

Microaggressions and Health Outcomes for Latina/o Americans:
Understanding the Influences of External Characteristics and Psychological Resources

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ABSTRACT

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Despite their rapid growth, Latina/o Americans still experience disparities in most social, economic, employment, and educational spheres in American society. These include disparities in mental and physical health outcomes. Previous research makes a convincing argument for perceived discrimination being associated with these poor health outcomes. Scholars propose that the manifestation of discrimination has changed over the decades from a predominantly overt form to a more subtle, covert form, known as microaggression. Additionally, given the within-group differences inherent in this population, it is possible that various characteristics and psychological resources might influence the magnitude of experiences with microaggressions and health outcomes for Latina/o Americans.

The present study investigated, 1) a specific type of discrimination, microaggressions, experienced by Latina/o Americans, and 2) the various within-group characteristics (skin color, Spanish language use, and accent) and psychological resources (ethnic identity and social support) that might inform health outcomes for Latina/o Americans. A path model, as well as moderation tests, explored these relationships with a sample of 328 Latina/o Americans. The results indicated support for the paths between accent and perceived microaggressions, as well as between perceived microaggressions and mental health outcomes. Additionally, the moderation tests indicated that social support moderated the relationship between perceived microaggressions and physical health outcomes. The results of the present study contribute to the literature on microaggressions by providing quantitative support for the harmful effects of

microaggressions and expanding the knowledge base concerning various dynamics involved in the microaggression process for Latina/o Americans.

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Chapter I

INTRODUCTION

The unjust and discriminatory treatment marginalized people experience in the United States is well documented in scholarly publications as well as in the popular press and other forms of mass media (Sue & Sue, 2008; Takaki, 1994). Psychologists, as well as social scientists and other scholars, have long studied the mechanics of discriminatory treatment between individuals and groups in American society (e.g., Allport, 1954; Steele, 1997; Sue, Capodilupo, et al., 2007). This research includes the theoretical underpinnings of discrimination, such as Allport's seminal work on prejudice, as well as the deleterious effects of discrimination and stereotype on marginalized groups, such as people of color and women (e.g., Jones, 1997; Strickland, 1992; Sue, 2003, etc.). Our knowledge about the effects of discrimination against marginalized groups, especially people of color, has increased because of these scholarly contributions.

However, previous research has neglected to delineate the various specific types of discrimination and differential treatment experienced by people of color, as well as the various unique individual characteristics that influence the relationship between exposure to discrimination and outcomes of discrimination (Araújo & Borrell, 2006; Edwards & Romero, 2008). For example, people of color report experiencing various types of discrimination, such as being treated like criminals, having their intelligence stereotyped, and being treated like a perpetual foreigner (Sue, 2010). Various groups of people of color, such as Asian Americans, African Americans, Latina/o Americans, and Native Americans, may be more heterogeneous than homogeneous in terms of within-group characteristics and experiences. Thus, it is important to consider within-group differences in investigations involving these populations (Sue

& Sue, 2008). This dissertation investigated, 1) a specific type of discrimination experienced by one such group, Latina/o Americans, and 2) the various within-group characteristics and experiences that might inform health outcomes for Latina/o Americans.

Acknowledging that Latina/o Americans can self-identify and be identified in various ways, the following working definition of this group will be used for this dissertation. Latina/o American “refers to an individual living in the United States who identifies racially and/or ethnically as Latina/o or Hispanic, or who ethnically and/or racially identifies with people coming from Mexico, Central America, South America, or the Spanish-speaking countries of the Caribbean” (Rivera, Forquer, & Rangel, 2010). The broadness of this definition respects the diverse ethnic and racial experience of Latina/o Americans and is in line with other definitions of this population (e.g., Casas & Pytluk, 1995). Additionally, including “a/o” in the term Latina/o is purposeful in that historically the term Latino has generally been used and can connote an air of male dominance. It must be noted that the terms Latina/o and Hispanic are considered to be ethnic designators by the United States Census, as well as by many scholars (Nadal & Rivera, 2008). Additionally, the usage of these terms as racial designators is a point of controversy among many scholars (e.g., Betancourt & Lopez, 1993; Marotta & Garcia, 2003).

Perceived Discrimination & Latina/o Americans

Investigations on discrimination experienced by people of color in the United States have traditionally focused on the experience of Black Americans (Araújo & Borrell, 2006). This is quite understandable given the history of race relations in the United States (Takaki, 1994); however, the racial and ethnic landscape of the United States has changed considerably to include substantial numbers of people of Asian and Latin decent. For example, the population of Latina/o Americans has surpassed that of Black Americans to become the largest ethnic group in

the United States (US Census Bureau, 2007). Given the increase in the Latina/o American population, as well as the projected growth of this group, it is paramount that we learn more about the various experiences of Latina/o Americans including the ways they are discriminated against. For the purposes of this dissertation the term *discrimination* will be used to refer to *perceived discrimination*, given that studies on discrimination are most often conducted from the perspective of the target of the discrimination and are concerned with the target's appraisal of the incident as being discriminatory in nature (Clark, Anderson, Clark, & Williams, 1999; Utsey & Ponterotto, 1996). Thus, this dissertation is primarily concerned with the subjective experience of discrimination, rather than the objective experience.

Despite their rapid growth, Latina/o Americans still experience disparities in most social, economic, employment, and educational spheres in American society. For example, Latina/o Americans are underrepresented in managerial and professional occupations (e.g., law, media, education, etc.) and overrepresented in service related occupations (e.g., food preparation, healthcare support, personal care, etc.; US Department of Labor, 2008). Additionally, Latina/o Americans have some of the lowest educational attainment rates, as compared to other racial and ethnic groups (US Census Bureau, 2008). It is plausible that these disparities are the result of discrimination experienced by Latina/o Americans. For example, research on educational outcomes suggests that when the campus racial climate fosters alienation and hostility towards students of color, Latina/o American students have lower rates of educational success (Hurtado, Milem, Clayton-Pedersen, & Allen, 1998). The employability of Latina/o Americans has been linked to discrimination likely to take place in the hiring phase of employment (Carlson & McHenry, 2006). The results of these studies, taken together with the statistics on Latina/o

American representation in various facets of American society, suggests that discrimination does indeed play a role in the disparities experienced by Latina/o Americans.

Largely missing from the discourse and investigation of discrimination experienced by Latina/o Americans are the specific types of discrimination experienced by this population. For example, the vast majority of discrimination studies conducted with Latina/o American participants do not report the specific types of discrimination they experience (e.g., Flores et al., 2008; Moradi & Risco, 2006; Rosenboom & Way, 2004). Rather, most studies simply report the extent to which Latina/o Americans experience discrimination. Thus, little is known about the extent to which Latina/o Americans experience specific types of discrimination, such as being treated like a criminal or having their intelligence assailed. As the conceptualization of discrimination experienced by Latina/o Americans and other marginalized groups is changing to include the study of chronic stressors, that is everyday experiences with discrimination that take a toll on one's wellbeing (Araújo & Borrell, 2006), it becomes increasingly important to identify the particular stressors that negatively affect the daily lives of Latina/o Americans in order to develop culturally appropriate interventions and prevention strategies. For example, studies on chronic stressors, also known as microaggressions, suggest that individuals experience discrimination differently based on their race or ethnicity, which indicates that this variation in experience should be taken into consideration when investigating how microaggressions manifest in the lives of specific groups of people of Color (Rivera, Forquer, & Rangel, 2010; Sue, Bucceri, Lin, Nadal, & Torino, 2007; Sue, Nadal, et al., 2008; a detailed review of these studies can be found in Chapter 2). Thus, the study of microaggressions provides a framework from which we can begin to identify the various types of daily insults and invalidations experienced by Latina/o Americans.

Microaggressions are defined 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” (Sue, Capodilupo, et al., 2007, p. 273). The phenomenon of racial microaggressions was conceptualized in the 1970s by Chester Pierce (Pierce, Carew, Pierce-Gonzalez, & Willis, 1978). However, educational and psychological scholars re-introduced the idea of microaggression as a way to conceptualize what are believed to be common, everyday interactions in which a worldview of supremacy is conveyed to those in the social minority (Solórzano, Ceja & Yosso, 2000; Sue, Capodilupo, et al., 2007). The scholarly work on microaggressions against marginalized groups describes the various types of discriminatory experiences that people of color perceive in their daily interactions (Rivera et al., 2010; Sue, Bucceri, et al., 2007; Sue, Nadal, et al., 2008; Watkins, LaBarrie, & Appio, 2010). This dissertation builds upon this body of work in order to more fully understand the prevalence and impact of microaggressions in the lives of Latina/o Americans.

Health Disparities & Latina/o Americans

Latina/o Americans also experience health inequities, in addition to disparities in education and employment (Williams, Neighbors, & Jackson, 2003). The health disparities that affect Latina/o Americans can be found in access to healthcare services, as well as a higher proportion affected by various physical and mental health ailments in comparison to other ethnic groups. For example, Latina/o Americans experience disproportionately higher incidences of human immunodeficiency virus (HIV), diabetes, and high blood pressure (Burke et al., 1999; Obiri, Fodyce, Singh, & Forlenza, 1998; Tarlton, 2007). Additionally, Latina/o Americans have been found to have relatively high rates of anxiety- and depression-related symptoms (Pole, Best,

Metzler, & Marmar, 2005; Saluja et al., 2004). Possibly more startling is that Latina/o American youth and young adults are at greater risk for engaging in suicidal behavior than any other ethnic group (Canino & Roberts, 2001). In spite of this, Latina/o Americans report significantly lower levels of access to any type of healthcare, such as preventative medical check-ups, being admitted to the hospital for various medical procedures, and utilizing mental health services (Guendelman & Wagner, 2000; U.S. Department of Health and Human Services, 2001).

The connection between perceived discrimination and health outcomes is gaining attention. As with the discrimination literature, the majority of studies on this connection focus on Black Americans (Harrell, Hall, & Taliaferro, 2003; Williams et al., 2003). These studies, in their totality, make a convincing argument for perceived discrimination being associated with poor health outcomes (see Harrell, et al, 2003 and Williams, et al., 2003 for meta-analyses). Although relatively few studies have investigated this relationship with a Latina/o American population, there is evidence that suggests that there is an association between perceived discrimination and the poor mental and physical health outcomes of Latina/o Americans (e.g., Finch, Hummer, Kolody, & Vega, 2001 for physical health; Finch, Kolody, & Vega, 2000 for depression; Flores et al., 2008 for general health; Szalacha et al., 2003 for stress). Given the fledgling support for this connection, this dissertation focused on the various mental and physical health outcomes of perceived microaggressions for Latina/o Americans.

Within-group Differences Among Latina/o Americans

Considerable variation exists within the Latina/o American community (Marotta & Garcia, 2003). However, researchers that include Latina/o American participants often conceptualize this group as a monolithic ethnic group. Investigators rarely include nor analyze the various demographic and physical characteristics or varying degrees of intrapersonal

psychological processes (e.g., ethnic identity & acculturation) that are found within the Latina/o American population (Weinick et al., 2004). For example, whereas historically Latina/o Americans were primarily found in the southwestern states, southern Florida and the New York City metropolitan area, they can now be found in increasingly larger numbers in many other geographic locations in the United States (Marotta & Garcia, 2003). Additionally, Latina/o Americans represent a diverse array of generational statuses, with the population of Latina/o Americans increasingly growing older (Marotta & Garcia, 2003). Latina/o Americans also vary in terms of physical appearance, such as skin color and phenotype (Montalvo & Codina, 2001; Telzer & Vasquez Garcia, 2009). Finally, although Latina/o Americans are often characterized as sharing a common non-English language, that of Spanish, the percentage of Spanish-speaking households is rapidly increasing, which is both reflective of the overall increase in the Latina/o American population and the variability in Spanish fluency among Latina/o Americans (Marotta & Garcia, 2003). Although research by and large fails to consider the variation that exists within the Latina/o American community, it is quite clear that Latina/o Americans are a diverse population. For example, a Latina/o American who is fair-skinned and speaks Spanish will more than likely have a lived experience that significantly differs from that of a Latina/o American who is dark-skinned and does not speak Spanish.

Taking into consideration the variation that exists among Latina/o Americans, a number of characteristics can be conceptualized as potential variables that influence the relationship between perceived microaggressions and health outcomes for this population. Few studies have included more than a few additional variables when investigating the relationship between discrimination and various outcomes for Latina/o Americans (e.g., Finch et al., 2000; Flores et al., 2008; Szalacha et al., 2003). As previously mentioned Latina/o Americans vary in terms of

skin color; however, no study could be found that investigates how skin color influences the relationship between discrimination and health outcomes. Similarly, presence of a Spanish influenced accent has been studied as an independent variable that leads to poor outcomes, such as negatively influencing employability; however, the research on how accent affects Latina/o Americans' experiences with discrimination is still in an early stage (Carlson & McHenry, 2006; Dovidio, Gluszek, John, Dittmann, & Lagunes, 2010). Thus, this dissertation investigated how various characteristics of Latina/o Americans, such as Spanish language use, accent, and skin color, influence the relationship between perceived microaggressions and health outcomes.

Ethnic identity has been investigated in various studies that include Latina/o American participants. This variable is more commonly investigated than skin color, accent and language use; however, few studies include ethnic identity as a moderator of the relationship between perceived discrimination and health outcomes (Mossakowski, 2003). There is evidence that suggests that ethnic identity might serve as a buffer between perceived discrimination and mental health outcomes for ethnic and racial minorities (Lee, 2005; Mossakowski, 2003). However, most of these studies were conducted with non-Latina/o American participants. The findings on the protective nature of ethnic identity are mixed, as studies with Asian American and African American populations suggest contradictory evidence (Noh, Beiser, Kaspar, Hou, & Rummens, 1999; Williams, Spencer, & Jackson, 1999). Since the role of Latina/o American ethnic identity in the relationship between perceived microaggressions and various outcomes is largely missing from the literature, this dissertation included ethnic identity as a possible moderator of this relationship.

Another variable that has been shown to serve as a moderator between perceived stressors and various health outcomes is that of social support (Campos et al., 2008; Krause,

2005). Social support as a buffer between perceived stressors in life and the outcomes of being exposed to stressors has long been established in the field of psychology (Cohen & Wills, 1985). This phenomenon has been referred to as the “buffering hypothesis.” Simply stated, the buffering hypothesis posits that social support buffers or attenuates the negative impact of stressful conditions (Cohen & Wills, 1985). Further, it has been suggested that the buffering qualities of social support may be even more useful for those who endure multiple and continual stressors, such as microaggressions (Wills & Langner, 1980). People of color have evaluated their experiences with microaggressions to be stressful or harmful (Sue, Capodilupo, & Holder, 2008). Even though no study has investigated the function of social support on perceived microaggressions and health outcomes, there is evidence that supports the premise that social support buffers the harmful effects of acculturative stress on various health outcomes for Latina/o Americans (Crockett et al., 2007; Finch & Vega, 2003). Thus, this dissertation considered the role that social support has in buffering the harmful effects of microaggressions on the mental and physical health of Latina/o Americans.

Overview of Dissertation

There is compelling evidence that suggests that Latina/o Americans do indeed perceive discrimination in their lives (e.g., Araújo & Borrell, 2006). Increasing evidence supports that this discrimination comes in the form of microaggressions (National Survey of Latinos, 2002; Rivera et al., 2010). Furthermore, the body of research that connects experiences with discrimination and health outcomes for Latina/o Americans is growing. Researchers also suggest that Latina/o Americans have historically been conceptualized as a monolithic ethnic, racial, and cultural group; however, strong evidence exists to support the contrary and suggests that Latina/o Americans are quite diverse in terms of physical characteristics and lived

experience (Marotta & Garcia, 2003; US Census, 2007). However, there are very few studies that incorporate the various external characteristics (e.g., skin color, Spanish language use, and accent) and psychological resources (e.g., ethnic identity and social support) that may influence the relationship between Latina/o Americans perceptions of microaggressions and various health outcomes. The current study attempts to connect these variables in order to gain a more comprehensive understanding of 1) how Latina/o Americans perceive microaggressions, 2) what health outcomes emerge from these perceptions of microaggressions, and 3) what variables influence the relationship between perceived microaggressions and health outcomes for Latina/o Americans.

Chapter II

LITERATURE REVIEW

The historical legacy of the United States is filled with individual, institutional and societal manifestations of discrimination and prejudice towards racial and ethnic minorities. The review of literature will explore several areas that are related to how people experience and are affected by discrimination in the United States. First, a focus on the various disparities that exist within the Latina/o American community and our current understanding of how discrimination and microaggressions are experienced by Latina/o Americans will be undertaken. Second, the various outcomes of discrimination will be explored, specifically concentrating on empirical studies that support the association between perceived discrimination and poor health outcomes for Latina/o Americans. Third, honoring the vast diversity that exists within the Latina/o American community, I will then discuss the various within-group characteristics and experiences that will be considered as possible variables that influence the relationship between perceived microaggressions and health outcomes. Fourth, recognizing that various psychological resources might also affect the relationship between perceived microaggressions and health outcomes, the literature review will include a discussion of ethnic identity and social support. Finally, the literature review will conclude with an overview and explanation of the hypotheses and proposed model that will serve as the conceptual framework for this dissertation.

The Evolving Nature of Racism & Ethnic Discrimination

The racial and ethnic landscape of the United States is in a continual state of evolution. Africans who were forcibly taken from their homeland and infused into a legal system of slavery over 400 years ago now live freely in a society where slavery is illegal. Irish, Italian, and other non-English men and women living in the U.S. were once categorized as belonging to a racial

group inferior to that of the English settlers, but are now categorized as White by the U.S. Census. A Bill of Rights defines civil liberties of all U.S. citizens, regardless of race or ethnicity. The first Black American was elected president of the United States in 2008, and the first Latina was nominated and confirmed to the U.S. Supreme Court in 2009. By all accounts the racial and ethnic climate of the United States has changed over time to include better protections for racial and ethnic minorities, as well as more opportunities for advancement in many areas of life. Despite these protections and advancements, the United States still remains a place where racist and ethnocentric ideologies operate, both overtly and covertly, to maintain a society wrought with social disparities for racial and ethnic minorities. This section will discuss how the racial and ethnic landscape of the United States has evolved over time and make an argument for how discrimination is alive and well in this society, despite the advancements of racial and ethnic minorities.

Racial and ethnic oppression and discrimination is conceptualized as being the manifestation of racist ideologies or worldviews that serve a narrow segment of U.S. society, also known as ethnocentric monoculturalism (Sue & Sue, 2008). The study of the negative treatment endured by marginalized people has traditionally concentrated on the psychological processes of the perpetrator. Allport (1954), in his seminal work on prejudice, essentially analyzed the social and psychological underpinnings that influence the manifestation of prejudice. Allport's work, largely based on previous investigations of intergroup relations, primarily sought to understand the dynamics and determinants of prejudicial behavior and to a lesser degree included how this behavior affects the targets of prejudice. This work continues to be very influential to the study of intergroup relations, prejudice and discrimination, and many credit Allport with bringing the topic of ethnic stereotyping into the mainstream (Katz, 1991).

Since then, the study of prejudice, including racial and ethnic discrimination, has evolved to concentrate more on the experience of the target of prejudicial behavior.

In terms of how racism and discrimination are conceptualized, there has been a tendency to group and label discrimination and oppression based on both race and ethnicity within the umbrella term racism or ethnic discrimination (Clark et al., 1999). This is problematic since interchanging the terms racism and ethnic discrimination causes major confusion in delineating the unique constructs of race and ethnicity. This may stem from the disagreement that various researchers have in terms of how to describe people of color; as people from marginalized racial backgrounds or marginalized ethnic backgrounds, or both. This issue can be even more nuanced when describing the phenomena of discrimination and oppression experienced by Latina/o Americans, given the disagreement in categorizing this group by race and ethnicity. Given that people of color, including Latina/o Americans can experience discrimination and oppression based on both their race and ethnicity, it might be justifiable to consider both of these dimensions when conceptualizing and measuring discrimination and oppression in this group.

Scholars propose that the manifestation of racism has changed over the decades from a predominantly overt form to a more subtle, covert form of racism (Dovidio & Gaertner, 2000; Essed, 1991; Rowe, 1990; Sue, Capodilupo, et al., 2007). The more common, subtle form of racism evident in contemporary American society has been given several labels with very similar definitions. Dovidio and Gaertner conceptualize it as *aversive racism*, which is defined as being “the racial attitudes of many Whites who endorse egalitarian values, who regard themselves as nonprejudiced, but who discriminate in subtle, rationalizable ways” (p. 315). This concept was exemplified by White Americans who self-identified as nonprejudiced against people of color, yet still expressed preference for a White job applicant over a Black job applicant even though

both had identical qualifications (Dovidio & Gaertner, 2000). Additionally, Essed (1991) describes *everyday racism* to be a covert form of racism that is normalized by the power group and thus not questioned by those in the given society. Further, a form of subtle discrimination that is believed to be largely responsible for workplace inequity has been called *microinequity* and has been applied to members of racial minority groups, women, and other marginalized populations (Rowe, 1990). There are differences in the way these forms of contemporary racism have been conceptualized and defined; however, they all share the common characteristic of manifesting in subtle and possibly hard to detect ways.

