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Racism Experiences and Mental Health: An Examination of Direct, Vicarious, and Appropriated Racism Experiences on Mental Health Symptom Expression

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RACISM EXPERIENCES AND MENTAL HEALTH: AN EXAMINATION OF DIRECT, VICARIOUS, AND APPROPRIATED RACISM EXPERIENCES ON MENTAL HEALTH SYMPTOM EXPRESSION

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy Virginia Commonwealth University.

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Abstract

RACISM EXPERIENCES AND MENTAL HEALTH: AN EXAMINATION OF DIRECT, VICARIOUS, AND APPROPRIATED RACISM EXPERIENCES ON MENTAL HEALTH SYMPTOM EXPRESSION

By Christina M. Barnett, M.S.

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The current study aimed to corroborate existing models of racism-related experiences by creating an explanatory model that operationalized direct, vicarious, and appropriated racism experiences. This study explored whether the factors of direct and vicarious racism experiences influenced mental health outcomes via appropriated racism experiences in a sample of Black women. This association was not present. However, results showed a positive association between vicarious and direct racism experiences, as well as predictive relations between direct and vicarious racism experiences and depression and trauma symptoms. Results, limitations, implications, and recommendations for future research are included.

Keywords: vicarious racism, appropriated racism, direct racism, mental health, Black women

Racism Experiences and Mental Health: An Examination of Direct, Vicarious, and Appropriated Racism Experiences on Mental Health Symptom Expression

Black psychologists have long been concerned with reclaiming the narrative of the Black American experience and explaining social and psychological phenomena via culturally relevant theory and clinical practice. One of the ways this has manifested in psychological literature has been through the exploration of how racism experiences have impacted the psychological and physiological well-being of Black people. Racist experiences have historically impacted Black citizenship and human rights—manifesting in the ways Black people are policed, housed, educated, and paid.

However, racism experiences not only manifest in critical awareness of one's own personal safety and well-being but also shape Black people vicariously, in their awareness of other Black people's safety and well-being (Harrell, 2000). For example, it can be hard to escape sensationalist and viral imagery and news updates that dominate the media about Black death at the hands of the police or about white supremacy efforts to harm Black people and other underrepresented groups, thus amplifying concern for Black people at the collective level. Racism experiences can also impact the way that Black people engage with their own Blackness, and their perceptions of their racial-ethnic identity. These experiences can shape the way Black people appropriate racist stereotypes and attribute them to a collective Black identity (Campón & Carter, 2015). Black issues that have garnered mainstream attention include the single-parent household, Black-on-Black crime, welfare queens, #teamlightskin versus #teamdarkskin, and more. These issues are often discussed through a lens that simultaneously homogenizes and Others Black people. Here, a mentality influenced by belief in White supremacy values implicates how racism experiences can influence a distorted sense of identity.

Seminal work within the realm of Black psychology such as Pierce's (1970, 1974) conceptualization of racial microaggressions or Jones's (1972, 1997) tripartite model of racism have provided the foundation for contemporary inquiry into how such racism experiences impact Black well-being via racism-related stress. Harrell's (2000) multidimensional model of racism-related stress is the most invoked conceptualization of how racism experiences are stressful for Black people. Other models have examined how racist socioenvironmental stimuli impacts Black well-being (Clark, Anderson, Clark, & Williams, 1999; Neville & Pieterse, 2009) and explored the relation between racism and trauma symptomatology (Carter, 2007).

Despite psychological theory demonstrating how racism experiences occur at the individual, cultural, and institutional levels and can be vicariously experienced or internalized, popular discourse about racism has been about operationalizing it: Who is racist? What constitutes racism? Words like offensive, divisive, controversial, biased, prejudiced, intolerant, patriotic, and terms such as racial anxiety, racial resentment, racist undertones/overtones continue to cloak racial discrimination and racist acts.

The current study aims to corroborate the aforementioned existing models of racism-related experiences by incorporating these models into an explanatory model that will operationalize what racism is, how it manifests, and its impact on the mental health of the person experiencing it. An explanatory model will be created to show the relationship between direct (e.g., individual, cultural, and institutional), vicarious, and appropriated racism experiences and expressed mental health symptoms. This model will add to the current literature by integrating the nonincluded domains of vicarious and appropriated racism experiences with the more traditional racism experiences models put forth by Carter (2007), Clark and colleagues (1999), Harrell (2000), and Jones (1972, 1997). Similarly, this research effort also hopes to demonstrate

the consequences of these types of racism-related experiences on expressed mental health symptoms. We also hope to add to the literature by providing a more in-depth understanding of psychological well-being beyond over-overemphasized quality of life correlates (e.g., life satisfaction, self-esteem).

Literature Review

What Is Racism?

The meaning of the word racism has been defined and augmented over time. Jones (1997) devised the tripartite model that conceptualized racism as existing at the individual, institutional, and cultural levels. He conceptualized individual racism as the interpersonal, face-to-face interactions designed to denigrate an individual because of their race. He described institutional racism as the racism embedded in social institutions and manifested in policy and practice. Cultural racism he conceived as perceiving one's cultural values and customs as superior to another's.

Clark and colleagues (1999, p. 805) operationalized racism as "the belief attitudes, institutional arrangements, and acts that tend to denigrate individuals or groups because of phenotypic characteristics or ethnic group affiliation." The authors conceptualized their definition as distinct from others because it included racism experiences perpetuated by members of different racial-ethnic groups and members of the same racial-ethnic group. Harrell (2000) argued that racism is perpetuated and maintained via stereotypes, prejudice, and discriminatory acts that are overt, covert, or unintentional and are "rooted in a historical continuity of injustice and disparity. . ." She created a multidimensional model of racism that outlined the many forms of racism; examined how these forms of racism exist across interpersonal, collective, cultural-symbolic, and sociopolitical contexts; and explored their stressful impact on Black people

(Harrell, 2000).

Essentially, the multifaceted operationalization of racism by the aforementioned scholars illustrates the term's complexity. Still, an understanding of how racism is defined is vital to an understanding of how to explicitly identify what racism is, where it exists, and how it impacts people's well-being. Several researchers, particularly those who study the link between racism-related experiences and stress, have created theoretical frameworks to conceptualize psychological consequences of racism-related experiences.

Theoretical Frameworks: Psychological Models of Racism and Psychological Well-Being

A Tripartite Model. J. M. Jones's (1972, 1997) tripartite model provided a foundation for categorizing racism-related experiences. Jones' multidimensional model demonstrated that racism experiences occur at the individual, institutional, and cultural levels. Jones (1972, 1997) operationalized individual racism as racism experiences that take place on a personal level whereby an individual is exposed to discrimination or another's belief that their own ethnic group is inferior to another's. Institutional was operationalized as exclusionary policies that limit the participation or benefit of an individual or group due to their racial-ethnic background. Finally, Jones (1972, 1997) defined cultural racism as the demonstration that one racial-ethnic group is superior to a subordinate racial-ethnic group.

The Biopsychosocial Model. Clark and colleagues (1999) proposed a biopsychosocial model of racism-related stress that described how one could be exposed to racism and how this exposure could elicit psychological and physiological responses. Their focus was on the socioenvironmental racist stimuli that exaggerated or created psychological and physiological stress. Clark and colleagues (1999) identified substandard housing, lack of minority promotion at work, and lower wages because of one's racial-ethnic background as racist environmental

stimuli.

Next, they identified moderating and mediating factors that influenced the relationship between this environmental racist stimuli and health outcomes. Such factors included constitutional factors like skin tone, occupational status, personal income, and family health history (e.g., cardiovascular health). Other factors included socioeconomic status, which, the authors hypothesized, influenced exposure to more or to less chronic stressors, as well as to access to resources used to cope. They also identified psychiatric factors, such as personality traits, that could influence the relation between environmental stimuli and health. These included neuroticism, cynicism, hostility, and anger expression/suppression.

The authors concluded that one's subjective analysis of the environmental stimuli mediated the potential health outcome based on whether the individual perceived the stimuli as racist, as a different type of stressor unrelated to race, or whether the stimuli was not perceived as stressful due to race or other contributing factors. If individuals did not perceive the stimuli as racist, the authors proposed no psychological or physiological stress response nor use of coping mechanisms. However, if the individual did interpret the stimuli as stressful, a myriad of psychological and physiological stress responses that influenced adaptive or maladaptive coping responses could manifest. Such psychological stress responses have been well documented in the psychological literature, such as feelings of hopelessness, resentment, anxiety, and fear (Graham, West, & Roemer, 2013; Harrell, 2011; Odafe, Salami, & Walker, 2017; Walker, Salami, Carter, & Flowers, 2014). These responses can trigger coping mechanisms like anger suppression, hostility, or substance use (Gibbons et al., 2012; Harrell, Hall, & Taliaferro, 2003; Pittman, 2011; Steffen, McNeilly, Anderson, & Sherwood, 2003). Physiological implications of racism-related stress have been shown to tax the immune, neuroendocrine, and cardiovascular systems

and increase vulnerability to disease (Brondolo, Gallo, & Myers, 2009; Paradies, 2006; Williams & Mohammed, 2013).

The Race-Based Trauma Model. Carter's (2007) raced-based trauma model explores the emotional and psychological impact of racism experiences on people of color. Carter (2007) qualified racial trauma in terms consistent with the psychiatric symptoms of post-traumatic stress disorder. Carter (2007) determined that trauma happens because of racial harassment, racial discrimination, and discriminatory harassment. Carter (2007) described the construct racial discrimination in biopsychosocial terminology, perhaps informed by Clark and colleague's (1999) conceptualization. Racial discrimination is the thoughts, behaviors, strategies, or policies—intentional or unintentional—that create distance between different racial-ethnic groups (Carter, Forsyth, Mazzula, & Williams, 2005). Racial discrimination Carter (2007) classifies as avoidant racism—a term that underscores the exclusion of a racial-ethnic group—and exists at the individual, cultural, and institutional levels. Racial harassment Carter and Helms (2002) conceptualized as the overt and intentional thoughts, behaviors, strategies, or policies that dominant groups communicate to convey their superiority and the minority group's inferiority. Discriminatory harassment is a marriage of racial discrimination and racial harassment. Discriminatory harassment are simultaneously hostile and aversively racist thoughts, behaviors, strategies, or policies (Carter, Forsyth, Mazzula, & Williams, 2005).

Carter (2007) emphasized that racism-related experiences, and the previously mentioned constructs of racism, are not merely stressful but are psychologically injurious and traumatic. Carter (2007) dictated that for race-based trauma to be present, one must first identify that they are experiencing racial discrimination, racial harassment, or discriminatory harassment. Then they must classify this experience as negative, abrupt, and not under their own control. Finally,

the individual will experience at least one of the following traumatic reactions: intrusion, avoidance, or arousal. Intrusion symptoms include such experiences as unwanted upsetting memories, nightmares, and flashbacks. Avoidance experiences are efforts to circumvent trauma-related thoughts, feelings, or other stimuli. Arousal symptoms include irritation, aggression, hypervigilance, easily startled, sleep difficulty, and concentration issues. Experiencing such a reaction, Carter (2007) argued, has implications for additional physiological, cognitive, behavioral, and emotional responses. Alternatively, individuals may engage in coping strategies that moderate the impact of the trauma (Carter, 2007).

