities can experience more specific types of stress known as minority stress (Meyer, 2003) or ethnostress (Linklater, 2014). For BBI folx, experiencing a lifetime of racial microaggressions – specifically, within a cultural context shaped by genocide, colonialism, and slavery – creates traumatic stress that can lead to a host of other psychological and physiological health problems such as anxiety, depression, self-harm, substance use, suicidality, and stress (Nadal, 2013; Nadal, 2018; Sue, 2010). These physiological and psychological injuries are a result of how bodies process trauma. Specifically, human bodies process trauma physically through the vagus nerve and the brain stem, the oldest part of the human brain. These brain systems do not process complex thoughts; instead, their entire biological function is to determine if information coming into the body is "safe" or "dangerous." If the brain interprets a stimulus as dangerous, these physical structures complete their biological function by storing a patterned response in the physical body, often in the form of sensation, meant to help that person move towards safety (Menakem, 2017; Linklater, 2014; Haines, 2019). Often, these responses include a type of contraction or constriction, or a reflexive trauma response, that when experienced over and over again can create physiological and psychological injury (Menakem, 2017). When BBI bodies experience microaggressions daily and their bodies recognize these experiences as threatening, the cumulative damage becomes a pathway through which BBI bodies carry an increased load of illness, disease, injury, and mental health challenges. These trauma responses are not only held in response to the trauma experienced during the lifetime of each body, but are also passed epigenetically from one generation to the next (Menakem, 2017; Linklater, 2014) in a context where people have been separated from their communal and historical forms of coping. BBI bodies are not the only bodies that carry trauma as a result of the dehumanization and violence of racism, including racial microaggressions. White bodies also carry a form of trauma as a result of these exchanges. Specifically, white bodies come to these commonplace interactions with generations of trauma as a result of the brutality of European life in the Middle Ages into the 16th and 17th century. This brutality is encoded into white bodies that they needed to dehumanize and subjugate those bodies labeled as "other," or be in danger themselves (Menakem, 2017). In *My Grandmother's Hands,*

Menakem argues this hereditary trauma now divorces many white bodies from their humanity and from connecting to the humanity in the bodies of BBI people.

While bodies can pass trauma to each other, they are also capable of passing resilience, strength, and the ability to "settle" - the state in which bodies experience relaxation and therefore are able to repair and move towards healing (Menakem, 2017). Resilience is defined as one's ability to recover from potential harm or injury to return to baseline functionality or wellness. Black Americans, and specifically descendants of those who were enslaved, have developed many communal somatic practices that help bodies to settle in connections with others, including collective humming, singing, drumming, and call and response rituals and traditions (Menakem, 2017). Indigenous practitioners have also documented and shared collective interventions as supportive of resilience and healing (Linklater, 2014). Resilience is most often developed in connection with other safe and protective people. This is foundational to the rationale of developing CPR (Calm yourself, Practice humility, and Repair). Increasing the likelihood and capacity that people who commit racial microaggressions will be able to respond reparatively and protectively towards the people who have experienced harm can help build resilience as opposed to injury.

Psychological Dilemmas

Racial microaggressions are most often social exchanges between people, and people use their cultural worldview, attitudes, and beliefs to interpret their lived experiences on both conscious and unconscious levels. In their study of racial microaggressions, Sue et al. (2007) determined that there are four psychological dilemmas that influence both the microaggressor and the targeted BBI person:

1) The Clash of Racial Realities,
2) Invisibility of Unintentional Bias,
3) Perceived Minimal Harm, and
4) The Catch-22 of Responding.

Though these psychological dilemmas are posed as differences in life experiences and perception, the outcome of such dilemmas almost always favor of the person with racial privilege.

The first dilemma, the Clash of Racial Realities, describes the different perceptions people have about race and racism, as well as its impacts on BBI folx. Debating racism is fertile soil for microaggressions, as is lack of awareness of one's implicit racial bias, or Invisibility of Unintentional Bias, the second dilemma. Because of white fragility, white solidarity, and white supremacy, many people believe that microaggressions are small and innocuous – the third dilemma, Perceived Minimal Harm – despite qualitative and quantitative research findings indicating otherwise. White fragility is discomfort and defensiveness that comes up when a white person is confronted with information about racial injustice or inequality (Caporuscio, 2020). White solidarity is "the unspoken agreement among whites to protect white advantage and not cause another white person to feel racial discomfort by confronting them when they say or do something racially problematic" (DiAngelo, 2018, p125). White supremacy is the belief that people with white skin are superior to others (Caporuscio, 2020). According to Nadal (2013), the most common response from a person who has been on the receiving end of a microaggression is actually non-response – because of the shock, disbelief, and trauma response that is