Microaggression Theory and Research

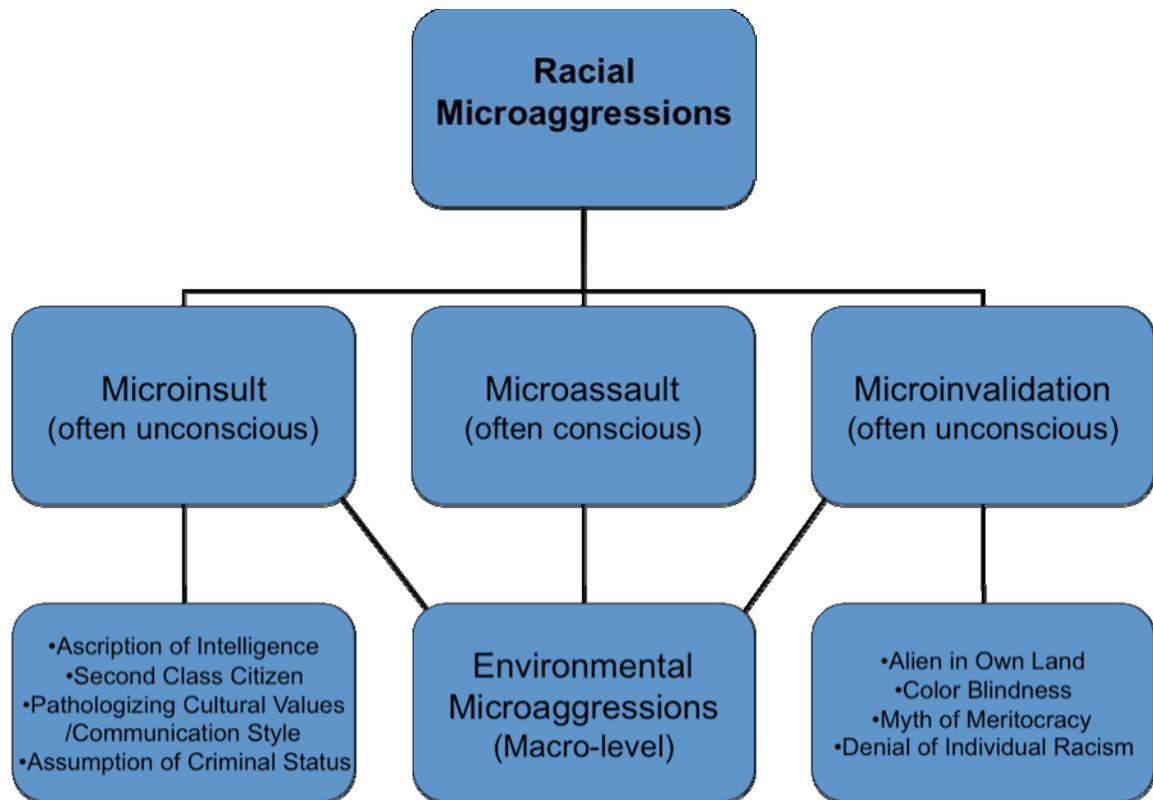
The contemporary conceptualizations of racism proposed by these scholars can be traced to the conceptualization of racism proposed by Pierce and his colleagues in the 1970s. Pierce, Carew, Pierce-Gonzales and Willis (1978) describe microaggressions as “subtle, stunning, often automatic, and non-verbal exchanges which are ‘put downs’ of blacks by offenders” (p. 66). To illustrate and provide evidence for the existence of microaggressions, Pierce et al. analyzed the content of television commercials. They found that not only are Black people highly underrepresented in television commercials, but when they are included they are generally portrayed in a negative manner (e.g., portrayed as subservient to White people, engaged in non-intellectual activities). Through the use of television commercials, which are conceivably innocuous, Pierce and colleagues were able to demonstrate how subtle negative representations (or lack of representation) of Black people in the media can have a large impact on society by perpetuating negative stereotypes about Black people to the large number of television viewers. This study exemplified the high prevalence of racial microaggressions in American society.

Expanding on the work of Pierce and colleagues (1978), a conceptualization of how racial microaggressions manifest in everyday life was proposed by Sue and his colleagues (See Figure 1; Sue, Capodilupo, et al., 2007). The authors define racial microaggressions 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). Racial microaggressions are further delineated into three sub-forms, which include microassaults, microinsults, and microinvalidations. The first sub-form, microassault, is considered to be more inline with the overt “old fashion” type of racism, and the other two, microinsult and microinvalidation, are considered to be the forms most commonly found in contemporary society and are often perpetrated at the unconscious level. The conceptualization offered by Sue and his colleagues (2007) mainly concentrates on the sub-forms of microinvalidation and microinsult, since it is hypothesized that these interactions may be more pervasive and harmful because of their ambiguity and unintentional nature. Microassaults are likely intentional and easier to identify than microinsults and microinvalidations. Additionally, various categories or types of microaggressions were classified under each sub-form of microaggression.

Microassaults are defined as “an explicit racial derogation characterized primarily by a verbal or nonverbal attack meant to hurt the intended victim through name-calling, avoidant behavior, or purposeful discriminatory actions” (Sue, Capodilupo, et al., 2007, p. 274). An example of a microassault would be a person of color being called a racial or ethnic epithet. For instance, a Latina/o American being referred to as a “wetback” or “spic” would exemplify a microassaultive encounter. In this example, the intentionality of the interaction is quite clear. Using racial or ethnic epithets are usually indicative of biased perceptions of the targets of these

Figure 1

Taxonomy of Racial Microaggressions (Sue, Capodilupo, et al., 2007)



remarks. Thus, microassaults are often committed with the conscious intention of being deliberately harmful in terms of their delivery and impact.

Unlike microassaults, microinvalidations and microinsults are delivered in more subtle ways and the intent behind these interactions is more ambiguous. Microinsults are defined as “communications that convey rudeness and insensitivity and demean a person’s racial heritage or identity” (Sue, Capodilupo, et al., 2007, p. 274). The authors identified various categories of microinsults that include, 1) ascription of intelligence, 2) second class citizen, 3) pathologizing cultural values and communication style, and 4) assumption of criminal status. An example of a microinsult would be when a Latina/o American is mistaken for a service worker in a store where they are shopping. The potential message from this seemingly harmless interaction is that Latina/o Americans are only suited for service-level positions. The perpetrator of this interaction is more than likely unaware of the message behind their behavior.

Finally, a microinvalidation is defined as “communications that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of a person of color” (Sue, Capodilupo, et al., 2007, p. 274). The authors identified various categories of microinvalidations that include, 1) alien in own land, 2) color blindness, 3) myth of meritocracy, and 4) denial of individual racism. An example of this type of microaggression would be when a Latina/o American is asked where they were born or assumed to be from Mexico or another Latin American or Caribbean country. The message in this interaction is that all Latina/o Americans share the common experience of being a first-generation immigrant to the United States. Although this may be true for some Latina/o Americans, it negates the experience of those who were born in the United States. These examples of microaggressive encounters do not reflect the

entire universe of how Latina/o Americans experience microaggressions, and are only meant to serve as potential situations that a Latina/o American may experience in their life.

Sue (2010) elucidates several psychological dilemmas and dynamics that differentiate microaggressions from other contemporary forms of racism and discrimination. These dilemmas describe how microaggressions might come to be enacted, what accounts for the difference in how they are perceived by the perpetrator and target, and the reasons why these encounters may go unchecked. These dilemmas and dynamics include: clash of racial (or other identity difference) realities, invisibility of unintentional bias, perceived minimal harm of microaggressions, and the “catch-22” of responding to microaggressions. In essence, these psychological dilemmas and dynamics provide the theoretical underpinnings for the construct of the microaggressive encounter.

The clash of racial realities, or the clash of realities that exists between people of any differing social identity (such as ethnicity, sexual orientation, disability, etc.), is described as how people have differing views of the world around them based on their experience belonging to their respective social groups. For instance, the racial and ethnic reality of a White American may be different than that of a Latina/o American since each is exposed to various cultural and social experiences that help shape their experience as racial and ethnic beings. The differences that exist between people of different racial and ethnic backgrounds may influence how they make sense of the world around them. In terms of the process that happens when microaggressions occur, this clash of realities is bound to surface when the perpetrator ignores or dismisses the occurrence of the microaggression, while the target of the microaggression acknowledges that something harmful has happened.

Again, in this scenario, it may be assumed that the perpetrator comes from a different racial and/or ethnic background than the target, and thus their perception of the microaggressive encounter is likely to be shaped by their unique racial and ethnic experience. When the perpetrator is from the dominant racial and/or ethnic group in society, their reality of what has just occurred is likely to take precedence over the reality of the target who belongs to the marginalized racial and/or ethnic group. This creates an imbalance in terms of whose reality is “valid” and thus whose experience is likely to be believed. The dynamic that occurs when there is a clash of realities is likely to promote the frequent occurrence of microaggressions against those from marginalized backgrounds.

Similarly, the invisibility of unintentional bias surfaces when, because of the social and cultural conditioning of the aggressor, acts of microaggressions are perpetrated unknowingly and thus have the propensity for remaining invisible and unchecked by those involved. Going back to aversive racism theory, it has been found that even though someone is self-regarded as unbiased and well-intentioned, they still may possess racist and ethnocentric ideologies that guide their decisions to engage in certain behaviors (Dovidio & Gaertner, 2000; Gaertner & Dovidio, 2005). For example, an aggressor who is complimenting a Latina American on her lack of an accent may construe this to be a genuine compliment; however, the underlying microaggressive message that may be perceived by the Latina is that having an accent is a deficit in some way. The result of this situation may be for the perpetrator to still believe that they are well-intentioned, and for the target to, at the very least, feel uneasy about the supposed compliment. Further, this type of interaction is likely to go unchecked by both the aggressor and the target because of the socially and culturally reinforced standards Americans have about accents.

Microaggressive incidents, when viewed as singular occurrences, are also perceived to cause minimal harm, as exemplified above. However, research indicates that it is not the single occurrence of a subtle, discriminatory event that leads to negative outcomes, but rather it is the accumulation of microaggressions or chronic exposure to bias that leads to negative outcomes of the target (Araújo & Borrell, 2006). That is, individuals ascribe their negative outcomes to repeated experiences with discrimination, and not singular episodes of discrimination. It has also been shown that exposure to ambiguous forms of discrimination, such as microaggressions, leads to worse cognitive functioning than does exposure to overt forms of discrimination (Salvatore & Shelton, 2007). Additionally, people who experience microaggressions have been shown to perceive future professional barriers (Panter, Daye, Allen, Wightman, & Deo, 2008). This suggests that microaggressions negatively influence future orientation. This evidence supports that microaggressions are indeed harmful interactions, especially when viewed as events that accumulate throughout the lived experience of marginalized people.

The final unique characteristic of microaggressions is that of the “catch-22” of responding to microaggressions. The target is placed in a catch-22 situation from the instant they perceive the interaction to be potentially harmful. For example, the target may think, “Did that just happen?” or “Did that person intend to harm me?” Next, the catch-22 continues when the target considers whether or not to respond to the perpetrator. Responding to microaggressions can often lead to unfavorable consequences for the target of the microaggression, such as being told that they are overreacting, or further minimization of the target's experience with the microaggression. Additionally, because the perpetrator was more than likely unconscious that their behavior was harmful, they may not be able to fully understand the deleterious effect of the incident on their unintended victim. Consequently, when the target considers the potential

harmful effects of acknowledging and responding to microaggressions, they may, more often than not, weigh in on the side of remaining silent. Thus, the microaggression remains hidden. These psychological dilemmas and dynamics are the defining characteristics of the process of microaggressive incidents.

Is the taxonomy of racial microaggressions proposed by Sue and his colleagues (2007) relevant to all racial and ethnic groups? Given the heterogeneity in the overall and individual experience of individuals in each American racial minority group, it is plausible that differences exist in the way racial microaggressions are experienced among these groups. Additionally, it is also reasonable to expect that similarities in the type of racial microaggressions experienced by the different racial minority groups will be found. Several qualitative studies, involving the use of semi-structured interviews with focus groups and individuals, have been conducted to explore and indirectly test the taxonomy of microaggressions with specific racial and ethnic groups (Rivera et al., 2010; Sue, Bucceri, et al., 2007; Sue, Nadal, et al., 2007).

Additionally, several empirical studies investigating the phenomenon of microaggressions in various educational and counseling settings have emerged as of recent (e.g., Constantine & Sue, 2007; Solórzano, 1998; Solórzano, Ceja & Yosso, 2000; Watkins et al., 2010). The majority of these studies investigated racial microaggressions in the life experience of African Americans (e.g., Constantine & Sue, 2007; Solórzano et al., 2000; Sue, Capodilupo, et al., 2008; Sue, Nadal, et al., 2008; Watkins et al., 2010). However, several studies have investigated this phenomenon in the life experience of other marginalized groups such as Asian Americans (Sue, Bucceri, et al., 2007) and Latina/o Americans (Rivera et al., 2010; Rivera, Molina, & Watkins, 2012; Solórzano, 1998). These studies not only present empirical evidence for the existence of microaggressions in different marginalized racial and ethnic populations,

they also present specific information about how individuals experience microaggressions.

Additionally, several studies have investigated the manifestation of microaggressions in other marginalized groups, such as people with disabilities and women (Capodilupo et al., 2010; Keller & Galgay, 2010). This finding suggests that microaggressions can be found in the life experience of non-racial or ethnic marginalized populations as well.

The empirical research on microaggressions suggests that individuals of different races and ethnicities do experience this phenomenon. The mechanics (i.e., perceiving the interaction as harmful and experiencing multiple microaggressions in daily life) of how microaggressions are experienced is similar throughout the different racial and ethnic groups studied thus far; however there are qualitative differences in the type of microaggression experienced by each specific racial or ethnic group. For example, there appear to be both similarities and differences in the types of microaggressions experienced by African Americans (Solórzano et al., 2000; Sue, Capodilupo, et al., 2008; Sue, Nadal, et al., 2008), Asian Americans (Sue, Bucceri, et al., 2007), and Latina/o Americans (Rivera et al., 2010; Solórzano, 1998). One type of microaggression experienced by all three of these groups is the message that they are “invisible” or a second-class citizen (Rivera et al., 2010; Sue, Bucceri, et al., 2007; Sue, Nadal, et al., 2008). This type of microaggression leaves the aggressed feeling overlooked or ignored by the aggressor. This feeling of invisibility can also translate into the aggressed feeling out of place in certain situations or in society in general (Solórzano, 1998).

A common theme found across these three populations is the ascription of intelligence. However, the way in which the intelligence of members of these three populations is assessed is different. Both African Americans and Latina/o Americans feel a sense of intellectual inferiority in how they are treated by aggressors of microaggressions (Sue, Nadal, et al., 2008; Rivera et al.,

2010). However, research revealed that Asian Americans are targets of a different type of intellectual racial microaggression (Sue, Bucceri, et al., 2007). Asian Americans are likely to receive the message that they excel academically. Although this can be perceived as a compliment, participants revealed that this form of racial microaggression might cause Asian Americans to feel undue pressure to perform successfully on tasks in which they might not be very proficient. For instance, African Americans and Latina/o Americans may be discouraged from entering science and engineering professions, while Asian Americans may be overly encouraged to enter these career fields. This can result in people of color “choosing” careers that are not in line with their actual vocational aptitudes, which can then lead to lower levels of job and life satisfaction for people of color.

There is additional evidence to suggest that microaggressions manifest differently among the various racial and ethnic minority groups. For example, African Americans and Latina/o Americans may experience feelings of not being trustworthy or of being ascribed to criminal status in response to microaggressions (Rivera et al., 2010; Solórzano et al., 2000; Sue, Nadal, et al., 2008). Whereas Asian Americans and Latina/os reported the feeling of being an alien in their own land, which appears to be a form of microaggression not as widely experienced by African Americans. Although African Americans, Asian Americans, and Latina/o Americans appear to vary in the way in which they are targets of microaggressions, it appears that some members of these groups have the overall experience of “not belonging” in certain situations (e.g., educational settings; Solórzano, 1998; Watkins et al., 2010).

Microaggressions and Latina/o Americans. Only three known studies have examined microaggressions in the lives of Latina/o Americans (Rivera et al., 2010; Rivera et al., 2012; Solórzano, 1998). The first was a study on Chicanas/os (a sub-group of Latina/o Americans that

often trace their lineage to Mexico and/or the Southwest United States), specifically investigating how racial and gender microaggressions affected the educational experience of doctoral graduate students and post-doctoral fellows (Solórzano, 1998). This qualitative study, using individual interviews, revealed several racial and gender microaggressions experienced by the 12 participants. The first pattern was that of *feeling out of place* in the university environment. The participants attributed this feeling to their racial and ethnic minority status, as well as their relative lower social class status. This pattern was further described by the participants as feelings of alienation by being ignored and avoided by other students and faculty. Additionally, examples of environmental microaggressions, through the absence of Latina/o faculty, added to the participants' feeling out of place at their respective institutions of higher education. Some participants hinted at potential psychological ramifications associated with feeling out of place on campus, such as developing the propensity for self-doubt and second guessing one's self.

The second pattern identified was that of having *lower expectations* set for them by their instructors and peers, which resulted in being stigmatized and receiving differential treatment. For example, some students reported that they were assumed to be recipients of affirmative action and thus were taking the place of a more qualified student. Participants also spoke about experiencing lower academic expectations because of their Spanish accent. These students spoke about how their comments in class were often regarded as irrelevant and felt especially slighted when a student without a Spanish accent would receive praise for mentioning the very same thing. The third and final pattern identified in this qualitative study was that of being the targets of *racist and sexist attitudes and behaviors*. These attitudes would often come out via "slips of the tongue." For example, one participant recounted being told on more than one occasion that he was "not like the rest of them (other Latinas/os)." This more than likely sent

him the message that he is an exception to his ethnic group. This was the first study that investigated the phenomenon of microaggressions in the lives of Latina/o Americans using Pierce and colleagues' (1978) conceptualization. It would be another decade until another study investigating microaggressions in the life experience of Latina/o Americans would emerge.

A qualitative study investigating the manifestation of microaggressions in the lives of Latina/o Americans, specifically testing the taxonomy of microaggressions proposed by Sue, Capodilupo, et al. (2007), was conducted with 11 self-identified Latina/o and Hispanic participants representing various races and ethnicities from throughout the United States (Rivera et al., 2010). Data was gathered by using semi-structured individual interviews. This study revealed seven unique microaggression themes and one theme representing a number of various Latina/o American stereotypes. The seven unique themes included: 1) ascription of intelligence, 2) second class citizen, 3) pathologizing communication style/cultural values, 4) characteristics of speech, 5) alien in own land, 6) criminality, and 7) invalidation of the Latina/o American experience (see Table 1 for definitions and examples). The one theme from this study that was not found in Sue, Capodilupo, and colleagues' taxonomy was that of *characteristics of speech*. Latinos experiencing microaggressions assailing their speech could be explained by the fact that Spanish is a common language for many Latina/o Americans, and by the anti-immigration sentiment and the English-only movement. A large majority of these sentiments have been directed specifically toward Latina/o Americans (Gallop Poll, 2008; Johnson & Martinez, 2000).

The above study suggests that Latina/o Americans experience a variety of microaggressions. Knowing the various types of microaggressions that Latina/o Americans experience in their daily lives can be helpful in identifying appropriate measures of

Table 1

Latina/o American Microaggression Themes & Examples (Rivera et al., 2010)

Themes	Examples
1. Ascription of Intelligence	Accomplishments/qualifications questioned Educational success seen as a surprise Exception to race/ethnicity Talked down to in public
2. Second Class Citizen	Being Ignored Being denied goods/received differential treatment Excluded Unwelcoming responses
3. Pathologizing Cultural Values/Communication Style	Cultural values pathologized Religion Communication style pathologized
4. Characteristics of Speech	Speaking Spanish Accent Quality of Speech
5. Alien in Own Land	U.S. citizenship questioned Latinas/os unwelcomed in U.S. Negative remarks regarding immigration Assumed undocumented status Language ability questioned
6. Criminality	Treated like a criminal Received messages implying illegal activity
7. Invalidation of the Latina/o Experience	Verbally dismissed Given excuses for negative treatment “You don’t look Latino”
8. Other Assumed Latina/o Attributes	Generalizations of Latinas/os Assumed poor Assumed laziness Pathologizing childbearing practices Misidentified ethnicity Drink (alcohol) too much

discrimination to use with this population. Using measures that ask about specific experiences with microaggressions (e.g., People treat me differently because of my accent), as opposed to measures that include more general items (e.g., People treat me differently because of my ethnicity) can be more informative in terms of learning more about the experience of Latina/o Americans. Additionally, the participants contextualized their experiences with microaggressions in various domains, such as education, the work place and public spaces. This suggests that microaggressions are a widespread problem for Latina/o Americans, further supporting the theory that microaggressions are endemic in American society. Furthermore, since there are differences in the types of microaggressions that are experienced by people of Color, it may be more appropriate to study this phenomenon from an emic perspective, rather than the etic perspective that is more commonly used. An emic perspective allows for the emergence of specific experiences with microaggressions for Latina/o Americans that might be culture-bound, rather than the etic perspective that would conceptualize microaggressions as a universal experience and negate the unique culture-bound factors that might influence how people from different racial and ethnic groups experience microaggressions. Given that Latina/o Americans are likely to experience a variety of microaggressions in their daily lives, this dissertation investigated the prevalence of microaggressions in the daily lives of Latina/o Americans via the use of a measure that inquires about specific microaggressive situations (i.e., Racial and Ethnic Microaggressions Scale; Nadal, 2011), rather than general experiences with discrimination.

The final study to date that examined microaggressions in the lives of Latina/o Americans, was quantitative in nature and utilized the Racial and Ethnic Microaggressions Scale (Rivera et al., 2012). This study included a sample of 331 self-identified Latina/o American

adults who completed the REMS, as well as measures of mental health, physical health and generational status. This study revealed that perceived microaggressions were indeed associated with an increase in psychological distress, as well as poorer physical health. The study also revealed that generational status (i.e., how long one's family has lived in the United States as measured by generation) had no significant impact on the relationship between perceived microaggressions and health outcomes. This study supports findings that suggest a connection between microaggressions and compromised mental and physical health for people of Color (Nadal & Davidoff, 2012; Nadal et al., 2012).

Microaggressions in context. Several conceptual papers and empirical investigations about microaggressions in various contexts (e.g., education, employment, mental health, etc.) have been published (e.g., Constantine & Sue, 2007; Sue, Lin, & Rivera, 2009; Watkins et al., 2010). For example, the existence of racial microaggressions in counseling relationships has been investigated (Constantine, 2007; Constantine & Sue, 2007). One study gives evidence for the existence of racial microaggressions in counseling situations involving Black clients and White counselors (Constantine, 2007). These results suggest that there is a negative association between clients' perception of racial microaggressions and their perception of both the therapeutic alliance and therapists' general and multicultural counseling competence. This suggests that racial microaggressions do negatively affect some important counseling constructs of a helping relationship. Additionally, the power differential that exists between the client and the counselor can exacerbate the effect of racial microaggressions in the counseling relationship.

Also pertaining to the counseling context, one study suggests that racial microaggressions might impede the work between Black supervisees and White supervisors (Constantine & Sue, 2007). Seven themes regarding how Black supervisees perceive racial microaggressions from

their White supervisors emerged in this qualitative study. The themes are: 1) invalidating racial-cultural issues, 2) making stereotypic judgments about Black clients, 3) making stereotypic judgments about Black supervisees, 4) reluctance to give performance feedback for fear of being viewed as racist, 5) focusing primarily on clinical weaknesses, 6) blaming client of color for problems stemming from oppression, and 7) offering culturally insensitive treatment recommendations. These themes, though presented in a specific context, appear to be similar to the types of microaggressions that emerged from other studies on microaggressions. For example, the theme of the supervisor focusing on clinical weaknesses may give the impression to the supervisee that they have a lower intelligence. This is similar to other findings that indicate that Blacks and Latina/o Americans receive a message of intellectual inferiority from microaggressive interactions. Additionally, the invalidation of cultural issues that were found in this study is similar to the type of cultural invalidation reported by Latina/o Americans (Rivera et al., 2010; Solórzano, 1998).