The Psychosocial Model. Neville and Pieterse (2009) framed the psychosocial model of racism to contextualize a systems-level analysis of racism. Their model dictates that racism comprises two parts: racial structure and racial ideology. Given their argument for the integral relationship between racial structure and mental health, they propose that rather than focusing on the stress that racism causes people of color, it is more important to understand how racism is structured and how it is manifests in ideology. Such correlates of racial structure include data representative of racial and economic disparity, such as the percentage of Black Americans who are in prison, underinsured, victims of crimes, and so forth. They characterize racial ideology as the belief in dominant and counterhegemonic discourse about race that shapes an individual's attitudes, beliefs, and psychosocial adjustment.

In their model, racial structures and racial ideologies influence the types of racism and the foci of the racism experienced. The types of racism and racism foci constructs influence each other. They adhere to Jones's (1972, 1997) tripartite model of racism that describes individual—including everyday racism (Essed, 1991) and microaggressions (Pierce, 1975)—institutional racism, and cultural racism types. Neville and Pieterse (2009) also argued that internalized

racism, or the belief, acceptance, and/or practice of racist ideology against one's own racial-ethnic group, is a type of racism. Racism foci describes the ways in which racism types, structures, and ideologies influence the attitudes, emotions, and behaviors of those oppressed by racism and those who oppress using racism. The authors note psychosocial impacts of racism such as hypertension (Paradies, 2006), symptoms of obsessive-compulsive disorder (Klonoff, Landrine, & Ullman, 1999), and feelings of anxiety and depression (Harrell, Hal, & Talieferro, 2003; Taylor & Turner, 2002).

A Multidimensional Model of Racism-Related Stress. The model of racism-related stress by Harrell (2000) is perhaps the most prolific and invoked model in contemporary psychological literature. Harrell (2000) drew upon others' conceptualization of racism (Jones, 1972; Ridley, 1995) and qualifies racism as overt, covert, intentional, or unintentional and foundational to "a historical continuity of injustice and disparity that is linked to contemporary circumstances and systematically influences the conditions and experiences of large groups of people." Harrell (2000) went on to state that racism itself provides a context for the development and maintenance of its by-products: stereotypes, prejudice, and discrimination. Harrell's multidimensional model conceptualizes three types of racism that exist across four contexts and leads to six types of stressors for Black people.

The three types of racism that Harrell (2000) described are individual, institutional, and cultural racism. Individual racism is the personal beliefs about another group's racial-ethnic inferiority. Institutional racism refers to systemic discrimination and oppression, while cultural racism describes ethnocentrism. Harrell (2000) went on to describe the ways that individual, institutional, and cultural racism occur across the interpersonal, collective, cultural-symbolic, and sociopolitical contexts. The interpersonal context describes how experiences of racial

discrimination and prejudice occur between people through direct communication or nonverbal communicative behaviors. The collective context describes the status characteristics of a large group of people. For example, the collective context can be attributed to racial disparities that exist between various racial-ethnic groups' access to resources (e.g., education, employment, health care, housing, food). The cultural-symbolic context describes how stereotypes, prejudice, and discriminatory behaviors are expressed in the news, in art, in the entertainment industry, and in science. Finally, the sociopolitical context describes how racism is perpetuated via policy, politics, and practices at the systems level. Harrell (2000) is clear that the three forms of racism and four contexts in which they are experienced occur simultaneously and across all levels.

Using this conceptualization of racism, Harrell (2000) delineated a model of racism-related stress that illustrated the relationship between racism and mental health. She depicted six types of racism-related stress experiences that follow the standard stress literature domains of episodic stress, daily hassles, and chronic stress. These six types are racism-related life events, vicarious experiences, daily racism microstressors (microaggressions), chronic-contextual stress, collective experiences of racism, and the transgenerational transmission of group traumas.

Racism-related life events describe time-limited experiences of racial discrimination. Vicarious racism experiences describe observed or reported racism that happens to others of the same racial-ethnic grouping. Daily racism microstressors are synonymous to racial microaggressions. Chronic-contextual stress describes institutional racism. Collective experiences of racism include group perceptions and experiences of racism, as well as racist perceptions that exist within the same racial-ethnic group. Finally, the transgenerational transmission of racism comprises how traumatic historical experiences of racial oppression manifests from one generation to the next.

An Integrative Model of Racism

The purpose of this research project is to create an integrative and multidimensional model of racism-related experiences that quantifies their psychological impact on Black-identifying people. This model keeps with Jones's (1972, 1997) tripartite model, whereby racism experiences happen at the individual, cultural, and institutional levels. It will add to the literature by including new domains of the traditional model, that is, racism-related experiences of vicarious racism and appropriated racism. The hope is to expand the literature by providing a more robust model of racism experiences that includes a multidimensionality of racism experiences that can impact Black people. This integrative model will emphasize the psychological correlates that are more consistent with psychiatric symptoms rather than quality of life variables (e.g., self-esteem, happiness, or life satisfaction) which are overemphasized in the literature. Also, the clinical relevance of these mental health outcomes has implications for intervention. To do so, the statistical model being assessed will evaluate a three-factor model with the following racism-related experiences/constructs: direct racism experiences, which will include individual, cultural, and institutional racism experiences that directly impact an individual; vicarious racism experiences; and appropriated racism experiences, which include internalized, or appropriated, racial oppression experiences. The relation between these factors and expressed depression, anxiety, and traumatic symptoms expression will also be explored.

Direct Racism Experiences

The construct of direct racism experiences will include individual, cultural, and institutional experiences of racism, as well as racial microaggressions. These forms of racism have been shown to have immediate impact on an individual whether at the interpersonal or cultural level or via policies and practices.

Individual. Individual racism describes racism experiences that take place at the individual level and typically connote an interpersonal interaction. Specifically, these interactions place the person of color on the receiving end of a racially discriminatory overt or covert act (Jones, 1972, 1997; McConahay, 1986; Sears, Henry, & Kosterman, 2000). One approach to conceptualizing individual racism has been to bifurcate the domain into "old-fashioned" versus "contemporary/aversive" forms of racism. Old-fashioned racism, or blatant racism, describes dominative and overt racism, while aversive racism is often subtle, innocuous, and couched in egalitarianism (Dovidio & Gaertner, 2004).

One way researchers have conceptualized experiences of individual racism is to determine the frequency of interpersonal experiences, whether overt, covert, episodic, or chronic. Researchers have looked at the frequency of experiences like being treated with less respect or being feared because of one's race (Clark, Coleman, & Novak, 2004; Kessler, Mickelson, & Williams, 1999). Researchers have also conceptualized individual racism as occurring in specific domains (e.g., work, education, housing). Regardless of how individual racism has been conceptualized, psychological literature has demonstrated that Black Americans have more individual discriminatory experiences than members of other racial-ethnic groups (Kessler, Mickelson, & Williams, 1999; Williams & Williams-Morris, 2000). In one study, 89% of Black respondents who felt they had been discriminated against believed that their race was the root cause of their discriminatory experience (Kessler, Mickelson, & Williams, 1999).

While the frequency and domains of racial discrimination have been established in the psychological literature, the contemporary focus has been on evaluating the relationship between the experience of individual racism and mental health. Perceived experiences of individual racism have shown to be associated with symptoms of depressive and anxiety symptoms in the

literature. Banks, Kohn-Wood, and Spencer (2006) found that individual experiences of racial discrimination were both moderately and positively associated with depressive and anxiety symptoms in a sample of Black women. This relationship also seems to prevail in adolescents as well as in adults. Brody et al. (2006) found a positive relationship between perceived discrimination experiences and depressive symptoms as well as conduct problems in a sample of 714 Black children between the ages of 10 and 12 years. There were no differences of depression between male and female teens in the sample. Greene, Way, and Paul (2006) found that this relationship was also true in an adolescent population of Black, Latino, and Asian American participants. Here, Black teens reported increased racial discrimination over time. For all ethnic groups, there was a positive relation between perceived discrimination and depressive symptoms. In a longitudinal study, Schulz and colleagues (2006) found that an increase in perceived individual racism was associated with an increase in depressive symptoms over time in a sample of Black women. This result was still significant when demographic variables such as age, education, and income were accounted for.

Cultural. Harrell (2000) and Jones (1972, 1997) described cultural racism, in conjunction with institutional racism, as the environmental support for the expression of individual racism. Harrell (2000) described cultural racism as experiences of ethnocentrism and status-quo maintenance. Examples of ways in which cultural racism is manifested according to Harrell (2000) is in the lack of racial-ethnic representation in the arts and other intellectual mediums. The lack of representation of one's racial-ethnic group's cultural contribution is deemed racist because its absence implies that this group is inherently uncivilized or unenlightened. This absence also allows for the narrative of one's racial-ethnic group to be reworked to fit this inferior portrayal. Williams and Williams-Morris (2000) provided such an example. The authors

discussed how negative attitudes and beliefs about Black Americans are manifested in stereotypes about Black people as unintelligent, lazy, in need of public support, and prone to violence (Williams & Williams-Morris, 2000). These cultural stereotypes become commonplace cultural myths that affirm White supremacy and disenfranchise Black people (Miliora, 2000). Oliver (2001) argued that cultural racism is another manifestation of institutional racism because of the systemic nature in which White culture is elevated in places like school systems, mass media, and religion.

In psychological literature, cultural racism has been understudied in general. Research examining cultural racism has done so in relation to mental health symptoms and resilience factors. In one study about the relationship between life stress, vulnerability, and resilience factors, researchers found that cognitive ability and social support together moderated the relation between cultural racism and quality of life outcomes in a sample of Black Americans (Utsey, Lanier, Williams, Bolden, & Lee, 2006). Specifically, the relation between cultural racism and quality of life is lessened for those who remained low in cognitive ability but whose social support increased (Utsey, Lanier, Williams, Bolden, & Lee, 2006). A study assessing whether gender moderated the relationship between racism-related stress and mental health symptoms found no significant gender differences in cultural racism stress appraisals between Black men and women, signifying that perhaps Black men and Black women do not differ in their exposure and appraisal of cultural racism (Greer, Laseter, & Asiamah, 2009). In a study examining cultural racism and Africultural coping mechanisms, the authors found that higher incidence of perceived cultural racism was predictive of less use of religious problem solving for Black women and greater use of collective coping strategies for Black men (Lewis-Coles & Constantine, 2006). While the literature has provided some examples of how cultural racism has

been impactful in the well-being of Black people, this domain needs further exploration of its mental health correlates.

Institutional Racism Experiences. Harrell (2000) described institutional racism in her model as one of the racism-related events that Black people could experience. Institutional racism describes racism that exists at the systems level. Jones (2000) described institutional racism as limiting the access to resources, services, goods, and opportunities due to race. He highlighted the normativity of institutionalized racism due to its perpetuation and codification in law, policies, and practices at most institutions (Jones, 2000). He hypothesized that institutional racism manifests in two forms: one that deals with people's access or lack of access to material conditions (e.g., housing, education, employment opportunities) and people's access or lack of access to power (e.g., access to information, voting rights).

