8-2020

Examining the Effects of Aspects of Resiliency and Vulnerability on the Relationship Between Experiencing Microaggressions and Mental Health Among Persons of Color

Amanda K. Blume
Utah State University

EXAMINING THE EFFECTS OF ASPECTS OF RESILIENCY AND VULNERABILITY ON THE RELATIONSHIP BETWEEN EXPERIENCING MICROAGGRESSIONS AND MENTAL HEALTH AMONG PERSONS OF COLOR

by

Amanda K. Blume

A dissertation submitted in partial fulfillment
of the requirements for the degree

of

DOCTOR OF PHILOSOPHY

in

Psychology

Approved:

Renee V. Galliher, Ph.D. Major Professor	Melissa Tehee, Ph.D., J.D. Committee Member
Melanie M. Domenech Rodríguez, Ph.D. Committee Member	Scott C. Bates, Ph.D. Committee Member
Jessica Lucero, Ph.D. Committee Member	Richard S. Inouye, Ph.D. Vice Provost for Graduate Studies

UTAH STATE UNIVERSITY
Logan, Utah

2020

ABSTRACT

Examining the Effects of Aspects of Resiliency and Vulnerability on the Relationship Between Experiencing Microaggressions and Mental Health Among Persons of Color

by

Amanda K. Blume, Doctor of Philosophy

Utah State University, 2020

Major Professor: Renee Galliher, Ph.D.
Department: Psychology

Microaggressions have been consistently linked with poorer mental health. This study critically examined factors hypothesized to decrease the negative impact of microaggressions in a sample of 207 young adults of color. In the present study, active coping emerged as a moderator between microaggressions and mental health outcomes. When active coping was low, microaggressions were associated with lower self-esteem ($p = .046$) and increased depression ($p < .001$) and anxiety ($p < .001$). Alternatively, when active coping was high, microaggressions were associated with higher self-esteem ($p = .009$) and decreased depression ($p = .003$), anxiety ($p = .002$), and drug use ($p = .038$). Disengaged coping emerged as a significant predictor of negative outcomes, including decreased self-esteem ($p < .001$) and increased depression ($p < .001$), anxiety ($p < .001$), alcohol use ($p = .006$), and drug use ($p < .001$).

Participants were randomly assigned to one of two conditions to explore emotional impacts of microaggressions. Experimental condition participants were asked to write about recent microaggressions, whereas control condition participants wrote about a neutral stimulus. Participants who wrote about microaggressions experienced significantly increased negative affect ($p = .024$). However, participants with higher active coping styles demonstrated increased positive affect despite writing about microaggressions ($p < .001$). For participants with high disengaged coping styles, positive affect significantly decreased after writing about microaggressions ($p = .006$). Thus, active coping (e.g., addressing the situation, seeking social support, using positive reframing or humor) appears to be a significantly more adaptive method of coping with microaggressions than disengaged coping (e.g., distraction, denial, disengagement, substance use).

(167 pages)

PUBLIC ABSTRACT

Examining the Effects of Aspects of Resiliency and Vulnerability on the Relationship Between Experiencing Microaggressions and Mental Health Among Persons of Color

Amanda K. Blume

Ethnic minorities experience discrimination frequently, especially a subtle form of discrimination called microaggressions—which are linked with poorer mental health. This study examined protective factors against microaggressions. In this study, responding to microaggressions actively (as opposed to ignoring the situation) was linked with better mental health. When use of active coping strategies was low, microaggressions were associated with lower self-esteem and higher depression and anxiety. Alternatively, when use of active coping styles was high, microaggressions were associated with higher self-esteem and less depression, anxiety, and drug use. Responding to microaggressions is a disengaged way (such as attempting to ignore or avoid the situation) was consistently linked with worse mental health, including lower self-esteem and higher depression, anxiety, and substance use.

Participants were randomly assigned to one of two conditions to examine emotional impacts of microaggressions. Experimental group participants wrote about recent microaggressions, whereas control condition participants wrote about a neutral activity. Participants who wrote about microaggressions reported higher negative emotions. Higher use of active coping styles was associated with higher positive

emotions. Alternatively, when the use of disengaged coping strategies was high, positive emotions decreased among experimental condition participants. Results suggest that the healthiest way to manage discrimination is to use active coping (such as addressing or attempting to change the situation, seeking support from friends or family, trying to view the other person's motives and behavior in a more positive light, or using humor to lighten the situation) rather than disengaged (such as distraction, denial, avoidance, or using drugs).

ACKNOWLEDGMENTS

I would foremost like to thank my advisor, Dr. Renee Galliher, for compassionately guiding me through the entirety of this project. I would like to thank my committee members, Drs. Melissa Tehee, Melanie Domenech Rodríguez, Scott Bates, and Jessica Lucero for their thoughtful and kind support throughout this entire process. You are all truly remarkable mentors and human beings, and I could not have asked for a better committee. Although completing a dissertation is inherently a stressful process, you helped make the experience interesting and fun.

I would also like to thank my partner, family, and friends for supporting me through the challenges of graduate school. I could not have done this without your kind words of encouragement and utmost faith in my ability to succeed. I am a better person to have known all of you. To my partner especially, you have been my rock throughout graduate school and I am eternally grateful for your unwavering support and patience these past 5 years. I look forward to the next chapter of our lives and discovering what our relationship can be without the ever-present third-wheel of graduate school. I feel truly blessed to have met you as I began my graduate school journey and elated you are still by my side at the end.

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CHAPTER I

INTRODUCTION

Ethnic minorities frequently experience discrimination, particularly a subtle subtype of discrimination referred to as "microaggressions" (Sue et al., 2007). Unfortunately, these experiences are often so commonplace for persons of color that they are sometimes even experienced as a daily occurrence (Blume, Lovato, Thyken, & Denny, 2012; Jones & Galliher, 2015; Ong, Burrow, Fuller-Rowell, Ja, & Sue, 2013; Sue et al., 2019). Microaggressions, and other forms of discrimination, have been continuously linked with poorer psychosocial functioning (including impairment in social, academic, and vocational domains), mental health (including increased depression and anxiety, as well as lower self-esteem), physical health, and increased alcohol and substance use (e.g., Blume et al., 2012; Brittian et al., 2015; DeCuir-Gunby & Gunby, 2016; Jones & Galliher, 2015; Minikel-Lacocque, 2013; Nadal, Griffin, Wong, Davidoff, & Davis, 2017; Nadal, Wong, Griffin, Davidoff, & Sriken, 2014; O'Keefe, Wingate, Cole, Hollingsworth, & Tucker, 2015; Ong, Cerrada, Lee, & Williams, 2017).

Recent research has focused on protective factors against microaggressions among persons of color, including ethnic identification (e.g., Chen, Szalacha, & Menon, 2014), critical consciousness (e.g., Diemer, Rapa, Voight, & McWhirter, 2016; Jemal, 2017), ethnocultural empathy (e.g., Le, Lai, & Wallen, 2009; Wei, Li, Wang, & Ko, 2016), and various coping strategies (e.g., religion/spirituality, positive reframing, perspective-taking, social support, self-care, social justice activism; Andrade, 2014; Gonzalez, 2017; Hernández, Carranza, & Almeida, 2010; Holder, Jackson, & Ponterotto,

2015; Kuper, Coleman, & Mustanski, 2014). A review of the literature illuminated the complexity of various protective factors, uncovering aspects of resiliency and vulnerability. For example, Jones and Galliher (2015) found that stronger ethnic identity was linked with higher levels of perceived daily racial microaggressions for Native Americans. Additionally, some studies have yielded mixed results concerning the utility of various coping strategies. For example, Andrade observed that certain coping strategies actually exacerbated distress when persons of color encountered specific subsets of microaggressions, but reduced distress when ethnic minorities encountered a different subset of microaggressions. The existing research suggests that there may not be a "one size fits all" approach to effectively handling microaggressions, and that there is more to be gleaned by continued examination of aspects of resiliency/vulnerability, in terms of both short-term (e.g., emotional affect immediately following experiences of microaggressions) and long-term effects (e.g., mental health outcomes).

The goal of this research was to examine aspects of resiliency and vulnerability among persons of color who experience microaggressions, in order to empower those who experience them to successfully navigate these experiences in ways that minimize the damage caused by discrimination. Part One of the study focused on the moderating effects of aspects of vulnerability and resiliency on the relationship between experiencing microaggressions and mental health among ethnic minority individuals. Research examining resiliency factors has almost exclusively focused on ethnic identity; less is known about the role other factors play in experiences of microaggressions and mental health. Additionally, a review of the literature uncovered some potential negative

outcomes associated with factors that are usually conceptualized as increasing resiliency (e.g., Crethar, Dorton-Clark, Erby, Zamora, 2010; Jones & Galliher, 2015; Mossakowski, Wongkaren, Hill, & Johnson, 2019), therefore, continued examination of the complexities of resiliency and vulnerability is warranted.

Part Two of the study involved having participants write about a personal microaggression experience and examined qualitative themes (e.g., type of microaggression, context of microaggression) that emerged through these narratives, as well as explored how thinking about microaggression experiences impacted individuals' emotional affect, and how this relationship may have varied depending on aspects of vulnerability and resiliency. Some research has suggested that factors generally associated with resiliency may actually serve to increase attentiveness to microaggressions, thus elevating the potential of certain risks associated with experiencing discrimination (e.g., Mossakowski et al., 2019), but these studies are limited. Additionally, limited research has demonstrated links between experiences of microaggressions and negative emotional affect, but these studies did not utilize an experimental design, so a causal relationship has not been established (e.g., Mercer, Zeigler-Hill, Wallace, & Hayes, 2011; Nadal, Griffin, et al., 2014; Nealious, 2017). Therefore, this study sought to fill a gap in the literature concerning influences of resiliency/vulnerability factors on subsequent emotional affect after reflecting on a personal microaggression experience. Additionally, this study aimed to establish a link between microaggression experiences and negative emotional affect.

The purpose of this study was to critically examine vulnerability and resiliency

factors in order to help researchers identify who is at the most risk of experiencing negative effects due to microaggressions and shed light on possible interventions that can strengthen resilience within marginalized populations. Information about the negative correlates of microaggressions is abundant, but less is known about what can be done to increase resiliency in the face of discrimination. Therefore, the main objective of this project was to investigate specific protective factors that are capable of change, so that researchers and clinicians may develop interventions that build upon the fierce fortitude present in communities of color.

CHAPTER II

LITERATURE REVIEW

Microaggressions

The blatant racism and overt discrimination that has long been a core experience of people of color in the U.S. have shifted in recent decades towards more subtle, covert discrimination and implicit racial biases (Sue et al., 2007). Researchers studying modern forms of discrimination have extensively documented the negative effects of covert discrimination, referred to as microaggressions. Chester Pierce was the first to use the term microaggression. He described microaggressions as "subtle, innocuous, preconscious, or unconscious degradations, and putdowns, often kinetic but capable of being verbal and/or kinetic" (Pierce, 1995, p. 281). Pierce indicated that although an individual microaggression may seem harmless, the cumulative burden of a lifetime of microaggressions can be quite detrimental, contributing to "diminished mortality, augmented morbidity, and flattened confidence" (Pierce, 1995, p. 281).

A wealth of recent literature has focused on racial microaggressions, with Sue and colleagues offering the most extensive definitions and evidence of their effects. Sue et al. (2007) expanded Pierce's definition of microaggressions, referring to them as "brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group" (p. 273). According to Sue et al., microaggressions are so pervasive and automatic that perpetrators are often not

consciously aware of their implications, and microaggressions are therefore often dismissed or glossed over as being innocent and innocuous.

Types of Microaggressions

Sue et al. (2007) describe three main types of microaggressions: microinsults, microinvalidations, and microassaults. Microinsults are often unconscious on the part of the perpetrator and entail "behavioral/verbal remarks or comments that convey rudeness, insensitivity, and demean a person's racial heritage or identity" (Sue et al., 2007, p. 278). Microinvalidations are also often unconscious and include "verbal comments or behaviors that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of a person of color" (Sue et al., 2007, p. 278). Microassaults, often conscious and deliberate on the part of the perpetrator, refer to "explicit racial derogations characterized primarily by a violent verbal or nonverbal attack meant to hurt the intended victim through name-calling, avoidant behavior, or purposeful discriminatory actions" (Sue et al., 2007, p. 278).

Specific forms (or subtypes) of microaggressions are associated with each of the three overarching types described above. Microinsults include: *ascription of intelligence* (i.e., assigning a degree of intelligence to a person of color based on their race), *second-class citizen* (i.e., treated as a lesser person or group), *pathologizing cultural values/communication styles* (i.e., notion that the values and communication styles of people of color are abnormal), and *assumption of criminality* (i.e., presumed to be a criminal, dangerous, or deviant based on race/ethnicity; Sue et al., 2007). Microinvalidations include: *alien in own land* (i.e., belief that visible racial/ethnic

minority citizens are foreigners), *color blindness* (i.e., denial or pretense that a White person does not see color or race/ethnicity), *myth of meritocracy* (i.e., statements which assert that race/ethnicity plays a minor role in life success), *denial of individual racism* (i.e., denial of personal racism or one's role in its perpetuation; Sue et al., 2007). Microassaults can include ethnic slurs (e.g., referring to someone as "colored" or "Oriental"), displaying a swastika, deliberately serving a White customer before an ethnic minority customer, or discouraging racial interactions (Sue et al., 2007). From a macro-level perspective, any of these three forms of microaggressions (i.e., insults, invalidations, assaults) can be manifested on systemic and environmental levels, referred to by Sue et al. as *environmental microaggressions*. Furthermore, Nadal (2011) also proposed another specific form of microaggression: *assumption of similarity* (i.e., assuming that all people of a certain race/ethnicity would be the same).

Prevalence

Numerous studies have highlighted the pervasiveness of experiences of microaggressions among persons of color. One such study indicated that college students of color experienced an average of 291 racial and ethnic microaggressions over a three-month period (Blume et al., 2012). In a study by Jones and Galliher (2015), 98% of Native American young adults reported experiencing microaggressions. Other studies have also observed high instances of microaggression experiences and other forms of discrimination. For example, one study indicated that 78% of Asian college students reported experiencing microaggressions over a 2-week period (Ong et al., 2013). Furthermore, in a major survey of over 3,300 respondents, over 75% of Black Americans

reported daily discrimination (American Psychological Association [APA], 2016).

Outcomes/Correlates

An extensive body of literature has documented the negative effects of microaggressions on persons of color, including emotional turmoil and negative impacts on mental health, psychological well-being, and self-esteem (e.g., Blume et al., 2012; Brittian et al., 2015; Jones & Galliher, 2015; Minikel-Lacocque, 2013; Nadal, Wong et al., 2014; Sue et al., 2019). For example, studies involving ethnic minority college students observed that racial microaggressions were linked with more negative self-concepts, stronger feelings of isolation and being misunderstood (Nadal & Wong et al., 2014; Solorzano, Ceja, & Yosso, 2000), and increased anxiety, depression, impaired sleep, suicidal ideation, and alcohol use (Blume et al., 2012; O'Keefe et al., 2015; Ong et al., 2017). These negative mental health outcomes have been demonstrated across different ethnic groups. For example, several studies have highlighted various associations with increased mental health risks including increased anxiety and depressive symptoms among Black and Latinx students (Brittian et al., 2015; Liao, Weng, & West, 2016), increased feelings of being a burden on others and suicidal ideation among Black college students (Hollingsworth et al., 2017), lower self-esteem and psychosocial functioning and increased substance use for Navajo adolescents (Galliher, Jones, & Dahl, 2011), as well as increased stress, depression, and anxiety, and decreased self-esteem and psychological well-being among Asian American college students (Choi, Lewis, Harwood, Mendenhall, & Huntt, 2017; Kim, Kendall, & Cheon, 2017; Wong-Padoongpatt, Zane, Okazaki, & Saw, 2017).

Some, albeit limited, research has specifically examined the effects of experiences of microaggressions on emotional affect. One such study found that experiencing several subtypes of racial/ethnic microaggressions (i.e., Ascriptions of Intelligence—assigning low or high intelligence on the basis of race/ethnicity, Assumption of Criminality—belief that a racial/ethnic group is more prone to crime, and Assumed Superiority of White Culture) was positively correlated with negative affect among Black college students (Nealious, 2017). Additional studies have also observed increased negative affect among Black college students who endorsed experiences of racial/ethnic microaggressions (e.g., Mercer et al., 2011). Another study found that racial microaggressions were significantly correlated with negative affect, as well as depressive symptoms, among persons of color aged 18 to 66 years (Nadal, Griffin et al., 2014). These studies did not employ an experimental design, therefore, an experimental exploration of the immediate effects of microaggression experiences on subsequent emotional affect is needed to provide evidence of a causal relationship between these experiences.

Research has also implicated microaggressions in negative outcomes for physical health and social and occupational functioning of persons of color. For example, in a study comprised of a diverse sample of adult participants recruited from college and community settings, experiences of microaggressions were correlated with role limitations due to physical health and/or emotional problems (Nadal et al., 2017). Findings suggest that as perceived microaggressions increase, so do physical and emotional difficulties that hinder a person's ability to fulfill various roles and obligations. Additional findings indicated that experiences of microaggressions were also associated

with decreased energy levels, emotional well-being, social functioning, and with more pain, poorer overall health, and decreased job satisfaction (DeCuir-Gunby & Gunby, 2016; Nadal et al., 2017).

Studies have observed the negative correlates of microaggressions across developmental periods and in both college and community samples; however, a gap in the literature exists comparing outcomes between these various groups. Some, albeit limited, research has examined racial/ethnic differences in frequency and perceived distress of experiencing various types of microaggressions. One such study with a sample of ethnic minority adults found that, while controlling for the frequency of exposure to microaggressions, Asian Americans reported comparatively lower distress than other ethnic groups and Latinx Americans reported comparatively higher distress, in response to several types of microaggressions (i.e., foreigner, low-achieving, invisibility, environmental). Additionally, Black Americans reported higher distress than other racial/ethnic groups in response to environmental microaggressions (Torres-Harding & Turner, 2015).

Demianczyk (2015) observed several racial/ethnic differences in frequency of experiences of various types of microaggressions among college students of color. For example, Black participants reported higher rates of various types of microaggressions (i.e., assumption of inferiority and second-class citizen/assumption of criminality) than Asian, Latinx, and multiracial participants. Additionally, Asian participants in the sample reported higher rates of exoticization/assumption of similarity than Black participants, and Black participants reported more work and school -place microaggressions than

Latinx participants. Although the frequency of various types of microaggressions varied between the different racial/ethnic groups examined in the study, the correlations between the overall experience of microaggressions and problematic alcohol use, anxiety, and depression did not significantly differ between the groups (Demianczyk, 2015).

Protective or Resiliency Factors/Vulnerability Factors

In the context of discrimination, Kumsa, Ng, Chambon, Maiter, and Yan (2013) described resiliency as a self-healing process through which minority individuals attempt to construct and reconstruct themselves in a way that minimizes damage from injurious social relations. In this way, resilient adaptation constitutes a relational process (Kubiliene, Yan, Kumsa, & Burman, 2015). Theoretical frameworks of coping and resiliency focus on the variation in different people's responses to the same experiences (Kubiliene et al., 2015; Rutter, 2012). Studying resilience allows researchers to better understand the complexity of how people successfully adapt or even thrive in the face of adversity. In recent years, resiliency theory has shifted from focusing on individual traits (e.g., character) to focus on biopsychosocial factors (e.g., social support) that might facilitate an individual's resilience (Kubiliene et al., 2015). As mentioned previously, resilience can encompass different factors for different people, even if they are facing similar challenges. Not surprisingly, a review of the literature on resilience for racial discrimination highlighted these inconsistencies, thus warranting further examination.

Specifically, recent research has focused on protective factors against microaggressions among persons of color, including ethnic identification, critical

consciousness, ethnocultural empathy, and various coping strategies. A review of the literature illuminated the complexity of various protective factors, uncovering both aspects of resiliency and vulnerability for many of the factors. The existing research suggests that there is more to be gleaned by exploring context and personal characteristics when considering aspects of resiliency/vulnerability.

Ethnic Identity

Protective aspects. Studies suggest that having a cohesive and positive ethnic identity, defined as the degree to which one has a sense of belonging and attachment to one's ethnic group (Nguyen, Wong, Juang, & Park, 2015), may serve as a buffering effect to increase resilience in ethnic minority individuals when they encounter discrimination (Chen et al., 2014) and may offer protective effects for mental health and substance use (Brittian et al., 2015; Choi et al., 2017; Romero, Edwards, Fryberg, & Orduña, 2014; Toomey, Umaña-Taylor, Updegraff, & Jahromi, 2013). For example, findings from studies of Asian American and Pacific Islander college students suggest that ethnic identity serves as a buffer for depressive and somatic symptoms when they encounter microaggressions and other forms of discrimination (Chen et al., 2014; Choi et al., 2017). Similarly, positive ethnic identification moderated the negative effects of discrimination on depressive symptoms and self-esteem among Latinx and Native American adolescents (Romero et al., 2014).

Pugh and Bry (2007) found that higher levels of ethnic identity were significantly related to lower beer/liquor use (31% of variance), wine use (6% of variance), and marijuana use (4% of variance) among Black college students, after controlling for year

in school, sex, and friends' substance use. Another study consisting of 2,007 Asian American adults from across the U.S. found that participants who reported high levels of ethnic identity had lower odds of history of alcohol abuse/dependence disorders (Chae et al., 2008). Ethnic identity moderated the influence of ethnic discrimination, such that for participants with low levels of ethnic identity, ethnic discrimination was associated with greater odds of having a history of alcohol abuse/dependence disorder, compared to participants with high levels of ethnic identity (Chae et al., 2008).

Protective effects of ethnic identification have also been observed for psychosocial health. For example, Galliher, Jones, and Dahl (2011) observed that embeddedness in and connection to Navajo culture served as a buffer to the negative effects of discrimination experiences on psychosocial functioning for Navajo adolescents. Similarly, this trend has also been observed in Latinx adolescent mothers, serving as a protective factor against subsequent externalizing symptoms (Toomey et al., 2013).