The other major contextual area that has been investigated is education. This contextual area of interest is pertinent due to the disparities in education that exist for racial and ethnic minorities. In addition to the previously described studies on how Chicana/o students experience microaggressions in higher education, the experience of African/Black Americans has also been investigated. The results of one study identify several major themes in reference to the manifestation and impact of racial microaggressions in and out of the classroom setting, as well as in social settings on campus (Solórzano et al., 2000). The general themes included feelings of invisibility, intellectual inferiority, ascribed criminality, and viewed as being dangerous. Similarly, psychological consequences were mentioned such as feeling self-doubt, drained, helpless, frustration, and isolation. A more recent study on Black American students' experience

on predominantly White campuses revealed that these students also had experiences of being treated or characterized as unintelligent, criminal, and low class, among other denigrating experiences (Watkins et al., 2010). Further, these students, as with the previous study on Black American students (Solórzano et al., 2000), reported experiencing an overall hostile campus climate with microaggressions being perpetrated by faculty, staff and students. However, these students also reported ways in which they coped with experiencing microaggressions, such as turning to social support systems (Watkins et al., 2010). These results give support for the existence of microaggressions, but also begin to illuminate the various factors that may attenuate the negative impact of microaggressions, such as using various coping strategies.

Researchers have also explored the role that microaggressions play in creating difficult dialogues on race in the classroom (Sue, Lin, Torino, Capodilupo & Rivera, 2009; Sue, Rivera, Capodilupo, Lin & Torino, 2010; Sue, Torino, Capodilupo, Rivera & Lin, 2009; Sue et al., 2011). This series of four research studies investigated difficult dialogues on race in the classroom from various participant perspectives with studies focusing on each of the following groups: students of color, White students, faculty of color and White faculty. The results not only illuminate the dynamics of difficult dialogues on race in the classroom, but also give support for microaggressions serving as triggers of these difficult dialogues. For example, students of color, including Latina/o American students, revealed that they experienced classroom situations where they were the targets of microaggressive behavior. The specific experiences included having inaccurate attributions made about their intelligence, having their English language ability questioned, the perception that White students were fearful of them, as well as having their experience as racial beings invalidated or dismissed (Sue, Lin, et al., 2009). Similarly, faculty of color reported instances when they witnessed microaggressive behavior

amongst their students and also were the direct targets of microaggressive behavior from students and their faculty peers (Sue et al., 2011).

These studies further illuminate the existence of microaggressions in various contexts. Although the study of microaggressions, especially in various specific contexts, is still in a nascent stage, there is evidence for the existence of microaggressions in everyday life. As suggested, microaggressions manifest in the mental health counseling relationship between clients of color and their White therapists (Constantine, 2007). Additionally, although not framed as a workplace microaggression study, the study on how microaggressions manifest between counseling trainees of color and their White supervisors can be conceptualized as a workplace issue (Constantine & Sue, 2007). In essence, this study suggests that microaggressions occur between a worker and a supervisor. Finally, the majority of context specific microaggression studies reveal how students and faculty of color perceive microaggressions in academic settings. In addition to providing evidence for the types of microaggressions they experience (e.g., being treated as unintelligent, criminal, or a foreigner), the various studies also give us a glimpse at the potential impact microaggressions have on people of color. For example, people of color reported psychological consequences such as feeling drained, helpless, frustrated, isolated, and self-doubt (Solórzano et al., 2000). However, we have yet to know the specific types and magnitude of the consequences of microaggressions in the life experience of people of color in general and Latina/o Americans in particular.

One way to begin to understand the potential impact that microaggressions have on the wellbeing of Latina/o Americans is to view these encounters as stressors. That is, microaggressive encounters can be viewed as stimuli that are of a discriminatory nature and have the potential to cause harm to the target. When the target of a microaggressive encounter

evaluates this event to be disturbing or harmful in some way, they issue a psychological stress response (Lazarus & Folkman, 1984). When the target issues a psychological stress response, then the encounter, or microaggressive encounter, can be deemed a stressor. Researchers have conceptualized discriminatory encounters as stressors (Clark et al., 1999; Meyer, 2003). Given that microaggressive encounters are discriminatory in nature, they can also be conceptualized as stressors. Further, researchers who have conceptualized discrimination and racism as potential stressors have found that they can possibly lead to negative physical and mental health outcomes (e.g., Williams et al., 1999; 2003). This suggests that there might be a connection between experiencing microaggressions and negative health outcomes.

Latina/o American Health Outcomes

People of color have been shown to be at higher risk for developing various mental and physical health problems than White Americans (U.S. Department of Health and Human Services, 2001; Williams, Lavizzo-Mourey, & Warren, 1994; Williams et al., 2003). For example, people of color have been shown to have a significantly high incidence of various mental health issues, such as depression, anxiety and somatization disorders (U.S. Department of Health and Human Services, 2001). Additionally, reports from the U.S. Department of Health and Human Services (2000) and the National Institutes of Health (2000) give evidence for high physical health disparities among people of color as compared to White Americans. People of color in the U.S. have higher rates of cardiovascular disease, diabetes, stroke, substance abuse, sexually transmitted diseases, as well as a shorter overall life expectancy. Given the high incidence of various health problems for people of color, including Latina/o Americans, this section will discuss the literature pertaining to mental and physical health disparities for Latina/o

Americans. Additionally, a concentration will be placed on literature connecting experiences with discrimination to negative health outcomes for Latina/o Americans.

Mental health. Various studies investigating mental health outcomes and people of color suggest that people of color do indeed have a higher incidence of certain mental health problems and disorders as compared to White Americans. The majority of these studies focused on either non-Latina/o people of color, or lumped various racial and ethnic minority groups together (Williams et al., 2003; U.S. Department of Health and Human Services, 2001).

Although the research on Latina/o Americans is scant in comparison to other racial and ethnic groups, there is some evidence to suggest that Latina/o Americans experience high rates of mental health disorders (U.S. Department of Health and Human Services, 2001). Similarly, when it comes to investigating the impact of discrimination on mental health, there is an overall lack of research focusing on the experience of Latina/o Americans. However, the extant research suggests that there is a connection between experienced discrimination and negative mental health outcomes for Latina/o Americans (Araújo & Borrell, 2006).

Before presenting the evidence for the link between experienced discrimination and negative mental health outcomes for Latina/o Americans, it may be helpful to have an understanding of the state of mental health for Latina/o Americans. Researchers suggest that Latina/o Americans have high rates of anxiety symptoms. For example, migrant farm workers of Mexican decent were found to have heightened levels of anxiety (Hovey & Magana, 2002). Similarly, several studies support that Latina/o Americans may be at a higher risk for developing post-traumatic stress disorder (PTSD) as compared to non-Latina/o Americans (Pole et al., 2005). Studies including various population samples, such as combat veterans (Rosenheck & Fontana, 1996), police officers (Pole et al., 2001), and survivors of natural disasters and terrorist

attacks (Galea et al., 2002; Perilla, Norris, & Lavizzo, 2002), provide support for the trend that Latina/o Americans may be more susceptible to PTSD as compared to their non-Latina/o American counterparts. These studies are striking in that they not only provide evidence supporting higher levels of anxiety-related symptoms for Latina/o Americans, but they also make a convincing argument for further research on the various characteristics and experiences of this group since there appear to be factors above and beyond the identified stressors that account for the heightened anxiety symptoms.

In addition to high rates of anxiety symptoms, Latina/o Americans also report high rates of depression symptoms and suicidal behaviors. There is evidence to suggest that certain Latina/o American sub-groups, such as recent immigrants, migrant farm workers and those with darker skin, may be at risk for developing depression (Alderete, Vega, Kolody, & Aguilar-Gaxiola, 1999; Codina & Montalvo, 1994; Hovey, 2000). Latina/o American youth also have been shown to be at greater risk for developing depression. In a school-based study of 9,863 students in grades 6, 8, and 10, 22% of Latina/o American youth reported depressive symptoms, while only 18% of youth in general reported depressive symptoms (Saluja et al., 2004). Another area of mental health concern that is often associated with depression is that of suicidal behavior. As mentioned in Chapter 1, Latina/o American youth have a higher incidence of suicidal behavior as compared to all other ethnic groups (Canino & Roberts, 2001; Quarté-Vélez & Bernal, 2007). For example, the National Institute of Mental Health (2001) reported that suicide was the third leading cause of death for Latina/o American youth.

This data on Latina/o mental health outcomes is startling, yet informative for a number of reasons. This information suggests that specific characteristics of Latina/o Americans, such as age, skin color and generational status, may give an indication about the likelihood for the

development of depressive symptoms. The results of these studies also provide suggestions for future research directions. For example, when conducting research with Latina/o American samples, it may be important to treat Latina/o Americans as multi-dimensional in terms of characteristics and experiences, rather than as a monolithic group. Finally, in order to develop culturally appropriate prevention and treatment interventions, it is necessary to investigate the determinants, such as experiences with discrimination, of negative mental health outcomes for Latina/o Americans.

Although there are few research studies on the topic, there is some evidence to suggest that Latina/o Americans who experience discrimination also have negative mental health outcomes (Aruajo & Borrell, 2006). Perceived discrimination has been correlated with low levels of overall wellbeing, including suicidal ideation, psychological distress, and low levels of self-control or personal agency (Hwang & Goto, 2008; Moradi & Risco, 2006; Schnieder, Hitlan, & Radhakrishnan, 2000; Shorey, Cowan, & Sullivan, 2002). The majority of these studies have been conducted with adult samples; however, studies suggest that there is also a connection between experiences with discrimination and negative mental health outcomes for Latina/o American youth as well. The studies on Latina/o American youth suggest that those who perceive discrimination are likely to experience a decrease in self-esteem and an increase in depression, anxiety, and stress (Green, Way, & Pahl, 2006; Suarez-Morales & Lopez, 2009; Szalacha et al., 2003). These studies suggest that Latina/o Americans across the lifespan, who experience discrimination, have higher chances of developing poor mental health outcomes.

The various studies connecting experiences with discrimination and negative mental health outcomes provide a starting point for understanding the causes of disparities in mental health for Latina/o Americans. However, there are several limitations inherent in most of these

studies. First, most of these studies do not provide information about the various individual characteristics of their participants, such as skin color, accent, and Spanish language use. Researchers have called for the use of these types of individual characteristics in conducting investigations with Latina/o American populations so that we can take into consideration the diversity that exists within this population and not perpetuate the myth of a monolithic Latina/o American group (Araújo & Borrell, 2006; Weinick et al., 2004).

Second, studies fail to take into consideration various manifestations of discrimination that may be more relevant for Latina/o Americans than other racial or ethnic groups (Araújo & Borrell, 2006). For example, many measures fail to take into account discrimination based on perceived citizenship (e.g., implying that a Latina/o American is from another country). Similarly, Latinas/os may be the targets of discrimination based on speaking Spanish. Since the preponderance of research on discrimination fails to take into account issues salient to Latina/o Americans, there might be an underreporting of experiences with discrimination by this population. Thus, it is necessary to use measures that attend to these issues, such as language and accent, when conducting discrimination and mental health outcomes research with a Latina/o American sample (Araújo & Borrell, 2006).

Physical health. Latina/o Americans have been shown to have disproportionate rates of various physical health conditions, as compared to the rate of incidence in the general population. For example, Latina/o Americans have a higher incidence of HIV, certain cancers, hypertension, and diabetes (Burke et al., 1999; Obiri et al., 1998; Parker, Johnston Davis, Wingo, Reis, & Heath, 1998; Tarlton, 2007). In an attempt to make sense of the determinants of various physical health disparities experienced by Latina/o Americans, researchers have suggested that various stressors such as poverty, safety issues, crowded living conditions, and unequal access to

health care account for these disparities in physical health (Spalter-Roth, Lowenthal, & Rubio, 2005). However, research has also indicated that perceived discrimination also plays a role in the creation and maintenance of physical health disparities for Latina/o Americans (Finch et al., 2001).

Only a few studies have investigated the relationship between perceived discrimination and physical health outcomes, as most other studies of this nature focus on mental health outcomes. Of the studies found on this topic that focus on Latina/o Americans, the majority utilized samples of Latina/o Americans of Mexican origin (Finch et al., 2001; Finch & Vega, 2003; Flores et al., 2008). For example, perceived discrimination predicted poorer general health and health symptoms in a sample of Mexican-origin adults (Flores et al., 2008). The health symptoms included fever, nausea, sore throat, stomachache, diarrhea, constipation, and headache. Additionally, it was shown that even when general stress was controlled for, perceived discrimination still had a significant effect on general health. This supports the notion that perceived discrimination is a unique stressor that may contribute to poorer physical health outcomes even when controlling for other stressors in life such as poverty. Given that little is known about the physical health outcomes associated with perceived discrimination, this dissertation investigated physical health outcomes, in addition to mental health outcomes, in an attempt to understand the overall health-related outcomes of Latina/o Americans who perceive microaggressions in their lives.

Within-Group Differences Among Latina/o Americans

There is great variation within the Latina/o American population (Marotta & Garcia, 2003). This variation, or within-group difference, can come in the form of physical appearance, language use, speech characteristics, generational status, geographic representation, acculturation

level and ethnic identity status (Marotta & Garcia, 2003; Weinick et al., 2004). For example, a study investigating generational status amongst various Latina/o American sub-groups found that Mexican Americans were more likely to be born in the United States when compared to non-Mexican American Latinas/os (Arbona & Novy, 1991). This finding has important implications for how researchers should consider Latina/o Americans when conducting investigations with this population. For example, generational status can impact one's acculturation level, ethnic identity status, language use and accent. More specifically, someone who is a first-generation Latina/o American may have a lower level of acculturation to the United States, have greater Spanish fluency, and have a more discernable Spanish accent, as compared to someone who is second-or third-generation Latina/o American.

However, by and large, researchers fail to take into consideration the various within-group differences inherent in the Latina/o American population when conducting research with this group (Araújo & Borrell, 2006). In order for us to have a better understanding of the nuances present within the Latina/o American population, it is necessary that we begin including factors that can account for how within-group differences affect various outcomes for this group. Thus, this dissertation considers the roles that skin color, language use, and accent play in the relationship between perceived microaggressions and health outcomes for Latina/o Americans.

Skin color. Skin color is considered to be a defining characteristic of race according to many scholars (Carter, 1995; Jones & Carter, 1996). For example, races have been named using color words (e.g., Black, White, etc.) and the term “people of Color” is commonly used in reference to racial and ethnic minorities. Accordingly, the concept of racial stratification, or the order in which individuals in society are ranked based on race, is largely based on the social standing of groups based on factors including skin color (Marger, 2006). Similarly, the concept

of pigmentocracy makes a more direct link between skin color and tenets of racial stratification in the United States, as well as in many other countries around the world (Bonilla-Silva & Dietrich, 2009). Pigmentocracy offers a tri-racial system used to categorize people from various racial and ethnic backgrounds in the United States: Whites, honorary Whites, and the collective Black. Interestingly, Latina/o Americans are found in each of the three racial categories according to this theory. For example, according to this theory, assimilated White Latina/o Americans are classified as White, light skinned Latina/o Americans are classified as honorary White, and dark skinned Latina/o Americans are classified as belonging to the collective Black. This is numerically supported by the U.S. Census (2000), such that Latina/o Americans self-reported belonging to various racial groups (Black, Asian, White, more than one race, etc.). Going along with the theory of pigmentocracy, and taking into consideration various studies exploring skin color and life chances for Latina/o Americans, there is compelling reason to include skin color in the study of disparities that exist for Latina/o Americans (Montalvo & Codina, 2001).

Although not widely used as an independent variable, there is some evidence that supports a connection between skin color and various outcomes for Latina/o Americans. Starting out broadly, research suggests that as Latina/o Americans progress toward the darker end of the skin color spectrum, the lesser their educational attainment and income level is likely to be (Arce, Murgia, & Frisbie, 1987; Espino & Franz, 2002; Telles & Murguia, 1990). In an attempt to make sense out of the relationship between skin color and income level, the researchers were not able to attribute these differences to human capital characteristics (e.g., age, work experience, marital status, etc.), and thus assume that these differences are accounted for by labor market discrimination (Telles & Murguia, 1990). The researchers in this study appear to have made the

assumption that darker skin was tantamount to having experiences with discrimination.

Although this may be an acceptable practice for research, this study did not directly measure or capture the direct experience with employment based discrimination.

The findings using skin color to predict outcomes for Latina/o Americans are mixed. Although rarely studied, associations between mental health outcomes and skin color have been made using Latina/o American samples. Researchers comparing immigrant Latinas to U.S.-born Latinas found significant differences in self-esteem scores, as well as feelings of attractiveness and desire to change skin color (Telzer & Vazquez Garcia, 2009). For example, the results of this study suggested that immigrant Latinas with darker skin had lower levels of self-esteem, whereas no significant association was found between skin color and self-esteem for U.S.-born Latinas. This suggests that although skin color does play a role in self-esteem outcomes for Latina Americans, there may be other factors that affect this relationship. Specifically, ethnic identity and racial socialization were shown to moderate this relationship, such that they served as protective factors.

On the contrary, researchers found that skin color is not always a predictor of poorer outcomes. The results of a study using self-esteem as an outcome indicated that both lighter skinned and darker skinned mainland Puerto Rican women had relatively high levels of self-esteem (López, 2008). However, when moderators of the relationship between skin color and self-esteem were included in the data analysis, differences in self-esteem level were found between the lighter skinned and darker skinned Puerto Rican women. For example, lighter skinned women who had higher levels of ethnic identity had the highest levels of self-esteem of the entire sample. Additionally, for the darker skinned women, there was an association with high levels of attachment to Puerto Rican culture and higher levels of self-esteem. Thus, it is

possible that ethnic identity and cultural affiliation play a role in buffering the harmful outcomes of discrimination.

Studies using samples of Chicanas/os have also drawn associations between mental health outcomes and skin color. One such study assessed the impact that skin color and phenotype have on depression scores (Codina & Montalvo, 1994). The results of this study suggest that there are gender differences in how skin color and phenotype impact depression scores for Chicana/o Americans. For example, a significant difference was found between depression scores for Chicano men born in the United States, such that darker Chicanos had higher depression scores than did the lighter Chicanos. However, no significant differences in depression scores were found for the women when taking into consideration skin color. These results, although mixed, suggest that various within-group characteristics, such as skin color, need to be taken into consideration when conducting studies with Latina/o Americans.

Spanish language use. The Spanish language is a characteristic that is often included when describing the Latina/o American population. When compared to other racial and ethnic groups, Latina/o Americans are most likely to be connected by a single common language, which is Spanish. Studies have indicated that the prevalence of Spanish-speaking households is on the rise (Marotta & Garcia, 2003). Furthermore, among Latina/o Americans, Spanish remains the dominant language (National Survey of Latinos, 2002). Given the prevalence and salience of Spanish in the lives of Latina/o Americans, it seems appropriate that researchers use Spanish language usage as a variable of concern in studies that include Latina/o American participants. It may be even more important to consider Spanish language use when investigating the impact of microaggressions on the lives of Latina/o Americans.

Several studies have investigated the impact that Spanish language use may have on Latina/o Americans. The National Survey of Latinos (NSL; 2002) found that 35% of their participants attributed the discrimination they experienced to speaking Spanish. This was further supported by results from a qualitative study on Latina/o Americans' experiences with microaggressions, in which participants stated that they were the targets of microaggressions because of speaking Spanish (Rivera et al., 2010). Additionally, studies suggest that Latina/o Americans who speak Spanish in the workplace experience discrimination that they attribute to their Spanish usage (Bergman, Watrous-Rodriguez, & Chalkley, 2008; Hitlan, Kelly, Schepman, Schneider, & Zarate, 2006). For example, participants reported negative effects associated with speaking Spanish in the workplace, such as exclusion, harassment, and discrimination (Bergman et al., 2008). Another study investigating the perceptions of discrimination that Latina/o Americans experience in a recreation context revealed similar results in that high Spanish language competence was correlated to higher levels of perceived discrimination (Floyd & Gramann, 1995). This suggests that the Spanish language is used as a marker to identify the Spanish speaker as an outsider, which can increase chances for exposure to microaggressions for Latina/o American Spanish speakers.

The exclusion that Spanish language speakers experience in the workplace can also be connected to poorer workplace outcomes. This notion is supported by research on language exclusion in the workplace. One study suggests that employees who are ostracized based on language use, including the use of Spanish, reported higher levels of experiencing prejudice and lower levels of organizational commitment and organizational citizenship behaviors (Hitlan et al., 2006). A compromise in these organizational psychology variables can lead to poor workplace outcomes, such as low job satisfaction and poor job performance. This suggests that

people who use a language other than English, such as Spanish, in the workplace have an increased incidence of experiencing discrimination and as a result develop poor psychological and behavioral outcomes.

In addition to the individual forms of discrimination based on language that Latina/o Americans perceive in their daily lives, there are also institutional, cultural and societal barriers that this population is most likely to experience. For example, state sponsored “English only” initiatives, such as California’s infamous Proposition 227, are examples of institutional and societal forms of discrimination that Latina/o Americans experience. Proposition 227 sought to impose strict parameters for the use of bilingual education programs through the enforcement of primarily teaching in English. Legal scholars suggest that, “by attacking non-English speakers, Proposition 227, in light of the historical context and modern circumstances, discriminates on the basis of race by focusing on an element central to the identity of many Latinas/os” (Johnson & Martinez, 2000, p. 1228). Supporting this statement, one study suggests that there is a correlation between earning potential and English language proficiency in states that have declared English as the official state language (Zavodny, 2000). More specifically, males with limited English language proficiency in this study earned significantly less than other males. This suggests that the presence of English only laws might allow for various forms of discrimination that lead to poor outcomes.

Furthermore, the sentiment of Proposition 227 and English only laws send subtle and not-so-subtle messages to both English and non-English speakers. One message is that English is the only acceptable language for use in the United States, and all other languages are inferior. Additionally, when government and other institutions endorse and enact laws that favor one language over another, this can leave an indelible influence on the worldviews of individuals,

which can help to form the opinions of individuals in terms of what is acceptable and what is unacceptable language use. In order to more fully understand the potential bias that Spanish-speaking Latina/o Americans experience, this dissertation explored the impact of microaggressions on the wellbeing of Latina/o Americans by taking into consideration differences in Spanish language use.