Neville and colleagues (2013) highlighted institutional racism in their discussion of power-evasion colorblind racial ideology. The authors discussed how denial of institutional racism by White individuals tends to be a prevalent contemporary trend. Rather, holding a color-blind racial belief system legitimizes victim blaming to rationalize institutional racial inequality. In addition to color-blind beliefs and attitudes, psychologists have investigated institutional racism in the context of present-day residential segregation as well as in the criminal justice system. Research has confirmed common knowledge about the reality of racial segregation (Williams & Mohammed, 2009), as well as the reality that Black and Latino people are more likely to be incarcerated at higher rates with more severe sentences than their White counterparts (Doerner & Demuth, 2010). While overt discrimination regarding housing has been illegalized, factors pertaining to individual acts of racial discrimination (e.g., White flight, gentrification)

continue to sustain institutional racism underlying segregation, which persists. The same pattern is also representative in school district zoning.

Essentially a conversation about institutional racism is a conversation about racial disparity and racial inequity. Griffith and colleagues (2007) theorized that institutional racism exists at three levels: the extraorganizational, intraorganizational, and individual. The extraorganizational level describes the two-way relationship between the organization and their surrounding environment. The intraorganizational level describes how institutional racism exists within the policies and procedures of the organization. The individual level describes the interpersonal attitudes, beliefs, and behaviors of the individuals of the organization. The authors reported that organizations tend to not reflect about where and how institutional racism exists and lack the capacity or mechanisms to promote a system change. They reported that organizations often do not reflect multicultural leadership that pays attention to racial-ethnic diversity at all levels of staffing. Oftentimes, organizations do not have boards or an oversight committee to monitor policies, practices, and where or how resources are allocated. Griffith and colleagues (2007) also identified that regular training and education opportunities must be present to edify staff and engage them in conversations about racism and race in society and at play within the organization. The authors determined that intraorganizational opportunities for growth and development must be clear and achievable for all members of the organization.

In the psychological literature, Greer and Spalding (2017) established a link between institutional racism and anxiety symptoms. They found that while older Black women had more exposure to cultural and institutional racism, they exhibited less anxiety symptoms. Meanwhile, younger Black women experienced more severe anxiety than their older counterparts in relation to greater exposure to institutional racism (Greer & Spalding, 2017). Lee, Neblett, and Jackson

(2015) also found a relationship between institutional racism experiences and anxiety symptoms. They attempted to explore the link between racism-related stress experiences, optimism, religious experiences, and anxiety symptoms in a sample of Black undergraduates. They found that racism-related stress brought on by institutional racism was positively related to both cognitive and somatic symptoms of anxiety. The researchers hypothesized that anxiety is present because, unlike racial discrimination experienced at the individual level, institutional racism is more nebulous, and individuals may feel like they have less agency over systemic pressures, which manifest in anxiety.

Other research has shown the relationship between institutional racism and coping mechanisms employed by Black people who experience it. Syzmanski and Lewis (2015) found that, in a sample of Black undergraduates, exposure to institutional racism was related to greater endorsement of anti-White attitudes and Afrocentric ideals, which in turn was related to greater involvement in Black activism. Lewis-Coles and Constantine (2006) found that Black women who perceived they had experienced institutional racism engaged more frequently in the use of cognitive and emotional debriefing, as well as spiritual and other collective coping mechanisms.

Racial Microaggressions. A form of racism experiences that underrepresented racial-ethnic groups acknowledge are racial microaggressions. The term seems to be a catch-all for what seems to be categorized as aversive, implicit, or modern racism, and can understood as "subtle insults—verbal, nonverbal, and/or visual—directed toward people of color, often automatically or unconsciously" (Pierce, 1974, p. 516). Racial microaggressions are brief and commonplace, and although they can take place because of an interpersonal interaction, microaggressions may also be brought about by the environment or context in which the individual finds themselves.

Dr. Chester Pierce first identified these types of experiences via the experiences of his Black clients during his tenure as a practicing psychiatrist at Harvard University Medical School in the 1970s. There, he developed a theory of "offensive mechanisms" to describe the ways in which his Black clients felt "the subtle, cumulative miniassault [that] is the substance of today's racism . . ." (Pierce, 1974, p. 516). He went on to coin the phrase microaggressions to describe these offensive mechanisms and continued to research and operationalize these types of experiences. His work helped identify qualities of racial microaggressions. For example, he described racial microaggressions as "subtle, stunning, often automatic, and non-verbal" put-downs of Black people (Pierce, 1974; Pierce, Carew, Pierce-Gonzalez, & Wills, 1978, p. 66). Pierce (1974, 1995) also addressed the impact that racial microaggressions have on Black people. He reported that microaggressions had an accumulative effect that is burdensome across the life span, with both physiological and psychological consequences.

Pierce's work informed Sue and colleagues (2007) contemporary conceptualization of racial microaggressions. Sue and colleagues (2007) identified nine themes of racial microaggressions. They are (1) alien in one's own land, (2) ascription of intelligence, (3) color blindness, (4) criminality/assumption of criminal status, (5) denial of individual racism, (6) myth of meritocracy, (7) pathologizing cultural values/communication styles, (8) second-class status, and (9) environmental invalidation. These themes fall into three main forms of racial microaggressions: microassaults, microinsults, and microinvalidations.

Microassaults are explicit offensive verbal or nonverbal attacks against an individual via name-calling, active avoidance, or other intentionally bigoted actions. Sue and colleagues (2007) use the examples of calling an individual a racial epithet, giving White patrons preferential treatment, or the public display of racist symbolism (e.g., swastikas, confederate flags).

Microinsults differ from microassaults in that they are less overt forms of racism but are nevertheless patronizing. When employed, microinsults tend to imply that the individual of color is less qualified in talent or ability and/or that their presence in an institution is a result of meeting quotas pertaining to diversity. Microinvalidations are typically communicated to an individual as a form of gaslighting. Here, the person of color's interpretation of an experience as racist or with racist motifs is dismissed as preposterous. Sue and colleagues (2007) illustrated microinvalidations as statements that allude to an individual's oversensitivity or negate their racial-ethnic experiences.

In a sample of Black adults in two focus groups Sue, Capodilupo, and Holder (2008) reported that individuals spoke about their experience of racial microaggressions across the following domains: incident, perception, reaction, interpretation, and consequence. Incidents were described as verbal, nonverbal, and environmental situations with potentially racially derogatory undertones. The perception domain describes whether the incident was racially motivated. The reaction domain captures what the individual's immediate emotional and behavioral reaction to the incident is, if perceived as racially motivated. These reactions included paranoia, sanity checking, feeling empowered and validated for recognizing that the aggressor was at fault, and/or feeling pulled to take care of the aggressor. The interpretation domain describes how individuals give context to the incident. Themes that arose included that the person of color interpreted the incident to mean that they did not belong, that they were abnormal, intellectually inferior, untrustworthy, and/or that all Black people were the same. The consequences domain describes the psychological impact of the microaggression. Participants reported feeling powerless, invisible, a duality of identity that lacked authenticity, and a pressure to represent their racial group.

Another conceptualization of the impact of racial microaggressions on Black men—racial battle fatigue— incorporates emotional, behavioral, psychological, and physiological domains (Smith, 2004, 2008; Smith, Hung, & Franklin, 2011). Racial battle fatigue describes how dealing with racial microaggressions depletes the personal resources of Black men and thus can result in increased psychosocial stress, which in turn increases psychological, physiological, and behavioral responses. These include the mental health correlates, as well as physiological and psychological symptoms such as headaches, high blood pressure, insomnia, social withdrawal, stereotype threat, and John Henryism (Smith, Hung, & Franklin, 2011).

Assessing the mental health implications of microaggressions have so far been understudied. Because racial microaggressions are ambiguous in nature, their intentionality and interpretation are often called into question. Thus, researchers have treated racial microaggressions as a form of perceived stress that has been found to enhance psychopathology. For example, Torres, Driscoll, and Burrow (2010) found that the racial microaggression, "underestimation of personal ability," was positively associated with greater perceived stress, which was also positively associated with greater depressive symptoms, in a longitudinal study that assessed the influence of racial microaggressions on Black graduate and doctoral students. O'Keefe et al. (2014) found similar results. They found a positive association between experiences of racial microaggressions and suicidal ideation (O'Keefe et al., 2014). They also found that depressive symptoms explained the relationship between the various racial microaggressions and suicidal ideation in a sample of Native American, Black, Latino, and Asian American undergraduates. In a sample of Asian American and Latino adolescents, Huynh (2012) found that state anger, anxiety, and stress were positively associated with experiencing

racial microaggressions and helped explain their relation to depressive and other somatic symptoms.

Vicarious Experiences

Vicarious Racism Experiences

Vicarious racism describes the experiences of witnessing or hearing about an individual or group of individuals who share one's same racial-ethnic group being on the receiving end of a racist act (Harrell, 2000). There is a paucity of psychological literature about this topic and Black people. However, qualitative research has begun to explore the ways in which vicarious racism manifests and its impact on people of color. In one study that explored the frequency of vicarious experiences in a sample of Black women in Southern California, 48% of respondents reported knowing someone during their childhood who had been a target of racial prejudice, while 45% of respondents acknowledged that they knew someone during adulthood who had experienced an act of racism (Dominguez, Dunkel-Schetter, Glynn, Hobel, & Sandman, 2008). This trend was also noticed in an Asian American sample, where 99% of participants reported at least one vicarious racism experience in the last five years.

The health implications of vicarious racism are scarce and contradictory in the literature. Priest, Perry, Ferdinand, Paradies, and Kelaher (2014) found that vicarious racism was not associated with depressive symptoms or feelings of loneliness in a sample of racial-ethnic minority children in Australia. However, Hilmert et al. (2014) found that childhood vicarious racism experiences predicted lower birth weight among newborn children in Black women with increased diastolic blood pressure. One study explored how race-based rejection sensitivity and private regard impact the reactions of people to the murder of Trayvon Martin (Mason, Maduro, Hacker, Winstead, & Haywood, 2017). They found that for the Black people in their sample who are sensitive to or concerned about racial discrimination and who identify with their racial-ethnic

group were more likely to react strongly to vicarious racism experiences (Mason, Maduro, Hacker, Winstead, & Haywood, 2017). In another study that attempted to explore the impact of vicarious racism on a sample of doctoral students of color, Truong, Museus, and McGuire (2014) found that these doctoral students experienced vicarious racism in the forms of observed racism—hearing stories about and/or seeing racism directed at faculty and students—and trickle-down racism—observing or hearing about how structural racism impacts faculty and mentors of color. The authors found that the emotional impact on these students fell into two categories, normalization of racism as a part of the graduate school experience and experiences of racial resistance (Truong, Museus, & McGuire, 2014).

While the conceptualization, experience, and impact of vicarious racism remain understudied, these examples demonstrate that vicarious racism exists at the interpersonal, cultural, and institutional levels. Vicarious racism experiences also seem to be familiar forms of racism experiences to populations of color. Still the body of research pertaining to this domain is small, and the impact of vicarious racism experiences remains obscure.

Appropriated Racism Experiences

Appropriated Racial Oppression. Appropriated racial oppression goes by many names in the psychological and sociological literature, including "internalized racism," "internalized racial oppression," "racial self-hatred," "internalized White supremacy," and "self-stereotyping." All these euphemisms describe the phenomena of how oppressed persons internalize and accept identities forced on them by their oppressors (Pyke, 2010). It is not a phenomenon that is unique to race but can take place with a myriad of other hegemonic narratives (e.g., gender, class, sexual orientation). The term appropriated racial oppression is used in this text rather than internalized racial oppression to expand beyond the idea that an individual accepts these attitudes, beliefs, or

behaviors via learning or unconscious assimilation (Campón & Carter, 2010; Jones, 2000; Tappan, 2006).