Some research has highlighted differences in the protective role of ethnic identification among various racial/ethnic groups. One such study, comprised of a nationwide sample of Latinx and Black college students, observed that the relationship between perceived ethnic group discrimination and depressive symptoms was mediated by ethnic identity affirmation (also referred to as ethnic pride) for Latinx students, such that higher discrimination was linked with higher depression via lower ethnic pride, but not for Black students. Alternatively, ethnic identity resolution (i.e., clarity and commitment regarding one's ethnic group membership) was negatively and indirectly linked with depressive symptoms through ethnic identity affirmation among students

from both ethnic groups, such that higher commitment to one's ethnic group was linked with lower depression via higher ethnic pride (Brittian et al., 2015). Another study, comprised of Black and White college students, found support for ethnic identity as a moderator of the relationship between depression and suicidal ideation for Black but not White students, such that Black participants who reported more symptoms of depression accompanied by poor ethnic identity displayed increased vulnerability to suicidal thoughts (Walker, Wingate, Obasi, & Joiner, 2008).

Aspects of vulnerability: Ethnic minority visibility. Ethnic identification is typically described in terms of its protective effects; however, there is some evidence that higher ethnic minority visibility, due to skin color, phenotypical characteristics, and/or the degree to which a person displays embeddedness in and connection to culture (an aspect of ethnic identification), places individuals at greater risk of experiencing microaggressions (e.g., Adames, Chavez-Dueñas, & Organista, 2016; Uzogara, 2018). For example, Jones and Galliher (2015) found that Native American young adults who reported stronger Native identity also reported higher prevalence of daily racial microaggressions, and this pattern was especially strong for men. In particular, identity exploration (i.e., active engagement in understanding one's ethnic roots, history, and traditions) was especially strongly associated with several forms of microaggressions. Concerning bicultural identification, higher White identification was linked to lower microaggression experiences for men. These findings provide evidence that ethnic identification may also serve as a vulnerability to experiencing increased discrimination and may shed light on some of the unique pressures bicultural persons may feel to

embrace White identities over other marginalized identities, in terms of ethnic identification (Jones & Galliher, 2015).

One possible explanation for this heightened susceptibility may be that persons of color with a greater sense of ethnic identity are at increased risk of being targeted by microaggressions due to increased visibility as a person of color, influenced by appearing (e.g., wearing clothing and hairstyles popular within culture-specific fashion trends) and behaving in a more traditionally culture-specific manner. Another possible explanation is that persons of color with higher ethnic identification demonstrate greater ability to recognize microaggressions and other forms of discrimination and prejudice than do persons of color who identify more with mainstream European American culture. According to Jones and Galliher (2015), discrimination experiences may serve as a catalyst for identity exploration and may prompt persons of color to consider their cultural and sociopolitical context, which may in turn lead to "greater awareness of historical and continuing inequity" (p. 7), rendering persons of color more alert to microaggressions and other forms of oppression. Therefore, persons of color who more closely identify with traditional values may be both more aware of and vigilant towards aspects of discrimination, and also this stronger ethnic identification may actually place them at greater risk of experiencing discrimination (Crethar et al., 2010; Jones & Galliher, 2015).

Critical Consciousness

Protective aspects. The concept of critical consciousness, first developed by Paulo Freire, entails "learning to perceive social, political, and economic contradictions,

and to take action against the oppressive elements of reality" (Freire, 2000, p. 35). Freire observed that oppressed peoples developed perceptions of themselves in relation to society based on their understanding of the social conditions they found themselves in. He noticed that more nuanced understandings of social structures led oppressed peoples to become less constrained by their social conditions, resulting in higher levels of agency to change these conditions (Diemer et al., 2016; Jemal, 2017).

Jemal (2017) stated that, from a critical consciousness perspective, internalized and structural oppression are at the heart of most individual (e.g., substance use, delinquent behavior) and social (e.g., community violence, health disparities, poverty) dysfunction. Jemal asserted that "the cyclical nature between processes (e.g., community policing practices) and outcomes (e.g., racial disparity in mass incarceration) of social injustice create a self-perpetuating phenomenon" (p. 2). A lack of critical consciousness, or inability to recognize how systemic inequities serve to disempower marginalized persons, creates the necessary conditions for the maintenance of oppression (Jemal, 2017). For this reason, critical consciousness has been referred to as an "antidote to oppression," because it provides marginalized persons with the "awareness, motivation, and agency to identify, navigate, and challenge social and structural constraints" (Diemer et al., 2016, p. 5).

Contemporary formulations of critical consciousness focus on three core elements: critical reflection, critical motivation (or efficacy), and critical action (Diemer et al., 2016). Critical reflection has been defined as "the process of learning to question social arrangement and structures that marginalize groups of people" (Diemer et al.,

2016, p. 1). This involves learning to critically examine histories of oppression and colonization, as well as understanding how structures of inequality are maintained by the status quo. Critical motivation refers to "the perceived capacity and commitment to address perceived injustices" (Diemer et al., 2016, p.1). Critical action is described as "engaging individually or collectively to change perceived injustices" (Diemer et al., 2016, p. 1; Watts, Diemer & Voight, 2011).

Diemer et al. (2016) highlighted the importance of critical consciousness for empowering persons of color. They explained that persons with higher levels of critical consciousness are more able to easily recognize systems of disadvantage within society, have more agency to respond to injustices, and are more likely to address inequities by engaging in thoughtful and appropriate social justice activities that have the potential to facilitate desired improvements. Conversely, persons with lower levels of critical consciousness are more likely to fail to recognize systems of disadvantage, ignore or minimize underlying racism or inequity, lack interest or feel powerless to change the situation, avoid discussing or acknowledging the issue, or blame the victims of systems of oppression (Diemer et al., 2016).

Fortunately, critical consciousness is an aspect of resiliency that is capable of being targeted by intervention. It is a strengths-based approach that promotes awareness and active engagement in solutions to challenge inequity underlying major social and health crises within marginalized communities (Jemal, 2017). Critical consciousness interventions promote critical reflection, motivation, and action, and seek "to foster a collective identity (often based on social identities) among participants" (Diemer et al.,

2016, p. 217). Studies of marginalized persons have found that higher levels of critical consciousness were associated with better overall mental health, healthier sexual choices, reduction in substance use, greater academic engagement and achievement, higher enrollment in higher education, civic participation, and higher paying and more prestigious occupations in adulthood (Diemer et al., 2016; Jemal, 2017). Additionally, self-determination and control over one's life, which can be impacted by the development of critical consciousness, have been associated with improved health, wellness, and quality of life (Jemal, 2017; Prilleltensky, Nelson, & Peirson, 2001).

Aspects of vulnerability: Greater ability to recognize microaggressions. Although critical consciousness is frequently cited as a protective factor against discrimination, heightened ability to recognize microaggressions could potentially increase attentiveness to microaggressions, thus elevating the potential of certain risks associated with experiencing discrimination (Buckle, 2018). As discussed previously, critical examination of one's sociopolitical context and various forms of institutional oppression and discrimination may lead persons of color to become more aware of and sensitive to microaggressions and other forms of oppression (Crethar et al., 2010; Jones & Galliher, 2015). For many who begin down the path of critical consciousness, it is as if a curtain has been lifted and they can no longer remain naïve about the oppression that surrounds them, for they see it everywhere they look and cannot return to ignorance of its existence. Thus, critical consciousness, like ethnic identity, can be a double-edged sword.

Ethnocultural Empathy

Most studies examining ethnocultural empathy, the ability to understand how

people with differing ethnic backgrounds think and feel and to see things from others' perspectives (Wei et al., 2016), have highlighted the positive effects of empathy on attitudes towards diversity. For example, ethnocultural empathy has been shown to mediate the relationship between intergroup contact and positive attitudes towards diversity, but not negative ones (Brouwer & Boros, 2010). According to Brouwer and Boros, while empathy can trigger more positive attitudes, it cannot prevent stereotyping, prejudice, and discrimination.

Limited research has explored the relationship between ethnocultural empathy and perceived discrimination or mental health. One study observed a positive correlation between ethnocultural empathy and subjective happiness for ethnic minority youth (Le et al., 2009). Other findings suggest that experiencing discrimination and marginalization may serve to increase ethnocultural empathy by allowing victims to be able to relate to discrimination others have experienced, thus increasing cultural awareness and understanding (Wei et al., 2016).

Coping Strategies/Skills

Kubiliene et al. (2015) provided an explanation of the subtle difference between resilience and coping. They suggested that although coping and resilience can both be understood as diverse responses to challenges, "coping refers to an individual's way of dealing with challenges, whereas resilience refers to their successful adaptation, which might include an effective coping strategy as well" (p. 340). Therefore, coping can be an important part of resilience, but not all coping strategies may constitute resilience. Kubiliene et al. stated "people's appraisals of racialized events, and the meaning and

importance that they attach to racial incidents, define their conscious intentions with respect to coping with these situations" (p. 340).

Various coping strategies have been observed in ethnic minorities who encounter microaggressions and other forms of discrimination. Adaptive strategies reported in the literature include religion and spirituality, armoring (e.g., having a sense of internal excellence and validation, having pride in self, family, and culture), positive reframing and shifting perspective, support networks, sponsorship and mentorship, self-care, using humor, viewing discrimination as a learning experience and impetus for increased motivation to work hard and prove stereotypes wrong, cultural nourishment/ replenishment, and engagement in social justice activism (Andrade, 2014; Gonzalez, 2017; Hernández et al., 2010; Holder et al., 2015; Kuper et al., 2014; Sue et al., 2019). These helpful coping responses are referred to in the literature as "active," "engaged," "adaptive," and "approach-based" strategies and are generally associated with more favorable mental health outcomes, such as greater self-efficacy and less anxiety and depression (Hernández & Villodas, 2019; Hill & Hoggard, 2018; Kuper, Coleman, & Mustanski, 2014; Nadimpalli, Kanaya, McDade, & Kandula, 2016).

Other strategies reported may be effective in the short-term but potentially problematic in the long-term, including repression, venting, rumination, avoidance and withdrawal, alcohol and substance use, emotional numbing, behavioral inhibition, disassociation, and other forms of behavioral and mental disengagement and distancing (Kaholokula et al., 2017; Polanco-Roman, Danies, & Anglin, 2016; Seaton, Upton, Gilbert, & Volpe, 2014; Wei, Alvarez, Ku, Russell, & Bonett, 2010). These less helpful

coping responses are referred to in the literature as “passive,” “disengaged,” “maladaptive,” and “avoidance-based” strategies. One problem with disengaged coping responses is that they “might lead to a racist event being relived (e.g., ruminating) as to prolong the negative emotional response it has on a person” (Kaholokula et al., 2017, p. 2). Additionally, these responses have been linked with greater distress and more negative mental health outcomes (Kuper et al., 2014; Pascoe & Smart Richman, 2009; Polanco-Roman et al., 2016; Sanchez, Adams, Arango, & Flannigan, 2018).

Alternatively, some studies have yielded mixed results concerning the utility of various coping strategies. For example, Andrade (2014) observed that high use of education and advocacy and high involvement in cultural traditions exacerbated distress when persons of color encountered a specific subset of microaggressions (i.e., environmental invalidations). Additionally, high use of detachment reduced distress when persons of color encountered a different subset of microaggressions (i.e., invisibility; Andrade, 2014). These results highlight the complexity of coping strategies used to manage discrimination experiences, suggesting that a “one size fits all” approach may not work for all types of microaggressions. Therefore, the effectiveness of various coping strategies warrants further investigation, and may vary depending on context and personal characteristics of the person experiencing the microaggression.

Summary and Objectives

Ethnic minorities frequently experience microaggressions, often as a daily occurrence. These microaggressions have been consistently linked with poorer

psychosocial functioning (e.g., impairment in social, academic, and vocational domains), mental health (e.g., increased depression and anxiety, lower self-esteem), physical health, and increased alcohol and substance use. A critical examination of the literature on resiliency in the face of discrimination revealed that factors frequently observed to increase resilience among persons of color have also been associated with increased vulnerability, including heighted vigilance and increased microaggression detection (e.g., ethnic identity and critical consciousness). Additionally, various coping strategies employed by persons of color have demonstrated mixed results when utilized to cope with microaggressions, and studies employing experimental designs examining the effects of microaggressions and aspects of resiliency on subsequent emotional affect are lacking. Therefore, more research is needed to examine the complex nature of resiliency and vulnerability, in terms of their short-term effects on emotional affect and long-term effects on mental health.

This study sought to better understand vulnerability and resiliency factors for ethnic minority individuals who experience microaggressions, in order to empower disadvantaged populations to successfully navigate these experiences in ways that minimize the potential damage caused by discrimination. Examining the associations between various vulnerability and resiliency factors and aspects of mental health will help researchers identify who is at the most risk of experiencing negative effects due to microaggressions and shed light on possible interventions that can strengthen resilience within marginalized populations. Information about the negative correlates of microaggressions is abundant, but less is known about what can be done to increase

resiliency in the face of discrimination. Therefore, the main objective of this project was to investigate specific protective factors that are capable of change, so that researchers and clinicians may develop interventions that build upon the fierce fortitude present in communities of color.

This dissertation project involved a two-part study. Part One focused on the moderating effects of aspects of vulnerability and resiliency on the relationship between experiencing microaggressions and mental health among ethnic minority individuals. Research examining resiliency factors has almost exclusively focused on ethnic identity; less is known about the role other factors play in experiences of microaggressions and mental health. A review of the literature uncovered some potential negative effects concerning factors that are usually conceptualized as increasing resiliency, therefore, continued examination of the complexities of resiliency and vulnerability is warranted. Additionally, the few publications that have posited negative effects of microaggressions on emotional affect have not employed experimental designs, so a causal relationship has yet to be established. Therefore, Part Two aimed to critically examine how reflecting on microaggression experiences impacted individuals' subsequent emotional affect (using an experimental design), and how this relationship may have varied depending on aspects of vulnerability and resiliency. Part Two also aimed to explore themes across microaggression narratives and examined associations between themes and ethnicity.

Research Questions

Part One

RQ_1: How did experiences of microaggressions, as well as aspects of vulnerability (e.g., ineffective coping strategies/skills) and resiliency (e.g., ethnic identity, critical consciousness, ethnocultural empathy, effective coping strategies/skills) vary among ethnic minority young adults?

RQ_2: What were the associations between microaggression experiences, aspects of vulnerability and resiliency, and various aspects of mental health (i.e., depression, anxiety, alcohol and substance use, self-esteem)?

RQ_3: Did aspects of vulnerability and resiliency moderate the negative effects of microaggressions on mental health for ethnic minority young adults?

Part Two

RQ_4: How did reflecting on a personal microaggression experience impact ethnic minority individuals' subsequent emotional affect, and what factors (i.e., vulnerabilities, resiliency) predicted subsequent emotional affect?

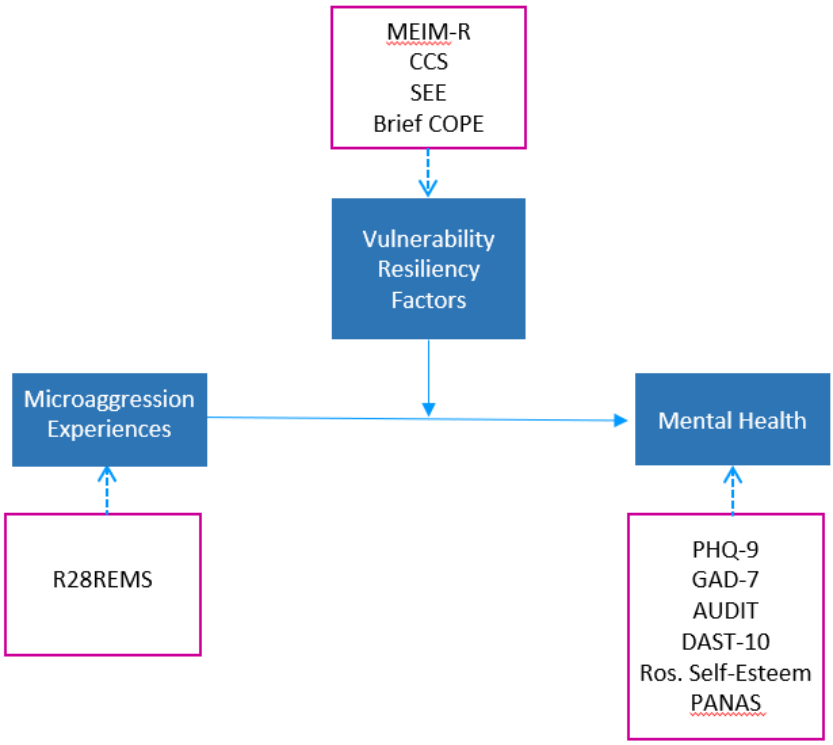
RQ_5: What themes emerged in the microaggression narratives, and did these themes vary by race/ethnicity?

CHAPTER III

METHOD

Design

Part One focused on the moderating effects of aspects of vulnerability and resiliency on the relationship between experiencing microaggressions and mental health among ethnic minority individuals (see Figure 1 for moderation model and associated measures). Part Two utilized an experimental manipulation to critically examine how



Note. R28REMS = Revised 28-Item Racial and Ethnic Microaggressions Scale; MEIM-R = Multigroup Ethnic Identity Measure-Revised; CCS = Critical Consciousness Scale; SEE = Scale of Ethnocultural Empathy; PHQ-9 = Patient Health Questionnaire-9; GAD-7 = Generalized Anxiety Disorder-7 item scale; AUDIT = Alcohol Use Disorders Identification Test; DAST-10 = Drug Abuse Screening Test; Ros. Self-Esteem = Rosenberg Self-Esteem Scale; PANAS = Positive and Negative Affect Schedule.

Figure 1. Moderation model. This figure illustrates the moderation design and measures used in the model.

reflecting on a personal microaggression experience impacted individuals' subsequent emotional affect, and how this relationship may have varied depending on aspects of vulnerability and resiliency. Additionally, Part Two analyzed themes across microaggression narratives and examined whether themes varied by ethnicity. This study's Letter of Information is found in Appendix A.

A survey methodology was used to obtain self-reports of various vulnerability and resiliency factors, mental health outcomes, and positive and negative affect. Demographic variables (e.g., age, gender, ethnicity) were assessed through self-report, based on the demographic question guidelines put forth by Hughes, Camden, and Yangchen (2016; see Appendix B). Additionally, participants in the experimental condition were asked to provide qualitative responses to a prompt asking them to describe a personal microaggression experience, following an explanation of what a microaggression entails (see Appendix C for experimental condition writing prompt). Participants in the control condition were asked to write about a neutral activity (i.e., getting ready in the morning; see Appendix D for writing prompt for control condition). This study utilized a Qualtrics panel to acquire participants and collect data.

Participants

Participants were recruited through a Qualtrics participant panel. Eligibility criteria was provided to Qualtrics and their system recruited and compensated participants. Data collection took place on their secure system, and data was delivered to researchers in an anonymous form. The Qualtrics panel was paid for by dissertation

funding from the Utah State University (USU) School of Graduate Studies and USU Psychology Department. Qualtrics distributed approximately 2,300 email invitations to participate in this study. Of those invited to participate, 1,745 respondents began the Qualtrics survey; 687 of these respondents either did not meet eligibility criteria or stopped the survey without finishing. Another 851 respondents were eliminated because they failed quality checks (e.g., incomplete or random responding, "straight-lining," contradictory responding, typing "gibberish," "speeding" through the survey). The remaining 207 participants passed quality checks and constituted the final sample for this study.

Participants included an ethnically diverse sample of 207 young adults of color living in the U.S., aged 18-30 years (M = 24.1, SD = 3.5), including college students (n = 101) and individuals not attending college (n = 105). The sample included roughly equal numbers of participants from four major racial groups: Asian/Asian American (n = 52), Black/Black American (n = 50), Hispanic/Latinx (n = 52), and Native American/Alaska Native (n = 53). Approximately one-third (33.8%) of the sample identified as multiracial or multiethnic (n = 70). Inclusion criteria was set so that no more than 60% of the participants in either of the two conditions identified as woman, transgender woman, female, or feminine. The majority of the sample (n = 124, 59.9%) identified as female, with 35.7% (n = 74) identifying as male, 1% (n = 2) transgender female, 1.9% (n = 4) gender nonconforming/queer/questioning, and 1.4% (n = 3) as intersex/two-spirit. See Table 1 for more detailed demographic information for each of the four racial groups.

A series of ANOVAs and chi-square analyses assessed for differences among the

Table 1

Demographic Information for Sample

	Asian (n = 52)				Black (n = 50)				Hispanic or Latinx (n = 52)				Native American or Alaska Native (n = 53)			
Variable	*M*	*SD*	*N*	%	*M*	*SD*	*N*	%	*M*	*SD*	*N*	%	*M*	*SD*	*N*	%
Age	24.5	3.4			23.7	3.8			23.4	3.3			24.8	3.6		
Multiracial/ethnic																
Yes			13	25.0			11	22.0			22	42.3			24	45.3
No			39	75.0			36	72.0			28	53.8			27	50.9
Gender																
Male			18	34.6			39	78.0			8	15.4			9	17.0
Female			32	61.5			11	22.0			41	78.8			40	75.5
Transgender or gender non-binary			2	3.8			0	0.0			3	5.8			4	7.5
College student																
Yes			21	40.4			42	84.0			25	48.1			13	24.5
No			31	59.6			7	14.0			27	51.9			40	75.5
Sexual orientation																
Heterosexual			47	90.4			46	92.0			42	80.8			30	56.6
LBGTQA+			5	9.6			3	6.0			10	19.2			23	43.4
Social class																
Poor			2	3.8			5	10.0			3	5.8			11	20.8
Working class			18	34.6			15	30.0			26	50.0			27	50.9
Middle class			30	57.7			29	58.0			20	38.5			15	28.3
Affluent			2	3.8			0	0.0			2	3.8			0	0.0
Geographic location																
Midwest			11	21.2			7	14.0			8	15.4			6	11.3
Northeast			9	17.3			11	22.0			8	15.4			4	7.5
South			13	25.0			23	46.0			16	30.8			23	43.4
West			19	36.5			9	18.0			18	34.6			20	37.7
U.S. territory			0	0.0			0	0.0			2	3.8			0	0.0
Religious affiliation																
Christian			25	48.1			33	66.0			30	57.7			21	39.6
Buddhist			4	7.7			0	0.0			0	0.0			1	1.9
Hindu			4	7.7			1	2.0			0	0.0			0	0.0
Other religion			2	3.8			5	10.0			3	5.8			6	11.4
Nonreligious (e.g., Atheist, Agnostic)			15	28.8			10	20.0			12	23.1			17	32.1

(*table continues*)

	Asian (n = 52)				Black (n = 50)				Hispanic or Latinx (n = 52)				Native American or Alaska Native (n = 53)			
Variable	*M*	*SD*	*N*	%	*M*	*SD*	*N*	%	*M*	*SD*	*N*	%	*M*	*SD*	*N*	%
Political views																
Far left			2	3.8			1	2.0			2	3.8			2	3.8
Liberal			21	40.4			16	32.0			22	42.3			12	22.6
Middle of the road			17	32.7			19	38.0			20	38.5			27	50.9
Conservative			8	15.4			8	16.0			2	3.8			4	7.5
Far right			2	3.8			0	0.0			0	0.0			0	0.0

Note. n = 207

ethnic groups for all demographic variables. The chi-square analysis for multiracial identity was significant, χ^2 (3, n = 200) = 10.10, p = .018, such that Asian and Black participants were less likely to identify as multiracial than Native American and Latinx participants. The chi-square analysis for gender was also significant, χ^2 (6, n = 207) = 57.21, p < .001, such that Black participants were more likely to identify as male than other ethnic groups, and Asian and Black participants were less likely to identify as transgender or gender non-binary than Native American and Latinx participants. Black participants were more likely to be in college than Native American and Asian participants in the sample, χ^2 (3, n = 206) = 40.69, p < .001. Asian and Black participants were less likely to identify as LGBTQA+ than Native American and Latinx participants, χ^2 (3, n = 206) = 27.65, p < .001. Native American and Black participants were less likely to identify as affluent than Asian and Latinx participants, χ^2 (9, n = 205) = 24.42, p = .004. Asian participants were more likely to identify as Buddhist or Hindu, χ^2 (12, n = 188) = 25.66, p = .012. No significant differences emerged among the ethnic groups for age, geographic location, or political views.