Accent. Although not a widely studied variable in the field of psychology, accent can be a marker of one's identity inasmuch as many other external characteristics, such as skin color and language. Legal scholar Mari Matsuda (1991) shares the following perspective on the salience of accent on one's identity:

Your accent carries the story of who you are—who first held you and talked to you when you were a child, where you have lived, your age, the schools you attended, the languages you know, your ethnicity, whom you admire, your loyalties, your profession, your class position: traces of your life and identity are woven into your pronunciation, your phrasing, your choice of words. Your self is inseparable from your accent. Someone who tells you they don't like the way you speak is quite likely telling you that they don't like you. (p. 1329)

Accent can be a marker of one's status in life, depending on the social and political landscape of a particular society. In addition to Matsuda, others suggest that accent is a status cue that can give information about an individual's ethnic identity (Riches & Foddy, 1989). Further, accent, especially a nonnative accent, has been theoretically related to experiences with stigma (Gluszek & Dovidio, 2010b). Recognizing that discrimination based on ethnicity exists in American society, accent can serve as a cue from which people can identify ethnicity and then discriminate based on this assessment (Padilla & Perez, 2003).

In particular, a few studies suggest that people do indeed discriminate based on the accent of the target (Brennan & Brennan, 1981; Fuertes & Gelso, 2000). The results of a study involving 212 European American college students suggest that these participants had a stronger

preference for engaging in a counseling therapeutic relationship with native accented Latino counselors than with nonnative accented Latino counselors (Fuentes & Gelso, 2000). Of the few studies conducted on the adverse influences of discrimination based on accent, the organizational psychology literature also supports the notion that people who have an accent dissimilar to those in the dominant group may experience discrimination because of their accent (Carlson & McHenry, 2006; Quinn & Petrick, 1993). For example, a study on the perceptions of 60 human resource specialists suggests that accent affects employability such that individuals with a maximally perceived accent (i.e., stronger accent) were perceived to be less employable than individuals with a minimally perceived accent (i.e., weaker accent; Carlson & McHenry, 2006). Much like most studies investigating accent, these studies were concerned with how people with accents are perceived by others, rather than with the direct experience of people who have accents.

As of recent, the study of how accent affects the life experience of people has begun to focus on the experiences and perspectives of those who have nonnative accents (Dovidio et al., 2010; Gluszek & Dovidio, 2010a; Rivera et al., 2010). A qualitative study on microaggressions revealed that Latina/o Americans might receive the message that having a discernable Spanish accent is a deficit and leaves them open to negative criticism by others (Rivera et al., 2010). Quantitative studies support the notion that Latina/o Americans might relate their experience with bias and discrimination to having a discernable nonnative accent. The results of a study including 88 participants who self-reported that they spoke English with a nonnative accent suggests that there is a correlation between perceived accent strength and perceived discrimination, such that participants with a stronger self-rated nonnative accent perceived more discrimination (Dovidio et al., 2010). In addition to providing a compelling argument for a

connection between self-rated accent and perceived discrimination, these studies also provide a measure for self-rated accent, which until now has been missing in the field of psychology (Dovidio et al., 2010; Gluszek & Dovidio, 2010a). Although few in number, these studies on the experiences with discrimination of people with nonnative accents provide a rationale for including accent as a variable that influences an individual's experience with microaggressions based on their ethnicity and race. Thus, this dissertation takes into consideration the role that accent plays in how Latina/o Americans experience microaggressions.

Psychological Resources

In addition to various external attributes or characteristics (skin color, Spanish language use, and accent) that may serve to heighten the experience of microaggressions for certain Latina/o Americans, there may also be psychological resources and processes that Latina/o Americans utilize to attenuate the harmful impact associated with experiencing microaggressions. More specifically, researchers have identified and conceptualized ethnic identity and social support as psychological resources that can serve a protective function in buffering the relationship between experiencing adverse conditions and maintaining or optimizing wellbeing (Cohen & Wills, 1985; Ong, Phinney, & Dennis, 2006). Since microaggressions are considered an adverse condition experienced by Latina/o Americans, it might be helpful to investigate the various psychological resources that might serve a protective function for those who experience microaggressions (Rivera et al., 2010; Sue, 2010). Further, it is expected that there will be variance in the levels of health outcomes for Latina/o Americans who experiencing microaggressions, thus studying these psychological resources might help to explain these differences.

Ethnic identity. The salience of social group membership or group identity on the development of an individual's sense of self is a concept that has relatively long standing in the field of psychology (Tajfel, 1981). For example, the concept of ethnic identity, a component of social identity, is a specific form of identity that emerges from one's experiences with the world around them (Phinney & Ong, 2007). Simply, ethnic identity has been conceptualized as a fluid, multi-faceted construct that emerges from the way an individual feels about and understands their ethnic and cultural group. Ethnic identity has been posited to change over time, in response to an individual's personal development over time, changes in setting and environment, as well as fluctuations in the makeup of one's social group. In order to fully understand one's ethnic identity, it is important to know how one self-categorizes or labels oneself as a member of a particular ethnic group. For example, a person of Latin decent, may self-identify as Latina/o, Hispanic, Mexican-American, Chicana/o, Puerto Rican, Guatemalan, or Chilean. Knowing how an individual self-identifies is only the starting point in understanding ethnic identity, as it is more important to know information about how an individual feels about and understands their ethnicity. Thus, several psychological processes are theorized to be the components of ethnic identity in terms of how this construct has been studied (Phinney & Ong, 2007).

Over time, various components have been used in the study of ethnic identity. These have included, sense of belonging, seeking information, engaging in ethnic behaviors, developing an opinion about the group, endorsing specific values and beliefs, as well as other components. However, as of recent, it has been suggested that the evaluation of only two components of ethnic identity might be sufficient in understanding one's ethnic identity. These components include: 1) Commitment, or the sense of belonging one has for their ethnic group, and 2) Exploration, or how one goes about seeking information and experiences that pertain to

their ethnic group (Ong et al., 2006). These two components form the theoretical basis for the formation of Multigroup Ethnic Identity Measure-Revised (MEIM-R; Phinney & Ong, 2007), which was adapted from the Multigroup Ethnic Identity Measure (MEIM; Phinney, 1992). This widely used measure has been used in evaluating the psychological construct of ethnic identity.

Ethnic identity has been used as a moderator of the relationship between experiencing adverse conditions and various functions of wellbeing (Ong et al., 2006). For example, in a study of Latino college students (n=123), ethnic identity was investigated as a moderator between the potential detrimental effects of low socioeconomic status and academic achievement (which can be considered as a measure of optimal functioning; Ong et al., 2006). The results of this study suggest that ethnic identity does indeed serve as moderator of this relationship, in that those students who had a greater sense of ethnic identity also had higher levels of academic achievement. Similarly, an exploratory study on Puerto Rican women (n=53) found that women with higher levels of ethnic identity also had higher levels of self-esteem (López, 2008). These results suggest that ethnic identity may be of significance in the promotion of wellbeing for Latina/o Americans.

More specifically relating to the focus of this dissertation, ethnic identity has been also studied as a psychological construct that serves to protect mental health for people of color who experience discrimination. Various studies conducted with Asian American participants suggest discrepant results for ethnic identity serving a protective function in the relationship between discrimination and various mental health outcomes (Lee, 2003; 2005; Mossakowski, 2003; Yoo & Lee, 2008). For example, while studies do lend support to the notion that ethnic identity serves a protective function in attenuating the harmful effects of discrimination (Lee, 2005; Mossakowski, 2003), one study suggests that a higher level of ethnic identity may actually

exacerbate the relationship between discrimination and wellbeing (Yoo & Lee, 2008), and another study suggests that ethnic identity has no moderating effect on this relationship (Lee, 2003). There are quite possibly many explanations for these discrepant results, such as the composition of the samples used for each study. For example, the studies that supported the protective function of ethnic identity were conducted with specific sub-populations of Asian Americans, Filipino Americans (Mossakowski, 2003) and Korean Americans (Lee, 2005); whereas the other two studies sampled Asian Americans across sub-Asian populations.

Regardless of the reasons for these discrepant results, the results support the inclusion of ethnic identity for future research exploring the relationship between perceived discrimination and wellbeing.

In addition to the studies conducted with Asian American samples, several studies have investigated the protective function of ethnic identity for Latina/o Americans. For example, in a study of adolescent Latina/o Americans (n=1062), results suggested a positive relationship between ethnic identity and self-esteem (Umana-Taylor, 2004). Similarly, a study investigating the relationship between skin color and self-perception of Latina Americans included ethnic identity as a moderator (n=81; Telzer & Vasquez Garcia, 2009). The results of this study suggest that ethnic identity does serve as a protective function, in that those Latina Americans with darker skin who had higher levels of ethnic identity had more positive self-perceptions as compared to darker skin Latina Americans with lower levels of ethnic identity. Although the studies on the protective function of ethnic identity may vary in terms of results, the evidence in favor of the protective function of ethnic identity is compelling. For the purposes of this dissertation, ethnic identity was investigated as a moderator of the relationship between perceived microaggressions and health outcomes for Latina/o Americans.

Social support. Social support is widely recognized as a resource that can help people endure and cope with stressful situations. However, researchers suggest that cultural determinants may influence how people utilize social support in their lives and recommend that social support be increasingly investigated with various cultural groups (Kim, Sherman, & Taylor, 2008). Nevertheless, social support has been conceptualized and investigated as a buffer between experiencing adversity and developing poor wellbeing outcomes for Latina/o Americans (Campos, Schetter, & Abdou, 2008; Crockett et al., 2007; Cruza-Guet, Spokane, Caskie, Brown & Szapocznik, 2008; Dunn & O'Brien, 2009; Finch & Vega, 2003). Social support can be defined as a set of “regular positive experiences and a set of stable, socially rewarded roles” that is fostered in part by interpersonal relationships that one gains and maintains in a given community (Cohen & Wills, 1985, p. 311). Social support is also defined as “the existence or availability of people on whom we can rely, people who let us know that they care about, value, and love us” (Sarason, Levine, Basham, & Sarason, 1983, p. 127). Further, social support has been found to positively impact physical and psychological wellbeing of individuals who report having relatively high levels of social support in their lives (Park, 1996; Swickert & Hittner, 2009). Specifically, it is suggested that social support has a special relationship with stress, and plays a role in how people cope with stressful events (Cohen & Wills, 1985). The issue of how social support influences the lives of individuals has been a well-studied phenomenon (e.g., House, Robbins, & Metzner, 1982; Mitchell, Billings, & Moos, 1982; Turner, 1981).

Cohen and Wills (1985) provide a model illustrating how social support serves as a buffer between potentially stressful events and negative physical or psychological wellbeing outcomes. They hypothesize that social support can act as a buffer at two different points along this relationship continuum; either at the point where an individual appraises whether or not the event

is stressful or at a later point when the individual is coping with the perceived stressful event. At both points it is suggested that the presence of social support in a person's life can buffer the negative effects of stressful situations. Additionally, these researchers define four types of social resources that can operate as potential stress buffers. These include: esteem support (support that indicates that one is valued and accepted), informational support (support in which help is offered to define, understand, and cope with stressful events), social companionship (support offered via leisure and recreational interpersonal interactions), and instrumental support (support offered to alleviate financial and need-based concerns).

Of the above four types of social resources, esteem support, informational support and social companionship appear to be included in a measure of social support. Sarason et al. (1983) developed and validated an instrument to measure perceptions of social support by assessing the presence of and satisfaction with support figures on a variety of support-related issues. The Social Support Questionnaire (SSQ; Sarason et al., 1983) was negatively related to anxiety and depression, meaning that people with high levels of social support reported lower levels of anxiety and depression. Additionally, people high in social support were more likely to have a more positive, or optimistic outlook on the future, than those low in social support. This could potentially have implications for how people judge stressful situations, as people with a more optimistic view of the future might perceive fewer barriers than people with a more pessimistic future outlook. Thus this dissertation considered social support as a moderator of the relationship between perceived microaggressions and health outcomes for Latina/o Americans.

Statement of the Problem

Studies on discrimination have primarily concentrated on either acute experiences with discrimination or a combination of acute and chronic experiences with discrimination. However,

as of recent, more attention is being given to the study of chronic discriminatory stressors, also known as microaggressions. Studies on Latina/o Americans indicate that they experience microaggressions in their daily lives, possibly more frequently than acute discriminatory stressors (NSL, 2002; Rivera et al., 2010). The current study concentrated on the experience and impact of microaggressions in the lives of Latina/o Americans in order to address the need to focus on these experiences that may have more salience in the daily, lived experience of this population.

Traditionally, researchers have conceptualized and treated Latina/o Americans as a monolithic group. The majority of research conducted with this group fails to take into consideration various experiences and physical characteristics that are found among Latina/o Americans. Thus, the results of studies that treat Latina/o Americans as a monolithic group can be misinterpreted to represent the experience of all Latina/o Americans, when it is quite possible that the experience of Latina/o Americans is more nuanced, especially when investigating their experiences with microaggressions. Although few in number, studies suggest that Latina/o Americans do differ in their experiences and status based on external characteristics such as skin color, Spanish language use, and degree of accent. Greater in number are the studies that include how psychological processes influence outcomes for Latina/o Americans, such as ethnic identity and social support. However, rarely, if ever, do investigators combine physical characteristic variables and psychological resource variables when investigating the relationship between perceived discrimination and health outcomes for Latina/o Americans. The current study seeks to broaden our understanding of how the nuanced, diverse experience of Latina/o Americans affects the impact of microaggressions on health outcomes for this group.

Research Hypotheses

The following model (see Figure 2) and hypotheses were proposed in an attempt to understand the relationship between the variables discussed thus far. The main variables that were examined include perceived microaggressions, skin color, accent, Spanish language use, ethnic identity, social support, and health outcomes (see Figure 2).

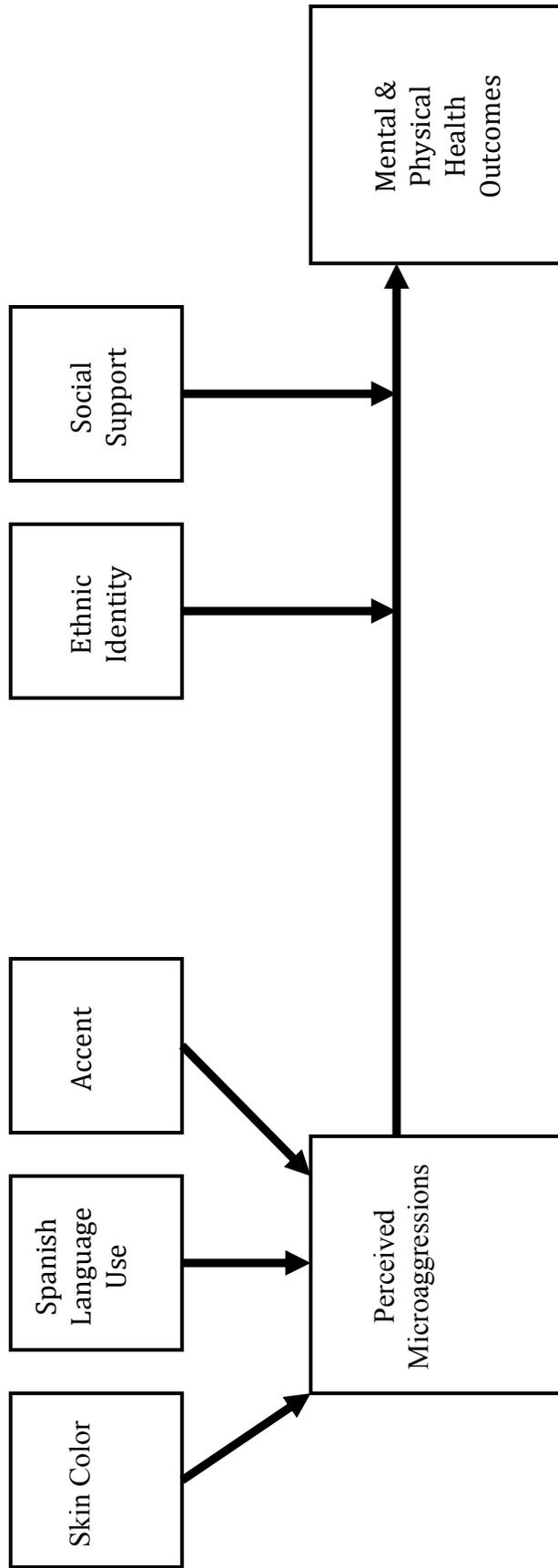


Figure 2. Variable Model for Study

Hypothesis 1a: Latina/o Americans with darker skin color will report higher frequencies of perceptions of microaggressions than Latina/o Americans with lighter skin color.

Hypothesis 1b: Latina/o Americans with a more distinct Spanish accent will report higher frequencies of perceptions of microaggressions than Latina/o Americans with a less distinct Spanish accent.

Hypothesis 1c: Latina/o Americans who speak more Spanish in their daily lives will report higher frequencies of perceptions of microaggressions than Latina/o Americans who speak less Spanish in their daily lives.

Hypothesis 2a: Perceived microaggressions will be negatively correlated with physical health outcomes, such that Latina/o Americans who perceive higher levels of microaggressions will report poorer physical health outcomes than Latina/o Americans who perceive lower levels of microaggressions.

Hypothesis 2b: Perceived microaggressions will be negatively correlated with mental health outcomes, such that Latina/o Americans who perceive higher levels of microaggressions will report poorer mental health outcomes than Latina/o Americans who perceive lower levels of microaggressions.

Hypothesis 3a: Perceived microaggressions will mediate the relationship between skin color and mental health outcomes, such that Latina/o Americans with darker skin color will perceive more microaggressions and have poorer mental health outcomes than Latina/o Americans with lighter skin color.

Hypothesis 3b: Perceived microaggressions will mediate the relationship between skin color and physical health outcomes, such that Latina/o Americans with darker skin color will

perceive more microaggressions and have poorer physical health outcomes than Latina/o Americans with lighter skin color.

Hypothesis 3c: Perceived microaggressions will mediate the relationship between Spanish accent and mental health outcomes, such that Latina/o Americans with a more distinct Spanish accent will perceive more microaggressions and have poorer mental health outcomes than Latina/o Americans with a less distinct Spanish accent.

Hypothesis 3d: Perceived microaggressions will mediate the relationship between Spanish accent and physical health outcomes, such that Latina/o Americans with a more distinct Spanish accent will perceive more microaggressions and have poorer physical health outcomes than Latina/o Americans with a less distinct Spanish accent.

Hypothesis 3e: Perceived microaggressions will mediate the relationship between Spanish language use and mental health outcomes, such that Latina/o Americans who speak more Spanish will perceive more microaggressions and have poorer mental health outcomes than Latina/o Americans who speak less Spanish.

Hypothesis 3f: Perceived microaggressions will mediate the relationship between Spanish language use and physical health outcomes, such that Latina/o Americans who speak more Spanish will perceive more microaggressions and have poorer physical health outcomes than Latina/o Americans who speak less Spanish.

Hypothesis 4a: Ethnic identity will moderate the negative relationship between perceived microaggressions and mental health outcomes, such that Latina/o Americans with higher levels of Latina/o ethnic identity will report more positive mental health outcomes than Latina/o Americans with lower levels of Latina/o ethnic identity.

Hypothesis 4b: Ethnic identity will moderate the negative relationship between perceived microaggressions and physical health outcomes, such that Latina/o Americans with higher levels of Latina/o ethnic identity will report more positive physical health outcomes than Latina/o Americans with lower levels of Latina/o ethnic identity.

Hypothesis 4c: Social support will moderate the negative relationship between perceived microaggressions and mental health outcomes, such that Latina/o Americans with higher levels of social support will report more positive mental health outcomes than Latina/o Americans with lower levels of social support.

Hypothesis 4d: Social support will moderate the negative relationship between perceived microaggressions and physical health outcomes, such that Latina/o Americans with higher levels of social support will report more positive physical health outcomes than Latina/o Americans with lower levels of social support.

Chapter III

METHODOLOGY

Participants

A total of 442 individuals logged on to the survey; however, the final sample included 328 self-identified Latina/o Americans recruited from throughout the United States. Cases were deleted to form the final sample based on the following, which is detailed in the results section: not being at least 18-years old or identifying as Latina/o or Hispanic, not completing all of the scales, or being an outlier. A review of previous studies that investigated constructs similar to those in the current study, as well as statistical analyses similar to those in the current study, were reviewed to estimate the number of participants needed for this study (e.g., Araújo & Borrell, 2006; Flores et al., 2008). In an effort to achieve a diverse sample in terms of age, gender, socioeconomic status, educational attainment, occupation, and geography, several recruitment techniques were employed. Suggested as a useful method for conducting research with Latina/o Americans, community organizations that serve Latina/o American populations were consulted to gain guidance and possible access to potential participants (e.g., community service agencies, churches, educational institutions; Marín & Marín, 1991). The National Council of La Raza, a Latino civil rights organization, hosts an annual expo open to the public that consistently attracts around 25,000 community members and participants were solicited from the Expo in San Antonio, Texas. Additionally, participants were solicited via various Latina/o American themed listservs (e.g., Latina/o Network of the American College Personnel Association, National Latina/o Psychological Association, etc.).

The participants' mean age was 30.80 years ($SD=9.24$), with a range of 18-67 years old. As shown in Table 2, a majority of the participants were female (72.9%), heterosexual (87.2%),

and did not have any accents (62.2%). Participants were of different races, with the largest group being White (20.4%). Other well-represented races were Mexican-Americans (13.7%), biracial participants (13.1%), Hispanics (12.2%) and Latinas/os (11.6%). Participants were of different ethnicities, with the largest group being Hispanic (18.6%). Other well-represented ethnicities were bi-ethnic participants (14.6%), Latinas/os (11.3%), and Mexican-Americans (11.9%). Just over half of the participants were from Western states (50.9%). About a third of the participants had a Bachelors degree (29.3%) or a Masters degree (32.9%). Close to half of the participants earned between \$10,000 and \$49,999 (46.7%). The rest of the sample earned either below \$10,000 (18.3%) or \$50,000 and above (33.5%).