Rather, this phenomenon is more complex. Pyke (2010) adamantly pointed out that appropriated racial oppression is not a cultural or biological character flaw due to ignorance, an inferiority complex, or another psychological defect. Nor is appropriated racial oppression a new idea, though it has recently made an appearance in psychological and sociological literature under this new moniker. For example, research about skin tone bias and a preference for a lighter skin tone in communities of color has been well documented in the psychological literature and is an example of appropriated racial oppression (Davis, 2005; Golden, 2008). The conceptualization of a colonial mentality (Fanon, 1963, 1967), or feelings of cultural inferiority as a result of a colonization history, has added to the literature about the psychological impact of internalizing a colonial mentality in West African and Filipino populations (David & Okazaki, 2006; Utsey, Abrams, Opare-Henaku, Bolden, & Williams, 2014). Research has also postulated about "defensive othering," that by demonstrating that negative stereotypes apply to the collective group one belongs to but is somehow not attributable to oneself, one can psychologically distance themselves from their own group and become a member of the dominant group (Schwalbe et al., 2000). Intra-ethnic othering is a form of appropriated racial oppression when discussing the value or devaluation of immigrant status (e.g., being "fresh off the boat") in Asian/Asian American populations (Poolokasingham, Spanierman, Kleiman, & Houshmand, 2014). In Black American populations, the term Oreo tends to be used by children and adolescents to describe Black people who are Black on the outside but who are "White" on the inside, typically meaning they behave or speak in a manner that is reminiscent of White-identifying people.

A unifying theme across these research domains is the buy-in by the individual engaging in appropriated racial oppression of the reductionist view of their racial-ethnic group. These individuals fail to recognize that heterogeneity exists in characteristics, beliefs, attitudes, behaviors, values, and identities that make up a member of their racial-ethnic group. Campón and Carter (2015) created a measure to capture this phenomenon. They defined appropriated racial oppression as "a process by which an individual's racial self-image is formed based on direct and indirect negative stereotypical messages communicated throughout one's life which, in turn influence the individual's self-image and worth, thoughts, emotions and behaviors" (Rangel, 2014). After reviewing the literature, they settled on five domains of appropriated racial oppression: negative stereotypes, patterns of thinking that maintain the status quo, adaptation of White American cultural standards, devaluation of one's own racial/ethnic group, and emotional reactions. Their model uses a US frame of reference of racial dynamics as they pertain to the influence of White supremacy in the lives of individuals of color.

The first dimension, appropriation of negative stereotypes, discusses how an individual may learn to believe in negative racial stereotypes from messages they have received from society, the media, family, friends, and other social environments. Appropriating these stereotypes may implicate feelings of inferiority. The second domain, patterns of thinking that maintain the status quo, describes the denial of racial discrimination and its consequences as existent. For example, these individuals may believe in systems of meritocracy or color-blind societies. The third dimension describes the conscious or unconscious adaptations of White cultural standards. For example, the appropriation of White beauty standards would be one way to adapt White cultural standards consciously or unconsciously. The fourth dimension, devaluation of one's racial-ethnic group, includes behaviors that purposefully exclude, avoid, or

mock people of your own racial-ethnic group. The last dimension, emotional reactions, describes feelings such as shame, anger, embarrassment, depression, and low self-esteem when thinking about one's own racial-ethnic membership or one's own racial-ethnic group.

The literature about this construct is extremely limited. While not exploring psychological correlates, Chae and colleagues (2010) found that appropriated racial oppression, in the form of negative racial group stereotypes, moderated the relationship between explicit discrimination experiences and cardiovascular health in Black American men. In this population, Black men who had experienced racial discrimination had worse cardiovascular health when they did not endorse appropriated racial oppression beliefs than those who did endorse appropriated racial oppression beliefs. However, they also found that Black men who claimed not to have experienced racial discrimination and endorsed appropriated racial oppression beliefs had worse cardiovascular health and the highest risk for cardiovascular disease (Chae, Lincoln, Adler, & Syme, 2010).

A minute amount of research considers the relationship between appropriated racial oppression and psychological well-being. Taylor and colleagues found a positive association between appropriated racial oppression and alcohol consumption and psychological distress (Taylor et al., 1990). Jones (2000) found that there was a main effect for appropriated racial oppression, or racial self-hatred identity attitudes, and racist stress events. Howard and Sommers (2017) examined how White religious iconography influenced Black people's intergroup and intragroup attitudes and pro-White attitudes. They found that exposure to images of a White Jesus led to a devaluation of their own racial-ethnic group. This study aimed to expand on the literature about appropriated racial oppression by learning how appropriated racial oppression is related to mental health symptoms.

Statement of Problem and Hypotheses

Prior research has yet to include the domains of vicarious and appropriated racism into a multidimensional statistical model of racism-related experiences. The psychiatric correlates of racism-related experiences are important to capture because of the implications of more strongly predicting the onset of disorder over and above stress (Cohen et al., 1995). It is the researcher's hope that, by adding to the conceptualization of racism-related experiences, the multidimensionality that Harrell (2000) and others described will be captured. This in turn will lead to a more accurate understanding of expressed mental health symptoms in Black populations by demonstrating how racism experiences can be predictive of other racism experiences as well as mental health outcomes.

The purpose of the present study is to examine the relations between direct, vicarious, and appropriated racism and mental health. The interplay of these domains has not been well captured in the literature. We will examine the predictive relations of racism experiences on anxiety, depression, and trauma symptoms. We will also examine the relations among racism experiences. Finally, we will propose our own multidimensional model of racism experiences and where appropriated racism experiences mediates the relation between direct and vicarious racism experiences and mental health correlates (see Figures 1–3). We hope to demonstrate that the internalization of direct and indirect racism experiences better explains the how racism experience impact mental health.

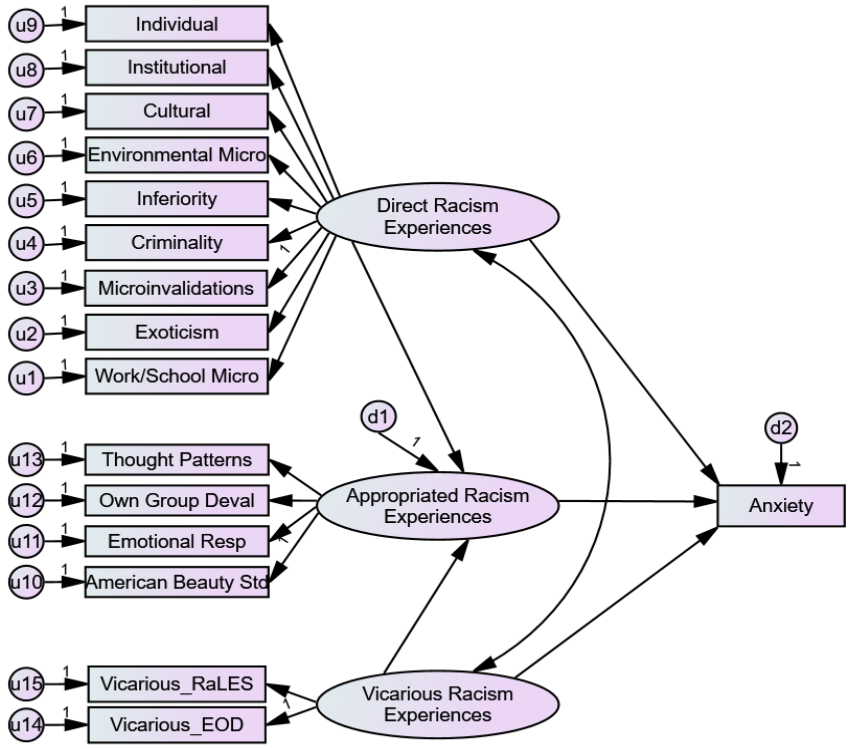
Hypotheses:

1) The first aim of this research was to develop a multidimensional model of racism-related experiences to be used as the measurement model. It was hypothesized that the model would yield robust pattern coefficients between each latent variable and its measured

indicators.

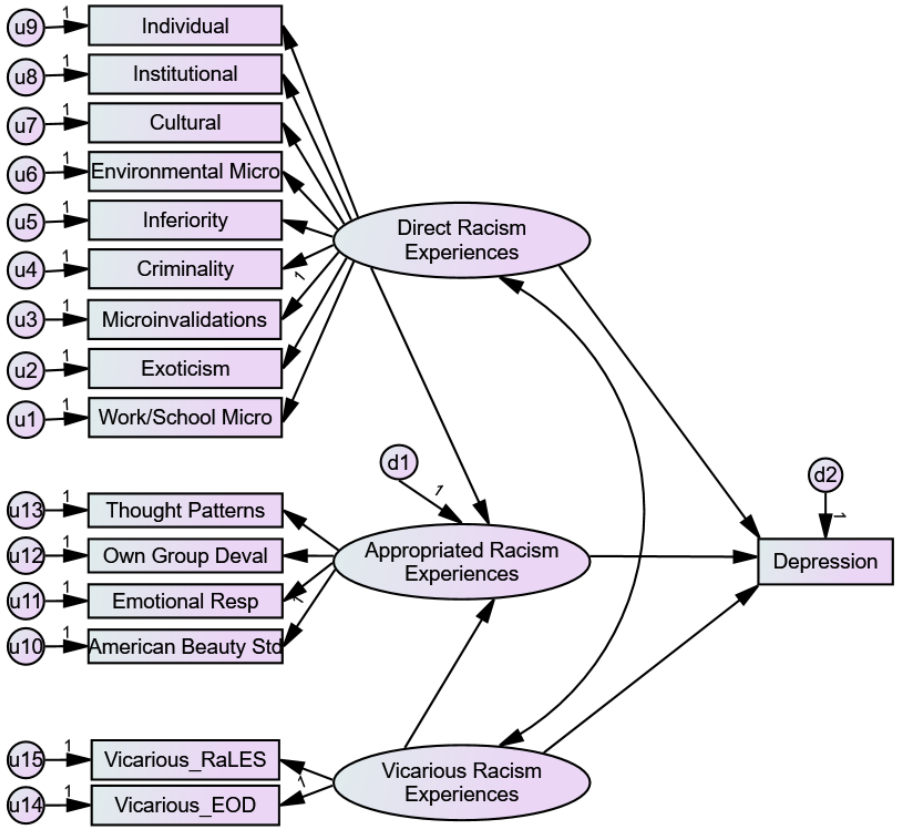
2) Direct, appropriated, and vicarious racism experiences will each directly and positively relate to anxiety, depression, and trauma symptoms.
3) Direct and vicarious racism experiences will be positively correlated.
4) Direct and vicarious racism experiences will each have a direct and positive effect on appropriated racism experiences.
5) Appropriated racism experiences will mediate the effects of vicarious racism on direct and vicarious racism experiences and mental health correlates such that
    a. Greater endorsement of direct racism experiences would predict an increase in anxiety, depression, or trauma symptoms via greater endorsement of appropriated racism experiences.
    b. Greater endorsement of vicarious racism experiences would predict an increase in appropriated racism experiences via greater endorsement of appropriated racism experiences.