often triggered. This speaks to what Sue et al. (2007) described in the Catch-22 of Responding to microaggressions – that the person who received a microaggression runs the risk of experiencing more microaggressions if they try to respond. As such, the potential for healing and repair is a gamble for the BBI person who experienced the microaggression and it can take a long time to weigh the benefits and burdens of calling out a microaggressor. According to Nadal (2013), the likelihood of healing and repair is very low, and we need interventions to change that.

The psychological dilemmas involved with racial microaggressions can lead to communication breakdowns and relationship ruptures; however, Rico (2018) and Schulman (2016) posit that successful navigation of conflict can actually lead to strengthening relationships. Therefore, the CPR Model is a healing-centered, humanistic approach to repairing relationships that have been harmed by racism, white supremacy, and racial microaggressions.

Why We Need the CPR Model

The CPR Model is both an ongoing practice and an in-the-moment tool for reducing the traumatic impact of racial microaggressions. CPR is an acronym that stands for three steps in a process: Calm yourself, Practice humility, and Repair. It is an intervention designed to be used by people of any race who commit a racial microaggression, although the practice may look different for each individual. The goals of the CPR Model are to 1) remain embodied during moments of extreme discomfort, 2) respond with intention, instead of reacting automatically after committing a racial microaggression, 3) reduce or prevent the occurrence of additional microaggressions, and 4) stay attuned to the needs of the person harmed by the microaggression in order to foster consensual healing. The CPR Model offers both a long-term and short-term intervention that requires self-care, community-care, and a commitment to improving one's relationship with oneself and others.

Development of the CPR Model

The authors developed the CPR Model to address the specific barriers to behavior change assessed after facilitating dozens of racial microaggressions trainings for medical providers, behavioral health providers, educators, and other adult learners in settings and cities across the United States. It is important to note that our trainings were designed for people in helping professions who typically hold social justice values, though not all participants fit this description. Our teaching experiences combined with a decade of microaggressions research indicated that both white folx and BBI folx intensely fear discussing racism but for different reasons: white people were often afraid to unintentionally say or ask something racist and were therefore either performative or silent during trainings, while BBI folx were understandably protective over their energy and resources in anticipation of racist comments, and therefore reluctant to engage in any discussion. We needed a way to bring our learners into their bodies, maintain consensual connection with each other in the face of harm, and prioritize the impact on the BBI person over the intentions of the microaggressor. In order to accomplish these goals, we developed – and over the years have refined – a healing-centered, embodied intervention that emphasizes authenticity over a hollow script for people

to follow.

Training participants consistently reported emotional barriers to acknowledging their complicity in perpetuating racism and managing shame around committing racial microaggressions. White people reported feeling stuck or unsure of how to acknowledge ways they had been harmful towards BBI folx, and this often led to more silence about racism. If people are not able to acknowledge racial microaggressions, then the harm and negative consequences of racial microaggressions continue to be disproportionately shouldered by BBI folx. This knowledge motivated the authors to consider ways to break down barriers that prevent white people from taking responsibility for their words and actions. Though we originally designed the CPR Model with white people as the target audience, we received feedback from BBI folx that they found the CPR Model helpful to them after they also committed racial microaggressions against other people from BBI communities.

Shame

Informed by social observations and personal internal reflection, the CPR Model is based on a workable theory that personal shame – specifically about what it means to be someone who would say or do something racially harmful – is a huge barrier to people being able to effectively move forward and attempt to repair the harm caused to a BBI person. Shame is a complicated emotion that has long been understood to heavily influence human behavior, specifically in interpersonal contexts. While there have been decades of theoretical academic work on shame, empirical research has only recently emerged due to the difficulty of reliably and accurately measuring an internal and subjective phenomenon (Tangney & Dearing, 2003). Brené Brown, a leading shame researcher, articulates shame as "the intensely painful feeling or experience of believing that we are flawed and therefore unworthy of love and belonging – something we've experienced, done, or failed to do makes us unworthy of connection" (Brown, 2013). Shame leads to someone feeling inferior for *who* they are, rather than feeling guilt or regret for making a mistake. This description supports the rationale behind the CPR Model.