Table 2

Frequencies and Percentages for the Demographic Variables (N = 328)

Variable	Frequency	Percentage
Sex		
Female	239	72.9
Male	87	26.5
Race		
Latina/o	38	11.6
Hispanic	40	12.2
Latina/o and Hispanic	17	5.2
Mexican-American	45	13.7
White	67	20.4
Mestizo	6	1.8
Native American	6	1.8
Black or Afro-Latino	6	1.8
Biracial	43	13.1
Multiracial (3 races)	15	4.6
Multiracial (4 races)	3	.9
Multiracial (5 races)	5	1.5
Other	23	7.0
None indicated	14	4.3

Variable	Frequency	Percentage
Ethnicity		
Latina/o	37	11.3
Hispanic	61	18.6
Latina/o and Hispanic	11	3.4
Mexican-American	39	11.9
Mexican	33	10.1
Puerto Rican	27	8.2
Chicano	5	1.5
Caribbean	9	2.7
South American	10	3.0
Central American	7	2.1
Bi-ethnic	48	14.6
Multiethnic (3 ethnicities)	19	5.8
Multiethnic (4 ethnicities)	4	1.2
Multiethnic (5 ethnicities)	2	.6
Other	10	3.0
Blank	6	1.8

Variable	Frequency	Percentage
Sexual Orientation		
Bisexual	9	2.7
Gay	15	4.6
Heterosexual	286	87.2
Lesbian	15	4.6
Geographic location		
Northeast	67	20.4
Midwest	32	9.8
South	61	18.6
West	167	50.9
Level of education		
9 th to 11 th grade	1	.3
High school diploma/GED	12	3.7
Some college	54	16.5
Associates degree	21	6.4
Bachelors degree	96	29.3
Masters	108	32.9
Doctorate	36	11.0

Variable	Frequency	Percentage
Household income		
Less than \$10000	60	18.3
\$10000 to \$49999	153	46.7
\$50000 to \$99999	84	25.6
\$100000 to \$149999	21	6.4
\$150000 or more	5	1.5
Have an accent		
Yes	97	29.6
No	204	62.2
Not sure	27	8.2

Measures

Demographic data sheet. Participants were asked to provide the following sociocultural demographics: a) race (open ended); b) ethnicity (open ended); c) age (open ended); d) sex (2 options; male or female); e) place of residence (options include all U.S. states and territories); f) education level (8 options; ranging from 8th grade or lower to doctorate); g) occupation (open ended); and h) income level (12 options; ranging from \$10K or less to \$150K or more). These demographic items were chosen based on previous research that suggests Latina/o Americans are diverse in terms of these characteristics and will help provide a snapshot of the sample of Latinas/os in the current study (Marotta & Garcia, 2003). Additionally, as mentioned in Chapter 1, the terms Latina/o and Hispanic are used as ethnic designators by the United States Census, as well as by many scholars. However, these terms are also commonly used as racial designators,

both by individuals who identify as such, and also by researchers (e.g., Betancourt & Lopez, 1993; Marotta & Garcia, 2003). Given the discrepancy in the usage of the term Latina/o as an ethnic or racial designator and also allowing those who fall in this group to exercise self-determination in terms of how they choose to identify, participants in the current study were allowed to write-in their race and ethnicity. Please see Appendix A for this measure.

Racial and Ethnic Microaggressions Scale (REMS). Participants' perceptions of microaggressions in their daily lives were measured using the Racial and Ethnic Microaggressions Scale (REMS; Nadal, 2011). The REMS measures the type and quantity of microaggressions perceived by participants in their daily interactions. The REMS consists of 45 items across 6 subscales. The subscales relate to the various types of microaggressions identified in previous qualitative research on microaggressions experienced by racial and ethnic minorities (e.g., Sue, Bucceri, et al., 2007; Sue, Nadal, et al., 2008; Rivera et al., 2010): 1) Assumptions of Inferiority; 2) Second-Class Citizen and Assumption of Criminality; 3) Microinvalidations; 4) Exoticization and Assumptions of Similarity; 5) Environmental Microaggressions; and 6) Workplace and School Microaggressions. Example items include, "I received substandard service in stores compared to customers of other racial groups," and "Someone assumed that my work would be inferior to people of other racial groups." Participants rated their experience with each item in the past six months via a 6-point Likert-type scale (*1=none of the time to 6=all of the time*). However, the REMS underwent scoring changes by the scale creator during the course of the current study. The newest iteration of the scoring recommends that the scale be treated like a checklist, thus the final scores were transformed such that responses of 1 (none of the time) are now equal to 0 and responses of 2-6, which indicate a range of perceiving microaggressions, are now equal to 1. The six subscale items were combined to produce a composite score,

ranging from 0-45, such that higher scores indicate higher perceptions of microaggressions. Please see Appendix B for this measure.

The initial reliability study of 407 participants, including 127 Latina/o Americans, indicated good internal consistency for the overall scale and yielded an alpha equal to .928 for all the participants and .905 for the Latina/o participants (Nadal, 2011). Confirmatory analyses, reported in the same study, indicated that internal consistency was acceptable at .882. Additionally, the REMS demonstrated adequate concurrent validity, as the Racism and Life Experiences Scales-Brief Version (Harrell, 1997) was significantly correlated with the instrument. Internal consistency reliability for the current study was high at .95.

New Immigrant Survey Skin Color Scale. Researchers assessing skin color in relation to self-esteem for Puerto Rican women found that subjective measures (participant and observer ratings) and objective measures (use of a reflectometry device) were highly correlated with each other (López, 2008). As such, this study used participants' self-ratings of their own skin color to gather this data. The New Immigrant Survey (NIS) Skin Color Scale (Massey & Martin, 2003) was used to assess skin color. Unlike other measures of skin color, the NIS Skin Color Scale offers a visual depiction of skin color, rather than only a short description (e.g., light skin, dark skin, etc.). The scale contains 10 hands (dorsal view) arranged on a continuum from lightest (1) to darkest (10) skin color. Thus, a single, numerical value is achieved ranging from 1 to 10 for each participant. Please see Appendix C for this measure.

Bidimensional Acculturation Scale-Language Use Subscale (BAS/LU). The Language Use Subscale of the Bidimensional Acculturation Scale (BAS/LU; Marín & Gamba, 1996) was used to assess language use. The BAS is composed of 24 items, representing 3 subscales. However, 12 basic items are used, with each being evaluated for both Spanish (the

Hispanic domain) and English (the non-Hispanic domain) use, thus producing the 24 items. Only the Language Use Subscale was used in the current study. The BAS/LU consists of 6 items, with 3 assessing Spanish use and 3 assessing English use. The items include the following questions for both Spanish and English: 1) How often do you speak _____ (English or Spanish)?, 2) How often do you speak _____ (English or Spanish) with your friends?, and 3) How often do you think in _____ (English or Spanish)? The items are rated by using a 4-point Likert-type scale (*1=almost never to 4=almost always*). Two scores are determined for each participant by separately averaging the scores of the items pertaining to 1) Spanish use and 2) English use. Since the current study is only concerned with Spanish use, only the score related to Spanish use was used. The possible range for each score is from 1 to 4, with higher scores indicating more of the indicated language use. Please see Appendix D for this measure.

Initial reliability and validity tests were conducted using a random sample of 254 adult Hispanics. Overall, the composite scale showed high internal consistency, ranging from .81 to .97. Additionally, the internal consistency alphas for the entire scale were .90 (for the Hispanic domain) and .96 (for the non-Hispanic domain). Validity tests were performed by correlating the scales with various acceptable indicators of acculturation previously used by researchers. For example, generation status, length of residence in the United States, and proportion of participant's life lived in the United States were used as indicators of acculturation. The researchers stated that the Language Use subscale and the composite scale were highly correlated with the various validating correlates. Internal consistency reliability for the current study was acceptable at .86.

Self-perceived Accent Scale. Accent was measured via self-ratings. Two studies correlating accent and perceived discrimination with Latina/o American samples used a measure

of self-perceived accent (Dovidio et al., 2010; Gluszek & Dovidio, 2010a). As the full measure inquires about both nonnative accent and regional accent, the current study used a shortened version of the measure since the focus of the current study is on nonnative (Spanish) accents. The shortened measure had the participants indicate if they have an accent and if so what type of accent (e.g., Spanish, German, Chinese, etc.). The next part of the measure had participants rate the degree of nonnative accent as compared to standard American accent on 5, 9-point continuums. (Note: Standard American accent is defined as “an accent that is accepted as a norm, for example TV announcers often have a standard accent.”) For example, participants rated their degree of nonnative accent on a continuum of 1 (I have no foreign accent) to 9 (I have a very strong foreign accent), and the degree that they believe they sound like a native English speaker on a continuum of 1 (I sound like a native English speaker) to 9 (I do not sound at all like a native English speaker). The three additional items had the participants rate the understandability of their accent, how much their accent interferes with communication, and their competency as an English speaker. For the purposes of this study, the mean of the five ratings was calculated to produce a score ranging from 1 to 9, with a higher score indicating a stronger perception of nonnative accent. Internal consistency reliability for the current study was acceptable at .83. Please see Appendix E for this measure.

Multigroup Ethnic Identity Measure (MEIM). The Multigroup Ethnic Identity Measure (MEIM; Phinney, 1992; Roberts et al., 1999) was used to assess ethnic identity. The original version of the MEIM (Phinney, 1992) was composed of 2 subscales (ethnic identity and other-group orientation), with the ethnic identity subscale composed of 3 sub-subscales (affirmation and belonging, ethnic identity achievement, ethnic behaviors) across 20 items. Since then, the MEIM has undergone a couple of revisions. Roberts et al. (1999), in their

structural analysis of the original instrument with a diverse group of 5,423 adolescents, concluded that two subscales were more appropriate based on factor analysis: affirmation/belonging and exploration. Affirmation and belonging refers to the sense of commitment and belonging one has for their ethnic group, while exploration refers to how one goes about seeking information and experiences that pertain to their ethnic group. Thus, this shorter, revised version was composed of 2 subscales across 12 items. Finally, an additional revision to the instrument, adhering to the 2-subscale model proposed by Roberts et al., reduced the MEIM to only 6 items (Phinney & Ong, 2007). However, the majority of studies that include the MEIM to assess ethnic identity use the original structure or the revised 12-item measure. Given that both have good psychometric properties, the 12-item measure, as proposed by Roberts et al., will be used in the current study. Please see Appendix F for this measure.

The revised (12-item) MEIM (Roberts et al., 1999) is composed of 2 subscales: the affirmation/belonging subscale containing 7 items, and the exploration subscale containing 5 items. Example items include: “I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs,” and “I am happy that I am a member of the group I belong to.” The scale has consistently yields good psychometric properties. The items are rated on a 4-point Likert-type scale (*1=strongly disagree to 4=strongly agree*) with no neutral option. The total score ranges from 12 to 48, with higher scores indicating stronger ethnic identity affiliation. Initial internal consistency tests revealed alphas of .85 for the composite scale, .84 for the affirmation/belonging subscale, and .70 for the exploration subscale (Roberts et al., 1999). A study of 81 female Latina undergraduate students revealed good internal consistency as well for the subscales, with alphas of .71 for affirmation/belonging and .78 for exploration (Telzer & Vazquez Garcia, 2009). The MEIM demonstrated adequate concurrent validity with

samples of Latina/o Americans, as various measures of acculturation (Schwartz, Zamboanga, & Jarvis, 2007; Wang, Schwartz, & Zamboanga, 2010) were significantly correlated with the instrument. Internal consistency reliability for the current study was high at .90.

Multidimensional Scale of Perceived Social Support (MSPSS). The Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988) is a measure of perceived availability of social support and was used in the current study. The MSPSS is composed of 3-subscales (significant others, family, friends) across 12-items. Participants are asked to rate on a 7-point Likert-type scale (*1=very strongly disagree to 7=very strongly agree*) how strongly they agree or disagree with each statement concerning available social support from a significant other, family and friends. Sample items include, “there is a special person who is around when I am in need,” “my family really tries to help me,” and “I can count on friends when things go wrong.” The MSPSS provides a total scale score that ranges from 12-84, with higher scores indicating a greater availability of social support. Please see Appendix G for this measure.

The MSPSS showed good internal consistency across various samples. Internal consistency tests produced alphas for the total scale score ranging from .84 to .94 and for the subscale scores ranging from .81 to .98 (Pedersen, Spinder, Erdman, & Denollet, 2009; Zimet et al., 1988; Zimet, Powell, Farley, Werkman, & Berkoff, 1990). A study utilizing a sample of 290 Mexican-American youth produced high internal reliabilities for the total scale score (.86) and two subscales (family=.88, friends=.90), and barley adequate internal reliability for the significant others subscale (.61; Edwards, 2004). Validity tests indicate that the MSPSS is positively correlated to other measures of social support and negatively correlated to reports of

anxiety and depression (Kazarian & McCabe, 1991; Pedersen et al., 2009; Zimet et al., 1988). Internal consistency reliability for the current study was high at .95.

Mental Health Inventory-18 (MHI-18). Psychological distress was measured using the Mental Health Inventory-18 (MHI-18), which is a shortened version of the Mental Health Inventory (MHI; Veit & Ware, 1983). The MHI-18 is a widely used instrument, with both clinical and community samples, and has been highly correlated with the MHI (The Consortium on Multiple Sclerosis Centers Health Services Research, 1997). The MHI-18 is composed of four subscales (anxiety, depression, behavioral control, and positive affect). Participants were asked to rate the items within the timeframe of the past four weeks. Sample items include, “has your daily life been full of things that were interesting to you,” “have you been a nervous person,” and “have you felt emotionally stable.” Subscale scores, as well as a total composite score, can be used to measure psychological health. Each item is rated on a 6-point Likert-type scale (*1=none of the time to 6=all of the time*). Overall scores range from 0 (lower mental health well-being) to 100 (higher mental health well-being). Please see Appendix H for this measure.

The MHI-18 showed good internal consistency across several clinical and community samples that included Latina/o participants. Internal consistency tests yielded alphas of .78 to .91 for the subscale scores, and .87 to .93 for the composite scale scores (The Consortium on Multiple Sclerosis Centers Health Services Research Committee, 1997; Manne, Ostroff, & Winkel, 2007; Whittaker & Neville, 2010). Initial validity tests indicate that the MHI is positively correlated to measures of wellbeing, such as social support and life satisfaction, and negatively correlated to measures of psychological distress, such as stressful life events, history of care for emotional problems, and physical illness (Ware, Manning, Duan, Wells, & Newhouse, 1984). Internal consistency reliability for the current study was high at .93.

Global Rating of Physical Health. A review of 27 community-based studies suggested that global self-ratings of physical health provide accurate information about health status and mortality (Idler & Benyamini, 1997). It was suggested that a global rating of health might be more informative than surveys inquiring about specific health issues because a global rating is more inclusive and allows the rater to consider information that is most salient to their particular health situation. A number of recent studies exploring the relationship between discrimination and physical health utilized a global rating of health as the major dependent variable (Finch et al., 2001; Finch & Vega, 2003; Flores et al., 2008; Williams, Neighbors, & Jackson, 2003; Williams, Yu, Jackson, & Anderson, 1997). For example, a study of 215 Mexican-origin adults found that perceived discrimination predicted poorer general health as assessed by a global self-rating of physical health (Flores et al., 2008). The majority of the referenced studies used a similarly worded item, rated on a 5-point Likert-type scale, to assess global physical health. The following item, which was modeled off of previously used ratings, was used to assess global physical health in the current study: “In general, would you say your physical health is ____?” Participants chose from 5 options (*1=poor to 5=excellent*). Please see Appendix I for this measure.

Procedure

Approval to begin the study was gained from the Teachers College, Columbia University Institutional Review Board (IRB). After approval from the IRB was received, participants were recruited via the plan outlined in the participants’ section of this chapter. Use of online surveys for psychological research is becoming more acceptable, especially when concerned with achieving a large, diverse sample of participants (Heppner & Heppner, 2004). The current project utilized an online survey as the primary mode of data collection. Potential participants

were directed to a website containing the survey either from e-mail solicitation that briefly described the research project, inclusion criteria, and brief background information about the investigator (See Appendix J). The first screen of the online survey presented the participant with consent and confidentiality information (See Appendix K). If the participant agreed to participate, they clicked on the “consent to participate” tab and proceed to the survey protocol (See Appendix L). The participant had unlimited time to complete the survey.

The online survey protocol included: Demographic Questionnaire, Racial and Ethnic Microaggressions Scale (REMS; Nadal, 2010), Bidimensional Acculturation Scale/Language Use Subscale (BAS/LU; Marín & Gamba, 1996), New Immigrant Survey Skin Color Scale (Massey & Martin, 2003), Self-perceived Accent Scale, Multigroup Ethnic Identity Measure (MEIM; Roberts et al., 1999), Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988), Mental Health Inventory-18 (MHI-18; Veit & Ware, 1983), and Global Rating of Physical Health Scale. The closing page thanked the participant for participating in the study and encouraged the participant to contact the primary investigator if they had any concerns or questions resulting from their participation in the study. Additionally, the closing page included a link to a different webpage where they could enter a raffle to receive a \$25 American Express gift card. Odds in winning were 1 in 25. The protocol was completed in approximately 20-30 minutes and participants were able to terminate participation at any time.

Data Analysis Plan

All analyses were conducted using SPSS 18 and the AMOS add-on. Descriptive statistical analyses (e.g., means and standard deviations) were performed to describe the sample. Preliminary analyses were conducted to determine reliability coefficients of the measures used. In addition, analyses were performed to check the skew and kurtosis of the sample, as well as to

check for outliers. Then, correlation analyses were performed to investigate the relationships between the observed variables. Finally, a path analysis and moderation tests, explained in more detail in Chapter 4, were used to investigate the hypothesized model (see Figure 2) and relationship between the variables.

Chapter IV

RESULTS

Preliminary Analysis

Deleted cases. Prior to analyzing the data, several cases were deleted. Eight participants were not at least 18-years old or did not identify as Latina/o and were deleted from the data set. Eighty-two participants only completed the demographic portion of the questionnaire and thus were deleted from the data set. Seventeen participants did not provide answers to one or more scales and thus were deleted from the data set as well. Demographic comparisons between the cases with missing data and the complete cases revealed significant differences in reported race and ethnicity; however, no significant differences were found with the other demographic variables.

Normality and outliers tests. A sum composite was created for the REMS scale and mean composites were created for all the other measures. Univariate normality was assessed via their skewness index, kurtosis index, and the Jarque and Bera LM test for normality using the macro developed by DeCarlo (1997). The macro revealed four multivariate outliers, which were removed from the sample (values 34.38-51.18, higher than the critical value of 31.55). The findings in Table 3 indicate that all but one of the variables was skewed. Thus, these variables were transformed to correct for non-normality. The composites that were positively skewed were transformed using a natural log function. For the composites that were negatively skewed, a three-step procedure was followed (Tabachnick & Fidell, 2007): the variables were reverse-coded; then the reverse-coded scores were transformed using a natural log function; thereafter, the transformed scores were coded back so that higher scores would indicate a greater degree of the variable under study. These transformed variables were used in subsequent procedures.

Table 3

Skewness and Kurtosis Statistics for the Study Variables (N = 332)

Scale/Item	Skewness	Kurtosis	LM ¹
MHI	-.71	.07	27.56 ***
REMS	.04	-1.16	18.73 ***
BAS/LU	.45	-.40	13.65 **
Accent	1.80	3.78	384.58 ***
MSPSS	-1.72	3.11	290.44 ***
MEIMR	-.99	1.51	83.83 ***
Physical health	-.20	-.18	2.81
Skin color	.93	2.16	108.82 ***

¹ Jarque and Bera LM test for normality. Note: MHI=Mental Health Inventory; REMS=Racial & Ethnic Microaggressions Scale; BAS/LU=Bidimensional Acculturation Scalse/Language Use; MSPSS=Multidimensional Scale of Perceived Social Support; MEIMR=Multigroup Ethnic Identity Measure-Revised.
 * $p < .05$. ** $p < .01$. *** $p < .001$.

Descriptive statistics. Descriptive statistics (i.e., means, standard deviations, reliability coefficients, range) were calculated for all of the measures used in the current study are reported in Table 4. All of the measures showed at least acceptable reliability (Nunnally & Bernstein, 1994). The mean scores describe the following about how the overall sample scored on each measure: above average mental health wellbeing, moderate physical health, moderate perceptions of microaggressions, moderate Spanish language use, minimal nonnative accents, moderately high levels of social support, strong sense of ethnic identity, and relatively light skin tones.

Table 4

Means, Standard Deviations, Reliability Coefficients, Item Numbers and Range of Scales

Variable	M	SD	Alpha	Item <i>N</i>	Actual Range	Potential Range
MHI	4.54	.74	.93	18	2.1-6.0	1.0-6.0
REMS	24.57	10.62	.95	45	5.0-45.0	1.0-45.0
BAS/LU	2.09	.81	.86	3	1.0-4.0	1.0-4.0
Accent	1.82	1.11	.83	5	1.0-6.8	1.0-9.0
MSPSS	5.76	1.25	.95	12	1.0-7.0	1.0-7.0
MEIMR	3.29	.52	.90	12	1.1-4.0	1.0-4.0
Physical Health	3.36	.90	--	1	1.0-5.0	1.0-5.0
Skin Color	2.81	1.12	--	1	1.0-7.0	1.0-10.0

N=328. Note: Alpha=Cronbach's alpha reliability coefficient; MHI=Mental Health Inventory; REMS=Racial & Ethnic Microaggressions Scale; BAS/LU=Bidimensional Acculturation Scale/Language Use; MSPSS=Multidimensional Scale of Perceived Social Support; MEIMR=Multigroup Ethnic Identity Measure-Revised.

Correlations between the variables. Pearson correlations were conducted between the study variables. A number of the variables were significantly correlated with one another as reported in Table 5. Mental health ratings were positively associated with physical health ratings ($r = .32, p = .001$), social support ($r = .40, p = .001$), and ethnic identity ratings ($r = .12, p = .028$) but negatively associated with perceived microaggressions ($r = -.14, p = .015$). Physical health ratings were positively associated with social support ($r = .22, p = .001$). Perceived microaggressions were negatively associated with social support ($r = -.18, p = .001$) but positively associated with accent self-ratings ($r = .13, p = .020$) and ethnic identity ratings ($r = .21, p = .001$). Use of the Spanish language was positively associated with accent self-ratings ($r = .38, p = .001$), social support ratings ($r = .15, p = .006$), and ethnic identity ratings ($r = .21, p = .001$). Social support was positively associated with ethnic identity ratings ($r = .22, p = .001$).

Table 5

Pearson Correlations between the Study Variables (N = 328)

Variable	1	2	3	4	5	6	7
1 MHI							
2 Physical health	.32***						
3 REMS	-.14*	-.08					
4 BAS/LU	.09	.07	.13*				
5 Accent	-.04	-.04	.23***	.38***			
6 MEIMR	.12*	.11	.21***	.34***	.09		
7 MSPSS	.40***	.22***	-.18***	.15**	-.07	.22***	
8 Skin color	.02	.00	.05	-.04	.02	.06	-.06

Note: MHI=Mental Health Inventory; REMS=Racial & Ethnic Microaggressions Scale; BAS/LU=Bidimensional Acculturation Scale/Language Use; MSPSS=Multidimensional Scale of Perceived Social Support; MEIMR=Multigroup Ethnic Identity Measure-Revised
 * $p < .05$. ** $p < .01$. *** $p < .001$.