Figure 1
Theoretical Structural Model Predicting Anxiety Symptoms



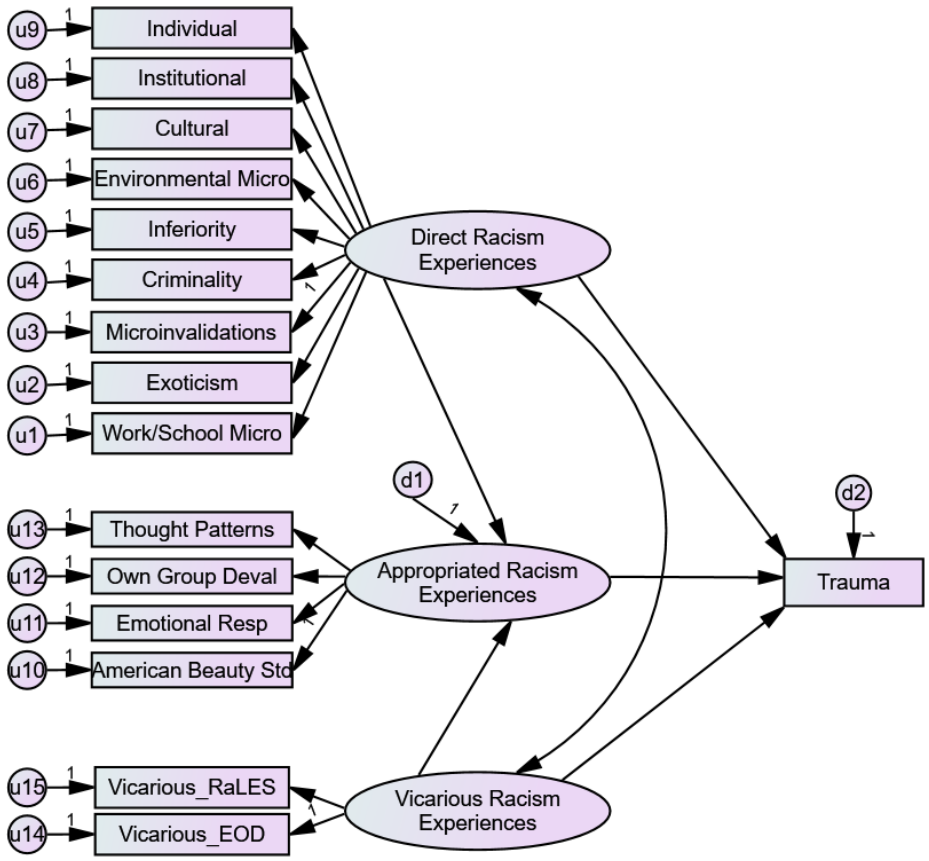
Note. This theoretical structural model predicts anxiety symptoms from direct, appropriated, and vicarious racism experiences with mediating effects of appropriated racism.

Figure 2
Theoretical Structural Model Predicting Depression Symptoms



Note. This theoretical structural model predicts depressive symptoms from direct, appropriated, and vicarious racism experiences with mediating effects of appropriated racism.

Figure 3
Theoretical Structural Model Predicting Trauma Symptoms



Note. This theoretical structural model predicts trauma symptoms from direct, appropriated, and vicarious racism experiences with mediating effects of appropriated racism.

Method

Participants

Participants were 229 Black women from a large Mid-Atlantic university and its surrounding communities. Overall, 355 participants responded to the online survey. However, 46 failed to meet the inclusion criteria which specified that all participants be 18 years of age or older and self-identify as Black (e.g., sub-Saharan African heritage). This identifier was inclusive of African Americans, Black Africans, Afro-Latinos, Afro-Caribbeans, and multiethnic Black-identifying individuals. Additionally, men (n=68), trans men (n=3), genderqueer/non-binary

individuals (n=2), and those missing gender (n=2) were excluded from the analyses because of too few observations to power multigroup analyses (Kline, 2005).

Demographic characteristics of the study sample are provided in Table 1. Of the 229 respondents, 188 identified their race as Black (82.1%) and 41 (17.9%) identified as multiracial—identifying as Black and one or more additional racial-ethnic categories. Respondents ranged in age from 18 to 66 years (M=24.98, SD =10.31). Respondents' countries of origins were diverse. Most respondents' origins were in the United States (59.9%). However, respondents whose origins were from the continent of Africa accounted for 17.9% of the sample population. Respondents with origins from Ethiopia (3.3%), Nigeria (3%), and Ghana (2.7%) were the most prevalent after respondents from the United States. Citizens of the United States made up 91.7% of respondents.

Table 1

Demographic Characteristics of Participants

Characteristic		n	%
Gender			
	Female	229	100.0
Race			
	Black	188	82.1
	Black, White	12	5.2
	Afro-Latina	8	3.5
	Black, Native American	5	2.2
	Black, Native American, White	4	1.8
	Black, North African	4	1.8

Black, Asian	1	0.4
Black, Asian, Latina	1	0.4
Black, Asian, Latina, Native American	1	0.4
Black, Asian, White	1	0.4
Black, Latina, White	1	0.4
Black, Middle Eastern	1	0.4
Black, Latina, Native American	1	0.4
Black, Other	1	0.4
Countries of Origin by Continent		
North America	225	67.8
Antigua	1	0.3
Barbados	1	0.3
Canada	1	0.3
Dominican Republic	1	0.3
El Salvador	1	0.3
Haiti	1	0.3
Honduras	2	0.6
Jamaica	4	1.2
Martinique	1	0.3
Mexico	1	0.3
Panama	3	0.9
Puerto Rico	4	1.2
St. Croix	1	0.3

St. Kitts & Nevis	2	0.6
St. Lucia	2	0.6
St. Vincent & the Grenadines	1	0.3
Trinidad & Tobago	3	0.9
United States of America	195	59.9
Africa	59	17.8
Cameroon	3	0.9
Cape Verde	1	0.3
Congo	1	0.3
Egypt	4	1.2
Eritrea	3	0.9
Ethiopia	11	3.3
Ghana	9	2.7
Ivory Coast	1	0.3
Kenya	1	0.3
Liberia	3	0.9
Libya	1	0.3
Mali	1	0.3
Nigeria	10	3.0
Senegal	1	0.3
Sierra Leone	1	0.3
Somalia	1	0.3
Sudan	4	1.2

Togo	2	0.6
Zambia	1	0.3
Europe	31	9.3
England	6	
Germany	7	
Ireland	9	
Italy	1	
Norway	1	
Poland	1	
Scotland	2	
Spain	1	
Sweden	1	
Wales	2	
South America	7	2.1
Colombia	1	
Guyana	5	
Peru	1	
Asia	5	1.5
China	1	0.3
India	1	0.3
Iran	1	0.3
The Philippines	1	0.3
Qatar	1	0.3

Education			
	Some college, no degree	118	51.5
	Bachelor's degree	38	16.6
	High school degree or equivalent	21	9.2
	Associate degree	17	7.4
	Master's degree	17	7.4
	Professional degree/doctorate	7	3.1
	Missing	11	4.8
US Citizen			
	Yes	210	91.7
	No	6	2.6
	Missing	13	5.7

Note: N = 229. Participants were able to select more than one country of origin on the demographic survey.

Procedure

Approval was obtained from the Institutional Review Board at Virginia Commonwealth University. Participants were recruited via email, course management, and the Division of Student Affairs. University participants could access the survey through SONA Systems Ltd. and via Qualtrics to complete the online survey. Participants who accessed the survey through VCU's SONA system received extra credit or course activity points for their participation. To recruit more Black men an oversampling strategy was employed due to historical low samples of Black men in the population. This additional recruitment took place via local community organizations a local newspaper, and social media. Before beginning the study, participants' informed consent

was collected, and they were informed of any possible risks and benefits of participation, as well as limits of confidentiality. Participants were also informed that they could discontinue the survey at any point. Participants were asked to complete the survey comprising measures assessing mental health and racism experiences. Measures were counterbalanced so that mental health was assessed prior to racism experiences to not bias participants' emotional state with questions about racism experiences. After completion, participants were debriefed and had the option to be redirected to a weblink to collect contact information to win one of three $45 e-gift cards. Study data and raffle participation were not linked and could not be paired.

Measures

Demographics. A demographic questionnaire preceded the survey questionnaire for all participants. The questionnaire included questions about gender, age, race, country of origin, and education.

Racial and Ethnic Microaggressions. The Racial and Ethnic Microaggressions Scale (REMS-Checklist; Nadal, 2011) measured the frequency of perceived experiences of racial microaggressions within the past 6 months. It is modeled after Sue's (2010) framework and uses a 5-point Likert-like response scale that ranges from 1 (I did not experience this event) to 5 (I experienced this event 7 times or more). The responses were then recoded into a dichotomous scoring system (e.g., 0 = I did not experience this event in the past 6 months and 1=I experienced this event at least once in the past 6 months), and the total score comprised the mean of each of subscale. The measure comprises six subscales. These include (1) Assumptions of Inferiority, (2) Second-Class Citizen and Assumption of Criminality, (3) Microinvalidation, (4) Exoticism/Assumptions of Similarity, (5) Environmental Microaggressions, and (6) Workplace and School Microaggressions. Example items include "Someone assumed that I would have a

lower education because of my race" or "My opinion was overlooked in a group discussion because of my race." Higher mean scores indicate greater frequency of perceived microaggressions. Prior research has demonstrated good reliability estimates with use of African American samples, with an alpha reliability coefficient of .92. This scale produced a Cronbach's alpha of .94 for this sample. Subscales had reliability coefficients of .88 for Assumptions of Inferiority, .81 for Second Class-Citizen and Assumption of Criminality, .87 for Microinvalidations, .71 for Environmental Microaggressions, .82 for Exoticization/Assumption of Similarity, and .79 for Workplace and School Microaggressions. All six subscales were included in the theoretical model as indicator variables of the Direct Racism Experiences latent variable.

Individual, Cultural, and Institutional Racism. The Index of Race-Related Stress–Brief Version (IRRS-B; Utsey, 1999) measured the racism-related stress experiences at the individual, cultural, and institutional levels. It is a 22-item measure that has a 5-point Likert-like response scale ranging from 0 (This never happened to me) to 4 (This event happened to me, and I was extremely upset). An example of an item from the Individual racism subscale is, "You have been threatened with physical violence by an individual or group of Whites." An example of an item on the Cultural Racism subscale is, "You seldom hear or read anything positive about Black people on radio, TV, newspapers, or in history books." An example of an item on the Institutional Racism subscale is, "While shopping at a store the salesclerk assumed you couldn't afford certain items" (i.e., you were directed toward the items on sale). Items from the subscales are summed. Reliability estimates for the individual, cultural, and institutional subscales are .84, .79, and .85, respectively. Directions were modified to assess only experiences that have happened to the respondent and not to others they may know. For this population, reliability

estimates were .78 for the individual racism subscale, .82 for the cultural racism subscale, and .73 for the institutional subscale.