A common cultural narrative is if a person causes race-based harm, then that person is racist. This narrative center and identifies the person, rather than the behavior, as unacceptable. Therefore, it follows that identifying a person's words or behaviors as racially harmful – which is necessary if they are to acknowledge and choose to repair that harm – would facilitate a socially conscious person who does not want to be seen as racist feel a sense of shame. In her writing about *shame resilience theory,* Brown (2006) describes how shame can motivate destructive behavior. In this context, destructive behavior is defined as the denial of or inability to respond to the harm caused by microaggressions that causes further harm to BBI folx.

Using this rationale, the authors offer the Compass of Shame (Nathanson, 1992) as a model that could help participants recognize tangible behavioral indicators for when they are feeling shame. It is suggested that this model is processed before the CPR Model is implemented because it facilitates increased participant self-awareness and the ability to examine

feelings of shame from a non-judgmental perspective. The Compass of Shame describes how most common behavioral responses to an internal experience of shame can be organized into four general categories: withdrawing or isolating, avoidance, attacking self, or attacking others. Having clear behavioral templates helps participants identify whether their own internal and external reactions to being made aware they committed a microaggression are being motivated by a sense of shame. By identifying these reactions in a facilitated environment (like a racial microaggressions training), participants are able to build self-awareness about when their reactions are rooted in shame. The CPR Model is offered as a guide that helps people to acknowledge the feelings of shame. and choose behaviors and responses that are *not* geared towards protecting the feelings of the person who has caused harm. Rather, the CPR Model offers opportunities to repair the harm and focus on valuing the BBI person who has been harmed, and the relationship between these two (or more) individuals.

Shame is a defining factor in many individuals' responses to being called out on racial microaggressions. Sometimes these feelings turn into what is called a "shame spiral," where feelings of shame deepen and become so overwhelming that the individual can only focus on their own feelings (Kaufman, 1992). Once a shame spiral begins, the emotional attention is fixed on the person who committed the racial microaggression, thus centering the microaggressor's feelings rather than addressing the harm they caused. As described in Pendler and Beverly (2015, p.12):

> The deceptive element of the shame spiral is that it allows the person to place the responsibility for the statement, behavior, or belief on something outside of him or herself. It elevates responsibility to the cultural level and absolves the transgressor without ever addressing the damage of the original interaction that was challenged.

Identifying and discussing shame is an important part of explaining the CPR Model, as it encourages participants to recognize and normalize their shame response and the feelings of overwhelm it may cause, while still locating the responsibility for harm and ability to create as much change as they can within their purview.

White Fragility

Another key concept that informed the development of the CPR Model is white fragility. White fragility describes the expectation that white people remain in racial comfort at all times, and thus they have a low ability to tolerate racial stress (DiAngelo, 2011). Whenever that racial comfort is challenged – e.g., being told you committed a racial microaggression – the feelings of discomfort that are triggered feel intolerable and often trigger a range of intensely defensive emotions and reactions designed to return to their desired state of white racial equilibrium. Because white people in general are inexperienced in being confronted with racism – or even talking about race in any way that does not center whiteness – they often lack the socio-cognitive skills to engage in constructive discussion about racism and their own role in upholding it. Consequently, being challenged on their racist words or behaviors feels so threatening that they feel physically unsafe, provoking an amygdala

(fight/flight/freeze) response. However, this sense that white people are unsafe when simply talking about racism discounts and minimizes the centuries of institutional harm – in the form of enslavement, lynching's, Jim Crow, mass incarceration, and other atrocities – experienced by BBI communities through white supremacy (Alexander, 2012; DiAngelo, 2011).

Additionally, white people have had the privileged ability to remain largely ignorant of the experiences of BBI folx and the historic systems of racial oppression that enable and perpetuate racism, which often leads to them questioning, doubting, or outright dismissing the experiences and perspectives of BBI folx after being called out (DiAngelo, 2011). It is therefore a necessary step in the CPR Model that they instead demonstrate humility by acknowledging their ignorance and seeking to educate themselves. It is important that this education is also considered through an anti-racist lens and should be sought through channels that either acknowledge and compensate BBI folx when they offer their emotional and intellectual labor, or by accessing any of the many available other resources that have already been developed around this topic.