Primary Analysis

Results of the path analysis. A path modeling procedure was used to evaluate the hypotheses of the current study. In order to test how well the hypothesized model fit the data, several fit indices were interpreted (Kline, 2005). The following fit indices were included in the analysis: Chi-square (χ^2), Comparative Fit Index (CFI), Tucker-Lewis Index (TLI), Root Mean Square Error of Approximation (RMSEA), Standardized Root Mean Square Residual (SRMR), and the normed chi-square. Based on these fit indices, the researcher was able to either accept or reject the model.

Following path modeling assumptions, we do not want to reject the null hypothesis, thus a significant chi-square statistic suggests that the model does not fit the observed data (Kline,

2005). Given this assumption, a non-significant chi-square test indicates that the model fits the data. Assessing the chi-square is not sufficient in path modeling, thus the additional fit indices (named above) were assessed. The CFI is a goodness of fit test that compares how well the hypothesized model fits as compared to the null model (Hu & Bentler, 1999). For the CFI, values range from 0-1, with values greater than or equal to .95 indicating good fit. Similarly, the TLI is a test comparison between the hypothesized and null models, and a value greater than or equal to .95 indicates good fit (Hu & Bentler, 1999). The RMSEA indicates the discrepancy in fit per degree of freedom and thus adjusts for sample size (Brown & Cudeck, 1993). RMSEA less than .05 indicates good model fit, and the upper confidence interval should not exceed .08. For the SRMR, values less than .08 indicate good model fit, with a value of 0 indicating perfect model fit (Hu & Bentler, 1999). Finally, the normed chi-square tries to correct for the chi-square sensitivity to large sample size by dividing by its degrees of freedom. An ideal fit would be 1, with a lower number indicating a better fit.

The fit indices for the proposed path model are summarized in Table 6. This model had very poor fit. As the modification indices suggested a strong correlation between the errors of mental and physical health and because, theoretically, it made sense that measures of health would be correlated, the two error terms were made to correlate with each other. The fit of this (slightly) revised path model is summarized in Table 6, the path coefficients are presented in Table 7, and the results are depicted in Figure 3.

The revised structural model fit the data well: the Normed chi-square was less than two, the TLI was above .95, the CFI was above .95, the RMSEA was low at .04, and the SRMR was also low at .04. In addition, this model fit the data better than the proposed path model, $\Delta\chi^2(1) = 23.96, p < .001$.

A direct effects model was tested, where paths were added from Skin Color, Spanish Language Use, and Accent Self-Ratings to the two health constructs. The fit of this final model is summarized in Table 6. This model did not fit the data well. Further, only one direct effect was statistically significant: Spanish language use positively predicted mental health ($\beta = .13, p = .026$). Since the revised model fit the data best, this model was used in subsequent procedures. The findings in Table 7 reveal that:

- a. Skin color did not positively predict perceived microaggressions ($\beta = .05, p = .341$);
- b. Spanish language use did not positively predict perceived microaggressions ($\beta = .05, p = .407$);
- c. Accent self-ratings positively predicted perceived microaggressions ($\beta = .22, p = .001$);
- d. Perceived microaggressions negatively predicted mental health ratings ($\beta = -.14, p = .014$);
- e. Perceived microaggressions did not significantly predict physical health ratings ($\beta = -.08, p = .157$).

Table 6

Chi-square Results and Fit Indices for the Path Model

Index	Proposed	Revised	Direct Effects
Chi-square	40.05	6.32	31.99
Degrees of freedom	7.00	6.00	1.00
Sig.	.00	.00	.00
Normed chi-square (chi-square/df)	5.72	1.05	31.99
Tucker-Lewis index (TLI)	.33	.99	-3.41
Comparative fit index (CFI)	.69	.99	.71
Root mean squared error (RMSEA)	.12	.01	.31
Lower bound of 90 percent confidence interval	.09	.00	.22
Upper bound of 90 percent confidence interval	.16	.07	.40
Standardized root mean square residual (SRMR)	.07	.03	.07

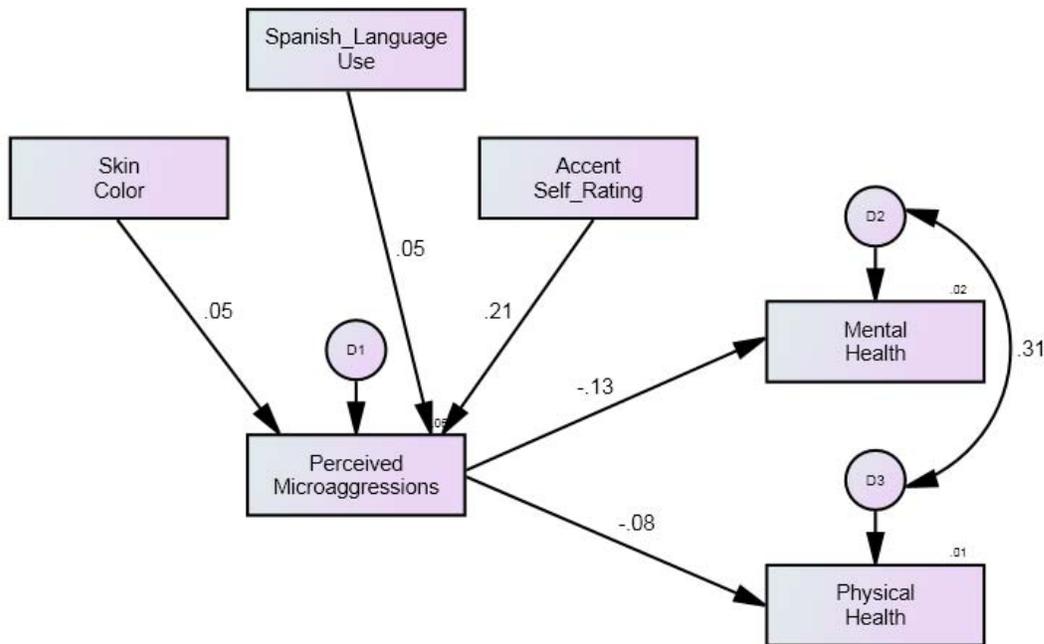


Figure 3. Standardized path coefficients for the revised path model.

Table 7

Unstandardized and Standardized Path Coefficients for the Revised Path Model

Path	<i>B</i>	<i>SE</i>	β	<i>t</i>
Skin color to microaggressions	.03	.03	.05	.95
Spanish language use to microaggressions	.03	.03	.05	.83
Accent self-rating to microaggressions	.10	.03	.22	3.70 ***
Perceived microaggressions to:				
Mental health	-.19	.08	-.14	-2.46 *
Physical health	-.30	.21	-.08	-1.42

* $p < .05$. ** $p < .01$. *** $p < .001$.

The Moderating Effects of Social Support and Ethnic Identity

Prior to testing the moderating effects of social support and ethnic identity on the relationship between perceived microaggressions and health, the independent variable and the mediating variables were centered (Aiken & West, 1991). The product of the centered variables was then taken.

Two sets of model tests were conducted to determine whether social support and ethnic identity moderated the effect of perceived microaggressions on mental and physical health. In the first procedure, the product term was not included. In the second procedure, the product term was included. The change in chi-square between the first and the second procedure was taken; if the change in chi-square was statistically significant, the construct under consideration (i.e., social support or ethnic identity) was deemed to be a moderator.

Ethnic identity. As shown in Table 8, the change in chi-square between the two path models was not significant ($\Delta\chi^2(1) = .66, NS$). Further, the paths from the product term to mental and physical health were also not significant. Thus, ethnic identity did not moderate the relationship between perceived microaggressions and mental and physical health.

Table 8

Moderator Analysis for Ethnic Identity

Model	χ^2	<i>df</i>	CFI	$\Delta\chi^2$	Δdf
Model without product term	14.15	7	.96		
Model with product term	14.81	8	.96	.66	1

Note. Critical $\chi^2(1) = 3.84, p < .05$.

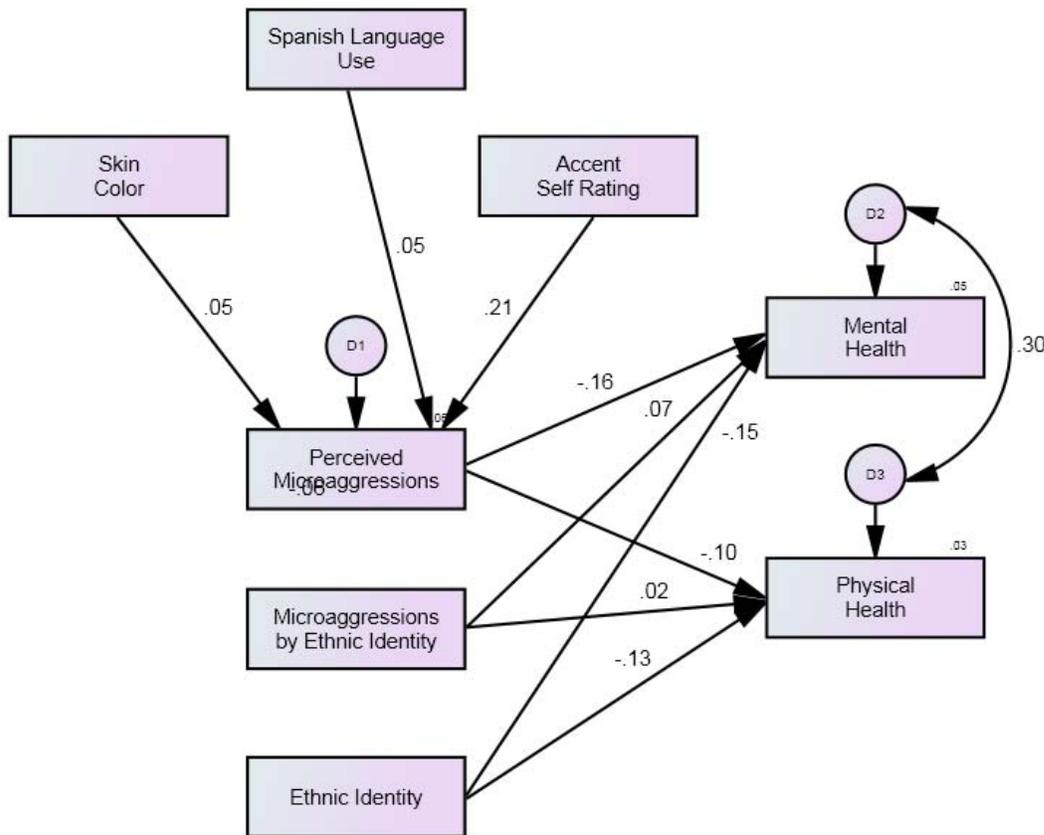


Figure 4. Standardized coefficients for the path model with the microaggression by ethnic identity product term.

Social support. As shown in Table 9, the change in chi-square between the two path models was not significant ($\Delta\chi^2(1) = .36, NS$). However, the path from the product term to physical health was statistically significant ($\beta = .12, p = .026$). As depicted in Figure 5, social support appeared to buffer the negative effects of perceived microaggressions, such that participants who perceived higher levels of microaggressions had lower physical health scores when they had minimal social support but they had higher physical health scores when they had higher levels of social support. Note, however, that this buffering effect was limited to participants who perceived higher levels of microaggressions; for participants who perceived minimal microaggressions, physical health ratings dropped when they had a high level of social

support. These findings suggest that social support did buffer the effects of perceived microaggressions on physical health, but only when participants experienced higher levels of perceived microaggressions.

Table 9

Moderator Analysis for Social Support

Model	χ^2	<i>df</i>	CFI	$\Delta\chi^2$	Δdf
Model without product term	12.60	7	.97		
Model with product term	12.96	8	.97	.36	1

Note. Critical $\chi^2(1) = 3.84, p < .05$.

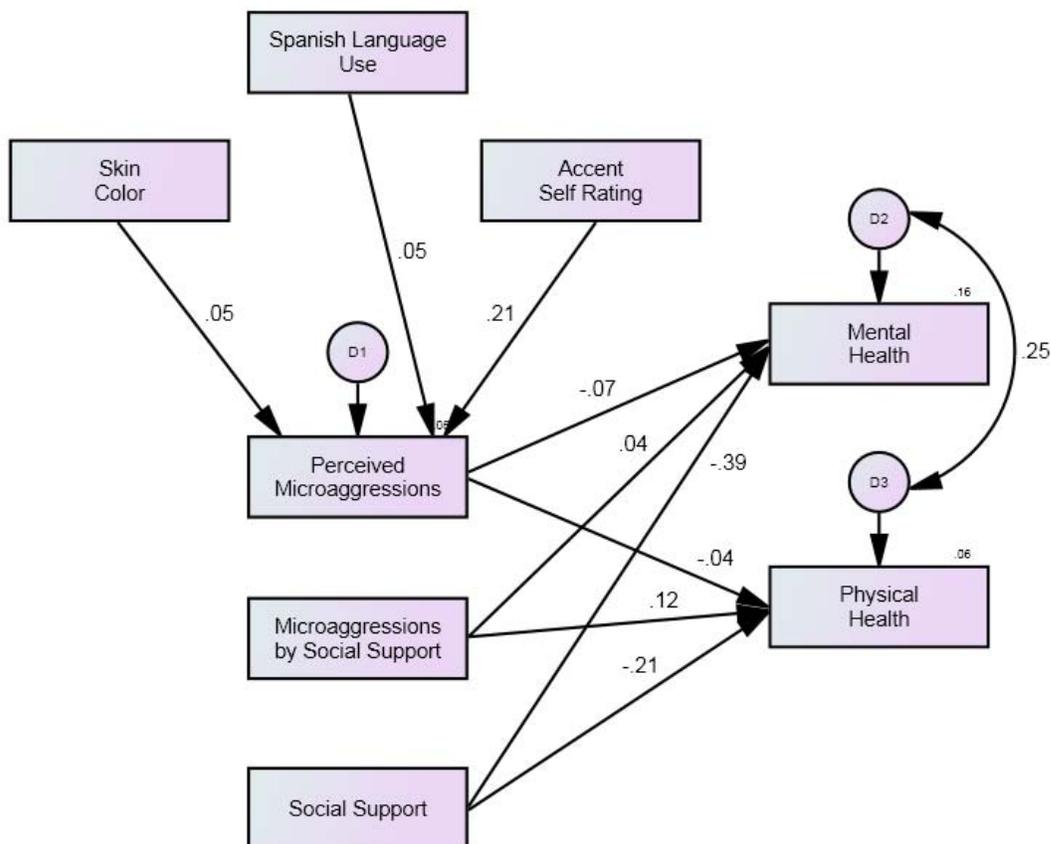


Figure 5. Standardized coefficients for the path model with the microaggression by social support product term.

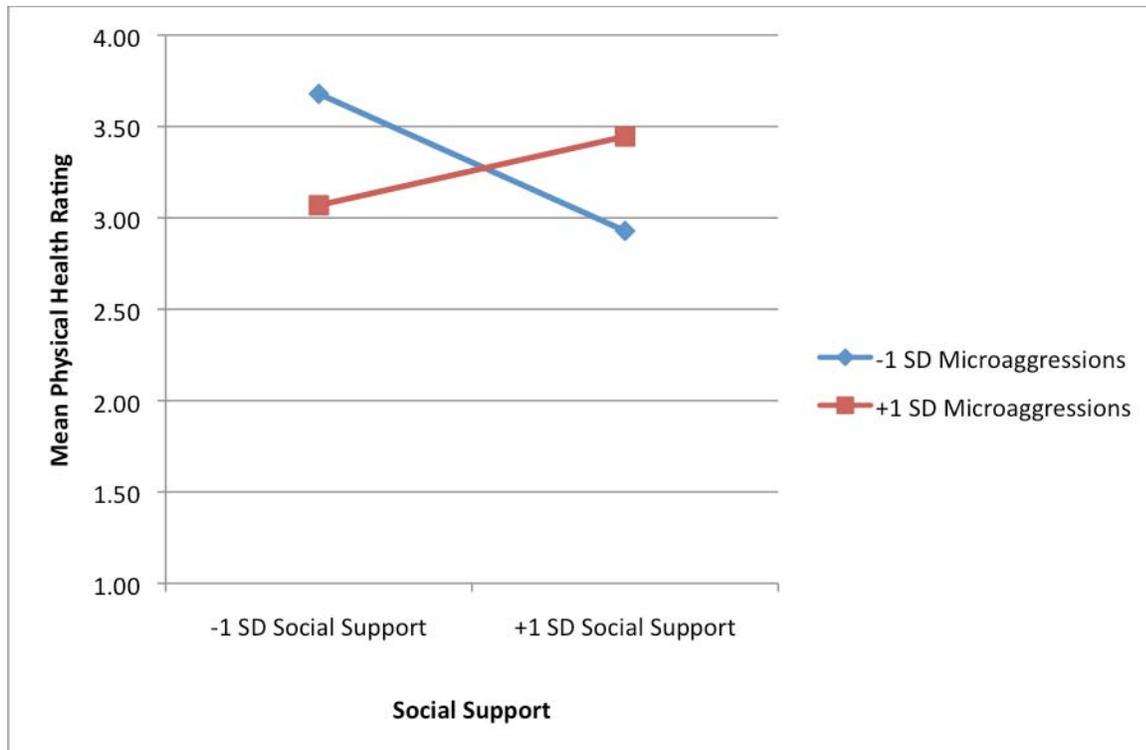


Figure 6. Mean physical health ratings as a function of social support and perceived microaggressions.

Summary of Findings

The findings indicate support for several of the hypothesized relationships between the variables of interest. The results support that Latina/o Americans with a more distinct nonnative (Spanish) accent reported higher frequencies of perceptions of microaggressions than Latina/o Americans with a less distinct nonnative (Spanish) accent (hypothesis 1b). It was also hypothesized that perceived microaggressions would be negatively correlated with mental health outcomes, and this hypothesis was supported (hypothesis 2b). Similarly, it was hypothesized that perceived microaggressions would mediate the relationship between Spanish accent and mental health outcomes, and this hypothesis was also supported (hypothesis 3c). Finally, the results indicate that social support moderated the negative relationship between perceived microaggressions and physical health outcomes (hypothesis 4d). A summary of all the hypotheses and corresponding results are presented in Table 10.

Table 10: Summary of Hypotheses

Hypothesis 1a: Latina/o Americans with darker skin color will report higher frequencies of perceptions of microaggressions than Latina/o Americans with lighter skin color.
<i>Result: Fail to reject the null.</i>
Hypothesis 1b: Latina/o Americans with a more distinct Spanish accent will report higher frequencies of perceptions of microaggressions than Latina/o Americans with a less distinct Spanish accent.
<i>*Result: Reject the null.</i>
Hypothesis 1c: Latina/o Americans who speak more Spanish in their daily lives will report higher frequencies of perceptions of microaggressions than Latina/o Americans who speak less Spanish in their daily lives.
<i>Result: Fail to reject the null.</i>
Hypothesis 2a: Perceived microaggressions will be negatively correlated with physical health outcomes, such that Latina/o Americans who perceive higher levels of microaggressions will report poorer physical health outcomes than Latina/o Americans who perceive lower levels of microaggressions.
<i>Result: Fail to reject the null.</i>
Hypothesis 2b: Perceived microaggressions will be negatively correlated with mental health outcomes, such that Latina/o Americans who perceive higher levels of microaggressions will report poorer mental health outcomes than Latina/o Americans who perceive lower levels of microaggressions.
<i>*Result: Reject the null.</i>
Hypothesis 3a: Perceived microaggressions will mediate the relationship between skin color and mental health outcomes, such that Latina/o Americans with darker skin color will perceive more microaggressions and have poorer mental health outcomes than Latina/o Americans with lighter skin color.
<i>Result: Fail to reject the null.</i>
Hypothesis 3b: Perceived microaggressions will mediate the relationship between skin color and physical health outcomes, such that Latina/o Americans with darker skin color will perceive more microaggressions and have poorer physical health outcomes than Latina/o Americans with lighter skin color.
<i>Result: Fail to reject the null.</i>
Hypothesis 3c: Perceived microaggressions will mediate the relationship between Spanish accent and mental health outcomes, such that Latina/o Americans with a more distinct Spanish accent will perceive more microaggressions and have poorer mental health outcomes than Latina/o Americans with a less distinct Spanish accent.
<i>*Result: Reject the null.</i>
Hypothesis 3d: Perceived microaggressions will mediate the relationship between Spanish accent and physical health outcomes, such that Latina/o Americans with a more distinct Spanish accent will perceive more microaggressions and have poorer physical health outcomes than Latina/o Americans with a less distinct Spanish accent.
<i>Result: Fail to reject the null.</i>

<p>Hypothesis 3e: Perceived microaggressions will mediate the relationship between Spanish language use and mental health outcomes, such that Latina/o Americans who speak more Spanish will perceive more microaggressions and have poorer mental health outcomes than Latina/o Americans who speak less Spanish.</p>
<p><i>Result: Fail to reject the null.</i></p>
<p>Hypothesis 3f: Perceived microaggressions will mediate the relationship between Spanish language use and physical health outcomes, such that Latina/o Americans who speak more Spanish will perceive more microaggressions and have poorer physical health outcomes than Latina/o Americans who speak less Spanish.</p>
<p><i>Result: Fail to reject the null.</i></p>
<p>Hypothesis 4a: Ethnic identity will moderate the negative relationship between perceived microaggressions and mental health outcomes, such that Latina/o Americans with higher levels of Latina/o ethnic identity will report more positive mental health outcomes than Latina/o Americans with lower levels of Latina/o ethnic identity.</p>
<p><i>Result: Fail to reject the null.</i></p>
<p>Hypothesis 4b: Ethnic identity will moderate the negative relationship between perceived microaggressions and physical health outcomes, such that Latina/o Americans with higher levels of Latina/o ethnic identity will report more positive physical health outcomes than Latina/o Americans with lower levels of Latina/o ethnic identity.</p>
<p><i>Result: Fail to reject the null.</i></p>
<p>Hypothesis 4c: Social support will moderate the negative relationship between perceived microaggressions and mental health outcomes, such that Latina/o Americans with higher levels of social support will report more positive mental health outcomes than Latina/o Americans with lower levels of social support.</p>
<p><i>Result: Fail to reject the null.</i></p>
<p>Hypothesis 4d: Social support will moderate the negative relationship between perceived microaggressions and physical health outcomes, such that Latina/o Americans with higher levels of social support will report more positive physical health outcomes than Latina/o Americans with lower levels of social support.</p>
<p><i>*Result: Reject the null.</i></p>

Chapter V

DISCUSSION

Overview

This chapter will elaborate upon the results and implications of this study. The chapter will begin with a summary of the research study followed by a discussion of the major findings. Next, the limitations of the study, as well as implications for theory, research, and practice will be presented. Finally, the chapter will conclude with a general summary and closing remarks.