The experimental manipulation was arranged so that roughly equal numbers of each racial group would be present in each condition (i.e., experimental versus control). The control condition included 25 Asian/Asian American, 25 Black/Black American, 27 Hispanic/Latinx, and 27 Native American/Alaska Native participants. The experimental condition included 27 Asian/Asian American, 25 Black/Black American, 25 Hispanic/ Latinx, and 26 Native American/Alaska Native participants.

An a priori power analysis using G*Power software yielded a minimum sample size of 178 with an effect size of .15, and power = .95 for proposed analyses for Part One. G*Power does not provide sample estimates for mixed ANCOVA; however, the estimated sample size for a 2 X 2 mixed ANOVA with an effect size of .25, alpha of .05, and power set at .95 was 158. The sample estimate for a 2 X 2 ANCOVA with fixed effects and interactions was 210. Thus, given the additional power provided by the repeated measures design, a sample size of 200 was considered sufficient for proposed analyses for Part Two.

Measures

Microaggressions

The Revised 28-Item Racial and Ethnic Microaggressions Scale (R28REMS) consists of 28 items designed to measure microaggression experiences over the past six months. The scale consists of five subscales: Second-Class Citizen and Assumptions of Criminality (6 items- 1, 2, 5, 7, 19, 26; demonstrating fear or avoidance because of someone's race), Assumptions of Inferiority (7 items- 8, 10, 12, 13, 20, 22, 24; making

assumptions, such as low intelligence and social status, because of someone's race), Assumptions of Similarities (5 items- 3, 17, 21, 27, 28; participation in certain aspects of culture were expected based on the assumptions that all people of that race would be the same), Microinvalidations (6 items- 4, 6, 9, 15, 18, 25; race and racial differences are minimized or invalidated), Media Microaggressions (4 reverse-scored items- 11, 14, 16, and 23; observations of people of color being presented positively in or contributing positively to media). Statements are responded to on a 6-point Likert-type scale (1 = *I did not experience this event*; 6 = *I experienced this event five or more times*) based on the participant's experiences over the past 6 months. Sample items include: Someone clenched her/his purse or wallet upon seeing me because of my race (Second-Class Citizen and Assumptions of Criminality); Someone assumed that I was poor because of my race (Assumptions of Inferiority); Someone told me that all people in my racial group look alike (Assumptions of Similarities). See Appendix E for full scale.

Respondents can obtain a score on each of the five microaggressions subscales as well as a total score, which are determined by calculating the mean of each subscale's item ratings. Higher scores indicate a greater frequency of microaggressions. The scale constitutes a shortened version of the 45-item Racial and Ethnic Microaggressions Scale (REMS) developed by Nadal (2011). Previously demonstrated reliability for the shortened R28REMS scale was good across racial groups (Total Scale $\alpha = .88$; Second-Class Citizen and Assumptions of Criminality $\alpha = .89$; Assumptions of Inferiority $\alpha = .91$; Assumptions of Similarities $\alpha = .80$; Microinvalidations $\alpha = .83$; Media Microaggressions $\alpha = .81$; Forrest-Bank, Jenson, & Trecartin, 2015). For this dissertation

project, only a R28REMS Total Score was used in analyses. Demonstrated reliability for the Total Score within the current sample was α = .90.

Ethnic Identity

The Multigroup Ethnic Identity Measure- Revised (MEIM-R) assesses ethnic identity across diverse groups. Respondents use a 5-point Likert-scale (1 = *strongly disagree*, 5 = *strongly agree*) to answer 6 items designed to assess two factors: Exploration (items 1, 4, and 5) and Commitment (items 2, 3, and 6). Sample items include: I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs (Exploration); I have a strong sense of belonging to my own ethnic group (Commitment). See Appendix F for full scale. Scores for the two subscales and the overall scale are calculated by averaging item values, with higher scores indicating a higher level of ethnic identity. The overall scale previously demonstrated good reliability among ethnically diverse participants (α = .81), with each of the two subscales demonstrating adequate reliability (α = .76 for Exploration; α = .78 for Commitment; Phinney & Ong, 2007). For this dissertation project, only a MEIM-R Total Score was used in analyses. Demonstrated reliability for the Total Score within the current sample was α = .88.

Critical Consciousness

The Critical Consciousness Scale (CCS) is comprised of 22 items that assess three factors of critical consciousness: Critical Reflection: Perceived Inequality (items 1-8; measures critical analysis of socioeconomic, racial/ethnic, and gendered constraints on

education and occupational opportunity), Critical Reflection: Egalitarianism (items 9-13; measures endorsement of societal equality, or all groups of people treated as equals within society), and Critical Action: Sociopolitical Participation (items 14-22; measures participation in social and political activities to change perceived inequalities). Items are scored on a 6-point Likert-type scale (1 = *strongly disagree*, 6 = *strongly agree*) for Critical Reflection items and on a 5-point behavioral frequency scale (1 = *never did this*, 5 = *at least once a week*) for Critical Action items. Item 9 is reverse scored. Sample items include: Certain racial or ethnic groups have fewer chances to get ahead (Critical Reflection: Perceived Inequality); Joined in a protest march, political demonstration, or political meeting (Critical Action: Sociopolitical Participation); All groups should be given an equal chance in life (Critical Reflection: Egalitarianism). See Appendix G for full scale.

Scores for the three subscales are calculated by averaging item values, with higher scores indicating a higher level of critical consciousness. Developers of the scale recommend that each of the three subscales be computed and considered independently, as each factor appears to measure a somewhat distinct aspect of critical consciousness (Diemer, Rapa, Park, & Perry, 2017). The three subscales have previously demonstrated high reliability among ethnically diverse participants ($\alpha = .90$ for Critical Reflection: Perceived Inequality; $\alpha = .88$ for Critical Reflection: Egalitarianism; $\alpha = .85$ for Critical Action: Sociopolitical Participation; Diemer et al., 2017). Demonstrated reliability for the subscales within the current sample was $\alpha = .94$ for Critical Reflection: Perceived Inequality, $\alpha = .82$ for Critical Reflection: Egalitarianism, and $\alpha = .91$ for Critical Action:

Sociopolitical Participation.

Ethnocultural Empathy

The Scale of Ethnocultural Empathy (SEE) assesses empathy toward people of racial and ethnic backgrounds different from one's own. It consists of 31 items that assess four factors: Empathic Feeling and Expression (15 items- 3, 9, 11-18, 21-23, 26, and 30), Empathic Perspective Taking (7 items- 2, 4, 6, 19, 28, 29, and 31), Acceptance of Cultural Differences (5 item- 1, 5, 8, 10, and 27), and Empathic Awareness (4 items- 7, 20, 24, and 25). Each item is rated on a 6-point Likert-type scale (1 = *strongly disagree*, 6 = *strongly agree*). Twelve items are reverse scored (items 1, 2, 5, 8, 10, 16, 17, 21, 27, 28, 29, and 31). Scores for the four subscales and the overall scale are calculated by summing the item values, with higher scores indicating a higher level of ethnocultural empathy (Wang et al., 2003; Wei et al., 2016). Sample items include: I get disturbed when other people experience misfortunes due to their racial or ethnic backgrounds (Empathic Feeling and Expression); It is easy for me to understand what it would feel like to be a person of another racial or ethnic background other than my own (Empathic Perspective Taking); I can see how other racial or ethnic groups are systematically oppressed in our society (Empathic Awareness). See Appendix H for full scale.

The overall scale previously demonstrated high reliability (α = .91), with the subscales demonstrating adequate to high reliability (α = .89 for Empathic Feeling and Expression; α = .75 for Empathic Perspective Taking; α = .73 for Acceptance of Cultural Differences; α = .76 for Empathic Awareness; Wang et al., 2003). Additionally, in studies involving ethnically diverse participants, demonstrated reliability for the overall scale and

subscales also ranged from adequate to high (e.g., α = .90 for overall scale; α = .88 for Empathic Feeling and Expression; α = .78 for Empathic Perspective Taking; α = .67 for Acceptance of Cultural Differences; α = .70 for Empathic Awareness; Cundiff & Komarraju, 2008). For this dissertation project, only a SEE Total Score was used in analyses. Demonstrated reliability for the Total Score within the current sample was α = .84.

Coping Strategies

The Brief COPE measures both active and disengaged (sometimes referred to as adaptive and maladaptive) methods of coping. The scale consists of 28 items measuring 14 types of coping, including self-distraction (1, 19), active coping (2, 7), venting (9, 21), positive reframing (12, 17), humor (18, 28), use of emotional support (5, 15), use of instrumental support (10, 23), planning (14, 25), acceptance (20, 24), religion (22, 27), denial (3, 8), substance use (4, 11), behavioral disengagement (6, 16), and self-blame (13, 26). These 14 types of coping represent the 14 two-item subscales of the measure. Participants respond with how often they employ each method of coping on a 4-point Likert-type scale (1 = *I haven't been doing this at all*, 4 = *I've been doing this a lot*). Sample items include: I've been turning to work or other activities to take my mind off things (Self-Distraction); I've been criticizing myself (Self-Blame); I've been concentrating my efforts on doing something about the situation I'm in (Active Coping). See Appendix I for full scale. Subscale scores (ranging from 2-8) are calculated by summing the item values, with higher scores indicating more frequent use of that coping style. Previously demonstrated reliability for the various subscales ranged from α = .50 to

α = .90, with the majority of the subscales exceeding α = .60 (except Venting, Denial, and Acceptance; Carver, 1997).

Previous research examining factor structure of the measure has uncovered two higher order factors: Active Coping and Disengaged Coping (e.g., S. David & Knight, 2008; Ruiz et al., 2015). Consistent with previous uses of the measure, subscales were combined into two higher order factors (i.e., Active Coping and Disengaged Coping) within this study. Higher order factors are calculated by taking the mean of all items within each factor, with higher scores indicating more frequent use of that coping style. The Active Coping factor includes the following eight subscales: Use of Emotional Support, Use of Instrumental Support, Active Coping, Positive Reframing, Planning, Humor, Acceptance, and Religion. The Disengaged Coping factor includes the following six subscales: Self-Distraction, Denial, Substance Use, Behavioral Disengagement, Venting, and Self-Blame (S. David & Knight, 2008). The two higher order factors have previously demonstrated adequate to high reliability across several ethnic groups (ranging from α = .74 to α = .87; S. David & Knight, 2008; Ruiz et al., 2015). Demonstrated reliability for the subscales within the current sample was α = .92 for Active Coping and α = .86 for Disengaged Coping.

Depressive Symptoms

The Patient Health Questionnaire- 9 (PHQ-9) is a frequently used screening tool and severity measure for depression in clinical and non-clinical individuals. It is comprised of nine items that correspond to various symptoms of depression (e.g., loss of interest or pleasure, low mood, sleep difficulties, fatigue). Items are responded to on a 4-

point Likert-type scale (0 = *not at all*, 3 = *nearly every day*). Sample items include: Feeling down, depressed, or hopeless; Thoughts that you would be better off dead or of hurting yourself in some way; Poor appetite or overeating. See Appendix J for full scale. The measure is scored by summing scores on items to produce a Total Score ranging from 0-27, with higher scores indicating higher depression (with scores 1-4, 5-9, 10-14, 15-19, and 20-27 reflecting minimal, mild, moderate, moderately severe, and severe depression levels, respectively). The scale previously demonstrated high reliability in two validation studies (α = .89, α = .86; Kroenke, Spitzer, & Williams, 2001). Furthermore, recent studies examining factor structure and measurement invariance of the PHQ-9 across diverse ethnic groups have observed that the PHQ-9 assesses depressive symptoms equivalently across gender and racial/ethnic groups (e.g., Galenkamp, Stronks, Snijder, & Derks, 2017; Keum, Miller, & Inkelas, 2018). Demonstrated reliability within the current sample was α = .91.

Anxiety Symptoms

Generalized Anxiety Disorder- 7 item (GAD-7) scale is a frequently used screening tool and severity measure for generalized anxiety disorder (GAD) in clinical and non-clinical individuals. It is comprised of 7 items which correspond to various symptoms of GAD (e.g., feeling nervous or on edge, difficulty controlling worry, difficulty relaxing, restlessness, irritability). Items are responded to on a 4-point Likert-type scale (0 = *not at all*, 3 = *nearly every day*). Sample items include: Not being able to stop or control the worry; Worrying too much about different things; Being so restless that it is hard to sit still. See Appendix K for full scale. The measure is scored by

summing scores on items to produce a Total Score ranging from 0-21, with higher scores indicating higher anxiety (with scores ≥ 5, ≥ 10, and ≥ 15 reflecting mild, moderate, and severe anxiety levels, respectively). The scale demonstrated high reliability in the initial validation study (α = .90; Spitzer, Kroenke, Williams, & Löwe, 2006) and, more recently, demonstrated high reliability within various ethnic groups (e.g., for Latinx populations α = .93; Mills et al., 2014). Demonstrated reliability within the current sample was α = .94.

Alcohol Use

The Alcohol Use Disorders Identification Test (AUDIT) consists of a 10-item questionnaire, established and validated by the World Health Organization, which screens for hazardous or harmful alcohol consumption. The AUDIT assesses three conceptual domains including hazardous consumption (Items 1-3), dependence symptoms (Items 4-6), and harmful consequences (Items 7-10). Response anchors for the items vary by question. Sample items include: How often do you have a drink containing alcohol?; How often during the last year have you found that you were not able to stop drinking once you started?; Have you or someone else been injured as a result of your drinking? See Appendix L for full scale. The measure is scored by summing scores on items to produce a Total Score ranging from 0-40, with higher scores indicating higher harmful alcohol use (with scores ≥ 8 indicating hazardous or harmful alcohol use; Saunders, Aasland, Babor, de la Fuente, & Grant, 1993). Previously demonstrated reliability for the scale was high (α = .80 across 10 studies comprised of ethnically diverse samples; de Meneses-Gaya, Zuardi, Loureiro, & Crippa, 2009). Additional studies have also demonstrated high reliability for the measure within various ethnic groups (e.g., for

American Indians α ≥ .90, Leonardson et al., 2005). Demonstrated reliability within the current sample was α = .90.

Substance Use

The Drug Abuse Screening Test (DAST-10) assesses drug use, not including alcohol or tobacco use, in the past year. Each of the 10 items is answered *yes* (1) or *no* (0), with higher scores indicating greater degree of problems related to drug use. Item 3 is reverse scored. Sample items include: Have you used drugs other than those required for medical reasons?; Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?; Do you ever feel bad or guilty about your drug use? See Appendix M for full scale. The measure is scored by summing scores on items to produce a Total Score ranging from 0-10 (with scores 1-2, 3-5, 6-8, and 9-10 reflecting low, moderate, substantial, and severe levels of problems, respectively; Skinner, 1982). A literature review conducted by Yudko, Lozhkina, and Fouts (2007) uncovered two studies examining psychometric properties of the DAST-10, one with a predominantly White sample and one with a psychiatric sample from India. In both of the studies, demonstrated reliability for the scale was high (α = .86 and α = .94, respectively; Yudko et al., 2007). Additionally, longer versions of the DAST have previously demonstrated high reliability within ethnically diverse samples (e.g., α = .92; El-Bassel et al., 1997). Demonstrated reliability within the current sample was α = .79.

Self-Esteem

The Rosenberg Self-Esteem Scale consists of 10 items designed to assess global

self-worth by measuring both positive and negative feelings about the self. All items are answered using a 4-point Likert-type scale (0 = *strongly disagree*, 3 = *strongly agree*). Items 2, 5, 6, 8, and 9 are reverse scored. The scale is believed to be unidimensional. Sample items include: On the whole, I am satisfied with myself; I feel that I'm a person of worth, at least on an equal plane with others; I take a positive attitude toward myself (Rosenberg, 1965). See Appendix N for full scale. The measure is scored by summing scores on items to produce a Total Score ranging from 0-30, with higher scores indicating higher self-esteem. Previously demonstrated reliability for the scale was high across various demographic groups living within the U.S. (α = .91; Sinclair et al., 2010). Additionally, studies comprised of predominantly ethnic minority samples have also demonstrated adequate to high reliability (e.g., for samples comprised of Black women, reported Chronbach's alphas ranged from α = .79 to α = .86; Hatcher, 2007; Hatcher & Hall, 2009) and measurement invariance across diverse ethnic groups (Michaels, Barr, Roosa, & Knight, 2007). Demonstrated reliability within the current sample was α = .91.

Positive and Negative Affect

The Positive and Negative Affect Schedule (PANAS) consists of 20 items that cover two mood scales (i.e., positive and negative affect). Each mood scale is comprised of 10 items. Each item pertains to a different emotion/feeling and each are responded to using a 5-point Likert-type scale (1 = *very slightly or not at all*, 5 = *extremely*). Time instructions can be varied (e.g., moment, today, past few days/weeks, year, general). For the purpose of this study, participants were asked to respond to items based on how they felt *at this moment*, to allow for assessment of potential affect changes between the

repeated measures. Sample items include: Interested; Distressed; Inspired; Irritable. See Appendix O for full scale. Each subscale is calculated separately, by summing scores of the items within each subscale to produce a Positive Affect score and Negative Affect score. The Positive Affect subscale consists of items 1, 3, 5, 9, 10, 12, 14, 16, 17, and 19. Scores can range from 10-50, with higher scores representing higher levels of positive affect. The Negative Affect subscale consists of items 2, 4, 6, 7, 8, 11, 13, 15, 18, and 20. Scores can range from 10-50, with higher scores representing higher levels of negative affect.

Previously demonstrated reliability for the scale was high (ranging from $\alpha = .86$ to $\alpha = .90$ for positive affect, and from $\alpha = .84$ to $\alpha = .87$ for negative affect, depending on the time instructions given; Watson, Clark, & Tellegen, 1988). In studies comprised of predominately ethnic minority samples, the PANAS demonstrated adequate reliability for both subscales (e.g., $\alpha = .79$ for Negative Affect, $\alpha = .82$ for Positive Affect; Vera et al., 2011). Demonstrated reliability for the subscales within the current sample ranged from $\alpha = .91$ (Time 1) to $\alpha = .94$ (Time 2) for Positive Affect, and $\alpha = .90$ (Time 1) to $\alpha = .93$ (Time 2) for Negative Affect.

Procedure

Figure 2 illustrates the experimental design and order of measures used in the study. Self-report measures were used to gather information on microaggressions, ethnic identity, critical consciousness, ethnocultural empathy, coping strategies/skills, depression, anxiety, self-esteem, alcohol and substance use, and positive and negative

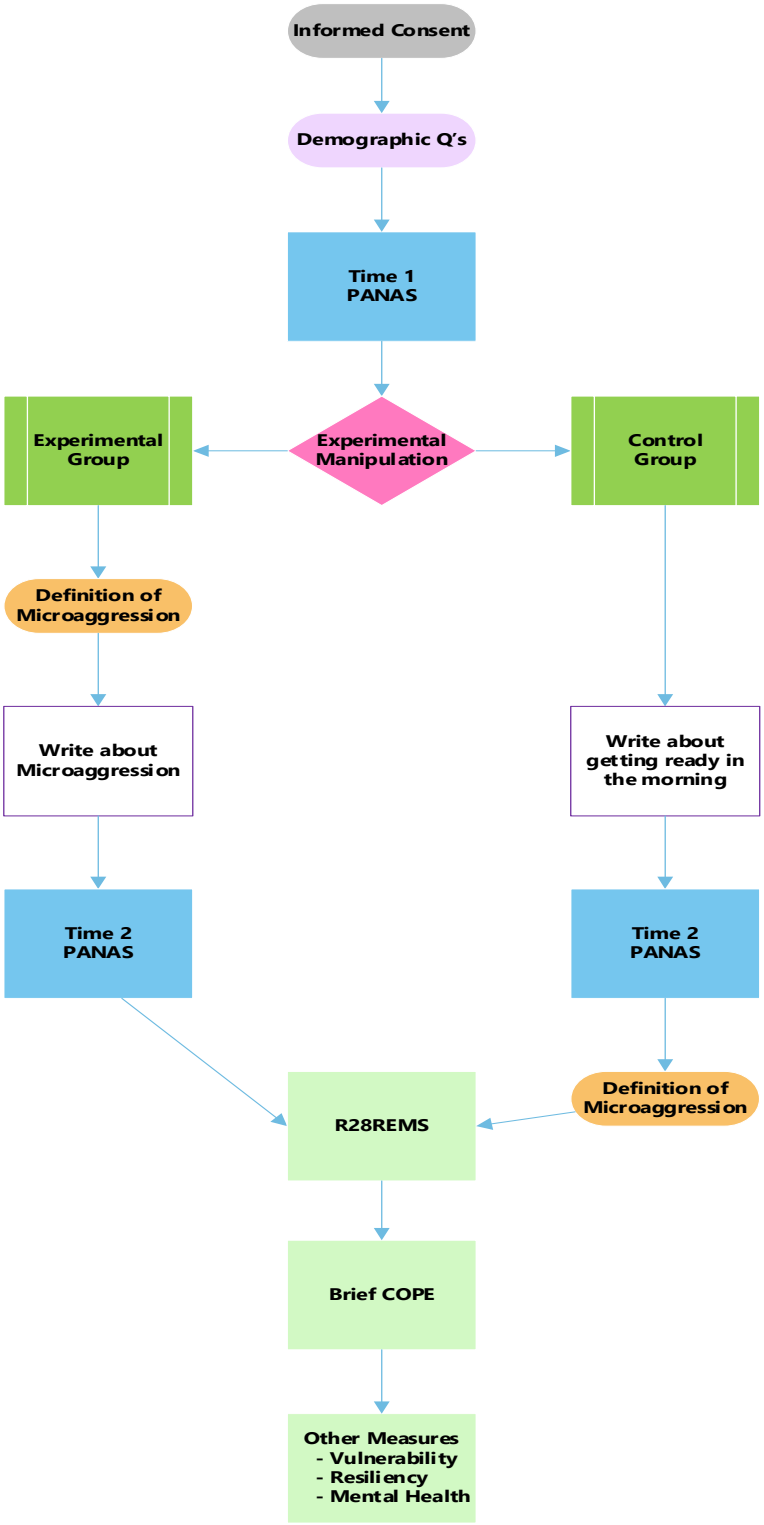


Figure 2. Experimental model. This figure illustrates the experimental design and order of measures used in the study.

affect. Demographic information was collected by self-report. The microaggression narrative and instructions were created with feedback from the dissertation committee, and the full survey was pilot-tested with 20 Qualtrics panel participants used in the "soft launch." The soft launch involved having 20 participants complete the survey prior to sending it out more broadly, in order to test the quality of participants' responses to verify understandability and logical flow of survey items. Based on the quality of participants' responses to the microaggression writing prompt and other survey items, the survey was then distributed more broadly to acquire the remainder of participants (referred to as the "full launch"). This study was reviewed and approved by the USU Institutional Review Board. Analyses to determine statistical significance between variables was completed using SPSS.