Appropriated Racism. The Appropriated Racial Oppression Scale (AROS; Campón & Carter, 2015) is a 24-item and is measured on a 7-point Likert response scale ranging from 1 (strongly disagree) to 7 (strongly agree). The measure comprises four factors: Emotional Responses, American Standard of Beauty, Devaluation of Own Group, and Patterns of Thinking. Example items include "Although discrimination in America is real, it is definitely overplayed by some members of my race" and "I find persons with lighter skin-tones to be more attractive." Items are summed from each of the four subscales to obtain a total score, with higher scores indicating greater appropriated racism. Reliability estimates for the four scales are good: Emotional Responses (.83), American Standard of Beauty (.85), Devaluation of Own Group (.86), and Patterns of Thinking (.70). This scale produced a reliability coefficient of .89 for the total scale, .82 for Emotional Responses, .76 for American Standard of Beauty, .71 for Devaluation of Own Group, and .61 for Patterns of Thinking. All three subscales were included in the theoretical model as indicator variables of the Direct Racism Experiences latent variable.

Vicarious Racism Experiences. Dominguez, Dunkel-Schetter, Glynn, Hobel, and Sandman (2008) modified the Experiences of Discrimination Scale (EOD; Krieger, Naishadham, Hartman, & Barbeau, 2005) to measure perceived vicarious racism. Using the measurement strategy employed by Dominguez, Dunkel-Schetter, Glynn, Hobel, & Sandman (2008) participants are asked to report about close others who were unfairly treated in nine domains, including school, work, in public settings, and so forth. The nine-item measure requires that responses for each situation are coded dichotomously (yes= 1, no = 0), and points per participant are summed then divided by the number of significant others reported. The Krieger and

colleagues (2005) measure demonstrates good reliability and validity in the general population (.74) and has been demonstrated to be a valid instrument for Black American populations (Landrine, Klonoff, Corral, Fernandez, & Roesch, 2006). This scale produced a Cronbach's alpha of .63 for this sample.

Vicarious racism experiences were measured using a subscale of the Racism and Life Experiences Scales (RaLES: EXP-TYP/STR; Harrell, 1997). The 20-item subscale measures the frequency and stressfulness of direct, vicarious, and collective racism experiences. This research used the vicarious subscale and assessed only the frequency of such experiences in the past year. Items were rated on a 5-point Likert-like response scale ranging from 0 (never) to 4 (daily) with items such as, "Witnessing racial discrimination or prejudice directed toward someone else" or "Hearing about someone else's experience of discrimination or prejudice." Scores of the items are summed and averaged. The RaLES-TYP measure is based on Harrell's (2000) article on multiple dimensions of racism. Reliability estimate of the Vicarious subscale is .87. For this population, the subscale produced a Cronbach's alpha of .80

Depression. Depressive symptoms were measured using the Patient Health Questionnaire-9 (PHQ-9; Kroenke, Spitzer, & Williams, 2001). The PHQ-9 is a well-validated Diagnostic and Statistical Manual of Mental Disorders-IV (4th ed.) criterion-based measure for diagnosing depression. It is a nine-item measure scored on a response scale of 0 (not at all) to 3 (nearly every day). Respondents are asked to answer how often they've been bothered by problems, such as "little interest or pleasure in doing things" or "thoughts that you would be better off dead, or of hurting yourself." Item scores are summed for a total score. Total scores between 1 and 4 indicate minimal depression. Total scores between 5 and 9 indicate mild depression. Total scores between 10 and 14 indicate moderate depression. Total scores between

15 and 19 indicate moderately severe depression, and scores between 20 and 27 indicate severe depression. Internal consistency reliability of the PHQ-9 is .80 in African American populations, with a sensitivity and specificity of 88% for the diagnosis of depression. This scale produced a Cronbach's alpha of .89 for this sample.

Anxiety. Generalized anxiety symptoms were assessed using the Generalized Anxiety Disorder Scale-7 (GAD-7; Spitzer, Kroenke, Williams, & Lowe, 2006). The GAD-7 is a seven-item screening measure of generalized anxiety disorder symptom severity. It is scored on a response scale of 0 (not at all) to 3 (nearly every day). Respondents are asked questions about being bothered with such problems as "trouble relaxing" or "becoming easily annoyed and irritated." Item scores are summed for a total score. A total score between 0 and 4 indicates minimal anxiety. Total scores that fall between 5 and 9 indicate mild anxiety. Total scores that fall between 10 and 14 indicate moderate anxiety, while total scores that fall between 15 and 21 indicate severe anxiety. Internal reliability of the GAD-7 is .92 in the general population and .85 in African American populations. This scale produced a Cronbach's alpha of .92 for this sample.

Traumatic Stress. Traumatic stress symptoms will be assessed using the PTSD Symptom Checklist for the Diagnostic and Statistical Manual of Mental, Fifth Edition (DSM-5; PCL-5; Blevins, Weathers, Davis, Witte, & Domino, 2015). The PCL-5 is a 20-item measure that assesses traumatic stress according to DSM-5 criteria and when used in nonclinical populations only assesses Cluster B-Cluster E symptoms. These include intrusion symptoms, persistent avoidance, negative alterations in cognitions and mood, and increased arousal. Items are scored on a 5-point Likert-type scale ranging from 0 (not at all) to 4 (extremely). Items assess whether respondents have experienced symptoms in the past month, such as "How much were you bothered by having strong negative feelings such as fear, horror, anger, guilt, or shame?" Total

scores are summed with higher scores indicating more expressed traumatic stress. Internal reliability coefficients in the literature range from .94 to .95, and in Black populations have been found to be .95. This scale produced a Cronbach's alpha of .94 for this sample.

Results

Preliminary Analyses

Analyses were conducted using IBM SPSS 28.0 and AMOS 21.0 (Arbuckle, 2007). Before proceeding with the data analysis, all variables were screened for possible code and statistical assumption violations, as well as for missing values and outliers with IBS SPSS Frequencies, Explore, Plot, Missing Value Analysis and Regression procedures. The respondents were screened for missing values (on the structural model variables). Data were found to be MCAR. However, 22% of values were missing ranging from 10% to 26% per variable. Estimation Maximization was used to impute missing values at the item level for each subscale used for analysis. Scale scores were then calculated based on the imputed values. Standardized scores were assessed for univariate outliers, and those data points greater than +/– 3 standard deviations were and deleted listwise (Hair et al., 2010). The variables Devaluation of Own Group, Patterns of Thinking, and the Perceived Vicarious Racism were positively skewed and kurtotic and were transformed with a base-10 logarithm. Assumptions of homoscedasticity and homogeneity were also tested. Computing the Mahalanobis distance for each case on the continuous variables screened multivariate outliers. Still Mardia's test coefficient for each measurement model suggested that the variables were multivariate kurtotic despite the transformations ($m_{ij} > 2$, $p < .001$; Bentler, 2005). As a result, the models should be interpreted considering their potential to generate smaller path coefficients or worse fit statistics than might be expected with a more normal distribution.

Descriptive Analyses

Descriptive statistics, including means, standard deviations, and ranges for all continuous variables in the study, are included in Table 2, and bivariate correlations are presented in Table 3. Respondents endorsed above average exposure to cultural racism experiences (M=27.59, SD=8.50) than individual (M=10.06, SD=6.07) and institutional (M=9.57, SD=5.03) which were in the moderate range. Respondents also endorsed above average experiences of environmental microaggressions (M=0.66, SD=0.23), while other microaggressions experienced were in the moderate range. In the appropriated racism domain, emotional responses (negative feelings about one's racial group; M=18.04, SD=7.44) were endorsed more than the other appropriated racism experiences. Vicarious racism experiences, as measured by the RaLES (Harrell, 1997), indicated that respondents had monthly experiences of vicarious racism (M=1.99, SD=0.80), while the modified EOD indicated that on average each respondent knew someone who had experienced at least one racist situation (M=1.33, SD=1.46). Respondents endorsed mild anxiety (M=8.78, SD=5.86) and depressive symptoms (M=9.39, SD=6.13). Respondents endorsed subthreshold trauma symptoms (M=27.20, SD=16.65).

Table 2

Descriptive Statistics for Racism and Mental Health Variables

Variable	M	SD	Range
Age	24.98	10.31	18.00−66.00
Individual Racism	10.06	6.07	0.00−24.00
Cultural Racism	27.59	8.50	4.00−40.00
Institutional Racism	9.57	5.03	0.00−24.00
Assumptions of Inferiority	0.41	0.30	0.00−1.00

Second-Class Citizen and Assumptions of Criminality	0.35	0.27	00.0−1.00
Microinvalidations	0.48	0.30	0.00−1.00
Exoticism/Assumptions of Similarity	0.29	0.24	0.00−1.00
Environmental Microaggressions	0.66	0.23	0.00−1.00
Workplace and School Microaggressions	0.32	0.29	0.00−1.00
Patterns of Thinking	5.64	2.64	3.00−16.00
Devaluation of Own Group	11.76	4.39	8.00−30.00
Emotional Responses	18.04	7.44	7.00−39.00
American Standards of Beauty	11.83	5.15	6.00−28.00
Vicarious Racism (EOD)	1.33	1.46	0.00−6.60
Vicarious Racism (RaLES)	1.99	0.80	0.43−4.00
Anxiety	8.78	5.86	0.00−21.00
Depression	9.39	6.13	0.00−27.00
Trauma	27.20	16.65	0.00−76.00

Table 3

Correlations Among Racism Experiences and Mental Health Variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1. Anx	--																	
2. Dep	.77**	--																
3.Trauma	.79**	.81**	--															
4. Ind	.18**	.20**	.23**	--														
5. Cul	0.09	0.11	.15*	.55**	--													
6. Inst	.20**	.24**	.28**	.69**	.60**	--												
7. Infer	.25**	.29**	.30**	.46**	.31**	.39**	--											
8. Crim	.24**	.30**	.30**	.41**	.26**	.33**	.63**	--										
9.Mic.In	.19**	.28**	.25**	.22**	.28**	.22**	.58**	.45**	--									
10. Exot	.21**	.22**	.21**	.13*	0.08	.16*	.61**	.58**	.64**	--								
11. EMic	0.05	0.08	0.04	.14*	.19**	.19**	.32**	.28**	.32**	.34**	--							
12WMic	.22**	.24**	.25**	.38**	.28**	.35**	.71**	.54**	.37**	.40**	.30**	--						
13. ERes	.17*	.13*	.13*	-.18**	-0.13	-0.09	0.07	0.07	0.12	.19**	-.14*	0.05	--					
14.Beauty	0.01	0.01	-0.01	-.24**	-.27**	-.16*	0.06	0.04	.14*	.21**	-0.001	0.02	.57**	--				
15.Think	-0.06	-0.07	-0.08	-.20**	-.34**	-.27**	-0.002	0.01	-0.01	.15*	-0.00	-0.07	.40**	.52**	--			
16. Deval	.15*	.14*	.15*	-0.12	-.20**	0.01	.15*	.22**	0.10	.31**	0.03	.14*	.55**	.50**	.28**	--		
17.RaLES	.22**	.19**	.26**	.36**	.49**	.37**	.31**	.25**	.24**	.13*	0.04	.28**	-0.03	-.19**	-.32**	-0.06	--	
18. EOD	0.03	0.11	.13*	.17**	.21**	.23**	.14*	0.02	.29**	.20**	0.02	0.01	0.03	0.06	-0.06	0.03	.17*	--

Note. ** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the 0.05 level (2-tailed). Anx=Anxiety; Dep=Depression; Ind=Individual Racism; Cul= Cultural Racism; Inst=Institutional Racism; Crim=Assumption of Second-Class Citizen,

Criminality; Mic. In= Microinvalidations; Exot=Exoticism; EMic=Environmental Microaggressions; WMic= Workplace/School Microaggressions; Beauty = American Standards of Beauty; Think=Patterns of Thinking; Deval=Own Group Devaluation; RaLES = Vicarious Racism (RaLES); EOD=Vicarious Racism (EOD).