Summary of Research Study

The current study examined how various characteristics and experiences of Latina/o Americans impact their health outcomes. Previous research suggests that Latinas/os experience discrimination in their daily lives and that these experiences might impact their wellbeing (Araújo & Borrell, 2006). However, many of these studies focus on acute experiences with discrimination or a combination of acute and chronic experiences with discrimination. As of recent, more attention is being given to the study of chronic discriminatory stressors, also known as microaggressions (Sue, 2010). Microaggression theory purports that these incidents may be more harmful on the wellbeing of marginalized people because of their covert and insidious nature than more overt forms of discrimination (Sue, 2010). Although the study of microaggressions is in an early stage of development, recent studies are lending support for both the existence of microaggressions and their harmful impact (e.g., Nadal et al., 2012; Rivera et al., 2010; Rivera, Molina, & Watkins, 2012, etc.). The current study concentrated on the experience and impact of microaggressions in the lives of Latina/o Americans in order to address the need to focus on these experiences that may have significant salience in the daily, lived experience of this population.

Governmental studies provide evidence to suggest that Latinas/os are underrepresented in white collar professions, have some of the lowest educational attainment rates, and have low rates of healthcare utilization (Guendelman & Wagner, 2000; U.S. Census Bureau, 2008; U.S. Department of Health and Human Services, 2001; U.S. Department of Labor, 2008). In terms of healthcare and health outcomes, Latina/o Americans have been shown to have high rates of various physical and mental health problems, such as diabetes, hypertension, certain cancers, anxiety-related disorders and suicidality (Burke et al., 1999; Canino & Roberts, 2001; Obiri et al., 1998; Pole et al., 2005; Tarlton, 2007). In order to more fully address the various health issues that affect the lives of Latina/o Americans, it is necessary that we identify potential determinants of these outcomes.

The study of social determinants of health suggests that one's environment has a significant impact on one's sense of wellbeing. One social phenomenon that has been suggested to adversely influence health is that of discrimination, including microaggressions (Araújo & Borrell, 2006; Williams et al., 2003). Microaggression theory suggests that marginalized people, including Latina/o Americans, experience these harmful interactions on a daily basis (Sue, 2010). Thus, microaggressions can also be conceptualized as a social determinant that has the potential to negatively affect the health of Latina/o Americans. Researchers have called for more study in the area of social determinants to health and wellbeing, as well as for more study of the nature and impact of microaggressions (Sue, 2010). In response to the call to more fully understand the impact that microaggressions have on wellbeing, this dissertation was primarily concerned with the impact of microaggressions on mental and physical health.

Furthermore, researchers have traditionally conceptualized and treated Latina/o Americans as a monolithic group, which perpetuates the idea that all Latina/o Americans have a

similar lived experience (Weinick et al., 2004). The majority of research conducted with this group fails to take into consideration various differences in experiences and physical characteristics that are found among Latina/o Americans (Marotta & Garcia, 2003). This is problematic, in that the results of many studies can misrepresent the experience of Latina/o Americans, since it is quite possible that the experience of Latina/o Americans is more nuanced, especially when investigating their experiences with social phenomena. For example, it is possible that physical characteristics, such as skin color, language use, and accent, can serve as social markers that may make certain Latina/o Americans more susceptible to microaggressive encounters than others. Although few in number, studies suggest that Latina/o Americans do differ in their experiences and status based on external characteristics such as skin color, Spanish language use, and degree of accent (Dovidio et al, 2010; Marotta & Garcia, 2003; Montalvo & Codina, 2001; Telzer & Vasquez Garcia, 2009). Thus, this study took into consideration the potential influence that these characteristics had on Latina/o Americans experiences with microaggressions.

Given the growing support for the negative relationship between microaggressions and wellbeing, it is necessary that we also begin to identify factors that might attenuate or protect Latina/o Americans from the adverse affects of microaggressions. For example, identifying these protective factors can help inform practitioners on treatment approaches for working with those who report experiencing microaggressions. More specifically, researchers have identified and conceptualized ethnic identity and social support as psychological resources that can serve a protective function in buffering the relationship between experiencing adverse conditions and maintaining or optimizing wellbeing (Cohen & Wills, 1985; Ong, Phinney, & Dennis, 2006). Compared to the other variables described thus far, there are a larger number of studies that

include how psychological processes influence outcomes for Latina/o Americans, such as ethnic identity and social support. However, these variables have yet to be investigated in studies investigating the nature of microaggressions. Thus, the current study included these psychological resources as moderators of the relationship between perceived microaggressions and health outcomes for Latina/o Americans.

Rarely, if ever, do investigators combine physical characteristic variables and psychological resource variables when investigating the relationship between perceived discrimination and health outcomes for Latina/o Americans. The current study seeks to broaden our understanding of how the nuanced, diverse experience of Latina/o Americans affects the impact of microaggressions on health outcomes for this group. The current study attempted to take into consideration the diversity inherent in the Latina/o American community by including variables that represent intra-group differences in physical characteristics, as well as psychological resources in a model that investigated the relationship between perceived microaggressions and health outcomes for this population.

Overview of the Major Findings

Best-fitting path model. To determine if the relationship between external characteristics (i.e., skin color, Spanish language use, and accent), perceived microaggressions, and health outcomes was a good fit for the proposed model, several goodness-of-fit indices were investigated. The proposed model revealed a poor fit; however, a slightly revised model revealed a good fit, as indicated by the previously reported fit indices.

The results of the final model indicated that several paths in the model were significant. The correlation between the predictor independent variable, accent, and perceived microaggressions was significant. This suggests that a higher self-report of having a nonnative

accent was associated with more perceptions of microaggressions. The correlation between perceived microaggressions and mental health was significant. This suggests that the more Latina/o Americans perceive microaggressions, the more likely they are to have compromised mental health. These results, in their totality, also give support for the mediating effect of perceived microaggressions. The findings suggest that the quantity of perceived microaggressions are related to the degree of nonnative accent for Latina/o Americans. Subsequently, more perceptions of microaggressions are suggested to lead to more compromises in mental for Latina/o Americans. These results are inline with the hypothesized direction of the relationships between the observed variables. A discussion of each of the findings follows.

External characteristics as predictors of microaggressions. The first set of hypotheses were concerned with variables that may serve as predictors of perceptions of microaggressions for Latina/o Americans. The current study examined the relationship between three external characteristics, accent, skin color, and Spanish language use, and perceptions of microaggressions. These external characteristics were conceptualized as predictors of perceived microaggressions in the lives of Latina/o Americans. The findings were mixed and provide support for one of the hypotheses, but do not support the other two hypotheses. The results provide support that Latina/o Americans who identify as having a stronger nonnative accent also report higher perceptions of microaggressions. However, the results do not suggest a significant relationship for the impact of skin color and Spanish language use on perceptions of microaggressions for Latina/o Americans. A discussion of the relationship between each predictor variable and perceived microaggressions follows.

As previously stated, the results indicate a significant relationship between self-rated nonnative accent and perceived microaggressions, which is consistent with previous studies

investigating the impact of accent on experiences with discrimination (Carlson & McHenry, 2006; Dovidio et al., 2010; Gluszek & Dovidio, 2010a; Quinn & Petrick, 1993). Although accent as a construct of study has not been widely investigated, it has been suggested that accent serves as a social marker that people use to identify ethnicity (Padilla & Perez, 2003; Riches & Foddy, 1989). Furthermore, theory suggests that having a nonnative accent (i.e., an accent that is different from that of the dominant or “native” group in a given geographic area) puts one at risk for being discriminated against (Gluszek & Dovidio, 2010b; Padilla & Perez, 2003). Thus, it is possible that Latina/o Americans who have a nonnative accent are targets of discrimination because their nonnative accent serves as a social marker that makes their ethnicity identifiable.

The previous studies that provide evidence for a connection between having a nonnative accent and experiences with discrimination and stigma did not specifically conceptualize discrimination as microaggressions. With regard to the study of microaggressions, a qualitative investigation revealed that Latina/o Americans attributed a portion of their experiences with microaggressions to having a distinct nonnative accent (Rivera et al., 2010). Anecdotal evidence shared by participants in this study revealed situations in which participants believed that their “Spanish or Latina/o” accent made them susceptible to negative treatment and criticism. In the words of one female participant of that study, “Every time a White person states that I have an accent, this implies to me that *only* the ‘White way’ of speaking is the right way (Rivera et al., 2010, p. 70).” This statement conveys a microaggressive experience of invalidation attributed to having a nonnative accent. The current study gives quantitative support to these qualitative assertions. Given that the study of accents and microaggressions are in their nascent stages of inquiry, the current study provides valuable insight into the relationship between these two variables.

Although accent was found to predict increased perceptions of microaggressions for the participants in this study, the two other predictor variables (skin color and Spanish language use) were not found to significantly predict perceptions of microaggressions. It was expected that skin color would influence perceptions of microaggressions; however, this did not appear to be a significant factor for the Latina/o participants in this study. The existing research using skin color to predict poor outcomes is mixed, which may help to explain why this hypothesis was not supported (e.g., Codina & Montalvo, 1994; López, 2008; Telzer & Vazquez Garcia, 2009). For example, darker skin color has been shown to be both positively and negatively correlated with self-esteem (López, 2008; Telzer & Vasquez Garcia, 2009). A study examining the relationship between skin color and income level in the workplace presumed that darker skin accounted for an increase in discrimination, which led to the income disparities. However, these researchers did not directly measure experiences with discrimination (Telles & Murguia, 1990).

Given the mixed results of previous studies, combined with possible measurement flaws in previous studies, it is difficult to be certain about the results obtained in the current study concerning the effects of skin color on perceptions of microaggressions. It could be that the relationship between skin color and perceptions of microaggressions is inconsequential because of the very nature of microaggressions that are experienced by Latinas/os. For example, it is possible that discrimination based on skin color is more inline with overt forms of discrimination (i.e., “old fashioned racism”), rather than with microaggressions, which are covert and subtle in nature. That is, a light skinned Latina/o and a dark skinned Latina/o might perceive the same types of microaggressions in their lives, such as being treated like a perpetual foreigner or as intellectually inferior, that may be attributed more to their ethnicity than their race. Thus, the

types of microaggressions experienced by Latinas/os might not have significant bearing on their skin color.

Similarly, it was expected that Spanish language use would influence perceptions of microaggressions. This, too, did not significantly predict perceptions of microaggressions for the Latina/o American participants in this study. It is difficult to deny the presence of a certain level of disdain for the use of non-English languages in American society (Bergman et al., 2008; Johnson & Martinez, 2000); however, it is possible that Spanish-speaking Latina/o Americans have responded to this sentiment by altering their speech patterns in their daily lives. This may be especially true for bilingual (Spanish/English) Latina/o Americans, as they have the ability to be more flexible with their language use, as compared to monolingual individuals. For example, it is possible that a bilingual Latina/o American will use English more in public places, such as in educational and workplace settings, and will reserve the use of Spanish for the home. If this is indeed the case for bilingual Latina/o Americans, then it is possible that they are protecting themselves from microaggressions that might be directed at them because of their language use. Although Spanish language use can serve as a social cue that identifies someone as a Latina/o, a bilingual Latina/o American might be able to deter this identification if they do not speak Spanish in public settings. Thus, the use of Spanish language might not be a good indicator of the degree of microaggressions perceived by this population, despite the negative sentiment for the use of non-English languages in American society.

Microaggressions and health outcomes. The results indicated mixed support for the relationships between perceived microaggressions and the health outcome variables. Consistent with hypothesis 2b, Latina/o Americans who reported more perceptions of microaggressions had poorer mental health outcomes than those who perceived less microaggressions in their lives.

This result is also consistent with previous research on the negative relationship between discrimination and mental health (Araújo & Borrell, 2006). However, the hypothesis (2a) proposing a similar relationship between perceived microaggressions and physical health was not supported by the data. Although mixed, these results provide preliminary support for the harmful effects of microaggressions on wellbeing for Latina/o Americans.

Previous research suggests that Latina/o Americans experience relatively high levels of mental health issues (U.S. Department of Health and Human Services, 2001). However, the particular determinants of these mental health issues have not been adequately addressed. In line with previous investigations on discrimination as a determinant of mental health for Latina/o Americans, the current study suggests that microaggressions do indeed have a negative relationship with mental health outcomes. Previous research suggests that Latina/o Americans who report experiencing discrimination have higher incidences of depression and anxiety related symptoms (Finch, Kolody, & Vega, 2000 for depression; Pole et al., 2005 for anxiety). Moreover, two recent studies that utilize the same mental health and microaggression measures as the current study revealed a similar relationship between perceived microaggressions and mental health outcomes for Latina/o Americans (Nadal et al., 2012; Rivera et al., 2012). Thus, there is a growing amount of evidence for the harmful impact of microaggressions on the mental health of Latina/o Americans.

Although the hypothesized relationship between microaggressions and mental health was supported, the hypothesized relationship between microaggressions and physical health was not supported by the results. Several explanations can be offered to help explicate the discrepancy in these results. First, although there is support for a relationship between discrimination and health outcomes for Latinas/os, a majority of this research concentrates on mental health components of

wellbeing, as opposed to physical health issues. Given that the research on discrimination as a social determinant to compromised physical health is in relatively early stage of development, especially concerning this relationship for Latina/o Americans, it might be too early to draw conclusions about the significance of this relationship for this particular population. Thus, this result should be interpreted tentatively, as the currently study is one of the first to examine the relationship between microaggressions and physical health for Latina/o Americans.

Second, the nature of microaggressions is proposed to be different than that of overt forms of discrimination that are typically the focus of discrimination and health outcomes studies. Microaggression theory proposes that the cumulative experience with microaggressions over the course of one's life is responsible for various harmful effects, including on health. Additionally, mental health consequences might be compromised by perceptions of microaggressions sooner than physical health, given the intense mental processing that is theorized to take place for individuals who experience microaggressions (e.g., the "catch-22" process of interpreting and responding to microaggressions).

Finally, a previous study indicated that microaggressions are significantly correlated to specific physical symptoms, such as fatigue and pain (Nadal & Davidoff, 2012). It could be that the immediate effects of microaggressions are more impactful on specific physical symptoms than they are on one's self-perception of their overall physical health (as it was measured in the current study). For example, if someone has chronic perceptions of microaggressions and they experience fatigue, as suggested above, the chronic fatigue they experience over time might eventually take a toll on their overall physical health. That is, it might take more time for microaggressions to have an impact on overall physical health. Taken together, it is possible that compromises to overall physical health might occur later in life than compromises to mental

health, which can help explain the discrepant results achieved in the current study for mental health and physical health outcomes.

Microaggressions as a mediator. The path model suggests that perceived microaggressions mediates the influence of nonnative accent on mental health outcomes. More specifically, these findings suggest that Latina/o Americans who report having a more distinct nonnative accent also report perceiving more microaggressions that lead to poorer mental health outcomes. This result is consistent with the hypothesized relationship between these three variables in the current study (hypothesis 3c). This is the first known study to use path modeling to investigate mediation when exploring the relationship between predictors of microaggressions and health outcomes for Latina/o Americans. These findings help to create a more nuanced picture of how microaggressions affect mental health by providing a possible explanation for how within-group differences, such as nonnative accent variability, are related to microaggressions and mental health.

Although there was support for microaggressions serving as a mediator between nonnative accent and mental health outcomes, the correlation tests and path model did not indicate support for the remaining mediation hypotheses (hypotheses 3a, 3b, 3d, 3e, & 3f). As previously discussed, Spanish language use and skin color were not significantly correlated with perceived microaggressions, and microaggressions were not significantly correlated with physical health. Given the lack of support for these individual correlations, the results cannot support any mediating effects for these hypothesized relationships for this sample of Latina/o Americans. There may be reasons similar to what has already been discussed that can explain the relationships between these variables. However, given that this is the first known study to

include these variables in a path model for Latina/o Americans, it might be premature to make any definitive conclusions about these hypothesized relationships.

Ethnic identity as a moderator. The results of the current study do not support the hypothesized moderating effects of ethnic identity on the relationship between perceived microaggressions and health outcomes. Again, this is the first known study to incorporate ethnic identity as a moderator in the study of microaggressions and health outcomes, so the moderation results, even though not significant, should be interpreted with care. As reviewed in chapter two of this dissertation, previous studies indicate mixed support for the influence of ethnic identity on discrimination and outcomes for various ethnic groups. For example, studies with Asians indicate that ethnic identity moderates the relationship between discrimination and wellbeing for specific ethnic groups, while other studies using pan-Asian samples indicate that ethnic identity does not moderate this relationship (Lee, 2003; 2005; Mossakowski, 2003; Yoo & Lee, 2008). Although these studies were conducted with Asians, the same principles might hold true for Latina/o Americans. Given that the current study utilized a pan-Latina/o sample, in terms of ethnic identification (e.g, Mexican-American, Puerto Rican, South American, Central American, bi-ethnic, etc.), moderation effects might be lost. Thus, it is possible that ethnic identity might moderate the relationship between microaggressions and health outcomes for specific Latina/o ethnic groups, rather than for a combination of various Latina/o ethnic groups.

Social support as a moderator. The results indicate mixed support for the hypotheses concerning social support (hypotheses 4c & 4d). The findings suggest that social support only moderated the relationship between microaggressions and physical health for this sample of Latina/o Americans, and not the relationship between microaggressions and mental health. In the current study, social support was conceptualized as a coping strategy that Latina/o Americans

use to attenuate the harmful effects of microaggressions on their health (i.e., the “buffering hypothesis”; Cohen & Wills, 1985). The significant findings suggesting that social support moderates the relationship between perceived microaggressions and physical health are supported by the literature (Finch & Vega, 2003). More specifically, inline with previous research, the current study suggests that the sampled Latina/o Americans who perceived higher levels of microaggressions had poorer physical health when they had had minimal social support, but had better physical health when they had higher levels of social support. Additionally, although this result is inline with previous studies investigating the buffering effects of social support on the relationship between discrimination and health outcomes, it is important to mention that the current study’s conceptualization of discrimination as microaggression is different than how discrimination was conceptualized and measured in previous studies.

Although social support was found to have a moderating affect on the relationship between perceived microaggressions and physical health outcomes, the moderating effects of social support was not supported for mental health outcomes. One possible explanation for the discrepancy found with these results is that the participants might place less significance on mental health issues and more significance on physical health issues, given the stigma that mental health issues can carry for people of Color (Gary, 2005; Nadeem et al., 2007). For example, mental health stigma has been suggested as a barrier to people of Color, including Latina/o Americans, accessing mental healthcare services. Thus, it is possible that Latina/o Americans do not utilize social support when coping with mental health distress, because of the stigma they might associate with mental health issues. If this is indeed the case, then social support might only be a significant coping strategy for Latina/o Americans when dealing with

their physical health concerns, and not a significant coping strategy when dealing with their mental health concerns.

Limitations of the Study

The findings gleaned from the current study need to be considered in conjunction with several limitations. First, it is possible that several of the measures used may not be the most accurate or appropriate in fully assessing the constructs explored in the current study. For example, the predictor variables measured specific physical and speech characteristics (skin color, Spanish language use, accent) of the participants via self-reports. It is quite possible that participants' self-reports of these characteristics differ from how they present objectively in these characteristic areas. Although, one study on skin color that used both subjective and objective measures to assess this construct found that there were not significant differences in self-perception and objective ratings for skin color (López, 2008), there is not wide-spread evidence to support that self-perceptions of skin color are significantly similar to objective measures of skin color. Thus, the self-reports of skin color, Spanish language use, and accent level might not actually be in accord with how one truly presents. Further complicating self-reports of these characteristics is the possibility that Latina/o Americans who have received messages over time about American standards of beauty and acceptable speech might have internalized stigma related to these characteristics, which might affect how they perceive themselves in these characteristic areas. That is, Latina/o Americans who have internalized stigma around these characteristics might either overestimate or underestimate their self-perceived skin color or accent.

In addition to the self-reports of physical characteristics, there might also be limitations for the use of the Multidimensional Scale of Perceived Social Support (MSPSS) and the Racial

and Ethnic Microaggressions Scale (REMS). First, many social support scales measure the *availability* of social support, as opposed the *utilization* of social support. Such is the case with the MSPSS. The MSPSS has been shown to be a reliable and valid measure of perceived availability of social support; however, it is possible that what is more important is whether or not people actually use their available social support to help them cope with microaggressions. In essence, the availability of social support might not be a strong enough force to help buffer the negative effects of microaggressions on health. What might be more impactful on this relationship is the actual utilization of social support. Finally, the current study used the first known microaggression scale appropriate for use with people of Color (Nadal, 2011). This measure includes many of the microaggression themes and incidents reported by Latina/o Americans. However, as is the case with measures that use critical incidents to measure a construct, the incidents described in the REMS items quite possibly do not account for the universe of microaggressive incidents experienced by Latina/o Americans. Thus, it is possible that an individual who scores low on the REMS does not actually perceive a lesser amount of microaggressions in their daily lives than someone who scores high on the REMS.

Another limitation that is worth considering when making sense out of the results is that of the ethnic and racial composition of the sample. The sample of Latina/o Americans used in the current study represented a wide array of races and ethnicities; however, there were not large enough numbers of each represented group to conduct meaningful group comparisons. As stated earlier in the discussion, measuring ethnic identity with a pan-ethnic sample might not be as significant as measuring the construct of ethnic identity for specific ethnic groups. Additionally, the representation of Mexican-origin participants was much higher than that of other ethnic groups. Although this is inline with the national trend for a higher proportion of Mexican-origin

Latinas/os in the United States, this significant disparity in the sample makes it difficult to generalize the results of the current study to various Latina/o subgroups.

It is also important to note that the use of an online data collection method for the current study might have also limited the study in several ways. First, this data collection method allowed participants to self-select to participate in the study. It is possible that there are significant differences between Latina/o Americans who chose to participate in the study and those who chose not to participate in the study. Solely using an online data collection method may have also restricted the participation of those who do not have access to computers or the Internet. Thus it is possible that the data collection method used in the current study left out the voices and experiences of certain segments of the Latina/o American community. As a result, the findings of the current study may not generalize to all Latina/o Americans. Finally, the limits of the statistical methods used in the current study need to be considered. For example, although path analysis can assess causal hypotheses, such as those in the current study, it cannot establish directionality or prove causation. It is possible that these limitations influenced the results achieved in the current study.

Implications for Theory, Research, and Practice

Theoretical implications. The current study is a significant contribution to the study of microaggressions and to the fields of counseling and health psychology. As previously established, the current study is one of the first to quantitatively explore the dynamics of microaggressions in general and also specifically for Latina/o Americans. The findings from the current investigation support the theory of microaggressions in several ways. First, the findings provide quantitative evidence to support the existence of microaggressions in the lived experience of a marginalized group in America. A number of qualitative studies have provided

the foundation for the manifestation of microaggressions in the lives of marginalized people (e.g., Rivera et al., 2010; Sue, Bucceri, et al., 2007; Sue, Nadal, et al., 2007). However, as is typically the case with qualitative work, small samples were used in these studies. The use of a quantitative methodology ensured the use of a larger sample, which helps to bolster the support for the existence of microaggressions.