Pendler and Beverly (2015) developed an analogy to describe the way white people's brains often react when they are confronted with a challenge to their racial equilibrium, which they named the Root Kit Program (2015). A computer root kit is a set of software tools that enable an unauthorized user to gain control of a computer system without being detected. The Racism Root Kit analogy posits that the human brain runs an automatic and unconscious process that immediately activates to try to gain control in a situation of racial stress (Pendler & Beverly, 2015). The authors argue there are 13 feelings or behaviors in the Racism Root Kit that emerge to prevent the conscious awareness or acceptance of racism, including denial, hurt feelings, shame, defensiveness, attack, and white guilt. Common responses that reflect these feelings and behaviors are listed in the "Defensive Responses" column of Table 1. The intention of the CPR Model is to teach individuals how to override this automatic system so that the response to committing a racial microaggression is thoughtful and intentional rather than automatic or unconscious, and that it stays focused on repairing the harm that the microaggressor caused the BBI person, rather than on maintaining racial equilibrium for the person who committed the racial microaggression.

Values and Priorities of the CPR Model

The authors developed the CPR model using a very specific set of values and priorities as a guide. The assumption is that participants accept, or are at least open to accepting, these values. The CPR Model is not intended for – and will not work for – individuals who are content with ignoring the impact of racism, who shun any feelings of social responsibility around racial harm, or who bristle at the ideas of anti-racism.

The first value behind the CPR Model is that the impact of an action is more important than its intent. This is especially important because often, when people commit a racial microaggression, they unconsciously act from their implicit racial bias and do not intend to be racist. Indeed, as described earlier, some forms of racial microaggressions are intended to be compliments. Implementing the CPR Model requires that the person acknowledges the reality that harm was

caused and prioritizes taking accountability for that harm, rather than arguing about whether or not the person intended to do harm. Simply put, the intent of an individual's words and actions is not an adequate defense if it contributed to furthering the marginalization, oppression, or dehumanization of BBI people and communities.

The second value is that emotional skills are important and valuable. The authors believe that emotional skills are beneficial both in the successful use of the CPR Model, as well as for building healthy reciprocal relationships in general. Specifically, the CPR Model requires that people are able to center and practice empathy. The authors use the work of empathy educator Kate Kenfield (2019) to inform their framing of empathy within the context of CPR. Empathy, according to Kenfield, is "the process of being curious and nonjudgmentally engaged with someone *else's* emotional experience. It is not about *assuming* we know what someone else is feeling. Empathy requires humility. That is part of why it is difficult. Sitting with the uncertainty of someone else's feelings, without knowing what those feelings are or how to fix them, is uncomfortable" (Kenfield, 2019). According to Brené Brown, empathy fuels connection, which is necessary in repairing harm caused by racial microaggressions. The CPR Model also requests that people practice mindfulness skills, including non-judgmental self-awareness – both internally and externally. These skills support the development of emotional regulation, which people need to manage uncomfortable internal feelings without responding to or trying to "fix" them externally.

The third value is that after harm has been caused to a BBI person, the most ethical and trauma-informed response is to move towards healing and repair. This is in direct conflict with American societal norms of punishment for transgressions rather than healing and repair. The CPR Model does not frame apologizing or recognizing that harm has occurred as punishment, although it can create uncomfortable feelings. Instead, the approach aims to repair and heal by applying care and attention.

Finally, the fourth component to the CPR Model is prioritizing racial justice. Racial justice requires an acknowledgement of the fact that the U.S. was founded on – and maintains today – a white supremacist system, and the historical realities of how that system was set up to benefit white people above people with other racial identities (Alexander, 2012; Omi & Winant, 2015). With this understanding, it is imperative that people's actions do not just maintain the status quo. The status quo is a system continuing to afford preferential treatment and opportunities to white people. Instead, people need to actively resist the ways our system creates and perpetuates inequities for BBI people and communities. The CPR Model also requires an understanding of the ways in which historical racial oppression has caused generational trauma to BBI communities (Leary, 2005). That historical and lifelong trauma is often triggered through experiencing daily racial microaggressions in ways that may not be understood in the moment, but should be contextualized within that reality.

Using the CPR Model

Applying CPR as a Tool

At its core, the CPR Model is a template for making an authentic response and taking responsibility for repair after committing a racial microaggression. Below are the steps of the CPR Model, designed to be applied *by the person who committed the racial microaggression*. This response model is *not* intended to be used by the BBI person who was harmed by a racial microaggression. Addressing that situation requires a very different model, which is outside the scope of this paper.