The survey began with information about the details of the study and confidentiality, which required participants to read and provide informed consent to participate in the study. Demographic information followed a disclaimer explaining the relevance of this information and reiterating confidentiality and was included at the beginning of the survey in order to be able to screen out participants who did not meet inclusion criteria (i.e., age, race, gender). Next, participants were randomly assigned to an experimental or control condition. In the control condition participants were asked to write about a neutral experience (i.e., getting ready in the morning) whereas in the experimental condition participants were asked to write about a personal microaggression experience, after they were provided with a definition of the term "microaggression." All participants were given a self-report measure of positive and negative affect (i.e.,

PANAS) prior to (Time 1) and immediately following (Time 2) the experimental manipulation.

Participants were then asked to complete a measure of recent racial microaggression experiences (i.e., R28REMS) following the Time 2 PANAS, in order to avoid priming participants on the PANAS. Prior to administering the R28REMS to those in the control condition, participants were provided with the same definition of "microaggression" that those in the experimental condition read, so they had the same knowledge of microaggressions prior to completing the measure. Next, participants were asked to complete a measure of coping (i.e., Brief COPE), by rating statements based on how they typically cope with microaggressions (with the additional prompt "such as the one you just wrote about" for those in the experimental condition). The Brief COPE followed the R28REMS so participants would have just been prompted to reflect on recent experiences of microaggressions, which would likely trigger similar emotions to the situations in which the microaggressions occurred, thus, prompting them to remember how they coped with the microaggressions and other instances in which they have felt similar emotions. All other measures (i.e., resiliency/vulnerability and mental health) followed the Brief COPE, to avoid priming on the PANAS. Vulnerability and resiliency factors, and positive and negative affect scores (Time 1) were examined as predictors of positive and negative affect scores (Time 2) following the experimental manipulation.

Analytic Plan

Descriptive statistics (including means, standard deviations, and frequency tables) were calculated for variables. A series of ANOVAS and chi-square analyses assessed for

differences among ethnic groups for study variables (RQ_1). Bivariate correlations were used to examine relationships among all study variables (RQ_2). Multiple regressions were used to assess the relative contribution of microaggressions, vulnerability, and resiliency factors in predicting mental health outcomes (RQ_3). A series of moderation analyses were conducted using the PROCESS macro in SPSS (Hayes, 2013) to assess the moderating effects of vulnerability and resiliency factors.

Two 2 X 2 mixed ANCOVAs, with time (pre- and post- test scores on the positive and negative affect subscales of the PANAS) as within-subject variables and experimental condition as a between-subjects variable, were used to examine the effect of writing about microaggression experiences on subsequent emotional affect (RQ_4). Resiliency and vulnerability factors were included as covariates to assess what factors influenced subsequent emotional affect following reflecting on personal experiences of microaggressions (RQ_4). Additional analyses examining themes across microaggression narratives were conducted (RQ_5). These analyses were primarily descriptive.

The narratives provided by participants were reviewed through a phenomenological framework for emergent themes. Thematic analysis was a collaborative process, in which the student researcher and supervising faculty member reviewed narratives separately for initial theme extraction. Subsequently, the research team convened to discuss thematic content until consensus was reached (i.e., consensus coding; Lynch, Cheyney, Chan, Walia, & Burcher, 2019). The first step of analysis was to categorize microaggression writing prompt responses into broad categories, to aid in further analysis. Six initial categories were identified through consensus coding: (a) racial

or ethnic microaggression, (b) other characteristic microaggression (i.e., microaggressions that were based on identity categories other than race or ethnicity), (c) negative experience, but not a microaggression, (d) did not recall a microaggression/ stated never happened/did not know what a microaggression was, (e) insufficient information required to classify, and (f) no response.

Subsequent steps of analysis involved coding the racial/ethnic microaggressions based on type (i.e., microinsult, microinvalidation, microassault), specific form (e.g., ascription of intelligence, second-class citizen, assumption of criminality), and degree of obviousness (i.e., subtle, overt, or somewhere in between). There was flexibility in the analyses for other emergent themes and codes (e.g., setting, context, power differential). Descriptive analyses (i.e., frequencies, percentages, chi-square) were also conducted to examine the effects of race/ethnicity on narrative themes.

CHAPTER IV

RESULTS

Descriptive Statistics

Means and standard deviations or frequencies for all study variables are presented separately for each ethnic minority subsample (i.e., by race/ethnicity) in Table 2. On average, participants reported experiencing various types of microaggressions a little more than one time in the past six months. Participants reported somewhat positive perceptions of their ethnic identity, on average. In terms of attitudes and behaviors related to critical consciousness, on average participants endorsed relatively neutral perceptions of perceived inequality among ethnic groups, relatively positive feelings towards egalitarianism, and relatively low levels of sociopolitical participation. On average, participants reported relatively neutral feelings of ethnocultural empathy. In terms of behaviors used to cope with microaggressions, participants reported relatively low use of both active and disengaged coping strategies (with slightly higher use of active coping). With regard to average scores on mental health outcomes, participants endorsed mild to moderate levels of depression ($M = 9.76$, $SD = 7.40$), mild levels of anxiety ($M = 7.89$, $SD = 6.66$), low risk of alcohol abuse ($M = 4.77$, $SD = 6.80$), low risk of drug abuse ($M = 0.95$, $SD = 1.69$), and relatively neutral feelings of self-esteem ($M = 15.68$, $SD = 6.79$).

A series of ANOVA analyses assessed for differences among the ethnic groups for study variables (RQ_1). Black participants reported significantly higher levels of microaggressions than participants from other ethnic groups, $F(3, 203) = 6.177$, $p < .001$

Table 2

Descriptive Statistics for Study Variables

Variable	Possible range	Asian (*n* = 52)		Black (*n* = 50)		Hispanic or Latinx (*n* = 52)		Native American or Alaska Native (*n* = 53)	
		M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Microaggressions	0-5	0.84	0.93	1.60	1.14	1.00	0.87	1.00	0.87
Ethnic identity	1-5	3.43	0.90	3.69	1.06	3.66	0.69	3.60	0.97
Critical consciousness: perceived inequality	1-6	4.13	1.26	3.72	1.49	3.82	1.44	4.00	1.34
Critical consciousness: egalitarianism	1-6	5.25	0.80	5.12	1.02	5.15	0.99	5.32	0.88
Critical consciousness: sociopolitical participation	1-5	1.40	0.63	1.88	0.96	1.41	0.59	1.55	0.66
Ethnocultural empathy	1-6	3.49	0.63	3.60	0.80	3.51	0.55	3.73	0.37
Active coping	1-4	2.19	0.80	2.42	0.75	2.07	0.70	2.24	0.74
Disengaged coping	1-4	1.71	0.61	1.90	0.59	1.76	0.60	2.18	0.68
Depression	0-27	8.92	7.60	7.64	6.00	8.60	6.11	13.74	8.20
Anxiety	0-21	6.92	6.55	5.74	5.61	6.92	5.75	11.81	7.04
Alcohol use	0-40	2.65	3.35	4.94	6.90	5.15	6.83	6.32	8.63
Drug use	0-10	0.37	0.71	1.08	1.77	0.88	1.58	1.47	2.18
Self-esteem	0-30	16.33	6.51	18.92	6.24	15.37	6.64	12.30	6.24

Note. $n = 207$

(Asian participants mean difference = 0.759, $p = .002$, Latinx participants mean difference = 0.597, $p = .020$, Native American participants mean difference = 0.595, $p = .020$). Black participants also reported significantly higher levels of sociopolitical participation than Asian and Latinx participants, $F(3, 203) = 4.863$, $p = .003$ (Asian participants mean difference = 0.478, $p = .020$, Latinx participants mean difference = 0.471, $p = .020$). Native American participants reported significantly higher levels of disengaged coping than Asian and Latinx participants, $F(3, 203) = 6.061$, $p = .001$ (Asian

participants mean difference = 0.473, $p = .001$, Latinx participants mean difference = 0.415, $p = .004$).

Significant differences also emerged between ethnic groups for mental health outcomes. Native American participants reported significantly higher levels of depression than participants from other ethnic groups, $F(3, 203) = 7.824$, $p < .001$ (Asian participants mean difference = 4.813, $p = .012$, Black participants mean difference = 6.096, $p < .001$, Latinx participants mean difference = 5.140, $p = .002$), as well as higher levels of anxiety, $F(3, 203) = 9.679$, $p < .001$ (Asian participants mean difference = 4.888, $p = .001$, Black participants mean difference = 6.071, $p < .001$, Latinx participants mean difference = 4.888, $p = .001$). Native American participants also reported significantly higher levels of alcohol use than Asian participants, $F(3, 203) = 2.730$, $p = .045$ (mean difference = 3.667, $p = .027$). Asian participants reported significantly lower levels of drug use than Black and Native American participants, $F(3, 203) = 4.071$, $p = .008$ (Black participants mean difference = -0.716, $p = .050$, Native American participants mean difference = -1.106, $p = .005$). Black participants reported significantly higher levels of self-esteem than Latinx and Native American participants, $F(3, 203) = 9.375$, $p < .001$ (mean difference = 6.618, $p < .001$). Native American participants also reported significantly lower self-esteem than Asian participants, $F(3, 203) = 9.375$, $p < .001$ (mean difference = -4.025, $p = .008$).

Primary Analyses

Tables 3-6 present bivariate correlations among all variables for each racial/ethnic

group (RQ_2). Microaggressions had the strongest correlations with mental health outcomes for Latinx participants, including positive associations with depression, anxiety, and alcohol use. Asian participants showed fewer significant correlations with mental health outcomes than other ethnic groups. In general, perceived inequality demonstrated negative associations with self-esteem. Overall, sociopolitical participation was associated with poorer mental health outcomes, including positive correlations with alcohol use for ethnic groups other than Asian, as well as drug use for Latinx participants, and depression and anxiety for Native American participants. Coping in general showed links with various mental health outcomes. For example, active coping was positively correlated with depression for both Latinx and Native American participants, as well as anxiety for Latinx participants, and alcohol use for Native American participants. However, disengaged coping showed the strongest links with poorer mental health outcomes, including positive correlations with depression, anxiety, and alcohol use (and even drug use for Latinx and Native American participants), as well as negative correlations with self-esteem. Egalitarianism attitudes were inversely linked with substance use for Native American (i.e., alcohol use) and Black participants (i.e., drug use).

Correlations among resiliency/vulnerability factors varied among ethnic groups, but patterns of relationships were in theoretically expected directions. In general, ethnic identity was positively correlated with ethnocultural empathy and sociopolitical participation. Active and disengaged coping were positively linked across ethnic groups. Critical consciousness attitudes (i.e., perceived inequality and egalitarianism subscales)

Table 3

Bivariate Correlations Among All Variables—Asian/Asian American Participants

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Microaggressions	1												
2. Ethnic identity	.210	1											
3. CC: Perceived Inequality	.263	.080	1										
4. CC: Egalitarianism	.132	.101	.187	1									
5. CC: Sociopolitical participation	.261	.383**	.313*	.097	1								
6. Ethnocultural empathy	.314*	.346*	.194	.466**	.315*	1							
7. Active coping	.442**	.388*	-.105	.348*	.228	.532**	1						
8. Disengaged coping	.262	.244	-.097	.198	.133	.375**	.815**	1					
9. Depression	-.005	-.116	-.004	.324*	-.062	.186	.244	.332*	1				
10. Anxiety	-.046	-.019	-.053	.254	.078	.181	.226	.289*	.900**	1			
11. Alcohol use	.067	.203	-.010	-.110	-.062	.185	.077	.273	-.203	-.147	1		
12. Drug use	.040	.211	-.274*	.063	-.025	-.041	.091	.060	.052	.102	.251	1	
13. Self-esteem	.228	.244	-.035	-.125	.222	.161	.120	-.068	-.769**	-.646**	.258	.024	1

Note. $n = 52$; CC = critical consciousness.

* Correlation is significant at the 0.05 level.

** Correlation is significant at the 0.01 level.

Table 4

Bivariate Correlations Among All Variables—Black/African American Participants

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Microaggressions	1												
2. Ethnic Identity	.081	1											
3. CC: Perceived Inequality	.406**	-.057	1										
4. CC: Egalitarianism	.184	.402**	.284*	1									
5. CC: Sociopolitical Participation	.367**	.305*	.048	-.137	1								
6. Ethnocultural Empathy	.329*	.446**	.511**	.627**	.230	1							
7. Active coping	.488**	.434**	.127	.315*	.401**	.550**	1						
8. Disengaged coping	.305*	.327*	.287*	-.056	.567**	.465**	.556**	1					
9. Depression	.110	-.146	.381**	-.143	.249	.263	.030	.484**	1				
10. Anxiety	.001	.005	.141	-.051	.135	.229	.167	.424**	.655**	1			
11. Alcohol use	-.013	.208	.127	-.205	.401**	.018	.119	.368**	.374**	.335*	1		
12. Drug use	-.289*	.078	-.077	-.324*	.068	-.117	.010	.152	.281	.349*	.478**	1	
13. Self-esteem	.089	.031	-.400**	.078	-.083	-.177	.218	-.420**	-.603**	-.472**	-.395**	-.198	1

Note. $n = 50$; CC = critical consciousness.

* Correlation is significant at the 0.05 level.

** Correlation is significant at the 0.01 level.

Table 5

Bivariate Correlations Among All Variables—Latinx/Hispanic Participants

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Microaggressions	1												
2. Ethnic Identity	.180	1											
3. CC: Perceived inequality	-.062	.244	1										
4. CC: Egalitarianism	-.172	.250	.452**	1									
5. CC: Sociopolitical participation	.218	.122	.174	-.172	1								
6. Ethnocultural empathy	.133	.370**	.309*	.272	.331*	1							
7. Active coping	.279*	.188	-.375**	-.120	-.041	.264	1						
8. Disengaged coping	.515**	-.032	-.183	-.293*	.083	.120	.699**	1					
9. Depression	.347*	.303*	.165	.139	.036	.275*	.314*	.578**	1				
10. Anxiety	.337*	.314*	.174	.104	.027	.096	.289*	.529**	.813**	1			
11. Alcohol use	.403**	.003	.013	-.036	.416**	.102	.050	.373**	.425**	.366**	1		
12. Drug use	.251	-.016	-.203	-.041	.295*	.048	.244	.320*	.356**	.228	.627**	1	
13. Self-Esteem	-.131	-.262	-.351*	-.081	-.091	-.148	-.022	-.303*	-.676**	-.602**	-.144	-.039	1

Note. $n = 52$; CC = critical consciousness.

* Correlation is significant at the 0.05 level.

** Correlation is significant at the 0.01 level.

Table 6

Bivariate Correlations Among All Variables—Native American/Alaska Native Participants

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Microaggressions	1												
2. Ethnic Identity	.302*	1											
3. CC: Perceived inequality	.004	.208	1										
4. CC: Egalitarianism	.055	.256	.302*	1									
5. CC: Sociopolitical participation	.550**	.286*	.203	-.031	1								
6. Ethnocultural empathy	.213	.329*	.181	.153	.261	1							
7. Active coping	.238	.098	.235	.046	.012	.368**	1						
8. Disengaged coping	.336*	-.036	.122	.058	.229	.326*	.651**	1					
9. Depression	.190	.071	.186	.236	.294*	.231	.297*	.609**	1				
10. Anxiety	.188	.090	.254	.251	.301*	.064	.260	.564**	.790**	1			
11. Alcohol Use	.264	.098	.133	-.385**	.315*	.235	.401**	.442**	.092	.099	1		
12. Drug Use	.035	.036	.107	-.030	.245	.116	.266	.388**	.375**	.308*	.412**	1	
13. Self-Esteem	-.111	.154	-.281*	-.237	-.223	.102	-.103	-.488**	-.647**	-.670**	.023	-.279*	1

Note. $n = 53$; CC = critical consciousness.

* Correlation is significant at the 0.05 level.

** Correlation is significant at the 0.01 level.

were positively correlated overall. Ethnocultural empathy was positively associated with critical consciousness, including positive correlations with egalitarianism attitudes (for Asian and Black participants) and sociopolitical participation (for Asian and Latinx participants). Microaggressions were positively correlated with ethnocultural empathy for Asian and Black participants, sociopolitical participation for Black and Native American participants, ethnic identity for Native American participants, and perceived inequality for Blacks participants. Relationships among resiliency/vulnerability factors were strongest for Black participants.

Regressions

Moderation analyses were conducted using the PROCESS macro in SPSS (Hayes, 2013). The PROCESS macro utilizes bootstrapping techniques and ordinary least square regression to calculate direct effects of the independent variable (microaggressions) on the dependent variables (mental health outcomes), as well as the interaction of the moderators (vulnerability and resiliency factors) and independent variable (RQ_3). Tables 7-11 present regressions for mental health variables. When statistically significant interactions are detected, the PROCESS macro provides tests of the significance of the relationship between microaggressions and the specified mental health outcome for values of the moderator at the mean (medium), one standard deviation below the mean (low), and one standard deviation above the mean (high). Thus, significant interactions can be "unpacked" by reporting the nature of the relationship between the independent variable and dependent variable at low, medium, and high levels of the moderator.