Second, the findings support some of the basic tenets of microaggression theory as proposed by Sue et al. (2007). For example, microaggressions are theorized to be the product of a clash of realities that exists between people of differing social identities. The items in the REMS had participants respond to various critical incidents that were attributed to race or ethnicity. If a participant endorsed an incident, this suggested that an element of the participant's social identity was at odds with their environment or another individual, thus supporting the notion that microaggressions occur when an individual perceives their identity to be devalued or attacked in response to a social situation or interaction. Additionally, one of the defining characteristics of microaggressions is that of debunking the idea that subtle, covert, and unintentional forms of discrimination bring forth minimal harm. The current study supports this tenet and suggests that microaggressions have a harmful impact on mental health for Latina/o Americans.

Research implications. Several implications for research from the current investigation will be discussed in this section. First, the current study is one of the first to consider the impact of several within-group characteristics in an investigation utilizing a Latina/o American sample. The vast majority of investigations using Latina/o American samples fail to recognize the many differences inherent within this population, which makes it extremely difficult to ascertain for whom the results of a study apply. Given that microaggressions occur in a social context, it is

important to identify the social cues that might make an individual susceptible to experiencing microaggressions. Thus, the current study included several social identity markers, skin color, language use, and accent, in exploring the prevalence and impact of microaggressions on the lives of Latina/o Americans. Additionally, even if not included as a major variable of study in an investigation, the inclusion of social identity markers can help to more thoroughly describe a sample used in research on social phenomenon, especially with groups that are more heterogeneous than homogeneous, as is the case with Latina/o Americans. Future studies should include a variety of variables (e.g., skin color, language use, accent, generational status, phenotype, etc.) that more fully describe a research sample so we can better understand the variation within a population of interest, such as Latina/o Americans and other racial and ethnic groups.

The current study provides a research model that can be applied to future studies on the manifestation and impact of microaggressions in the lives of marginalized people. The model suggests that individual characteristics (predictors) lead to microaggressions (mediator) that in turn lead to compromised health (outcomes). Future studies can use a similar model to investigate microaggressions with other samples of Latina/o Americans and also samples of other marginalized social groups. The application of this model can help to explain why certain members of a particular social group are more susceptible to experiencing microaggressions and potential differences in the impact of microaggressions.

In addition to investigating the influence of microaggressions on health outcomes for Latina/o Americans, it is important that future research include other variables, such as employment, economic, and educational outcomes. As previously mentioned, Latina/o Americans experience disparities in many spheres of American society despite their rapid

growth. For example, Latina/o Americans are underrepresented in professional occupations and overrepresented in service-related occupations (US Department of Labor, 2008). Likewise, compared to other racial and ethnic groups, Latina/o Americans have some of the lowest educational attainment rates (US Census Bureau, 2008). Qualitative research suggests that Latina/o Americans experience microaggressions in educational and employment settings (Rivera et al., 2010; Solórzano et al., 2005). It is possible that the microaggressions present in educational and employment settings help to create and maintain the inequities experienced by Latina/o Americans. Thus, it is important that researchers continue to reveal the impact that social determinants, like microaggressions, have on various outcomes for Latina/o Americans, as well as other socially marginalized groups.

Practice implications. The findings of the current study also have practical implications for healthcare service providers and other practitioners. Several frameworks and guidelines for developing cultural competence have been established in the helping fields. A widely accepted framework for developing multicultural counseling competencies recommends that practitioners examine their awareness of cultural issues, increase their knowledge of cultural issues and develop culturally appropriate skills (Sue, Arredondo, McDavis, 1992). This framework can also be found in specific guidelines incorporated by the helping professions, as exemplified by the American Psychological Association's Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (APA, 2003). The results of the current study support the APA's guidelines by increasing the knowledge base of multicultural issues.

For example, the APA's guidelines call for psychologists to "recognize the importance of multicultural sensitivity/responsiveness, knowledge, and understanding about ethnically and

racially different individuals (APA, 2003, p. 385).” The guidelines, in essence, call for an understanding of the worldviews of those who are different than oneself. The current study increases our knowledge and understanding about the lived experience of Latina/o Americans by providing information about the significant impact of microaggressions experienced by members of this group. It is necessary for health practitioners to be knowledgeable about the various experiences that may have an impact on the creation of compromised health for their clients and patients. In the case of Latina/o Americans, it may be necessary to consider how the social context influences their health. This study suggests that microaggressions are inherent in the social context of Latina/o Americans. Additionally, the study suggests that certain subsets of Latina/o Americans might be more at risk for experiences with microaggressions, such as those with a nonnative accent, which might have a negative impact on their health. Healthcare professionals can use this information to increase their knowledge about the worldviews and experiences of their Latina/o clients and patients so that they can be better prepared to develop culturally sensitive conceptualizations concerning the etiology of a presenting health concern.

The current study also has implications for skill development, which is a necessary component to developing cultural competency. The current investigation suggests that social support may be a significant factor in the relationship between microaggressions and health outcomes. Additionally, there is support for the notion that Latina/o Americans may be more communally and relationally oriented than individualistically oriented in their worldview (Comas-Díaz, 2006). Coupled with the results of the current study, it may be important for healthcare practitioners to recognize this significance and utilize social support as a component of their treatment approach when working with Latina/o Americans. For example, a thorough assessment of a Latina/o Americans social support network may be helpful in determining if

there is a lack of availability of social support or actual utilization of social support, and recommendations can be made to address any gaps. Additionally, it is important to recognize that recent immigrants may be particularly lacking in the social support that is immediately available to them, which might impact their ability to effectively cope with microaggressions and any related adverse health outcomes.

Summary and Conclusion

Latina/o Americans are one of the fastest growing social groups in the United States and are currently recognized as the largest ethnic minority group. However, Latina/o Americans experiences a range of disparities, including in health-related outcomes. The current study investigated a model that attempted to identify and make sense out of the factors that influence health outcomes for Latina/o Americans. As such, the model included the role of microaggressions on health outcomes for Latina/o Americans, the role of within-group differences on perceptions of microaggressions, and the role of psychological processes on this relationship. The findings suggest that the presence of a nonnative accent predicts higher perceptions of microaggressions, which lend support to the significant impact of within-group differences on perceptions of microaggressions for this group. Additionally, the findings suggest that microaggressions do indeed have a harmful impact on the mental health of Latina/o Americans. Finally, the current study provides evidence for the protective nature of social support on the harmful effects of microaggressions on the physical health of Latina/o Americans.

The current investigation adds to the study of microaggressions by providing empirical support for the harmful effects of microaggressions, the manifestation of microaggressions among Latina/o Americans, and how microaggressions manifest differently within this group. Additionally, the current study calls for future research utilizing Latina/o American samples to

incorporate variables that might account for within-group differences inherent in this group.

This shift moves us away from conceptualizing Latina/o Americans as a monolithic, homogeneous group, which can be construed as a microaggressive way of conducting research in and of itself. The current study is one of the first to quantitatively investigate microaggressions in the lives of Latina/o Americans and also to incorporate a number of characteristic variables that help to highlight the diversity inherent in this population. It is hoped that future research will continue to increase our knowledge of how microaggressions impact marginalized people by incorporating and expanding upon the research framework used in the current study.

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Appendix A: Demographic Questionnaire

- 1) What race(s) best describes you? (open)
- 2) What ethnicity best describes you? (open)
- 3) Age: (open)
- 4) Sex: ____Female ____Male
- 5) Place of Residence: (drop-down box with all U.S. states & territories listed)
- 6) What is the highest level of education you have completed? (drop-down box)
 - a) 8th grade or lower
 - b) 9th grade-11th grade
 - c) High School Diploma/GED
 - d) Some College
 - e) 2-year college degree (associates)
 - f) 4-year college degree (bachelors)
 - g) Masters Degree
 - h) Doctoral Degree (Ph.D., J.D., M.D., etc.)
- 7) What is your income level?
 - a) less than \$10,000
 - b) \$10,000 to \$19,999
 - c) \$20,000 to \$29,999
 - d) \$30,000 to \$39,999
 - e) \$40,000 to \$49,999
 - f) \$50,000 to \$59,999
 - g) \$60,000 to \$69,999
 - h) \$70,000 to \$79,999
 - i) \$80,000 to \$89,999
 - j) \$90,000 to \$99,999
 - k) \$100,000 to \$149,999
 - l) \$150,000 or more

Appendix B: Racial and Ethnic Microaggressions Scale (Nadal, 2010)

Racial and Ethnic Microaggressions Scale (REMS)
Kevin L. Nadal, Ph.D.
John Jay College of Criminal Justice- City University of New York

Instructions: Think about your experiences with race. Please read each item and think of how many times this event has happened to you in the **PAST SIX MONTHS**.

- 1 = none of the time
- 2 = a little bit of the time
- 3 = some of the time
- 4 = a good bit of the time
- 5 = most of the time
- 6 = all of the time

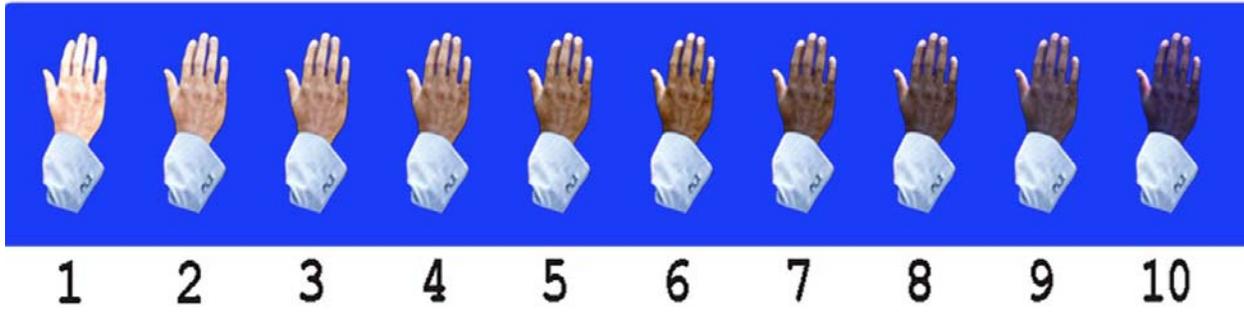
1. I was ignored at school or at work because of my race.
2. Someone's body language showed they were scared of me, because of my race.
3. Someone assumed that I spoke a language other than English.
4. I was told that I should not complain about race.
5. Someone assumed that I grew up in a particular neighborhood because of my race.
6. Someone avoided walking near me on the street because of my race.
7. Someone told me that she or he was colorblind.
8. Someone avoided sitting next to me in a public space (e.g., restaurants, movie theaters, subways, buses) because of my race.
9. Someone assumed that I would not be intelligent because of my race.
10. I was told that I complain about race too much.
11. I received substandard service in stores compared to customers of other racial groups.
12. I observed people of my race in prominent positions at my workplace or school.
13. Someone wanted to date me only because of my race.
14. I was told that people of all racial groups experience the same obstacles.
15. My opinion was overlooked in a group discussion because of my race.
16. Someone assumed that my work would be inferior to people of other racial groups.
17. Someone acted surprised at my scholastic or professional success because of my race.
18. I observed that people of my race were the CEOs of major corporations.
19. I observed people of my race portrayed positively on television.
20. Someone did not believe me when I told them I was born in the US.
21. Someone assumed that I would not be educated because of my race.
22. Someone told me that I was "articulate" after she/he assumed I wouldn't be.
23. Someone told me that all people in my racial group are all the same.
24. I observed people of my race portrayed positively in magazines.

25. An employer or co-worker was unfriendly or unwelcoming toward me because of my race.
26. I was told that people of color do not experience racism anymore.
27. Someone told me that they “don’t see color.”
28. I read popular books or magazines in which a majority of contributions featured people from my racial group.
29. Someone asked me to teach them words in my “native language.”
30. Someone told me that they do not see race.
31. Someone clenched her/his purse or wallet upon seeing me because of my race.
32. Someone assumed that I would have a lower education because of my race.
33. Someone of a different racial group has stated that there is no difference between the two of us.
34. Someone assumed that I would physically hurt them because of my race.
35. Someone assumed that I ate foods associated with my race/culture every day.
36. Someone assumed that I held a lower paying job because of my race.
37. I observed people of my race portrayed positively in movies.
38. Someone assumed that I was poor because of my race.
39. Someone told me that people should not think about race anymore.
40. Someone avoided eye contact with me because of my race.
41. I observed that someone of my race is a government official in my state
42. Someone told me that all people in my racial group look alike.
43. Someone objectified one of my physical features because of my race.
44. An employer or co-worker treated me differently than White co-workers.
45. Someone assumed that I speak similar languages to other people in my race.

Appendix C: New Immigrant Survey Skin Color Scale (Massey & Martin, 2003)

Instructions: Please select the number of the hand that best matches your skin color.

Scale of Skin Color Darkness



Appendix D: Bidimensional Acculturation Scale-Language Use (Marín & Gamba, 1996)

Instructions: Please read each question and choose the response that best represents you.

(1) almost never; (2) sometimes; (3) often; (4) almost always

1. How often do you speak English?
2. How often do you speak English with your friends?
3. How often do you think in English?
4. How often do you speak Spanish
5. How often do you speak Spanish with your friends?
6. How often do you think in Spanish?

Appendix E: Self-perceived Accent (Dovidio et al., 2010; Gluszek & Dovidio, 2010a)

1. Do you think you have an accent when speaking English?

Yes No Not sure

a. If yes, please specify the type of accent (or accents) you think you have (e.g., Spanish, German, Chinese): _____

2. Please rate the degree of a foreign accent (non-English) you think you have as compared to the standard American accent. *Standard American Accent refers to an accent that is accepted as a norm, for example TV announcers often have a standard accent.

1	2	3	4	5	6	7	8	9
I have no foreign accent								I have a very strong foreign accent
1	2	3	4	5	6	7	8	9
I sound like a native English speaker								I do <u>not</u> sound at all like a native English speaker
1	2	3	4	5	6	7	8	9
My accent is extremely easy to understand								My accent is impossible to understand
1	2	3	4	5	6	7	8	9
My accent does <u>not</u> interfere with communication								My accent interferes extremely with communication
1	2	3	4	5	6	7	8	9
I am a competent English speaker								I am <u>not</u> a competent English speaker

Appendix F: Multigroup Ethnic Identity Measure (Roberts et al., 1999)

Instructions: In this country, people come from many different countries and cultures, and there are many different words to describe the different backgrounds or ethnic groups that people come from. Some examples of the names of ethnic groups are Hispanic or Latino, Black or African American, Asian American, Chinese, Filipino, American Indian, Mexican American, Caucasian or White, Italian American, and many others. These questions are about your ethnicity or your ethnic group and how you feel about it or react to it.

Please fill in: In terms of ethnic group, I consider myself to be _____

Use the numbers below to indicate how much you agree or disagree with each statement.

(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree

- 1- I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs.
- 2- I am active in organizations or social groups that include mostly members of my own ethnic group.
- 3- I have a clear sense of my ethnic background and what it means for me.
- 4- I think a lot about how my life will be affected by my ethnic group membership.
- 5- I am happy that I am a member of the group I belong to.
- 6- I have a strong sense of belonging to my own ethnic group.
- 7- I understand pretty well what my ethnic group membership means to me.
- 8- In order to learn more about my ethnic background, I have often talked to other people about my ethnic group.
- 9- I have a lot of pride in my ethnic group.
- 10- I participate in cultural practices of my own group, such as special food, music, or customs.
- 11- I feel a strong attachment towards my own ethnic group.
- 12- I feel good about my cultural or ethnic background.
- 13- My ethnicity is
 - (1) Asian or Asian American, including Chinese, Japanese, and others
 - (2) Black or African American
 - (3) Hispanic or Latino, including Mexican American, Central American, and others
 - (4) White, Caucasian, Anglo, European American; not Hispanic
 - (5) American Indian/Native American
 - (6) Mixed; Parents are from two different groups
 - (7) Other (write in): _____
- 14- My father's ethnicity is (use numbers above)
- 15- My mother's ethnicity is (use numbers above)

Appendix G: Multidimensional Scale of Perceived Social Support (Zimet et al., 1988)

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the "1" if you Very Strongly Disagree

Circle the "2" if you Strongly Disagree

Circle the "3" if you Mildly Disagree

Circle the "4" if you are Neutral

Circle the "5" if you Mildly Agree

Circle the "6" if you Strongly Agree

Circle the "7" if you Very Strongly Agree

1. There is a special person who is around when I am in need.	1	2	3	4	5	6	7
2. There is a special person with whom I can share joys and sorrows.	1	2	3	4	5	6	7
3. My family really tries to help me.	1	2	3	4	5	6	7
4. I get the emotional help & support I need from my family.	1	2	3	4	5	6	7
5. I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
6. My friends really try to help me.	1	2	3	4	5	6	7
7. I can count on my friends when things go wrong.	1	2	3	4	5	6	7
8. I can talk about my problems with my family.	1	2	3	4	5	6	7
9. I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
10. There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7
11. My family is willing to help me make decisions.	1	2	3	4	5	6	7
12. I can talk about my problems with my friends.	1	2	3	4	5	6	7

Appendix H: Mental Health Inventory-18 (Veit & Ware, 1983)

Instructions: The next set of questions are about how you feel, and how things have been for you during the past 4 weeks. Please select the appropriate response (1, 2, 3...). Please answer every question. If you are not sure which answer to select, please choose the one answer that comes closest to describing you.

(1) all of the time; (2) most of the time; (3) a good bit of the time; (4) some of the time; (5) a little bit of the time; (6) none of the time

During the past 4 weeks, how much of the time...

1. Has your daily life been full of things that were interesting to you?
2. Did you feel depressed?
3. Have you felt loved and wanted?
4. Have you been a very nervous person?
5. Have you been in firm control of your behavior, thoughts, emotions, feelings?
6. Have you felt tense or high-strung?
7. Have you felt calm and peaceful?
8. Have you felt emotionally stable?
9. Have you felt downhearted and blue?
10. Were you able to relax without difficulty?
11. Have you felt restless, fidgety, or impatient?
12. Have you been moody, or brooded about things?
13. Have you felt cheerful, light-hearted?
14. Have you been in low or very low spirits?
15. Were you a happy person?
16. Did you feel you had nothing to look forward to?
17. Have you felt so down in the dumps that nothing could cheer you up?
18. Have you been anxious or worried?

Appendix I: Global Rating of Physical Health

Instructions: Choose the item that best completes the following question.

(1) poor; (2) fair; (3) good; (4) very good; (5) excellent

1. In general, would you say your physical health is _____?

Appendix J: Recruitment E-mail Message

Dear Potential Participant:

You are invited to participate in my dissertation study exploring the effects of subtle discrimination on the health of Latinas/os and Hispanics. The study is based on research suggesting that racism has changed over the decades from a predominantly overt form to a more subtle, covert form known as microaggression.

Participation is open to anyone who is 18-years old or over and identifies as Latina/o or Hispanic (or racially/ethnically identifies with people coming from Latin America, including Mexico, Central America, South America, or the Spanish-speaking countries of the Caribbean). Participation in this study will involve filling out an internet-based survey. If you would like to participate in this study, please click on the following link.

www.surveymonkey.com/s/healthstudy

Should you choose to participate, you will be eligible to enter a raffle for a chance to receive a \$25 American Express gift card (odds of receiving a gift card are 1 in 25). Your participation in this study is confidential and anonymous, and no personal identification, such as name, phone number, or physical address will be collected at anytime. Only your e-mail address will be collected should you choose to participate in the raffle; however, it will not be connected to your survey responses.

This dissertation study is being conducted under the supervision of Professor Derald Wing Sue, Ph.D., and has been approved by the Teachers College, Columbia University Institutional Review Board (#10-279).

In order to increase the diversity of participants, please forward this message to Latinas/os and Hispanics in your personal network.

Your participation is greatly appreciated.

www.surveymonkey.com/s/healthstudy

Sincerely,

David Rivera, M.S.
Doctoral Candidate, Counseling Psychology
Teachers College, Columbia University
Dpr2106@columbia.edu

Appendix K: Informed Consent Form

Teachers College, Columbia University

INFORMED CONSENT

DESCRIPTION OF THE RESEARCH: You are invited to participate in a research study on experiences of subtle discrimination towards Latinas/os or Hispanics and health issues. You will be asked a number of questions through an internet-based survey. The research will be conducted by David P. Rivera, M.S. The research will be conducted at a secure location of your choice.

RISKS AND BENEFITS: There is minimal to no physical or psychological risk involved in this study. If there is any discomfort in answering some of these questions, please feel free not to answer them. You will not be penalized in any way if you do not answer questions or choose not to participate in this study. If any of these questions causes discomfort, I encourage you to discuss these pertinent issues with a counselor. If you do not have access to a counselor, the principal investigator will refer you to one.

The study has several potential scientific and practical benefits. First, it may serve as a guide for self-awareness and exploration of one's self as a racial/cultural being. Second, it may be able to help reveal different types of discrimination experienced by Latinas/os or Hispanics and enhance future research in their manifestation, process and effects.

PAYMENTS: Upon completion of the survey, you may enter a lottery to receive a \$25 American Express gift card. The odds of receiving a gift card are 1/25.

DATA STORAGE TO PROTECT CONFIDENTIALITY: All data collected will be completely confidential. The only identification that we request is your race, ethnicity, gender, age, education, and income level. In addition, if you choose to participate in the lottery for the \$25 American Express gift card, you will be directed to a website not connected to your survey responses. Your e-mail address will be kept confidential and deleted after the lottery winners are selected. All other identifying information, such as name, address, or phone number will not be collected or stored at anytime. Your anonymous responses will be stored on a password-protected, secure computer that only the primary investigator has access to.

TIME INVOLVEMENT: Your participation will take approximately 45 minutes.

HOW WILL RESULTS BE USED: The results of the study will be used for the primary investigator's dissertation on understanding subtle discrimination experienced by Latinas/os or Hispanics and health issues. It is possible that content from the study may be used for future educational publications or conferences. Confidentiality is ensured in all circumstances.

Appendix L: Final Screen Text of Online Survey

“Thank you for participating in this study. If you have any questions or concerns about your participation, please contact David Rivera at dpr2106@columbia.edu. To enter for a chance to receive a \$25 American Express gift card, please click on the following link:
<https://www.surveymonkey.com/s/healthstudyraffle>”