1. **C - Calm Yourself.** The CPR Model begins by specifically naming the emotional stress that people feel when they have been identified as causing harm. While the CPR Model acknowledges this emotional stress, it also tasks the emotional management of this stress as an internal responsibility instead of allowing the person harmed by the racial microaggression, or the surrounding witnesses, to be responsible for managing these emotions. The CPR Model uses education about the autonomic nervous system and basic mindfulness skills to offer the participants tangible tools to help them manage the uncomfortable feelings, and the bodily responses that often accompany them.

When individuals are called out for committing a racial microaggression, their immediate reaction may run the gamut of strong emotions: defensiveness, anger, confusion, fear, humiliation, shame, angst, panic. When individuals are confronted about committing a racial microaggression — either privately or publicly — they often interpret feelings of being uncomfortable with feeling unsafe or being under attack. They may experience physical manifestations — heart pounding, face flushing, palms sweaty, eyes tearing. The feeling of being uncomfortable can be so strong it can trigger an amygdala response (fight/flight/freeze), also known as the acute stress response. When individuals' bodies feel that they are under acute stress, it can be hard to think clearly. Their bodies are acting on instinct to get them out of perceived danger. Defensive words may come tumbling out before they can think, lines such as "That's not what I meant!" or "You misunderstood me!" They become reactive instead of intentional.

A strategy to help keep calm during these uncomfortable sensations is to breathe deeply, which has been validated as a physiologically proven technique to calm the sympathetic nervous system (Brown, 2012). Individuals can use deep breathing to remind themselves that they are not in danger. It may be helpful to think of a calming mantra, such as "I am safe, "I am going to be OK," or simply to count to 10. By taking a few moments to calm down, most people are then able to react in a more controlled way and be more intentional and thoughtful in choosing how to respond. Over time, by practicing this step of calming the autonomic nervous system, it is possible to retrain the body's acute stress response in these types of situations.

2. **P - Practice Humility.** The second step in the CPR Model guides people towards how to frame the interaction in their mind. The construct of humility is characterized by an accurate assessment of one's characteristics, an ability to acknowledge limitations, and a "forgetting of the self" (Tangney, 2012). In the CPR Model, it is a reminder to focus attention on the other person – the person who was harmed by the racial microaggression. It is important to center their feelings and their experiences, rather than the microaggressor's feelings. This step also helps the microaggressors to remember not

to get defensive, explain their intent, or otherwise aim to focus the conversation on their own feelings. While it may be human nature to want to defend oneself by clarifying intentions, that could make the interaction worse by leading to microinvalidations. Defending or explaining is one way of prioritizing the microaggressor's feelings, intentions, or reputation. It does not communicate that harm was caused to a BBI person. Even if there was no intention to cause harm, it is critical to realize the *impact* of microaggressive words and actions. In reality, good intentions often do not matter if the impact of microaggressions is the continued marginalization and dehumanization of BBI folx. A commitment to anti-racism requires the willingness to affirm the perspective of BBI people who have experienced generational trauma through centuries of explicit and implicit racial oppression and reflect on how racial privilege may prevent white people from being able to perceive the impact of racial microaggressions.

In many cases, the individual who committed the racial microaggression gets caught up in trying to prove that what they said was not wrong or harmful. When it comes to racial microaggressions, the pursuit of being right is antithetical to repairing the harm. Even if there was a misunderstanding regarding what was said, the focus in that moment should still remain on the harmed individual. The painful impact of racial microaggressions is rooted in generations of historic oppression — it goes much deeper than a single comment. Thus, focusing on the harm caused by a single comment without understanding the history of oppression that the comment reflected is not sufficient.

In applying step two, people should aim to use words that take responsibility for their actions. [See Table 1 for examples of reparative responses compared to defensive responses.] Because white people are unable to experientially understand the impact of racial microaggressions, they should demonstrate a commitment to listening to and believing BBI folx when they share their experience.

3**. R – Repair.** The final step in the CPR Model guides people towards actions that value the relationship and aim to repair and make amends for the initial racial harm. This step requires the first two elements of the CPR Model to be in effect so that the priority can be considering ways to respond that could 1) prevent the harm from occurring in the future, 2) take accountability for the harm that was caused, and 3) offer support and care to the BBI person harmed.