Interactions. Active coping consistently emerged as a protective factor against

Table 7

Regressions Examining Microaggressions and Resiliency/Vulnerability Variables as Predictors of Depression

Predictors	R^2	*F*	*p*	coefficient	*t*	*p*
	.098	0.655	.581			
Microaggressions				0.359	0.175	.861
Ethnic identity				-0.268	-0.306	.760
χ				0.103	0.191	.848
	.066	4.808	.003			
Microaggressions				4.509	2.705	.007
CC: Perceived inequality				1.953	3.521	< .001
χ				-0.916	-2.500	.013
	.060	4.338	.006			
Microaggressions				7.501	2.611	.010
CC: Egalitarianism				2.744	3.321	.001
χ				-1.294	-2.416	.017
	.015	1.041	.375			
Microaggressions				0.356	0.255	.799
CC: Sociopolitical participation				0.760	0.599	.550
χ				0.059	0.081	.936
	.078	5.703	< .001			
Microaggressions				6.515	1.936	.054
Ethnocultural empathy				4.394	3.764	< .001
χ				-1.675	-1.883	.061
	.162	13.100	< .001			
Microaggressions				9.146	5.205	< .001
Active coping				5.467	5.776	< .001
χ				-3.632	-5.371	< .001
	.293	27.981	< .001			
Microaggressions				0.237	0.147	.883
Disengaged coping				6.892	6.885	< .001
χ				-0.439	-0.594	.553

Note. $n = 207$; CC = critical consciousness; *df* (3, 203).
χ = interaction

Table 8

Regressions Examining Microaggressions and Resiliency/Vulnerability Variables as Predictors of Anxiety

Predictors	R^2	*F*	*p*	coefficient	*t*	*p*
	.014	0.937	.424			
Microaggressions				-1.840	-0.999	.319
Ethnic identity				-0.269	-0.342	.733
χ				0.582	1.201	.231
	.036	2.493	.061			
Microaggressions				2.782	1.825	.070
CC: Perceived inequality				1.315	2.593	.010
χ				-0.584	-1.742	.083
	.037	2.575	.055			
Microaggressions				4.040	1.543	.124
CC: Egalitarianism				1.922	2.554	.011
χ				-0.701	-1.437	.152
	.016	1.119	.342			
Microaggressions				1.272	1.011	.313
CC: Sociopolitical participation				1.811	1.586	.114
χ				-0.665	-1.010	.314
	.041	2.903	.036			
Microaggressions				4.283	1.387	.167
Ethnocultural empathy				2.945	2.749	.007
χ				-1.127	-1.381	.169
	.138	10.852	< .001			
Microaggressions				6.993	4.360	< .001
Active coping				4.748	5.496	< .001
χ				-2.898	-4.697	< .001
	.258	23.472	< .001			
Microaggressions				-0.068	-0.045	.964
Disengaged coping				5.859	6.350	< .001
χ				-0.356	-0.522	.602

Note. $n = 207$; CC = critical consciousness; df (3, 203).
χ = interaction

Table 9

Regressions Examining Microaggressions and Resiliency/Vulnerability Variables as Predictors of Alcohol Use

Predictors	R^2	*F*	*p*	coefficient	*t*	*p*
	.048	3.406	.019			
Microaggressions				2.928	1.584	.115
Ethnic identity				1.347	1.708	.089
χ				-0.493	-1.014	.312
	.036	2.530	.058			
Microaggressions				1.833	1.177	.240
CC: Perceived inequality				0.371	0.717	.475
χ				-0.143	-0.417	.677
	.087	6.405	< .001			
Microaggressions				5.746	2.208	.028
CC: Egalitarianism				-0.485	-0.648	.518
χ				-0.841	-1.733	.085
	.112	8.494	< .001			
Microaggressions				-1.452	-1.189	.236
CC: Sociopolitical participation				0.994	0.897	.371
χ				1.114	1.742	.083
	.052	3.682	.013			
Microaggressions				6.110	1.948	.053
Ethnocultural empathy				2.102	1.088	.055
χ				-1.337	-1.613	.108
	.053	3.792	.011			
Microaggressions				2.730	1.590	.113
Active coping				1.863	2.015	.045
χ				-0.732	-1.109	.269
	.171	13.965	< .001			
Microaggressions				-2.224	-1.387	.167
Disengaged coping				2.790	2.803	.006
χ				1.257	1.710	.089

Note. $n = 207$; CC = critical consciousness; df (3, 203).
χ = interaction

Table 10

Regressions Examining Microaggressions and Resiliency/Vulnerability Variables as Predictors of Drug Use

Predictors	R^2	*F*	*p*	coefficient	*t*	*p*
	.007	0.457	.713			
Microaggressions				0.256	0.546	.586
Ethnic identity				0.221	1.104	.271
χ				-0.072	-0.584	.560
	.019	1.266	.287			
Microaggressions				0.638	1.631	.105
CC: Perceived inequality				0.066	0.505	.614
χ				-0.140	-1.624	.106
	.016	1.082	.358			
Microaggressions				0.761	1.135	.258
CC: Egalitarianism				-0.017	-0.085	.932
χ				-0.140	-1.121	.264
	.035	2.412	.068			
Microaggressions				-0.207	-0.655	.513
CC: Sociopolitical participation				0.389	1.357	.176
χ				0.049	0.295	.769
	.006	0.396	.756			
Microaggressions				0.818	1.026	.306
Ethnocultural empathy				0.261	0.944	.346
χ				-0.217	-1.033	.303
	.055	3.947	.009			
Microaggressions				0.831	1.954	.052
Active coping				0.788	3.438	< .001
χ				-0.379	-2.315	.022
	.105	7.926	< .001			
Microaggressions				0.044	0.106	.916
Disengaged coping				0.993	3.870	< .001
χ				-0.106	-0.557	.578

Note. $n = 206$; CC = critical consciousness; df (3, 203).
χ = interaction

Table 11

Regressions Examining Microaggressions and Resiliency/Vulnerability Variables as Predictors of Self-Esteem

Predictors	R^2	*F*	*p*	coefficient	*t*	*p*
	.022	1.492	.218			
Microaggressions				3.371	1.801	.073
Ethnic identity				1.284	1.609	.109
χ				-0.772	-1.568	.119
	.104	7.854	< .001			
Microaggressions				-1.656	-1.105	.271
CC: Perceived inequality				-2.087	-4.185	< .001
χ				0.583	1.768	.079
	.026	1.785	.151			
Microaggressions				-2.413	-0.899	.370
CC: Egalitarianism				-1.461	-1.893	.060
χ				0.576	1.151	.251
	.009	0.624	.600			
Microaggressions				1.082	0.840	.402
CC: Sociopolitical participation				0.010	0.009	.993
χ				-0.224	-0.333	.740
	.015	1.009	.390			
Microaggressions				0.912	0.286	.776
Ethnocultural empathy				-0.928	-0.838	.403
χ				-0.042	-0.050	.960
	.057	4.051	.008			
Microaggressions				-4.711	-2.752	.007
Active coping				-1.535	-1.665	.098
χ				2.084	3.164	.002
	.172	14.059	< .001			
Microaggressions				3.182	1.988	.048
Disengaged coping				-3.744	-3.767	< .001
χ				-0.776	-1.058	.291

Note. $n = 207$; CC = critical consciousness; df (3, 203).
χ = interaction

microaggressions for all mental health outcomes, except alcohol use. Participants who reported low and medium levels of active coping evidenced a positive relationship between microaggressions and depression ($t = 4.47$, $p < .001$ for low; $t = 2.16$, $p = .032$ for medium), whereas those who reported high levels of active coping demonstrated a negative relationship between microaggressions and depression ($t = -3.03$, $p = .003$; Table 7). When participants reported low levels of active coping, microaggressions were also associated with higher levels of anxiety ($t = 3.53$, $p < .001$), whereas those who reported high levels of active coping demonstrated a negative relationship between microaggressions and anxiety ($t = -3.17$, $p = .002$; Table 8). When active coping was medium, there was no association between microaggression experiences and anxiety.

Active coping emerged as a moderator for drug use, such that when participants reported high levels of active coping, microaggressions were associated with less drug use ($t = -2.09$, $p = .038$; Table 10). When active coping was low or medium, there was no association between microaggression experiences and drug use. Active coping also moderated the relationship between microaggression experiences and self-esteem (Table 11). When participants reported low levels of active coping, microaggressions were associated with lower levels of self-esteem ($t = -2.01$, $p = .046$), whereas those who reported high levels of active coping demonstrated a positive relationship between microaggressions and self-esteem ($t = 2.63$, $p = .009$). When active coping was medium, there was no association between microaggression experiences and self-esteem.

Critical consciousness attitudes emerged as a moderator of the relationship between microaggression experiences and depression (Table 7). Specifically, when

participants reported low levels of critical reflection, microaggressions were associated with higher levels of depression ($t = 2.65$, $p = .009$ for perceived inequality; $t = 2.68$, $p = .008$ for egalitarianism). However, when critical reflection (i.e., perceived inequality, egalitarianism) was medium or high, there was no association between microaggression experiences and depression. No significant interactions emerged for alcohol use (Table 9).

Direct effects. Several direct effects also emerged between moderators and mental health outcomes. For all regression models, disengaged coping consistently emerged as a significant predictor of more negative mental health outcomes (i.e., a main effect for disengaged coping emerged in all models, with no interactions). Effects were as follows: $t = 6.89$, $p < .001$ for depression; $t = 6.35$, $p < .001$ for anxiety; $t = 2.80$, $p = .006$ for alcohol use; $t = 3.87$, $p < .001$ for drug use; $t = -3.77$, $p < .001$ for self-esteem. Significant direct effects of critical reflection on anxiety emerged ($t = 2.59$, $p = .010$ for perceived inequality; $t = 2.55$, $p = .011$ for egalitarianism). A significant direct effect of perceived inequality on self-esteem also emerged ($t = -4.19$, $p < .001$). Significant direct effects of ethnocultural empathy on depression ($t = 3.76$, $p < .001$) and anxiety emerged ($t = 2.75$, $p = .007$). A significant direct effect of active coping on alcohol use also emerged ($t = 2.02$, $p = .045$).

Significant direct effects also emerged between microaggression experiences and mental health outcomes in two regression models. In the regression model examining egalitarianism as a moderator of the relationship between microaggression experiences and alcohol use, a significant direct effect emerged for microaggressions on alcohol use (*t*

= 2.21, p = .028). In the regression model examining disengaged coping as a moderator of the relationship between microaggression experiences and self-esteem, a significant direct effect emerged for microaggressions on self-esteem (t = 1.99, p = .048).

Analysis of Experimental Manipulation

Descriptive statistics for the Positive and Negative Affect Schedule (PANAS) are presented in Table 12. In general, participants in both groups reported higher positive affect than negative affect. Bivariate correlations between resiliency/vulnerability factors and the PANAS are presented in Table 13. Two 2 X 2 mixed ANCOVAs, with time (pre- and post- test scores on the positive and negative affect subscales of the PANAS) as within-subject variables and experimental condition as a between-subjects variable, were used to examine the effect of writing about microaggression experiences on subsequent emotional affect (as determined by the PANAS; RQ_4). Resiliency and vulnerability factors (seven variables) were included as covariates to assess what factors influenced subsequent emotional affect following reflecting on personal experiences of microaggressions. Results of the ANCOVAs are presented in Table 14. Figures 3 and 4 illustrate changes in positive and negative affect for both groups. In general, neither group experienced significant changes in positive affect following the writing task.

Alternatively, a significant interaction between time and survey condition emerged on the negative affect subscale of the PANAS $F(1, 205) = 5.204$, p = .024. Experimental group participants experienced an increase in negative affect following the writing task, whereas participants in the control group experienced a decrease.

Table 12

Descriptive Statistics for the Positive and Negative Affect Schedule (PANAS)

		Control group (n = 104)		Experimental group (n = 103)	
Subscale		*M*	*SD*	*M*	*SD*
Positive Affect	Time 1	30.92	9.79	27.99	10.23
	Time 2	30.47	10.64	26.55	11.19
Negative Affect	Time 1	17.26	7.98	17.81	7.95
	Time 2	16.06	8.71	18.28	8.41

Note. n = 207.

Table 13

Bivariate Correlations Between Resiliency/Vulnerability Factors and PANAS

	Time 1		Time 2	
Variables	Positive affect	Negative affect	Positive affect	Negative affect
Ethnic Identity	.229**	-.139	.141	-.018
CC: Perceived Inequality	-.267**	-.061	-.266**	-.080
CC: Egalitarianism	-.058	-.253**	-.069	-.263**
CC: Sociopolitical Participation	.206**	.226**	.189*	.263**
Ethnocultural Empathy	.136	.057	.076	.003
Active Coping	.398**	.168*	.411**	.055
Disengaged Coping	.240**	.452**	.181*	.395**

Note. n = 158; CC = critical consciousness.

* Correlation is significant at the 0.05 level.

** Correlation is significant at the 0.01 level.

Table 14

ANCOVAs Examining Effects of the Experimental Manipulation on Subsequent Emotional Affect

Scale	Predictors	*F*	*p*
Positive Affect	Time	0.992	.320
	Survey condition	4.338	.039
	χ	1.306	.255
Negative Affect	Time	0.781	.378
	Survey condition	1.979	.161
	χ	5.204	.024

Note. $n = 207$; $df\ (1, 205)$
χ = interaction.

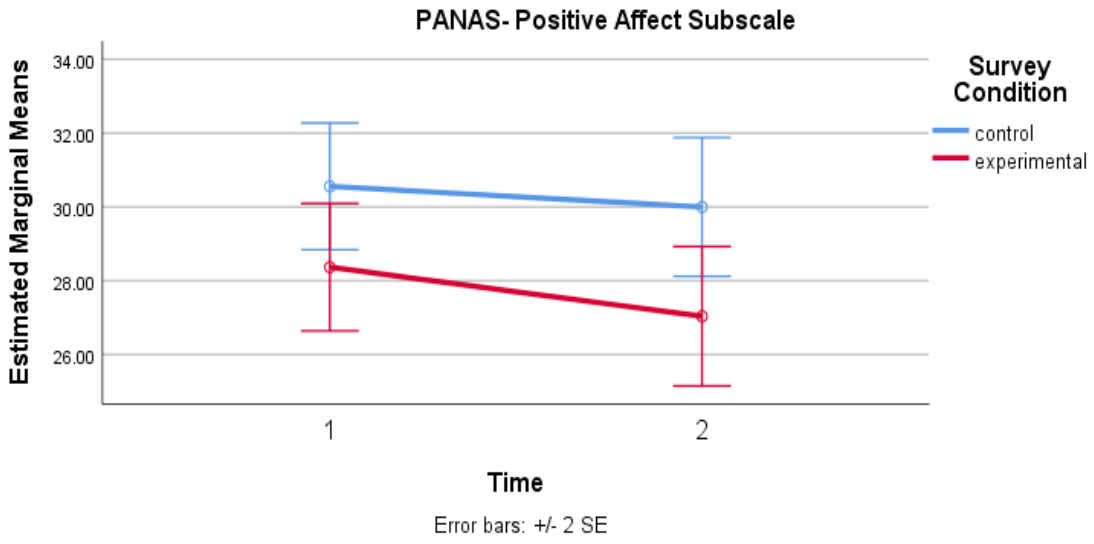


Figure 3. Estimated marginal means of the PANAS positive affect subscale. This figure illustrates the effects of the experimental manipulation on positive affect. Positive Affect subscale range = 10-50, with higher scores representing higher levels of positive affect.

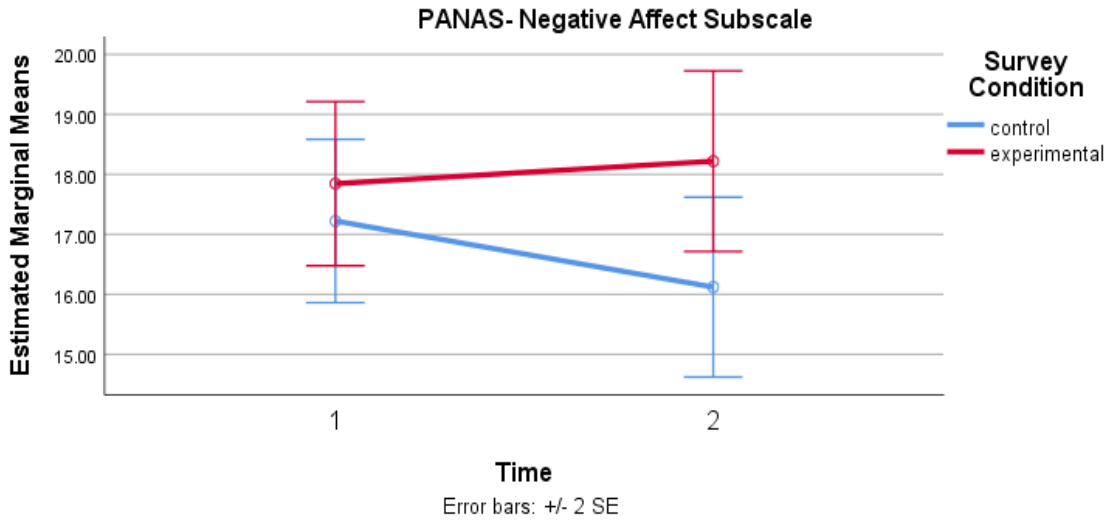


Figure 4. Estimated marginal means of the PANAS negative affect subscale. This figure illustrates the effects of the experimental manipulation on negative affect. Negative Affect subscale range = 10-50, with higher scores representing higher levels of negative affect.

Significant interaction effects for ethnic identity and time emerged for both positive, $F(1, 205) = 5.030$, $p = .026$, and negative affect, $F(1, 205) = 6.862$, $p = .009$. When ethnic identity was high, positive affect decreased (between Time 1 and 2) for both conditions, but participants in the experimental condition experienced a greater decrease. Additionally, higher ethnic identity was associated with higher positive affect at baseline for both conditions. For participants in the experimental condition, those who reported high levels of ethnic identity experienced a greater increase in negative affect than those with low levels of ethnic identity.

Significant interaction effects for active coping and time also emerged for both positive, $F(1, 205) = 8.591$, $p = .004$, and negative affect, $F(1, 205) = 4.260$, $p = .040$. Those in the control condition experienced a decrease in positive affect when active

coping was low, but an increase in positive affect when active coping was high. Additionally, higher active coping was associated with higher positive affect at Time 1 and 2 for both conditions. With regard to participants in the experimental condition, those who reported high levels of active coping experienced an increase in negative affect, whereas those with low levels of active coping did not experience much change in negative affect. Significant interaction effects for disengaged coping and time emerged for positive affect, $F(1, 205) = 7.821$, $p = .006$. When disengaged coping was high, positive affect decreased for both conditions, but those in the experimental group experienced the greatest decrease.

Content of Microaggression Narratives

The first step of analysis was to categorize microaggression writing prompt responses into broad categories, to aid in further analysis. Six initial categories were identified through consensus coding: (a) racial or ethnic microaggression, (b) other characteristic microaggression (i.e., microaggressions that were based on identity categories other than race or ethnicity), (c) negative experience, but not a microaggression, (d) did not recall a microaggression/stated never happened/did not know what a microaggression was, (e) insufficient information required to classify, and (f) no response. Table 15 presents descriptive statistics (i.e., frequencies, percentages) for these categories, and other emergent themes/categories.

Approximately 40% of participants in the experimental condition wrote about a microaggression that pertained to race or ethnicity. Approximately 22% of the experimental condition participants stated they did not recall, had never experienced, or

Table 15

Descriptive Statistics for Emergent Themes in the Microaggression Narratives

		Asian (n = 27)		Black (n = 25)		Hispanic or Latinx (n = 25)		Native American or Alaska Native (n = 26)	
Category	Variable	n	%	n	%	n	%	n	%
Initial narrative categories									
	Racial/ethnic MA	17	63.0	10	40.0	10	40.0	4	15.4
	Other characteristic MA	1	3.7	0	0.0	3	12.0	10	38.5
	Neg. exp., but not a MA	2	7.4	3	12.0	4	16.0	8	30.8
	Don't recall/never happened/don't know	5	18.5	9	36.0	6	24.0	3	11.5
	Insufficient info	0	0.0	2	8.0	0	0.0	1	3.8
	No response	2	7.4	1	4.0	2	8.0	0	0.0
	Further classification of all racial/ethnic microaggressions								
Type of microaggression									
	Microinsult	8	38.1	7	70.0	7	63.6	4	100.0
	Microinvalidation	10	47.6	0	0.0	3	27.3	0	0.0
	Microassault	3	14.3	2	20.0	0	0.0	0	0.0
	Insufficient info	0	0.0	1	10.0	1	9.1	0	0.0
Specific form of microaggression									
	Ascription of intelligence	3	14.3	1	8.3	2	20.0	0	0.0
	Second-class citizen	2	9.5	5	41.7	3	30.0	2	50.0
	Pathologizing cultural values/ communication styles	1	4.8	0	0.0	1	10.0	0	0.0

(*table continues*)

Category	Variable	Asian (*n* = 27)		Black (*n* = 25)		Hispanic or Latinx (*n* = 25)		Native American or Alaska Native (*n* = 26)	
		n	%	*n*	%	*n*	%	*n*	%
	Assumption of criminality	0	0.0	3	25.0	1	10.0	1	25.0
	Alien in own land/perpetual foreigner	7	33.3	0	0.0	2	20.0	0	0.0
	Assumptions of similarity/ethnic gloss	5	23.8	0	0.0	0	0.0	0	0.0
	Purposefully ignored due to race/ethnicity	1	4.8	1	8.3	0	0.0	0	0.0
	Ethnic slur	2	9.5	0	0.0	0	0.0	0	0.0
	Insufficient info	0	0.0	2	16.7	1	10.0	1	25.0
Nature of microaggression									
	Subtle	4	23.5	1	10.0	5	50.0	0	0.0
	Overt	8	47.1	6	60.0	3	30.0	4	100.0
	In between	3	17.6	2	20.0	0	0.0	0	0.0
	Insufficient info	0	0.0	1	10.0	2	20.0	0	0.0
Setting in which microaggression occurred									
	Work	1	5.9	2	20.0	1	10.0	2	50.0
	School	4	23.5	2	20.0	2	20.0	0	0.0
	Family	0	0.0	0	0.0	0	0.0	0	0.0
	Friends	2	11.8	0	0.0	2	20.0	0	0.0
	Retail store/restaurant	3	17.6	2	20.0	0	0.0	0	0.0
	Friend's parents	0	0.0	0	0.0	1	10.0	1	25.0
	Romantic partner	1	5.9	0	0.0	0	0.0	0	0.0
	Other	1	5.9	0	0.0	2	20.0	0	0.0
	Insufficient info	5	29.4	4	40.0	2	20.0	1	25.0

Note. *n* = 103; MA = microaggressions; neg. exp. = negative experience; info = information.

Several participants described multiple microaggression experiences and several microaggressions described fit with more than one category; therefore, the section titled *Further Classification of all Racial/Ethnic Microaggressions* may contain numbers higher than the number of participants who wrote about racial/ethnic microaggressions.

did not know what a microaggression was. Additionally, 16.5% of participants wrote about a negative experience that was not a microaggression and 13.6% wrote about a microaggression that pertained to a different identity category other than race, such as gender.

A chi-square analysis was conducted to examine ethnic differences in participants' narratives based on initial coding. The chi-square analysis was significant, χ^2 (15, n = 103) = 39.262, p = .001. Native American participants were significantly more likely than other ethnic groups to write about other characteristic microaggressions (i.e., gender, SES, sexual orientation, mental health), as opposed to racial or ethnic microaggressions. Native participants were also more likely to write about negative experiences that did not constitute microaggressions (e.g., emotionally abusive parents, rude comments made by siblings or peers).

The next step of analysis involved coding the racial/ethnic microaggressions based on type (i.e., microinsult, microinvalidation, microassault). Coding schemes for these types were based on those generated by Sue et al. (2007). The majority of the racial/ethnic microaggressions described by the participants in the experimental condition were categorized as microinsults (56.5%), followed by microinvalidations (28.3%) and microassaults (10.9%). Asian participants' microaggression narratives included the highest instance of microinvalidations, mostly related to assumptions of similarity and being treated as perpetual foreigners.

Racial/ethnic microaggression narratives were further categorized in terms of specific form (i.e., ascription of intelligence, second-class citizen, pathologizing cultural

values/communication styles, assumption of criminality, alien in own land/perpetual foreigner, assumptions of similarity/ethnic gloss, purposefully ignored due to race/ethnicity, ethnic slur). These coding schemes were again based on those put forth by Sue et al. (2007), as well as Nadal (2011). Nadal did not specify which overarching type of microaggression *assumption of similarity* would fall under. Therefore, the research team decided to classify this specific form under microinvalidation, since it seemed conceptually similar to beliefs that ethnic minorities are perpetual foreigners.

Frequencies of specific forms of microaggressions varied by ethnicity. For example, Asian participants were more likely to report someone assumed they would be highly intelligent because of their race/ethnicity, whereas Black and Latinx participants were more likely to report someone assumed that they would be less intelligent. Black participants reported the highest instances of someone treating them like a second-class citizen or assuming they were a criminal. Asian participants reported the highest instance of someone treating them like a perpetual foreigner. In fact, this specific form of microaggression accounted for one-third of all racial/ethnic microaggressions Asian participants wrote about, followed by assumptions of similarity at 23.8%. Asian participants in the sample were also the only ethnic group to write about being called an ethnic slur. No participants wrote about environmental microaggressions, nor microinvalidations related to color blindness, myth of meritocracy, or denial of individual racism.