Fit Indices

The following criteria were selected to assess goodness of fit based on their status as the most used indices (Kenny, 2015). The goodness of fit index (GFI) is known as an absolute index and is based on simple variations on chi-square. The recommended cutoff for adequate fit is .90 (Byrne, 2016; Hu & Bentler, 1999). The Tucker-Lewis index (TLI) is considered a relative fit index meaning it compares the chi-square for the model tested to one from a so-called null model that specifies that all measured variables are uncorrelated. A comparative fit index (CFI; Bentler, 1990) is least resistant to changes in sample size and is commonly used to assess fit (Hooper et al., 2008). Both the TLI and the CFI use a conventional cutoff of .90 for establishing adequate fit (Byrne, 2016; Hu & Bentler, 1999). Lastly, a root mean square error of approximation (RMSEA) <.08 indicates good fit while an RMSEA $\leq$.10 indicates adequate fit (Myers et al., 2017). The RMSEA uses errors of prediction and measurement to assess the degree of match between the hypothesized and true models (Tabachnick, Fidell, & Ullman, 2007).

Measurement Models

For each structural model a measurement model was used to identify whether the hypothesized model fit the data appropriately. It was hypothesized that the model would yield robust pattern coefficients between each factor and its measured indicator (see Figures 4–6). The initial model proposed was evaluated without including any correlations between error variables. This lack of specification is an acknowledged oversimplification of the model because errors are frequently correlated (e.g., Browne & Moore, 2012; Kline, 2015), but it is usually difficult to determine at the outset the error correlations that need to be considered in configuring the original model.

Results from the initial model evaluation did not yield pattern coefficients relating all the

indicator variables to their latent variable. Environmental microaggressions (.381), vicarious racism (EOD, .10), and cultural racism (.365) did not adequately load onto their factors and were therefore not included in the final respecified measurement models, even after the model was modified to improve fit. Thus, the Vicarious Racism Experiences latent variable was removed from the analysis despite, the Vicarious subscale of the RaLES (Harrell, 1997) loading of. 84 (anxiety measurement model), .74 (depression measurement model), and .67 (trauma measurement model). Because of the Vicarious subscale of the RaLES high factor loadings as well as a desire to understand the unique role that vicarious racism plays on mental health; it was added to the final structural models as an exogenous variable.

An examination of the modification indices for each of the measurement models suggested that the addition of correlations between pairs of errors would improve model fit. The following error terms were correlated for theoretical reasons: e3 (associated with exoticism/assumption of similarity) and e4 (associated with microinvalidations); e3 and e5 (associated with second-class citizen and assumptions of criminality); e5 and e9 (associated with individual racism); e7 (associated with institutional racism) and e9; and e11 (associated with emotional responses) and e12 (associated with devaluation of own group). These pairs of correlated errors represent misspecified error covariances that are systematic rather than random measurement error. They derive from characteristics specific to the items. For example, all these correlated errors reflect subscales with items that overlap in content and thus reflects redundancy or an untapped third factor.

Figure 4
Hypothesized Measurement Model, Anxiety

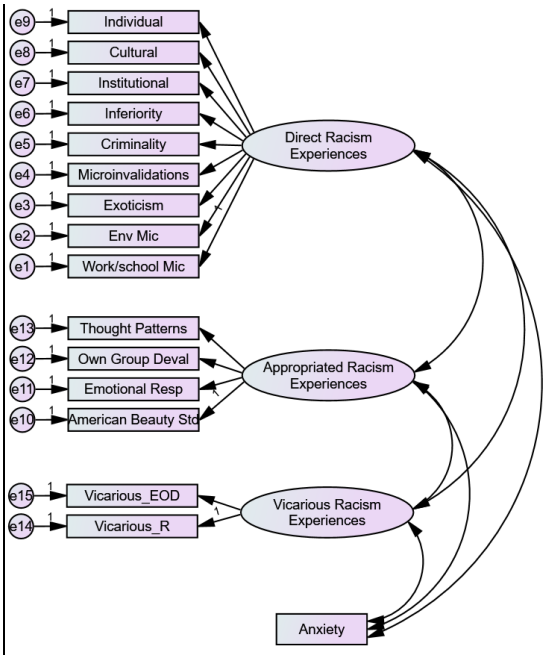


Figure 5
Hypothesized Measurement Model, Depression

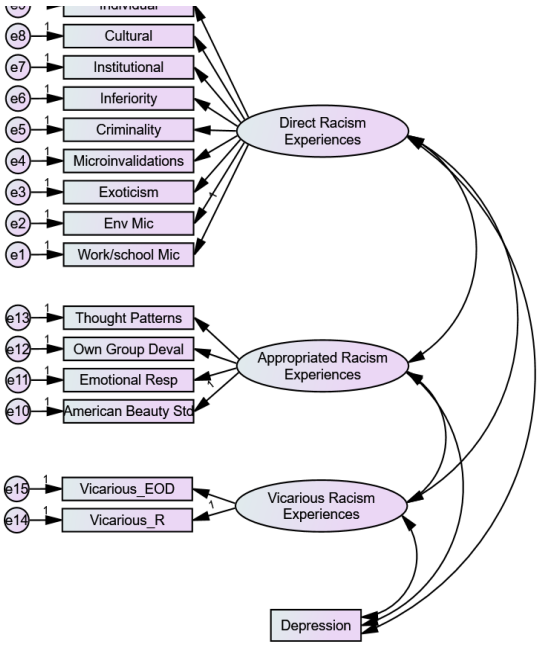
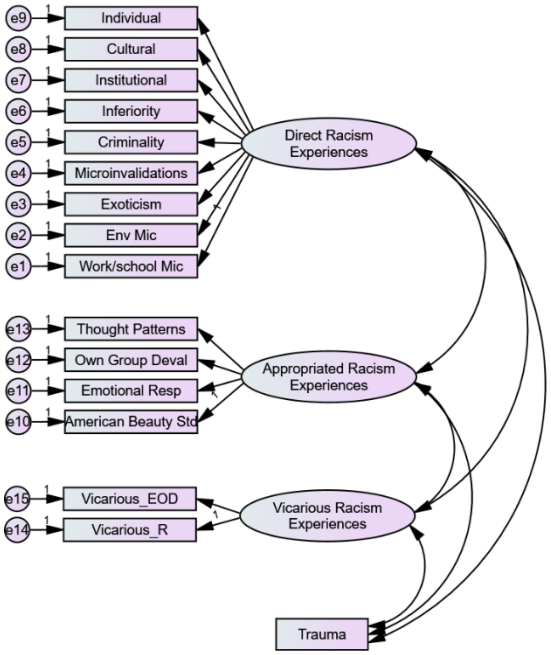


Figure 6
Hypothesized Measurement Model, Trauma



Anxiety Structural Model

A two-step structural equation modeling strategy was used. This strategy involves the separate estimation of the measurement model prior to the simultaneous estimation of the measurement and structural models. The measurement model in conjunction with the structural model enables a comprehensive assessment of the full latent model. The model as configured appeared to represent an adequate fit to the data. Although the chi-square test was statistically significant 121 (47, N=229), p<.001 this may be due to the sample size and not an indication that the model failed to fit the data. The GFI (.916), TLI (.905), CFI (.932), and RMSEA (.083) were in the adequate range after the model was respecified—making the aforementioned changes of correlating the error terms and removing the Vicarious Racism Experiences latent variable, the cultural racism subscale, and the environmental microaggressions subscale. Table 4 shows the fit indices for the respecified measurement model. Ultimately, the final model yielded coefficients relating the latent variables with their indicator variables that were reasonably robust, ranging from .42 to .95, and all were statistically significant (p<.001; see Figure 7). Statistically significant associations were present between direct racism experiences and anxiety (r=.28, p<.001). However, no significant relationships existed between direct racism experiences and appropriated racism experiences (r=.09, p=.26) or appropriated racism experiences and anxiety (r=.06, p=.41).

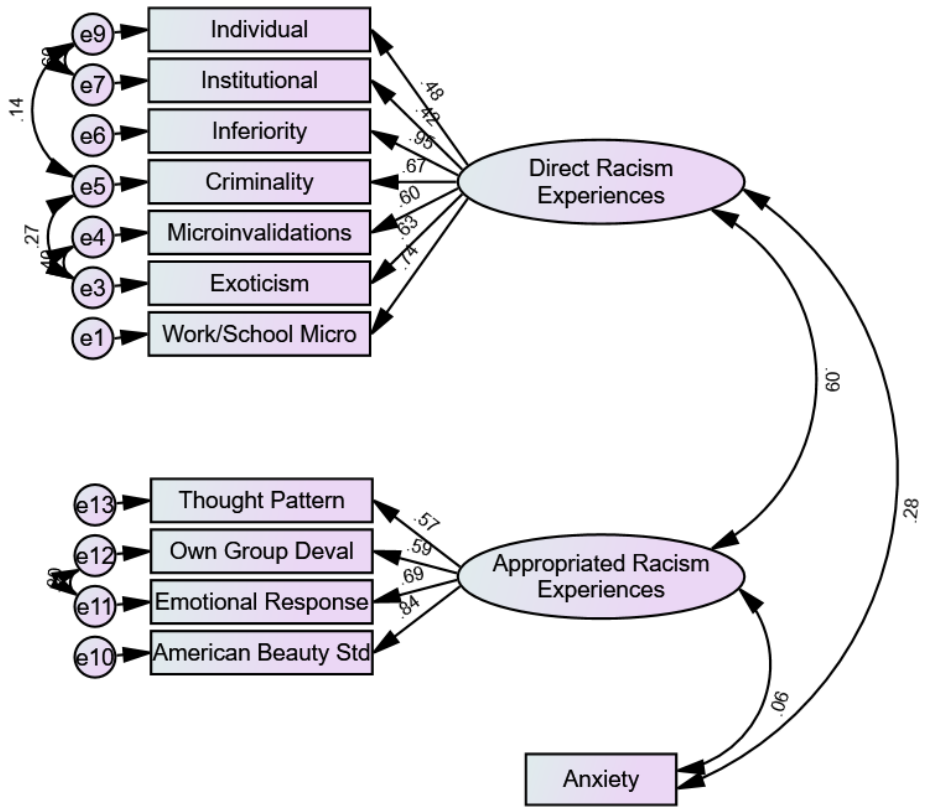
Table 4

Fit Indices of Anxiety Measurement Models 1–9

Fit Index	CFA 1	CFA 2	CFA 3	CFA 4	CFA 5	CFA 6	CFA 7	CFA 8	CFA 9
GFI	.754	.764	.823	.872	.894	.901	.907	.915	.916
TLI	.648	.661	.752	.837	.871	.884	.895	.899	.905
CFI	.709	.721	.798	.871	.900	.911	.922	.931	.932
RMSEA	.135	.145	.124	.102	.091	.086	.088	.086	.083

Note. GFI = Goodness of Fit Index; TLI = Tucker-Lewis Index; CFI = Comparative Fit Index; RMSEA= Root Mean Square Error of Approximation.