Repair can happen in a myriad of ways, and it is important that the CPR Model not be formulaic or a script for people to follow. Instead, this step encourages people to consider what repair might look like in each unique situation. As explained in step two, the focus should remain on the BBI person who was harmed by microaggressive words or actions. One common repair strategy includes considering what would need to happen to facilitate future behavior change. Repair is a social process that requires emotional labor. White people should undertake the emotional labor of educating themselves, without placing the burden of providing this type of education on BBI folx. Instead of saying "I don't understand why you are offended, can you explain it to me?" a more reparative response would be, "I realize I need to learn more about this issue so I can better understand why my words had a negative impact and make sure

I don't make this same mistake in the future." While asking BBI folx to do emotional labor is not aligned with the values of the CPR Model, getting consent to ask BBI folx if there are specific actions or responses that would feel healing from their perspective is. Another common repair strategy is to offer a genuine apology. Apologies that center the experience of the BBI folx should not necessitate or request a response or reward from the BBI person.

The most important aspect of the Repair step is to do the work to *change future behavior*. Demonstrating a commitment to learning about racial oppression and understanding the power of words to either perpetuate or fight white supremacy are critical tools to guide the repair of the ruptured relationship.

Table 1: Responses to committing racial microaggressions

Reparative Responses	**Defensive Responses**
I am sorry my words and actions hurt you.	I am sorry if you are offended.
Thank you for holding me accountable. Thank you for doing the emotional labor to let me know.	Why are you being so sensitive?
I recognize I have work to do about this.	No one else was offended.
I will reflect on this so I can do better next time.	I am deeply hurt that you think I am racist.
I need to learn more about this and will take responsibility for educating myself.	You are being so divisive.
What can I do to regain your trust? How can I make this right?	I feel attacked.
I understand that what I said/did hurt you and I am so sorry.	I'm not privileged. I've had a hard life, too.

Changing behavior that stems from implicit racial bias requires an ongoing commitment to unlearning white supremacy and practicing new emotional skills. Part of the racial microaggressions training includes providing opportunities for all participants to demonstrate the CPR Model through small group role plays. Facilitators encourage participants to develop calming strategies and some possible responses in their own words as well as think about how they will react the next time — acknowledging that there most likely WILL BE a next time eventually — so that they can intentionally react in a thoughtful manner.

Applying CPR as a Practice

The CPR Model is more than a post-microaggression intervention, it is also an ongoing practice for actively working against implicit racial bias. The same steps apply in practicing CPR, though they may look different for white people than for BBI people. Below are the steps of the CPR Model as a practice, designed to be applied *by everyone with a commitment to racial justice.*

1. C – Calm Yourself. Previously, we stated that both white and BBI participants attend training with heightened anxiety and fear about discussing racism. This activated state of the body increases the likelihood of amygdala responses and could make it more difficult to apply CPR in the moment if one's central nervous system is already flooded with stress hormones. We offer that both white bodies and BBI bodies could benefit from intentional efforts to reflect on how racism and white supremacy inform and affect attitudes and beliefs, and how this manifests somatically. This awareness takes repetition and a focus on what physical sensations arise when these beliefs and attitudes are activated. For white people, this should look like dismantling white fragility through shame tolerance and management, which can be practiced through connecting with other white people who are consciously working to unpack their white privilege and sever ties with white solidarity, and establishing an accountability group for ongoing support and information that does not come at the expense of unpaid, non-consensual labor from BBI folx. As an in-the-moment tool, Calm Yourself serves the purpose of halting amygdala responses so that microinvalidations can be prevented and people can respond instead of react to the microaggression they committed. As an ongoing practice, Calm Yourself deepens this intervention so that a body is already calm when called out on a microaggression and the microaggressor can move right into Practice Humility.

For BBI folx, calming both self and community around racism and white supremacy is first and foremost an act of self-love. We are not suggesting that BBI folx "get over" or even through racism by ignoring the psychological and physiological impacts on their bodies; rather we highly suggest that BBI folx take more time to notice and respond to both fresh and old wounds from racism, validate their own and other BBI peoples' experiences of racism and white supremacy, and most importantly, that BBI folx take as much time as possible to rest. Specific practices for this are recommended in the book "My Grandmother's Hands: Racialized Trauma and the Mending of Our Bodies and Hearts" by Resmaa Menakem. Over time, Calm Yourself can help prevent dissociation and other trauma responses which may not only prevent future microaggressions, but also mitigate the harmful effects of racism and white supremacy.