Other codes examined in this study included obviousness of the racial/ethnic microaggression (i.e., subtle, overt, or somewhere in between) and the setting that the

microaggression occurred in (e.g., work, school, retail store or restaurant). Results from these analyses showed that the majority (51.2%) of the narratives discussed rather overt forms of racial/ethnic microaggressions, as opposed to subtle (24.4%). Black participants within the sample were the only ethnic group that more frequently wrote about subtle rather than overt racial/ethnic microaggressions. A high instance of racial/ethnic microaggressions were discussed that occurred at school (19.5%), work (14.6%), or while at a retail store or restaurant (12.2%). Participants from all ethnic groups wrote about racial/ethnic microaggressions that occurred while at work, but only Asian and Black participants wrote about racial/ethnic microaggressions that occurred at a retail store or restaurant.

Power differentials constituted another qualitative theme that emerged in the racial/ethnic microaggression narratives. Many of the microaggressions discussed were committed by an authority figure (e.g., boss, parents of a friend, retail store worker). This was especially true for Black participants, who described experiencing racial/ethnic microaggressions committed by an authority figure at a rate of 1.7 to 2.5 times higher than other ethnic groups.

CHAPTER V

DISCUSSION

The goal of this research was to examine aspects of resiliency and vulnerability among persons of color who experience microaggressions, in order to empower disadvantaged populations to successfully navigate these experiences in ways that minimize the damage caused by discrimination. Examining associations between various vulnerability and resiliency factors and aspects of mental health could help identify who is at highest risk of experiencing negative effects due to microaggressions and shed light on possible interventions to strengthen resilience. The main objective of this study was to investigate specific protective factors that can be changed, so that researchers and clinicians may develop interventions that build upon the fierce fortitude present in communities of color.

This dissertation project involved a two-part study. Part One focused on the moderating effects of aspects of vulnerability and resiliency on the relationship between experiencing microaggressions and mental health among ethnic minority individuals. Part Two critically examined how reflecting on microaggression experiences impacted individuals' subsequent emotional affect (utilizing an experimental design), as well as how this relationship may have varied depending on aspects of vulnerability and resiliency. Part Two also examined themes across microaggression narratives and explored associations between themes and ethnicity.

The current study found evidence that active coping behaviors are more conducive to favorable mental health outcomes than disengaged coping, at least in terms

of managing microaggressions. Similarly, findings seemed to suggest that actively coping with microaggressions may result in higher positive emotional affect, whereas disengaged coping behaviors appear to have the opposite effect. Other resiliency/vulnerability factors examined in this study displayed minimal ability to predict mental health outcomes or emotional affect, in terms of both direct and moderating effects.

Part One

On average, participants reported relatively low levels of microaggressions in the past six months. This finding was surprising, given that numerous studies have highlighted the pervasiveness of experiences of microaggressions among persons of color (e.g., Blume et al., 2012; Jones & Galliher, 2015; Ong et al., 2013; Sue et al., 2019). Additionally, relatively underwhelming associations emerged between microaggressions and mental health outcomes, despite a vast literature documenting the negative affects of microaggressions on mental health (Nadal, Griffin, Wong, Hamit, & Rasmus, 2014; Sue et al., 2019). Therefore, the way that microaggressions were measured in this study may have been problematic for a number of reasons. For example, participants may not have had the language or knowledge to identify microaggressions in their owns lives and the measurement was very individual (what happened to *you*) rather than recognizing environmental/society-level experiences (e.g., border patrol/ICE, Donald Trump's tweets). In future studies, it may be beneficial to include questions about broader discrimination experiences that may be affecting society as a whole or disproportionately

targeted at a specific ethnic group, rather than narrowly focusing on individual-level microaggressions. Consistent with previous research (Demianczyk, 2015; Forrest-Bank & Jenson, 2015), Black participants in this study reported significantly higher levels of total microaggressions than participants from other ethnic groups.

Participants endorsed somewhat high levels of critical consciousness attitudes, but minimal sociopolitical participation. One possible explanation for this finding is that increased knowledge of societal inequality and aspirational beliefs about egalitarianism do not necessarily translate into activism for young adults of color. In fact, previous research has yielded mixed results regarding links between critical consciousness attitudes and activism (e.g., Bañales, Mathews, Hayat, Anyiwo, & Diemer, 2019; Diemer & Rapa, 2016; Moore, Hope, Eisman, & Zimmerman, 2016). Another explanation might simply be that young people are not engaging in much activism in general. Current data suggests that political involvement (e.g., voting, participating in boycotts or protests) among young adults today is notoriously low (Moore et al., 2016). Sociopolitical participation can be emotionally exhausting, particularly for marginalized populations who are less likely to experience "wins" as the result of their sociopolitical efforts (e.g., Native Americans). The burden of activism was observed in the data—sociopolitical participation was positively correlated with alcohol use for ethnic groups other than Asian, as well as drug use for Latinx participants, and depression and anxiety for Native American participants. Thus, low levels of sociopolitical participation may be the result of participants carefully weighing the likelihood of getting a "win" against the burden and cost of activism.

Participants reported relatively low use of both active and disengaged coping strategies to handle microaggressions (with slightly higher use of active coping). Since participants endorsed relatively infrequent microaggression experiences in general, lower use of coping strategies to manage microaggression experiences was expected. With regard to differences in coping behaviors between ethnic groups, Native American participants reported significantly higher levels of disengaged coping than Asian and Latinx participants. Research shows that alcohol and drug use are prevalent among Native American young adults, and therefore may represent one area in which Native persons may turn to higher disengaged coping strategies than some of their peers. According to the Substance Abuse and Mental Health Services Administration (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015), rates of substance use are higher among Natives than any other population group. Alcohol dependence (although not overall alcohol use) has also been shown to be higher within Native communities (APA, 2017a; SAMHSA, 2015).

Learned helplessness may also be prevalent among Native American communities, due to extensive histories of colonization—which included centuries of oppression, forced relocation and assimilation, and genocide. Learned helplessness includes (a) negative expectations about an outcome and (b) the expectation that one is helpless to change the negative outcome. Theories of learned helplessness postulate that uncontrollable and aversive events (such as trauma) can lead to deficits in behavioral coping, associative learning, and emotional expression (Overmier, 2002). Extensive research has highlighted the role of learned helplessness in depression, and some have

even hypothesized links between learned helplessness and disengaged coping strategies (e.g., alcohol and drug use; Garcia, 2017). Thus, disengaged coping is not only an individual process, but a community-level variable that arises as a reaction to extensive experiences of powerlessness in the context of centuries of oppression and marginalization. In fact, there is some evidence that suggests that persons of color may be more inclined to use disengaged coping strategies to manage discrimination specifically, as opposed to general life stressors (Hoggard, Byrd, & Sellers, 2012). These findings seem to suggest that disengaged responses may be a learned behavior within a specific context. As such, active coping may only be possible for people who do not have significant disempowering histories that foster a more disengaged coping style.

With regard to mental health outcomes, participants endorsed mild to moderate levels of depression, mild levels of anxiety, low risk of alcohol abuse, low risk of drug abuse, and relatively neutral feelings of self-esteem, on average. In general, Native American participants reported the poorest mental health outcomes. Native participants endorsed significantly higher levels of depression and anxiety than participants from other ethnic groups. These differences were most noticeable when comparing Native and Asian participants. Specifically, Native participants reported significantly higher levels of alcohol and drug use and lower levels of self-esteem than Asian participants. This is consistent with available mental health data from the American Psychiatric Association (2017a), which shows that Native Americans typically have disproportionately higher rates of mental health problems than the rest of the U.S. population (e.g., substance use, depression, PTSD, suicide). Asians living in the U.S. have the lowest instance of mental

illness (including alcohol and substance use) compared to other ethnic groups (although Asians are also less likely to use mental health services than other ethnic groups, so actual rates of mental illness among Asians may be higher than current estimations; APA, 2017b).

Mostly small and nonsignificant correlations emerged between microaggressions and mental health outcomes for all ethnic groups except Latinx. For Latinx participants, correlations with microaggressions were mostly significant and medium in size, including positive associations with depression, anxiety, and alcohol use. These results are surprising, given that microaggressions have been consistently linked with poorer mental health outcomes across ethnic groups (e.g., Blume et al., 2012; Brittian et al., 2015; Choi et al., 2017; Galliher et al., 2011; Liao et al., 2016; O'Keefe et al., 2015; Ong et al., 2017). Limited research has examined ethnic differences in perceived distress of experiencing microaggressions, sometimes yielding mixed results. For example, Torres-Harding and Turner (2015) observed that, while controlling for the frequency of exposure to microaggressions, Asian American participants reported comparatively lower distress than other ethnic groups and Latinx Americans reported comparatively higher distress, in response to several types of microaggressions. However, other researchers (Demianczyk, 2015; Sanchez et al., 2018) have not observed significant differences between microaggressions and mental health outcomes (i.e., depression, anxiety, and alcohol use) across ethnic groups.

Active coping consistently emerged as a moderator of relationships between microaggressions and various mental health outcomes. When active coping was low,

microaggressions were associated with lower self-esteem and more depression and anxiety. Alternatively, when active coping was high, microaggressions were associated with higher self-esteem and less depression, anxiety, and drug use. Active coping did not significantly moderate the relationship between microaggressions and alcohol use.

Overall findings suggest that using active coping strategies to manage microaggressions serves as a protective factor for many mental health outcomes for persons of color. Furthermore, for all regression models, disengaged coping consistently emerged as a significant predictor of more negative mental health outcomes (i.e., a main effect for disengaged coping emerged in all models, with no interactions), including decreased self-esteem and increased depression, anxiety, alcohol use, and drug use. Thus, actively responding to microaggressions appears to be more conducive to mental health, rather than using strategies aimed at avoiding or ignoring the negative experience. Therefore, interventions aimed at effectively supporting persons of color who encounter microaggressions should focus on increasing active coping skills (e.g., addressing or attempting to change the situation, seeking social support, using positive reframing or humor), while limiting disengaged coping behaviors (e.g., distraction, denial, behavioral disengagement, substance use).

These findings are consistent with previous literature on coping, which generally described the use of active coping strategies as adaptive, and disengaged coping strategies as potentially providing short-term relief, but ultimately problematic in the long-term. Adaptive strategies identified in the literature include positive reframing and perspective-taking, support networks, mentorship, self-care, humor, cultural

nourishment/replenishment, social justice activism, and viewing discrimination as a learning experience and impetus for increased motivation to work hard and prove stereotypes wrong (Andrade, 2014; Gonzalez, 2017; Hernández et al., 2010; Holder et al., 2015; Kuper et al., 2014). Disengaged strategies identified in the literature include avoidance and withdrawal, repression, alcohol and substance use, venting, rumination, and other forms of behavioral and mental disengagement and distancing (Kaholokula et al., 2017; Seaton et al., 2014; Wei et al., 2010).

Consistent with previous literature which observed links between critical consciousness attitudes and mental health outcomes (i.e., depression, anxiety, self-esteem, substance use; Windsor, Jemal, & Benoit, 2014; Zimmerman, Ramírez-Valles, & Maton, 1999), this study found that critical consciousness attitudes moderated the relationship between microaggression experiences and depression. When participants reported low levels of critical reflection (i.e., perceptions of societal inequality, aspirational beliefs about egalitarianism), microaggressions were associated with higher levels of depression, but when critical reflection was medium or high, this relationship was no longer significant. Consistent with previous literature, these findings suggest that critical consciousness attitudes serve as a protective factor against depression when people encounter microaggressions.

Proponents of critical consciousness argue that increased critical reflection not only helps persons recognize systems of disadvantage within society, but also increases individuals' agency to effectively respond to injustice in ways that have the potential to affect meaningful change. Alternatively, individuals with low levels of critical

consciousness are not only less likely to recognize injustice, they may also attempt to ignore or minimize racism and inequity, lack interest or feel powerless to change the situation, or even blame victims of oppression (Diemer et al., 2016). Therefore, critical consciousness attitudes may link to mental health in several important ways.

Agency, including a sense of self-determination and control over one's life, has been associated with improved health, wellness, and quality of life (Jemal, 2017; Prilleltensky et al., 2001). This may suggest that persons with higher critical consciousness reap better mental health by way of increased agency, and possibly even pride at being able to affect meaningful societal change. Social justice activism is also an active coping strategy, which is associated with better mental health. Alternatively, many aspects of low critical consciousness map on to disengaged coping strategies (e.g., denial, repression, behavioral disengagement, self-blame), which are typically associated with worse mental health. Furthermore, powerlessness (another aspect of low critical consciousness) is often associated with depression (Garcia, 2017). As mentioned previously, some have argued that disengaged coping strategies may also be linked to a sense of helplessness and disempowerment (e.g., Garcia, 2017). Just as active coping and critical consciousness are theorized to increase empowerment, disengaged coping and low critical consciousness may be conceptualized as doing the opposite.

Fortunately, critical consciousness is an aspect of resiliency that is capable of being targeted through intervention. The objective of critical consciousness interventions is to promote awareness and understanding of interlocking systems of power and privilege within society, help individuals understand how their various identities fit

within power hierarchies (i.e., intersectionality), and increase participation in sociopolitical action to challenge inequity within marginalized communities (Diemer et al., 2016; Jemal, 2017). Results from this study suggest that critical consciousness attitudes specifically (as opposed to sociopolitical participation) seem to be the most crucial in reducing depression that results from microaggressions.

It should be noted that critical consciousness attitudes were not always associated with favorable mental health outcomes in this study. For example, awareness of societal inequality and desires for egalitarianism demonstrated significant direct effects on anxiety, such that critical consciousness attitudes were associated with more anxiety. Awareness of societal inequality was also associated with lower self-esteem. Similarly, significant positive direct effects of ethnocultural empathy on depression and anxiety also emerged. Although both of these constructs have previously been associated with favorable mental health outcomes for ethnic minorities (Le et al., 2009; Windsor et al., 2014; Zimmerman et al., 1999), other researchers have warned about the potential burden critical consciousness and ethnocultural empathy place on persons of color.

Critical examination of one's sociopolitical context and various forms of institutional oppression may lead persons of color to become more aware of and sensitive to marginalization and inequality, thus elevating the potential of certain risks associated with experiencing discrimination (Buckle, 2018; Crethar et al., 2010; Jones & Galliher, 2015). By way of increasing awareness of systems of power and privilege, critical consciousness removes all naivety about the pervasiveness of societal oppression, which can be a painful and lonely experience. In fact, research suggests that realization that one

is living in a world that continually mistreats them often contributes to psychological distress and lower self-esteem (Velez, Cox, Polihronakis, & Moradi, 2018; Velez, Moradi, & DeBlaere, 2015). Ethnocultural empathy, like critical consciousness, can be a double-edged sword because it entails the ability to relate to discrimination others have experienced, which also involves coming to terms with omnipresent societal oppression.

Part Two

Analysis of changes in emotional affect prior to and immediately following the experimental manipulation showed that participants who were asked to write about a personal microaggression experience demonstrated a significant increase in negative affect, whereas those in the control group experienced a decrease. These findings are consistent with previous literature, which has observed links between microaggressions and negative affect among ethnic minorities (Mercer et al., 2011; Nadal et al., 2014; Nealious, 2017). Previous studies examining the effects of microaggressions on affect have not used experimental designs; therefore, the present study contributes to the literature by documenting changes in affect that can be reasonably attributed to thinking about personal experiences with microaggressions. Within the current sample, no significant differences between conditions emerged for changes in positive affect. This was surprising, given that previous research has linked microaggressions with decreased positive affect (Lui & Quezada, 2019), although this study employed a correlational design. Results from this study suggest that positive affect may be more resilient than negative affect to the impacts of discrimination.

Higher ethnic identity was associated with higher positive affect at baseline for both conditions. However, significant interaction effects for ethnic identity and time emerged for both positive and negative affect, such that participants in the experimental condition who reported high levels of ethnic identity experienced a greater increase in negative affect than those with low levels of ethnic identity. Additionally, when ethnic identity was high, positive affect decreased for both conditions, but participants in the experimental condition experienced a greater decrease. Ethnic identity is typically described in terms of its protective effects; however, there is some evidence that higher ethnic identity may place individuals at greater risk of experiencing microaggressions (Jones & Galliher, 2015). Research suggests that persons of color who more closely identify with traditional values may be both more aware of and vigilant towards aspects of discrimination, and also stronger ethnic identity may actually place them at greater risk of experiencing discrimination due to increased ethnic minority visibility—influenced by appearing and behaving in a more traditionally culture-specific manner (Crethar et al., 2010; Jones & Galliher, 2015).

Therefore, one explanation for participants who reported high levels of ethnic identity experiencing a greater increase in negative affect and decrease in positive affect is simply that these participants have experienced more frequent and salient microaggressions with which to reflect on and write about in the experimental condition. However, correlations between microaggressions and ethnic identity were only significant for Native Americans within the sample. Another possible explanation is that stronger ethnic identity did not result in higher *frequency* of microaggressions, but

increased *impact* (i.e., emotional toll) of microaggressions. It may be that racial microaggressions are easier to ignore, dismiss, repress, minimize, or otherwise not engage deeply with if an individual does not closely identify with the culture or ethnicity being targeted.

Previous researchers have argued that ethnic identity serves as a buffering effect to increase resilience in ethnic minority individuals when they encounter discrimination, including offering protective effects for various aspects of mental health and substance use (Brittian et al., 2015; Chen et al., 2014; Choi et al., 2017; Romero et al., 2014; Toomey et al., 2013; Walker et al., 2008). Taken together, research findings may suggest that although a strong ethnic identity has the potential to increase vulnerability to the immediate negative effects of microaggressions on emotions, the long-term benefits for mental health are abundant. Thus, ethnic identity still appears to be a protective factor for persons of color, although it is perhaps more accurate to adopt a more balanced view of its benefits.

Significant interaction effects for active coping and time emerged for negative affect, such that participants in the experimental condition who reported high levels of active coping experienced an increase in negative affect, whereas those with low levels of active coping did not experience much change in negative affect. This finding may be somewhat misleading since participants in this study were asked to respond to items about coping behaviors as they pertained to how they typically cope with microaggressions specifically (as opposed to how they cope with other stressors). This is why coping strategies, both active and disengaged, were generally correlated with

microaggressions in this study. Interpreted within this framework, the interaction effects for active coping and time may suggest that individuals who have had more opportunities to cope with microaggressions (i.e., higher instances of microaggression experiences) are more susceptible to experiencing changes in negative affect. This may be because these participants (a) had more microaggression experiences to reflect on and write about, (b) possessed increased awareness or knowledge of microaggressions, and/or (c) were more sensitive to the burden of microaggressions—since the negative effects of microaggressions are thought to be cumulative (Pierce, 1995; Sue et al., 2007).

Overall, higher active coping was associated with increased positive affect at Time 1 and 2 for both conditions. This finding seems to suggest that being able to more adaptively cope with microaggressions is associated with higher positive affect, possibly through increased sense of self-efficacy (self-efficacy has been linked with positive affect in the literature; e.g. Calandri, Graziano, Borghi, & Bonino, 2018). Significant interaction effects for disengaged coping and time emerged for positive affect, such that when disengaged coping was high, positive affect decreased for both conditions, but those in the experimental group experienced the greatest decrease. This finding, combined with the literature on coping, seems to provide further support that disengaged coping is often maladaptive (e.g., Carr, 2020), especially when used to cope with microaggressions. Again, active coping emerged as a protective factor, while disengaged coping appeared to increase vulnerability.

Although this study's experimental manipulation appeared to work overall, in terms of observed changes in emotional affect, the content of the microaggression

narratives was not always consistent with what the research team hoped to capture (i.e., microaggressions based on *race* or *ethnicity*). The majority of participants in the experimental condition (53.6%) did in fact write about a microaggression experience. However, only 40% of participants who were asked to write about a microaggression experience chose one that specifically pertained to race or ethnicity. Other participants may have been confused by the microaggression writing prompt. Roughly one sixth of participants in the experimental condition wrote about a negative experience that was not actually a microaggression, and about one fifth stated they did not recall, had never experienced, or did not know what a microaggression was.

Microaggressions are by their very nature subtle, more covert forms of discrimination (Pierce, 1995; Sue et al., 2007), and therefore may often go unnoticed by victims. This fact, combined with the inherent difficulty of explaining microaggressions concisely and thoroughly without providing specific examples, may have led to underreporting of racial/ethnic microaggression experiences. The research team did not want to skew the data by providing specific examples of microaggressions, and this likely limited participants' ability to understand the nuances of the writing prompt. Furthermore, the writing prompt did not specify that the research team was interested in racial and ethnic microaggressions, so participants included other forms of discrimination as well (e.g., sexism). Moreover, some of the negative experiences that were described might have been rooted in ethnic/racial experiences even though participants did not articulate them as such. For example, microaggressions that appeared to be primarily based on gender or sexual orientation may have also been influenced by race or ethnicity

(i.e., intersectionality). Other negative experiences simply lacked enough detail to be classified as microaggressions at all, even if they were in fact microaggressions.

Internalized racism (i.e., the process by which persons of color internalize and accept dominant White culture's actions and beliefs towards minorities; Sosoo, Bernard, & Neblett, 2019) may also have played a role in understanding the denial of microaggressions, or the difficulty articulating microaggression experiences. Researchers argue that sustained denigration and injustice often lead to self-doubt, identity confusion, and feelings of inferiority among those who are oppressed (E. J. R. David, Schroeder, & Fernandez, 2019; Graham, West, Martinez, & Roemer, 2016). When these feelings of inferiority and undesirability become attached to one's racial group, "the oppressed might develop a desire to distance oneself from the racial or ethnic group and to emulate the oppressor because their ways are seen as superior" (E. J. R. David et al., 2019, p. 1060). Thus, internalized racism may lead persons of color to negate, dismiss, ignore, or minimize microaggressions (consciously or unconsciously) due to a desire to better fit in with dominant society. Alternatively, if a particular intervention increases awareness of microaggressions (e.g., critical consciousness), persons with high levels of internalized racism may suffer as they realize how their previously held beliefs have harmed themselves and other persons of color.

Several ethnic differences emerged in the microaggression narratives. Native American participants were significantly more likely than other ethnic groups to write about other characteristic microaggressions (i.e., gender, SES, sexual orientation, mental health), as opposed to racial or ethnic microaggressions. Native participants were also

more likely to write about negative experiences that did not constitute microaggressions (e.g., emotionally abusive parents, rude comments made by siblings or peers). One explanation for this finding stems from the fact that Native American participants in this sample identified as multiracial/ethnic at a higher rate than other ethnic groups. Specifically, 21 Native American participants in the overall sample selected White as one of their racial/ethnic identifiers. Due to mixed Indigenous and White heritage, Native participants in this study may have appeared more racially/ethnically ambiguous or been less visible to others as persons of color (sometimes referred to as being able to "pass" as White). Therefore, Native participants may have experienced microaggressions due to race/ethnicity at a reduced rate compared to more visible ethnic minorities within the sample. There is some evidence to support this hypothesis (e.g., Jones & Galliher, 2015).

Furthermore, Native American participants may have simply experienced more microaggressions related to other marginalized identities (e.g., gender, SES, sexual orientation, mental health) than other groups. Demographic data from this sample provides support for this hypothesis. Within the sample, Native participants identified as transgender or gender non-binary, LGBTQA+, and low SES at higher rates than other ethnic groups. Additionally, this study, along with others (e.g., APA, 2017a), have shown that Native Americans experience various mental health concerns at higher rates than other ethnic groups. With regard to the high instance of Native American participants who wrote about a negative experience that did not constitute a microaggression, one explanation is that Native participants in this sample were less likely to be in college than other ethnic groups, so they may have been less familiar with the concept of

microaggressions in general and/or the language used to describe subtle forms of discrimination.

The majority of the racial/ethnic microaggressions described by participants in the experimental condition were categorized as microinsults and microinvalidations, rather than microassaults. This fits with previous literature which suggests that discrimination has shifted to become more subtle, and perhaps less conscious and deliberate in recent years (Sue et al., 2007). There is arguably considerable external pressure in modern U.S. society to not behave in a racist manner, so it is not surprising that persons of color may experience fewer microassaults than unintentional forms of microaggressions.

Consistent with previous research, frequencies of specific forms of microaggressions varied by ethnicity. For example, a high percentage (one-third) of Asian participants wrote about someone treating them like a perpetual foreigner or someone assuming all Asians are the same (one fourth). These findings are supported by previous literature examining ethnic differences in microaggression experiences (e.g., Demianczyk, 2015; Forrest-Bank & Jenson, 2015). Asian participants also described many instances of someone assuming they would be highly intelligent because of their race. An extensive literature has examined this phenomenon of viewing Asians as the "model minority" (i.e., intellectually and academically superior to other groups, as well as economically successful due to hard work, inherent ability, and good citizenship; Daga & Raval, 2018; Nguyen, Carter, & Carter, 2019). Conversely, high numbers of Black participants in this sample wrote about someone treating them like a second-class citizen, or assuming they were a criminal or less intelligent based on their race. These stereotypic

tropes have also been documented in previous literature examining ethnic differences in microaggressions (Demianczyk, 2015; Fernandez, 2014; Forrest-Bank & Jenson, 2015).

Limitations

One limitation of this study was the potentially vague and/or confusing wording of the microaggression writing prompt. It appears that by not specifying the research team was interested in *racial/ethnic* discrimination, as well as by not providing examples of microaggressions, the writing prompt may have primed some participants to reflect on a negative interpersonal experience in general. However, only a fraction (one-sixth) of participants did in fact write about a negative interpersonal interaction that was not a microaggression. Since slightly more than half of participants in the experimental condition actually wrote about a microaggression experience (with 40% of participants in the experimental condition describing a racial/ethnic microaggression specifically), conclusions about changes in affect can likely still be attributed to microaggressions in general, although specific conclusions about racial/ethnic microaggressions may be less appropriate. Future researchers interested in measuring the effects of racial/ethnic microaggressions specifically will likely want to explicitly specify they are referring to discrimination based on *race or ethnicity*. Additionally, future researchers may wish to experiment with different microaggression definitions and potentially provide examples of racial/ethnic microaggressions to see how this might influence results.

Another potential limitation involves lumping all ethnic minority groups into one category (i.e., persons of color) for primary analyses. The research team made a

conscious decision to include a diverse sample of participants in order to increase generalizability of findings, and also allow for comparisons across ethnic groups. However, the scope of this project did not always allow for each ethnic group to be considered independently in all analyses. Some ethnic group differences emerged in terms of demographic variables, microaggression experiences, resiliency and vulnerability factors, and mental health outcomes. In some cases, separate analyses for different groups may have been more appropriate, and the decision to collapse groups into one category may limit the application of some findings to specific ethnic groups.

With regard to measuring coping behaviors within this sample, researchers decided to prompt participants to answer items based on how they typically cope with microaggressions specifically. Thus, both types of coping (i.e., active, disengaged) were positively correlated with microaggressions in the study. This decision allowed researchers to examine the moderating effects of different types of coping behaviors (specific to microaggressions) on mental health outcomes. However, this decision does not allow researchers to make interpretations about the utility of different types of coping behaviors on mental health in general, only as related to coping with microaggressions specifically. Researchers may wish to explore coping behaviors more broadly in future studies to understand if findings from this study generalize to coping widely.

Conclusion

Overall, actively coping with microaggressions emerged as a protective factor for various mental health outcomes (i.e., depression, anxiety, self-esteem, drug use) when

persons of color encountered discrimination. Alternatively, disengaged coping consistently emerged as a significant predictor of more negative mental health outcomes, including decreased self-esteem and increased depression, anxiety, alcohol use, and drug use. In terms of emotional affect, findings suggest that actively coping with microaggressions exhibits positive benefits on affect, whereas disengaged coping behaviors appear to have the opposite effect. Thus, interventions aimed at effectively supporting persons of color who encounter microaggressions should focus on increasing active coping skills (e.g., addressing or attempting to change the situation, seeking social support, using positive reframing or humor), while limiting disengaged coping behaviors (e.g., distraction, denial, behavioral disengagement, substance use).

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APPENDICES

Appendix A

Letter of Information

Letter of Information

Examining the Effects of Aspects of Resiliency and Vulnerability on the Relationship Between Experiencing Microaggressions and Mental Health among Persons of Color

Introduction

You are invited to participate in a research study conducted by Renee Galliher, a professor in the Department of Psychology, and Amanda Blume, a doctoral student in the Department of Psychology, at Utah State University. The purpose of this research is to examine the effects of subtle discrimination (referred to as microaggressions) on the mental health of persons of color, and assess the degree to which various factors influence risk.

This form includes detailed information on the research to help you decide whether to participate in this study. Please read it carefully and ask any questions you have before you agree to participate.

Procedures

Your participation will involve completing an online survey assessing your multicultural experiences and attitudes, including experiences with discrimination, and aspects of mental health (e.g., self-esteem, coping strategies, substance use). Additionally, this study will involve a brief writing task. You will be randomly assigned to a writing topic, and you will report on your emotional experiences associated with reflecting on the topic you have been assigned. In addition, your written responses may be analyzed later in our efforts to more fully understand the daily experiences of people of color. Participation in the survey is anonymous and is expected to take 30 minutes. We anticipate that 200 people will participate in this research study.

Risks

This is a minimal risk research study. That means that the risks of participating are no more likely or serious than those you encounter in everyday activities. There is some risk that your identity as research participants will be disclosed to others, which can be minimized if you complete the survey in a private location and close the browser upon completion. There is also the possibility that you may experience some discomfort answering personal questions about your experiences. You may refuse to answer questions or discontinue the participation at any time. If you have a bad research-related experience or are injured in any way during your participation, please contact the principal investigator of this study right away at (435) 797-3391 or renee.galliher@usu.edu.

Benefits

There is no direct benefit to you for participating in this research study. More broadly, this study will help the researchers learn more about factors that impact the mental health of ethnic minority individuals and may help future researchers design interventions to help increase resilience against discrimination and foster more positive mental health outcomes for persons of color.

Confidentiality

The researchers will make every effort to ensure that the information you provide as part of this study remains confidential. Your identity will not be revealed in any publications, presentations, or reports resulting from this research study. No identifying information is intended to be collected in the survey. However, it may be possible for someone to recognize your particular response to the open-ended writing prompt, but this risk may be minimized by refraining from disclosing personal information which may reveal your identity to others. For example, disclosing your place of employment and job title could make you identifiable to researchers, and should be avoided.

The information you provide as part of this study will be delivered to the researchers in anonymous form. Your responses will be collected by Qualtrics and sent to the researchers with no identifying information. There will be no way to link your responses to your name. De-identified survey responses will be kept indefinitely. This data will be securely stored in an encrypted, cloud-based storage system.

It is unlikely, but possible, that others (Utah State University, or state or federal officials) may require us to share the information you give us from the study to ensure that the research was conducted safely and appropriately. We will only share your information if law or policy requires us to do so.

The research team works to ensure confidentiality to the degree permitted by technology. It is possible, although unlikely, that unauthorized individuals could gain access to your responses because you are responding online. However, your participation in this online survey involves risks similar to a person's everyday use of the Internet.

Voluntary Participation, Withdrawal [and Costs]
Your participation in this research is completely voluntary. If you agree to participate now and change your mind later, you may withdraw at any time by simply exiting the survey. If you choose to withdraw after we have already collected information about you, we will be unable to delete collected information as we will not be able to determine whose data is who's since participation is anonymous.

Compensation
For your participation in this research study, you will compensation from Qualtrics in accordance with your agreement with them.

IRB Review
The Institutional Review Board (IRB) for the protection of human research participants at Utah State University has reviewed and approved this study. If you have questions about the research study itself, please contact the Principal Investigator at (435) 797-3391 or renee.galliher@usu.edu. If you have questions about your rights or would simply like to speak with someone other than the research team about questions or concerns, please contact the IRB Director at (435) 797-0567 or irb@usu.edu.

Renee V. Galliher, PhD
Principal Investigator
(435) 797-3391; renee.galliher@usu.edu

Amanda K. Blume, M.S.
Student Investigator
(417) 379-4481; amandakblume@aggiemail.usu.edu

Informed Consent
By clicking "agree" below, you agree to participate in this study. You indicate that you understand the risks and benefits of participation, and that you know what you will be asked to do. You also agree that you have asked any questions you might have, and are clear on how to stop your participation in the study if you choose to do so. Please be sure to retain a copy of this form for your records.

Appendix B

Demographic Questionnaire

We understand some of this information can be sensitive and personal. However, we remind you all of the information you provide will be completely confidential. We hope you will answer these questions to the best of your ability as it is important we be able to explore experiences of people with different backgrounds.

1. How do you currently describe your gender identity?
o Man, male, or masculine
o Transgender man, male, or masculine
o Woman, female, or feminine
o Transgender woman, female, or feminine
o Gender nonconforming, genderqueer, or gender questioning
o Intersex, disorders of sex development, two-spirit, or other related terms
o Other, please specify: _____
o Prefer not to answer

2. What is your age in years?
o Please specify: _____
o I prefer not to answer.

3. Which categories describe you? Select all that apply to you:
▢ American Indian or Alaska Native (e.g., Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community)
▢ Asian or Asian American (e.g., Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese)
▢ Black or African American (e.g., Jamaican, Haitian, Nigerian, Ethiopian, Somalian)
▢ Hispanic, Latinx, or Spanish Origin (e.g., Mexican or Mexican American, Puerto Rican, Cuban, Salvadoran, Dominican, Colombian)
▢ Middle Eastern or North African (e.g., Lebanese, Iranian, Egyptian, Syrian, Moroccan, Algerian)
▢ Native Hawaiian or Other Pacific Islander (e.g., Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese)
▢ European or White American (e.g., German, Irish, English, Italian, Polish, French)
▢ Some other race, ethnicity, or origin, please specify:
_____
▢ I prefer not to answer

4. Do you identify as multiracial or multiethnic?

o Yes
o No

5. If you answered yes, which race/ethnicity do you most identify with?
o American Indian or Alaska Native
o Asian or Asian American
o Black or African American
o Hispanic, Latinx, or Spanish Origin
o Middle Eastern or North African
o Native Hawaiian or Other Pacific Islander
o European or White American
o Some other race, ethnicity, or origin, please specify:
_____
o I prefer not to answer
o Not applicable

6. Which categories describe you? Select all that apply to you:
▢ Some high school
▢ High school diploma or equivalent
▢ Vocational training
▢ Some college
▢ Associate's degree (e.g., AA, AE, AFA, AS, ASN)
▢ Bachelor's degree (e.g., BA, BBA BFA, BS)
▢ Some post undergraduate work
▢ Master's degree (e.g., MA, MBA, MFA, MS, MSW)
▢ Specialist degree (e.g., EdS)
▢ Applied or professional doctorate degree (e.g., MD, DDC, DDS, JD, PharmD)
▢ Doctorate degree (e.g., EdD, PhD)
▢ Other, please specify: _____

7. Where do you live?
o Midwest—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, North Dakota, South Dakota, Wisconsin
o Northeast—Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont
o South—Arkansas, Alabama, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia
o West—Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming
o Puerto Rico or other U.S. territories
o Other, please specify: _____

8. Do you have biological, adopted, foster, or step children?

o No
o No, but I am (or my partner is) pregnant or in the process of adopting
o Yes, one child
o Yes, two children
o Yes, three children
o Yes, four or more children

9. Have you been diagnosed with any of the following disabilities or medical conditions? Mark all that apply.

☐ A physical impairment (e.g., vision, hearing, mobility, speech)
☐ A learning disability (e.g., ADHD, dyslexia)
☐ Chronic illness (e.g., cancer, diabetes, autoimmune disorders)
☐ A mental health disorder (e.g., depression, anxiety)
☐ A disability or impairment not listed above
☐ None
☐ I prefer not to answer

10. On average, how many hours do you work a week, including time at an office, in a field, or working in the home?

o 35 or more hours
o Less than 35 hours

11. Are you currently in a romantic relationship with a partner or partners?

o No
o Yes, one partner
o Yes, I have multiple partners

12. If you answered yes, are you? (Mark all that apply):

☐ Not applicable
☐ Married or in a civil union, and living together
☐ Married or in a civil union, and living apart
☐ Not married or in a civil union, and living together
☐ Not married or in a civil union, and living apart

13. How do you describe your religion, spiritual practice, or existential worldview?

o Agnostic
o Animist
o Atheist
o Baha'i
o Buddhist
o Christian (e.g., Catholic, Lutheran, Methodist, Mormon, Presbyterian, Protestant)
o Deist
o Hindu
o Humanist

- o Jewish
- o Muslim
- o Pagan
- o Pantheist
- o Polytheist
- o Secular
- o Sikh
- o Spiritual but not religious
- o Taoist
- o Traditional American Indian spirituality
- o Unitarian Universalist
- o Wiccan
- o Other, please specify: _____
- o Prefer not to answer

14. Do you consider yourself to be:

- o Heterosexual or straight
- o Gay or lesbian
- o Bisexual
- o Fluid
- o Pansexual
- o Queer
- o Demisexual
- o Questioning
- o Asexual
- o I identify differently. Please specify: _____
- o I prefer not to answer.

15. Which social class group do you identify with?

- o Poor
- o Working Class
- o Middle Class
- o Affluent

16. How would you characterize your political views?

- o Far left
- o Liberal
- o Middle of the road
- o Conservative
- o Far right

17. Are you attending college?

- o Yes
- o No

18. If you answered yes, which best describes your enrollment status?

- o Full-time student
- o Part-time student
- o Not applicable

Appendix C

Experimental Condition Writing Prompt – Microaggression Narrative

We will now ask you to engage in a writing task. Your response is greatly appreciated and is an extremely important part of this study. However, this task may lead you to feel strong and/or unpleasant emotions. Please remember all of your responses are voluntary. "Microaggressions" is a term used to describe a specific type of discrimination. Microaggressions are not obvious to everyone right away, if at all. Like obvious discrimination, microaggressions are insulting, belittling, or disrespectful. Unlike obvious discrimination, not everyone can see microaggressions, or see them clearly, because they can be quick comments or actions that are often not intended to hurt the person. The insults can be intentional or unintentional and are often so automatic on the part of the person committing the microaggression that they are not fully aware of their significance. Sometimes microaggressions are delivered as compliments, but those compliments are founded on negative or hurtful stereotypes and while the person making the comment *thinks* they are giving a compliment, the person hearing it feels hurt or put down.

Please use the space below to write about a microaggression experience that happened to you.

How long ago did this microaggression occur? (select the closest in time that applies):
[ ] the past month
[ ] past 3 months
[ ] past 6 months
[ ] past year
[ ] more than 1 year ago
[ ] I have never experienced a microaggression

Appendix D

Control Condition Writing Prompt – Morning Routine Narrative

We will now ask you to engage in a writing task. This task might seem odd; however, your response is greatly appreciated and is an extremely important part of this study.

Please use the space below to write about the usual steps of your morning routine (e.g., what time you wake up, what you eat for breakfast, and other morning activities—such as showering or walking your dog).

Appendix E

Revised 28-Item Racial and Ethnic Microaggressions Scale (R28REMS)

Instructions: Please respond to the following statements by indicating how often each event has happened to you in the past six months.

I did not experience this event	I experienced this event one time	I experienced this event two times	I experienced this event three times	I experienced this event four times	I experienced this event five or more times
1	2	3	4	5	6

1. I was ignored at school or at work because of my race
2. Somebody's body language showed they were scared of me, because of my race
3. Someone assumed that I spoke a language other than English
4. I was told that I should not complain about race
5. Someone avoided walking near me on the street because of my race
6. Someone told me that she or he was color-blind
7. Someone avoided sitting next to me in a public space (e.g., restaurants, movie theatres, subways, buses) because of my race
8. Someone assumed that I would not be intelligent because of my race
9. I was told that I complain about race too much
10. Someone acted surprised at my scholastic or professional success because of my race
11. I observed people of my race portrayed positively on television
12. Someone assumed that I would not be educated because of my race
13. Someone told me that I was "articulate" after she/he assumed I wouldn't be
14. I observed people of my race portrayed positively in magazines

15. Someone told me that they "don't see color"
16. I read popular books or magazines in which a majority of contributions featured people from my racial group
17. Someone asked me to teach them words from my "native language"
18. Someone told me that they do not see race
19. Someone clenched her/his purse or wallet upon seeing me because of my race
20. Someone assumed that I would have a lower education because of my race
21. Someone assumed that I ate foods associated with my race/culture every day
22. Someone assumed that I held a lower-paying job because of my race
23. I observed people of my race portrayed positively in movies
24. Someone assumed that I was poor because of my race
25. Someone told me that people should not think about race anymore
26. Someone avoided eye contact with me because of my race
27. Someone told me that all people in my racial group look alike
28. Someone assumed that I speak similar languages to other people in my race

Appendix F

Multigroup Ethnic Identity Measure—Revised (MEIM-R)

Instructions: Please respond to the following statements by indicating how much you agree or disagree with each statement.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

1. I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs.
2. I have a strong sense of belonging to my own ethnic group.
3. I understand pretty well what my ethnic group membership means to me.
4. I have often done things that will help me understand my ethnic background better.
5. I have often talked to other people in order to learn more about my ethnic group.
6. I feel a strong attachment towards my own ethnic group.

Appendix G

Critical Consciousness Scale (CCS)

Instructions: Please respond to the following statements by indicating how much you agree or disagree with each statement.

Strongly Disagree	Mostly Disagree	Slightly Disagree	Slightly Agree	Mostly Agree	Strongly Agree
1	2	3	4	5	6

1. Certain racial or ethnic groups have fewer chances to get a high school education
2. Poor children have fewer chances to get a good high school education
3. Certain racial or ethnic groups have fewer chances to get good jobs
4. Women have fewer chances to get good jobs
5. Poor people have fewer chances to get good jobs
6. Certain racial or ethnic groups have fewer chances to get ahead
7. Women have fewer chances to get ahead
8. Poor people have fewer chances to get ahead
9. It is a good thing that certain groups are at the top and other groups are at the bottom
10. It would be good if groups could be equal
11. Group equality should be our ideal
12. All groups should be given an equal chance in life
13. We would have fewer problems if we treated people more equally

Instructions: Please respond to the following statements by indicating how often you were involved in each activity in the last year.

Never did this	Once or twice last year	Once every few months	At least once a month	At least once a week
1	2	3	4	5

14. Participated in a civil rights group or organization
15. Participated in a political party, club or organization
16. Wrote a letter to a school, community newspaper, or publication about a social or political issue
17. Contacted a public official by phone, mail, or email to tell him or her how you felt about a social or political issue
18. Joined in a protest march, political demonstration, or political meeting
19. Worked on a political campaign
20. Participated in a discussion about a social or political issue
21. Signed an email or written petition about a social or political issue
22. Participated in a human rights, gay rights, or women's rights organization or group

Appendix H

Scale of Ethnocultural Empathy (SEE)

Instructions: Please respond to the following statements by indicating how much you agree or disagree with each statement.

Strongly Disagree	Mostly Disagree	Slightly Disagree	Slightly Agree	Mostly Agree	Strongly Agree
1	2	3	4	5	6

1. I feel annoyed when people do not speak standard English.
2. I don't know a lot of information about important social and political events of racial and ethnic groups other than my own.
3. I am touched by movies or books about discrimination issues faced by racial or ethnic groups other than my own.
4. I know what it feels like to be the only person of a certain race or ethnicity in a group of people.
5. I get impatient when communicating with people from other racial or ethnic backgrounds, regardless of how well they speak English.
6. I can relate to the frustration that some people feel about having fewer opportunities due to their racial or ethnic backgrounds.
7. I am aware of institutional barriers (e.g., restricted opportunities for job promotion) that discriminate against racial or ethnic groups other than my own.
8. I don't understand why people of different racial or ethnic backgrounds enjoy wearing traditional clothing.
9. I seek opportunities to speak with individuals of other racial or ethnic backgrounds

about their experiences.