2. P - Practice Humility. The quickest way to Practice Humility after committing a microaggression is to prioritize impact over intent. As an ongoing practice of thinking of oneself less instead of thinking less of oneself (see Shame section), Practice Humility looks like proactively educating oneself about other cultures for the purposes of decreasing the likelihood of making an ignorant comment in the form of a racial microaggression. For white people, this looks like not only educating oneself about BBI cultures, but also acknowledging that white culture exists as the norm due to centuries of colonization

and erasure of BBI culture, and that what feels normal to a white person and/or people indoctrinated in a white supremacy is not superior. For BBI folx, Practice Humility could look like educating oneself about other cultures of color as well as the diversity within one's own culture – a history that was most likely not included in any U.S. formal education. Both of these practices are rooted in maintaining a consistent internal sense of curiosity, and the assumption that there is always more to learn and more variation and diversity than what has been encountered thus far.

While Calm Yourself is self-focused and an act of self-love and care, Practice Humility is other-focused, and its emphasis is on responsible, consensual community care. The CPR Model is an intervention designed to keep people connected during conflict and hopefully strengthen communication and relationship building after racial harm has been caused. With the first two steps focusing on self and other, the last step naturally centers around the relationship between the microaggressor and the BBI person who was targeted.

3. R – Repair. Ongoing repair is the most nebulous aspect of the CPR Model as a practice because the stages of repair are contingent upon the context of the relationship. In other words, repair with a new co-worker typically looks different than repair with an intimate partner. Similar to Repair in the moment, an ongoing practice of repair also depends on how capable and resourced the microaggressor and the BBI target are, and resources can shift over time; also, the people involved in the relationship may have differing opinions on definitions of repair. It is critical to gain consent from the BBI person who was harmed before continuing to embark on repairing the harm that was caused. In other words, the decision-making power and timeline around discussions and actions towards repair need to be determined by the BBI person who was harmed.

The successful navigation of conflict can lead to strengthening communication and connection, but sometimes racial microaggressions cause ruptures that cannot be repaired. This does not relieve the microaggressor of their duties of continuing to work on repair; instead, it is an invitation to deepen one's understanding about their impact on others without falling into a shame spiral, as well as maintaining a commitment to lasting behavior change. Used solely as an in-the-moment tool, the stage of Repair has the potential to amplify the harm caused by a microaggressor. Instead, it is imperative to increase attunement to the needs and wants of the person who was harmed. As an ongoing practice, Repair has the potential to prevent future microaggressions and continue to foster healing after relationship ruptures have been restored to equilibrium. For white people who have committed a microaggression, an ongoing practice of repair could include standing up for and in solidarity with BBI people, de-centering your own voice, and supporting and amplifying BBI voices, leadership, and decision-making. For BBI people, repair might include ways of accessing racial affirmation and validation, celebrating BBI joy, investing in therapeutic practices where possible. It may involve the practice of incorporating "microaffirmations," which are defined as "small acts, which are often ephemeral and hard-to-see, events that are public and private, often unconscious but very effective, which occur wherever people wish to help others to succeed" that specifically aim to "value the perspectives, thoughts, and feelings of

the other person within the context of a society that privileges some identities over others" (Rowe, 2008).

Limitations of the Reparative Response Model

The CPR model is intended to guide individuals through a sequential series of decisions, to diffuse defensiveness, to intentionally choose words and actions to demonstrate that they take responsibility for committing a racial microaggression, and to seek to repair the harm that they caused. However, it is not a script. While examples of reparative responses are offered in Table 1, the responses must be based on the microaggressor's sincere feelings of humility and an honest desire to apologize and repair the harm that was caused. The conversations need to be customized so that they respond to the unique situations and relationships. In past trainings, participants have often sought examples of specific words, disclosing that they "just want to say the right thing" or they "don't want to make it worse." Practicing the CPR Model in trainings, or with colleagues or friends before it needs to be used in a response to committing a racial microaggression is often helpful for individuals to gain confidence in using the CPR Model in an authentic way. Practicing the three steps also helps individuals develop emotional skills of being able to tolerate discomfort and override the brain's automatic defensiveness that often make these situations worse. Using the CPR Model does not ensure that there will be repair, that the person harmed by the microaggression will feel they were able to move towards healing, or that the person who committed a microaggression will have a comfortable sense of closure after the interaction. It is useful as a guide, but not to be seen as a guarantee for any outcome.