10. I feel irritated when people of different racial or ethnic backgrounds speak their language around me.
11. When I know my friends are treated unfairly because of their racial or ethnic backgrounds, I speak up for them.
12. I share the anger of those who face injustice because of their racial and ethnic backgrounds.
13. When I interact with people from other racial or ethnic backgrounds, I show my appreciation of their cultural norms.
14. I feel supportive of people of other racial and ethnic groups, if I think they are being taken advantage of.
15. I get disturbed when other people experience misfortunes due to their racial or ethnic backgrounds.
16. I rarely think about the impact of a racist or ethnic joke on the feelings of people who are targeted.
17. I am not likely to participate in events that promote equal rights for people of all racial and ethnic backgrounds.
18. I express my concern about discrimination to people from other racial or ethnic groups.
19. It is easy for me to understand what it would feel like to be a person of another racial or ethnic background other than my own
20. I can see how other racial or ethnic groups are systematically oppressed in our

society.

21. I don’t care if people make racist statements against other racial or ethnic groups.
22. When I see people who come from a different racial or ethnic background succeed in the public area, I share their pride.
23. When other people struggle with racial or ethnic oppression, I share their frustration.
24. I recognize that the media often portrays people based on racial or ethnic stereotypes.
25. I am aware of how society differentially treats racial or ethnic groups others than my own.
26. I share the anger of people who are victims of hate crimes (e.g., intentional violence because of race or ethnicity).
27. I do not understand why people want to keep their indigenous racial or ethnic cultural traditions instead of trying to fit into the mainstream.
28. It is difficult for me to put myself in the shoes of someone who is racially and/or ethnically different from me.
29. I feel uncomfortable when I am around a significant number of people who are racially/ethnically different than me.
30. When I hear people make racist jokes, I tell them I am offended even though they are not referring to my racial or ethnic group.
31. It is difficult for me to relate to stories in which people talk about racial or ethnic discrimination they experience in their day to day lives.

Appendix I

Brief COPE

The following items reflect various ways people can cope with stress. Please respond to these statements based on how you typically cope with microaggressions [such as the one you just wrote about]. There are many ways to try to deal with problems. Don't answer on the basis of whether it seems to be working or not—just whether or not you're doing it. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I've been doing this a lot
1	2	3	4

1. I've been turning to work or other activities to take my mind off things.
2. I've been concentrating my efforts on doing something about the situation I'm in.
3. I've been saying to myself "this isn't real."
4. I've been using alcohol or other drugs to make myself feel better.
5. I've been getting emotional support from others.
6. I've been giving up trying to deal with it.
7. I've been taking action to try to make the situation better.
8. I've been refusing to believe that it has happened.
9. I've been saying things to let my unpleasant feelings escape.
10. I've been getting help and advice from other people.
11. I've been using alcohol or other drugs to help me get through it.
12. I've been trying to see it in a different light, to make it seem more positive.
13. I've been criticizing myself.

14. I've been trying to come up with a strategy about what to do.
15. I've been getting comfort and understanding from someone.
16. I've been giving up the attempt to cope.
17. I've been looking for something good in what is happening.
18. I've been making jokes about it.
19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.
20. I've been accepting the reality of the fact that it has happened.
21. I've been expressing my negative feelings.
22. I've been trying to find comfort in my religion or spiritual beliefs.
23. I've been trying to get advice or help from other people about what to do.
24. I've been learning to live with it.
25. I've been thinking hard about what steps to take.
26. I've been blaming myself for things that happened.
27. I've been praying or meditating.
28. I've been making fun of the situation.

Appendix J

Patient Health Questionnaire-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Not at all	Several days	More than half of the days	Nearly every day
0	1	2	3

1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless
3. Trouble falling or staying asleep, or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things, such as reading the newspaper or watching television
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual
9. Thoughts that you would be better off dead or of hurting yourself in some way

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? Not difficult at all Somewhat difficult Very difficult Extremely difficult

Appendix K

Generalized Anxiety Disorder- 7 Item (GAD-7) Scale

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Not at all	Several days	More than half of the days	Nearly every day
0	1	2	3

1. Feeling nervous, anxious or on edge
2. Not being able to stop or control worrying
3. Worrying too much about different things
4. Trouble relaxing
5. Being so restless that it is hard to sit still
6. Becoming easily annoyed or irritable
7. Feeling afraid as if something awful might happen

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
Not difficult at all Somewhat difficult Very difficult Extremely difficult

Appendix L

Alcohol Use Disorders Identification Test (AUDIT)

Please respond to a list of questions concerning information about your alcohol use. If you have difficulty with a statement, then choose the response that is mostly right. For the purposes of this survey, one drink of alcohol refers to one 12 oz. beer, one mixed drink, one shot of liquor, or one 5 oz. glass of wine.

Questions	**0**	**1**	**2**	**3**	**4**
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10.Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

Appendix M

Drug Abuse Screening Test (DAST-10)

Please respond to a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months. If you have difficulty with a statement, then choose the response that is mostly right.

When the words “drug abuse” are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

These questions refer to the past 12 months.	**No**	**Yes**
1. Have you used drugs other than those required for medical reasons?	0	1
2. Do you abuse more than one drug at a time?	0	1
3. Are you always able to stop using drugs when you want to? (If never use drugs, answer “Yes.”	1	0
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose “No.”	0	1
6. Does your spouse (or parents) ever complain about your involvement with drugs?	0	1
7. Have you neglected your family because of your use of drugs?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	0	1

Appendix N

Rosenberg Self-Esteem Scale

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3

1. On the whole, I am satisfied with myself.
2. At times I think I am no good at all.
3. I feel that I have a number of good qualities.
4. I am able to do things as well as most other people.
5. I feel I do not have much to be proud of.
6. I certainly feel useless at times.
7. I feel that I'm a person of worth, at least on an equal plane with others.
8. I wish I could have more respect for myself.
9. All in all, I am inclined to feel that I am a failure.
10. I take a positive attitude toward myself.

Appendix O

Positive and Negative Affect Schedule (PANAS)

This scale consists of a number of words that describe different feelings and emotions.

Please indicate to what extent you feel this way *right now*, that is, *at the present moment*.

Very slightly or not at all	A little	Moderately	Quite a bit	Extremely
1	2	3	4	5

1. Interested
2. Distressed
3. Excited
4. Upset
5. Strong
6. Guilty
7. Scared
8. Hostile
9. Enthusiastic
10. Proud
11. Irritable
12. Alert
13. Ashamed
14. Inspired
15. Nervous
16. Determined
17. Attentive
18. Jittery
19. Active
20. Afraid

CURRICULUM VITAE

AMANDA K. BLUME

Educational History

August 2019 – July 2020	**Predoctoral Internship** (APA Accredited) *Salt Lake City VA Health Care System*, Salt Lake City, UT
January 2017 – August 2020	**Doctor of Philosophy, Clinical/Counseling Psychology** (APA Accredited) *Utah State University, Logan, UT* Dissertation: *Examining the Effects of Aspects of Resiliency and Vulnerability on the Relationship Between Experiencing Microaggressions and Mental Health among Persons of Color*
August 2014 – December 2016	**Master of Science in Psychology** *Utah State University, Logan, UT* Thesis: *Diversity-Related Experiences and Academic Performance among Ethnic Minority College Students*
August 2007 – May 2013	**Bachelor of Arts in Psychology, Bachelor of Arts in Philosophy** *Missouri State University, Springfield, MO*

Awards and Honors

June 2016 – 2018	**Student Representative**, *Society of Indian Psychologists*
May 2019	**Graduate Enhancement Award**, *USU Graduate School*
April 2018	**Applied Practice and Research Award**, *USU Psychology Department*
April, 2018; 2016	**Diversity Scholarship Award**, *USU Psychology Department*
August 2017	**Student Travel Award**, *American Psychological Association*
August 2017	**Student Travel Award**, *APA Division 45*
September 2015	**Student Scholar Award**, *Native Children's Research Exchange*
December 2012	**Psi Chi International Honor Society in Psychology**

Publications

Blume, A. K., Tehee, M., & Galliher, R. V. (2019). Experiences of discrimination and prejudice among Native American youth: Links to psychosocial functioning. In H.

E. Fitzgerald, D. J. Johnson, D. B. Qin, F. A. Villarruel, & J. Norder (Eds.), *Handbook of children and prejudice: Integrating research, practice, and policy* (pp. 482-501). New York City, NY: Springer.

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Blume, A. K. & Galliher, R. V. (under peer review). Diversity-related experiences and school belonging among ethnic minority college students.

Blume, A. K., Galliher, R. V., & Franco, J. (under peer review). Moderated mediation of associations between college diversity experiences and school belonging.

Tehee, M., Trimble, J., Forgays, D. K., **Blume, A. K.**, Willis Esqueda, C. (revise and resubmit). Attitudes and bias towards American Indians: Measurement and theoretical considerations.

Conference Presentations – Oral Papers and Workshops

Tehee, M., Straits, K. J. E., & **Blume, A. K.** (August, 2018). *An indigenous perspective on the APA Ethics Code*. Continuing education workshop presented at the 2018 Annual American Psychological Association (APA) Convention, San Francisco, CA.

Blume, A. K., Pauldine, M. R., & Varela, A. (November, 2017). *(In)Visibility of culture in the APA Ethics Code: Considerations from Latinx, American Indian, and*

LGBTQ+ communities. Continuing education workshop presented at the 2018 Annual Utah University and College Counseling Center Conference (UUCCCC), Salt Lake City, UT.

Tehee, M., Domenech Rodríguez, M. M., Capielo-Rosario, C., & **Blume, A. K.** (August, 2017). *The ethics code through a cultural lens*. Continuing education workshop presented at the 2017 Annual American Psychological Association (APA) Convention, Washington, D.C.

Conference Presentations – Posters

Blume, A. K., Reveles, A., & Galliher, R. V. (August, 2017). *Moderated mediation of associations between diversity experiences and school belonging*. Poster presented at the 2017 Annual American Psychological Association (APA) Convention, Washington, D.C.

Reveles, A., **Blume, A. K.**, & Galliher, R. V. (August, 2017). *Links among diversity-related college experiences and multicultural competence*. Poster presented at the 2017 Annual American Psychological Association (APA) Convention, Washington, D.C.

Blume, A. K. & Galliher, R. V. (June, 2016). *Diversity experiences as predictors of academic functioning among Native American college students*. Poster presented at the 2016 Annual Society of Indian Psychologists (SIP) Convention, Logan, UT.

Reveles, A., **Blume, A. K.**, & Galliher, R. V. (April, 2016). *Diversity-related experiences among college students and ethnic differences in the awareness of racism*. Poster presented at the 2016 Biennial Society for Research on Adolescence (SRA) Conference, Baltimore, MD.

Blume, A. K. & Galliher, R. V. (September, 2015). *Diversity-related campus climate experiences of Native American college students*. Poster presented at the 2015 Annual Native Children's Research Exchange (NCRE) Conference, Denver, CO.

Research Experience

August 2014 – August 2019 **Multicultural and Rural Mental Health Lab**
Utah State University, Logan, UT
Roles: Primary Investigator; Research Assistant
Supervisor: Renee Galliher, Ph.D.

- Co-authored published manuscripts and book chapters related to mental health and psychosocial functioning among ethnic minority and LGBTQ+ populations; Data collection and statistical analysis; Research dissemination at conferences

Dissertation Project (Defended July 2019): *Microaggressions and Mental Health: Examining the Effects of Aspects of Resiliency and Vulnerability among Persons of Color*

Thesis Project: *Diversity-Related Experiences and Academic Performance among Ethnic Minority College Students*

May 2016 – July 2019 **Native American Psychology Lab**
Utah State University, Logan, UT
Role: Research Assistant
Supervisor: Melissa Tehee, Ph.D., J.D.

- Co-authored published manuscripts, book chapters, and grant proposals related to Native American issues; Conducted literature reviews and statistical analysis of data; Selected research project survey instruments

August 2012 – December 2012 **Missouri Mental Health Court**
Missouri State University, Springfield, MO
Supervisor: Paul Deal, Ph.D.

- Participant management, data collection, and statistical analysis to evaluate the effectiveness of participating in the mental health court system on participants' subsequent mental health and recidivism rates

Clinical Experience

August 2019 – July 2020 **Psychology Intern, General Track**
VA Salt Lake City Healthcare System Psychology Predoctoral Internship, Salt Lake City, UT

Rotations:

Inpatient Psychiatric Unit (20-25 hours/ week)
August 2019 – November 2019
Supervisors: Jo Merrill, Ph.D.; Rich Weaver, Ph.D.

- Provided crisis-oriented services to a high-risk veteran population, including individual psychotherapy, process and psychoeducational groups (e.g., Seeking Safety), comprehensive personality and neuropsychological assessment, and interdisciplinary team consultation

Intensive Cognitive Processing Therapy (20-25 hours/week)
November 2019 – February 2020
Supervisor: Harrison Weinstein, Ph.D.

- Implemented daily individual Cognitive Processing Therapy (CPT),

Conducted tele-mental health through VA Video Connect; Conducted PTSD diagnostic intake assessments and provided relevant recommendations, Co/facilitated PTSD Start Point class, including providing psychoeducation on PTSD symptoms and treatment options

Neuropsychological Assessment (15-20 hours/week)
August 2019 – January 2020
Supervisor: Janet Madsen, Ph.D.

- Administered neuropsychological assessment batteries and clinical interviews in an outpatient medical setting; Addressed referral questions related to differential diagnosis of neurocognitive, mental and physical health concerns; Integrated data from chart review, clinical interview, and assessment results in a comprehensive report with relevant recommendations. Testing battery included Wechsler Adult Intelligence Scale (WAIS-IV), Wechsler Memory Scale (WMS-IV), Boston Naming Test, Controlled Oral Word Association (COWA), Rey Auditory Verbal Learning Test (RAVLT), Trails A/B, Rey 15 Item, and Rey Complex Figure Test (RCFT).

Residential PTSD/SUD Treatment (20-25 hours/week)
February 2020 – April 2020
Supervisor: Jacek Brewczynski, Ph.D.

- Co/facilitated process and psychoeducational groups; Training in Prolonged Exposure and other evidence-based treatments for trauma and addictions; Assessment and case conceptualization of comorbid PTSD/SUD; Relapse prevention planning; Interdisciplinary team meetings; Navigation of interpersonal dynamics encountered in residential treatment

VA Rollout Cognitive Processing Therapy (CPT) Training and Consultation (5-7 hours/week)
August 2019 – April 2020
Supervisor: Harrison Weinstein, Ph.D.
Completed two-day CPT training program; Successfully completed the CPT protocol with five individual cases; Participated in weekly group consultation led by a certified CPT trainer; Completed all aspects of training required for CPT certification equivalence

Medical Psychology and Chronic Pain (20-25 hours/week)
February 2020 – July 2020
Supervisor: Amber Martinson, Ph.D.

- Provided individual and group-based Cognitive-Behavioral Therapy for Chronic Pain; Collaborated with interdisciplinary team and consulting providers; Conducted brief assessment, intervention, and coordinated patient care within medical settings; Conducted opioid overdose risk assessments and co/facilitated pain and opioid education

classes (all activities conducted in person and via telehealth)

Military Sexual Trauma (20-25 hours/week)
April 2020 – July 2020
Supervisor: Jim Asbrand, Ph.D.

- Provided individual and group psychotherapy to veterans who experienced military sexual trauma (MST), including conducting individual Prolonged Exposure therapy, co/facilitating process and psychoeducational groups (e.g., DBT skills groups), and co/facilitating PTSD treatment orientation groups and individual PTSD treatment planning sessions (via telehealth).

LGBTQ+ Veteran Support (3-5 hours/week)
December 2019 – July 2020
Supervisors: Michelle Wilcox, LCSW; Jim Asbrand, Ph.D.

- Co/facilitated weekly LGBTQ+ veteran support groups, recreation therapy outings; Met with LBGTQ+ veterans individually as needed for additional support; Organized outreach activities; Served as liaison to the Utah Pride Center (all activities conducted in person and via telehealth)

June 2017 – May 2018 **VA Medical Center, Outpatient Addiction Recovery (10 hours/week)**
Salt Lake City, UT
Supervisor: Jonathan Codell, Ph.D.

- Conducted psychodiagnostic evaluations with veterans presenting with alcohol and substance abuse and comorbid disorders; Co-facilitated mindfulness-based relapse prevention psychotherapy groups; Participated in multidisciplinary staff meetings and case conferences

August 2016 – May 2019 **Utah State University Counseling Center (20-25 hours/week)**
Logan, UT
Supervisors: Eri Bentley, Ph.D.; Justin Barker, Psy.D.

- Provided evidence-based individual and group psychotherapy; Treated a broad array of concerns including alcohol and substance abuse, trauma, anxiety, depression, disordered eating, personality disorders, and suicidality; Planned and led outreach events on campus; Conducted psychodiagnostic assessments (i.e., learning disability, ADHD, personality, and mental health assessments); Participated in multidisciplinary staff meetings, case conferences, and weekly didactic trainings; Provided supervision to a MFT practicum student

August 2018 – May 2019 **Urban Indian Center, Red Mesa Counseling (15-20 hours/week)**
Salt Lake City, UT
Supervisor: Melissa Tehee, Ph.D., J.D.

- Conducted individual psychotherapy and psychodiagnostic

evaluations with Native Americans with a range of presenting issues, particularly with regard to alcohol and substance abuse and trauma; Designed and co/facilitated culturally adapted evidence-based therapy groups; Participated in multidisciplinary staff meetings and case conferences; Coordinated with the Utah Department of Corrections

July 2016 – May 2017 **Bear River Head Start Counseling Center (10-15 hours/week)**
Logan, UT
Supervisor: Sara Boghosian, Ph.D.

- Provided evidence-based psychotherapy and psychodiagnostic assessments to low-income families, children, and couples with a range of presenting issues, predominantly addressed through behavioral parent training methods and family systems approaches; Participated in multidisciplinary staff meetings and coordinated with the Division of Child and Family Services (DCFS); Provided community outreach workshops and trainings

August 2015 – May 2016 **Utah State University Community Clinic (20-25 hours/week)**
Logan, UT
Supervisor: Susan Crowley, Ph.D.

- Provided evidence-based psychotherapy and psychodiagnostic assessments to patients across the lifespan; Participated in weekly didactic training and seminars and comprehensive case presentations

Clinical Workshops and Trainings

Tehee, M. & **Blume, A. K.** (May, 2018; May 2019). *Multicultural competence and ethics from an Indigenous perspective*. Continuing education and intern training workshop presented at Wasatch Mental Health, Provo, UT.

Blume, A. K. (April, 2018). *Historical trauma and epigenetics: Clinical considerations for working with Native American and Alaska Native clients.* Seminar presented at Utah State University Counseling and Psychological Services (CAPS), Logan, Utah.

Diversity Certifications and Trainings

- **LGBTQ+ Allies on Campus Seminar Facilitator Training** (*USU Access and Diversity Center*, November 2016)
- **LGBTQ+ Allies on Campus Training** (*USU Access and Diversity Center*, May 2016)
- **Interfaith Ally Training** (*USU Access and Diversity Center*, April 2016)

Volunteer Outreach Involvement

June 2016 – June 2018 **Student Representative, Society of Indian Psychologists**
- Participated in executive committee conference calls; Voiced students' concerns to the executive committee on conference calls and to the entire membership at the annual convention; Planned and organized student member activities at the annual convention; Facilitated a social media networking site for student members

June 2016 – June 2018 **Professional Committee Member, Society of Indian Psychologists**
Committee Chair: Kee Straits, Ph.D.
- Participated in committee conference calls; Edited a funded grant proposal to disseminate the SIP Ethics Commentary; Helped create study materials to accompany the SIP Ethics Commentary, for dissemination to training sites and community clinics across the country; Co-facilitated continuing education workshops on the SIP Ethics Commentary

January 2017 – May 2019 **LGBTQ+ Allies on Campus Seminar Facilitator**
Logan, UT
Program Coordinator: Macy Keith, B.A.
- Co-facilitated the Allies training seminar, which includes a combination of didactic training, experiential activities, a LGBTQ+ student panel, and providing community resources for further trainings and support groups

August 2015 – May 2017 **Cache Refugee and Immigrant Connection**
Logan, UT
Supervisors: Melissa Tehee, Ph.D., J.D. and Nelda Ault, M.A.
- Co/facilitated the weekly U.S. Citizenship Clinic, which included preparing refugees for the U.S. citizenship exam and training undergraduate volunteers

May 2016 – August 2018 **Convention Coordinator Assistant, Society of Indian Psychologists**
Supervisor: Melissa Tehee, Ph.D., J.D.
- Planned and organized the agenda for the conference and retreat; Coordinated services, materials, and finances with the Utah State University event planner and psychology department graduate program coordinator; Facilitated activities and presentations at the conference and retreat

Teaching Experience

August 2014 – December 2018 **Teaching Assistant**
Psychology Department, Utah State University
Graduate Course: Intellectual Assessment

- Provided instruction on administering and scoring the WAIS-IV and WISC-V; Reviewed WAIS-IV and WISC-V certifications for administration and scoring accuracy; Provided consultation and feedback on intellectual assessment reports

Undergraduate Courses: Multicultural Psychology (4 semesters); Psychology of Gender; Psychological Statistics; Introduction to Counseling; Introduction to Psychology

- Constructed and graded assignments; Provided statistics tutoring; Managed the course website and email correspondence with students; Guest lectured on topics, such as identity development for ethnic and sexual minorities, developing cultural competence in therapy, and abnormal psychology.

January 2015 – May 2015 **Direct Instructor**
Psychology Department, Utah State University
Course: Cognitive Psychology Lab

- Facilitated weekly lab meetings and discussion groups that included didactic and experiential material designed to supplement the lecture course; Constructed and graded assignments; Managed the course website and email correspondence with students

Professional Affiliations

- **Society of Indian Psychologists** (June 2014-Present)
- **American Psychological Association** (Nov. 2013-Present)
- **Society for the Psychological Study of Culture, Ethnicity and Race** (*APA Div. 45*, Dec. 2016-Present)
- **Society for the Psychology of Women** (*APA Div. 35*, Dec. 2016-Present)
    - **Section VI: Alaska Native/American Indian/Indigenous Women** (Dec. 2016-Present)
    - **Section IV: Lesbian, Bisexual, and Transgender Concerns** (Dec. 2016-Present)
- **Society for the Psychology of Sexual Orientation and Gender Diversity** (*APA Div. 44*, Jan. 2018-Present)
- **Society of Addiction Psychology** (*APA Div. 50*, Jan. 2018-Present)
- **American Psychological Association of Graduate Students – APAGS** (Dec. 2016-Present)