We are offering the CPR Model as a communication tool. It is not an intervention that has been tested or developed into some type of measurement. Evaluation feedback results have demonstrated that participants who have learned the CPR Model find it overwhelmingly useful. Future research could include testing the applications of the CPR Model and measuring behavior change or other outcomes.

Other Applications

The CPR Model can be applied in many situations, including professional settings where an individual commits a microaggression in an interaction with a client, where there is a clear power differential. In those instances, additional work is needed during the Repair phase to center the needs of the harmed person. Ideally, the client should be offered options for continuing their interaction with your agency/company so that they can make choices to accommodate their safety and comfort. For example, in a healthcare setting, asking "Would you like to continue with another medical provider?" may be appropriate.

While the CPR Model was designed specifically for racial microaggressions, it has been adapted for use in trainings for application with other kinds of microaggressions – specifically, transgender and mental health microaggressions. The co-authors are in a collaborative process with colleagues and other scholars of determining whether the model applies equally as well to other kinds of microaggressions (gender, sexual orientation, disability, etc.).

The CPR Model was only designed for individuals to implement after they *commit* a racial microaggression – not for individuals who are on the receiving end of a racial microaggression. BBI folx who are the *target* of a microaggression could benefit from a response model that centers their own feelings and guides them through a decision-making process for whether, when, and how to respond. Likewise, there is a demand for response models for individuals who are bystanders witnessing a microaggression occur. These response models are currently under development by the authors of this manuscript.

Responses to the CPR Model

Since implementation of the CPR model as a training tool in November 2017, more than 2000 participants to date have been trained on their ability to identify, describe, and implement the CPR Model. A sub-analysis of post-training evaluations of 269 participants who received training on and practice in the CPR Model between 2017-2020 (before the COVID-19 pandemic required pausing on these trainings) rated their ability to meet the objective of practicing implementing CPR an average of 3.38 out of 4.00 on a Likert scale. Participants who responded to an open-ended question asking them to list a new fact they learned during training, replied "CPR" or "the response model" 38.2% of the time. The CPR Model was the most cited response to that question, occurring more commonly than any other category, including learning the definitions and types of microaggressions. When asked what they would do differently after the training, participants cited the CPR Model 18.6% of the time and 29.2% of the time when asked what in the training was most useful.

Sample qualitative responses about the CPR model

In response to what they found most useful, one participant replied the following: "The repair step […] was helpful - both for realizing the barriers to repair attempts (for myself) and for realizing what I need from others in their repair attempts directed at me (i.e. vulnerability, lack of expectation that I'll soothe them). Thank you." Another participant replied that the CPR Model was the most challenging part of the training for them "because it was scary and uncomfortable, which is also why I found it most useful". Another wrote: "I had participated in many 'trainings' regarding microaggressions. It was helpful to have a strategy to deal with microaggressions which focused on the injured party and didn't pander to making white people more comfortable."

Conclusion

The CPR Model supports individuals who commit racial microaggressions to recover and begin to repair the harm they have caused. The authors offer CPR as both a tool and an ongoing practice from the perspective that white supremacy needs to be fought on all levels of social systems, from micro to macro. The CPR Model is offered as one tool to address racial harm that occurs on one level – interpersonally. We theorize that the benefits of adopting the CPR Model, which supports people in centering the needs of BBI folx and to value healing and repair, could potentially occur along many social systems, as the consequences of microaggressions have been demonstrated to negatively impact BBI folx from intrapersonal levels to social indicators at macro levels of our culture (Sue, 2010). The authors recognize the continued struggle against white supremacy

requires constant evolution and commitment to rigorous self-evaluation and personal and professional growth. We are hopeful that the CPR Model is framed as one part of a larger conversation that will inevitably require adaptation and development to remain relevant to the constantly evolving fight towards racial justice. Next steps include the development of models for people from BBI communities who have experienced a microaggression and a framework for bystander intervention. This work could also be furthered by the gathering and analyzing of more information about the impacts of learning and beginning to adopt the CPR Model. Even before these steps are taken, the authors believe that the CPR Model is an effective tool aimed at addressing the harm caused by racial microaggressions.

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