Figure 7
Respecified Measurement Model, Anxiety



Note. Measurement model for the model containing direct racism experiences, appropriated racism experiences, and anxiety. Criminality=Assumption of Second-Class Citizen, Criminality; Work/School Micro= Workplace/School Microaggressions; Beauty = American Standards of Beauty; Thought Patterns=Patterns of Thinking; Own Group Deval=Own Group Devaluation.

The first full SEM including the structural model explained 10.3% of the variance in anxiety and 7.9% of the variance in appropriated racism experiences. Within this model a greater endorsement of direct racism experiences (β =.23, p=.003) and vicarious racism (β=.15, p=.03)

were both uniquely associated with anxiety symptoms. However, appropriated racism was not (β=.07, p=.34). The effect of direct racism experiences on appropriated racism experiences (β =.19, p=.03) was statistically significant as was the direct effect of vicarious racism on appropriated racism experiences (β=−.29, p<.001). Finally, the correlation between direct racism experiences and vicarious racism experiences was statistically significant (r=.35, p<.001). The fit indices for this model (Table 5) suggested adequate fit, although the RMSEA indicated slightly less than adequate fit.

The final SEM (see Figure 8) freed up the least statistically significant path from the first model—appropriated racism experiences to anxiety symptoms. The standardized path loadings and correlation remained the same except for the loading of vicarious racism to anxiety symptoms (β=.13, p=.05). The fit indices for the second model were like the first and suggested adequate fit (see Table 5). All path loadings were statistically significant as well, suggesting retention of the second model. The final model still explained 10.3% of the variance in anxiety symptoms and 7.9% of the variance in appropriated racism experiences.

This second model partially supported the hypothesis that direct, appropriated, and vicarious racism experiences would be directly and positively associated to anxiety. While direct racism experiences and the vicarious racism indicator were positively associated to anxiety symptoms, appropriated racism experiences were not. The hypothesis that direct and vicarious racism experiences would be positively correlated was supported. The hypothesis that direct and vicarious racism experiences would have a direct and positive effect on appropriated racism was not supported. While direct racism experiences were positively associated to appropriated racism experiences, vicarious racism had an inverse association to appropriated racism. The SEM did not support the appropriated racism hypothesized mediation pathway. Bootstrapping analyses

with 2,000 samples confirmed the absence of a significant mediation pathway, with a point estimate of .093 and 95% CI of -.120 to .296.

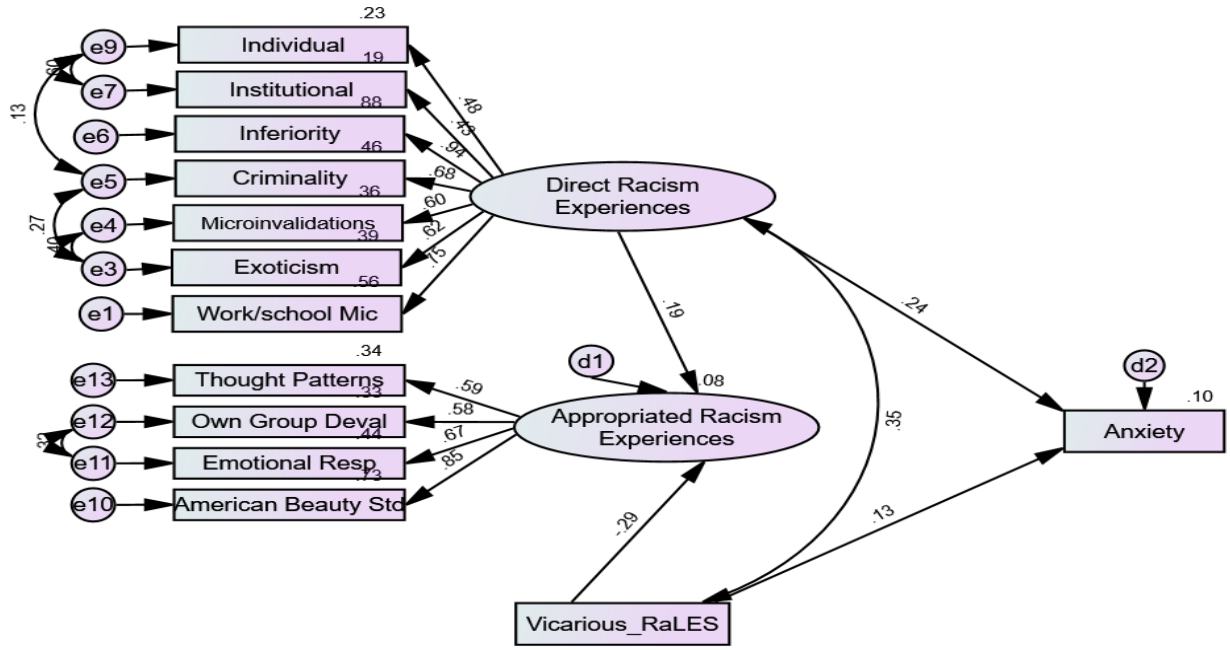
Table 5

Fit Indices of SEMS 1 and 2, Anxiety

Fit Index	SEM 1	SEM 2
GFI	0.906	0.905
TLI	0.888	0.890
CFI	0.920	0.920
RMSEA	0.085	0.084

Note. GFI = Goodness of Fit Index; TLI = Tucker-Lewis Index; CFI = Comparative Fit Index; RMSEA= Root Mean Square Error of Approximation.

Figure 8
Respecified Structural Model: Racism Experiences and Anxiety

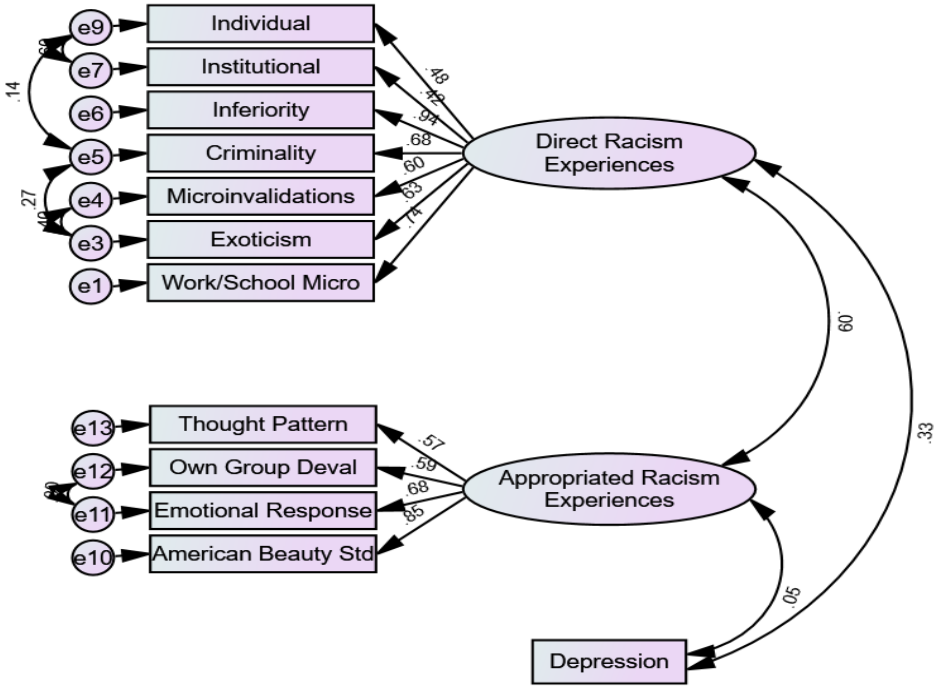


Note. Criminality=Assumption of Second-Class Citizen, Criminality; Work/School Micro= Workplace/School Microaggressions; Beauty = American Standards of Beauty; Thought Patterns=Patterns of Thinking; Own Group Deval=Own Group Devaluation.

Depression Structural Model

Again, a two-step structural equation modeling strategy was used involving the separate estimation of the measurement model prior to the simultaneous estimation of the measurement and structural models. The model as configured appeared to represent an adequate fit to the data. Although the chi-square test was statistically significant, 123.69 (47, N=229), $p<.001$, this may be due to the sample size and not an indication that the model failed to fit the data. The GFI (.914), TLI (.903), CFI (.931), and RMSEA (.085) were in the adequate range after the model was respecified. Ultimately, the final model yielded coefficients relating the latent variables with their indicator variables that were reasonably robust, ranging from .42 to .94, and all were statistically significant ($p<.001$; see Figure 9). Statistically significant associations were present between direct racism experiences and depression ($r=.33$, $p<.001$). However, no statistically significant relationships existed between direct racism experiences and appropriated racism experiences ($r=.09$, $p=.27$) or appropriated racism experiences and depression ($r=.05$ $p=.52$).

Figure 9
Respecified Measurement Model, Depression



Note. Measurement model for the model containing direct racism experiences, appropriated racism experiences, and depression. Criminality=Assumption of Second-Class Citizen, Criminality; Work/School Micro= Workplace/School Microaggressions; Beauty = American Standards of Beauty; Thought Patterns=Patterns of Thinking; Own Group Deval=Own Group Devaluation.

The first full SEM including the structural model explained 12.3% of the variance in depression. Within this model a greater endorsement of direct racism experiences (β =.30, p<.001) was uniquely associated with depression symptoms. However, appropriated racism experiences (β=.04, p=.59) and vicarious racism (β=.09, p=.19) were not. The direct effect of direct experiences of racism on appropriated experiences of racism (β =.19, p=.03) was statistically significant as was the direct effect of vicarious racism on appropriated racism

experiences (β=−.29, p<.001). Finally, the correlation between direct racism experiences and vicarious racism experiences was statistically significant (r=.35, p<.001). The fit indices for this model (Table 6) suggests adequate fit, although the RMSEA indicates slightly less than adequate fit.

The second SEM freed up the least statistically significant path from the first model between appropriated racism experiences and depression symptoms. The standardized path loadings and correlations all remained the same, except for the loading of vicarious racism to depression symptoms though it remained not statistically significant. This path was removed next. The third and final SEM (see Figure 10) freed up the least statistically significant path from the second model—vicarious racism experiences to depression symptoms. The standardized path loadings and correlation remained the same except for the correlation between direct and vicarious racism (r=.36, <.001). The fit indices for the third model were like the first and second and still suggested adequate fit (see Table 6). All path loadings were statistically significant as well suggesting retention of the third model. The model explained 11.9% of the variance in depression symptoms and 8.0% of the variance in appropriated racism experiences.

This third model did not support the hypothesis that direct, appropriated, and vicarious racism experiences would be directly and positively associated to depression symptoms. While direct racism experiences were positively associated to depression symptoms, vicarious racism and appropriated racism experiences were not. The hypothesis that direct and vicarious racism experiences would be positively correlated was supported. The hypothesis that direct and vicarious racism experiences would have a direct and positive effect on appropriated racism was not supported. While direct racism experiences were positively associated to appropriated racism experiences, vicarious racism had an inverse association to appropriated racism. The SEM did

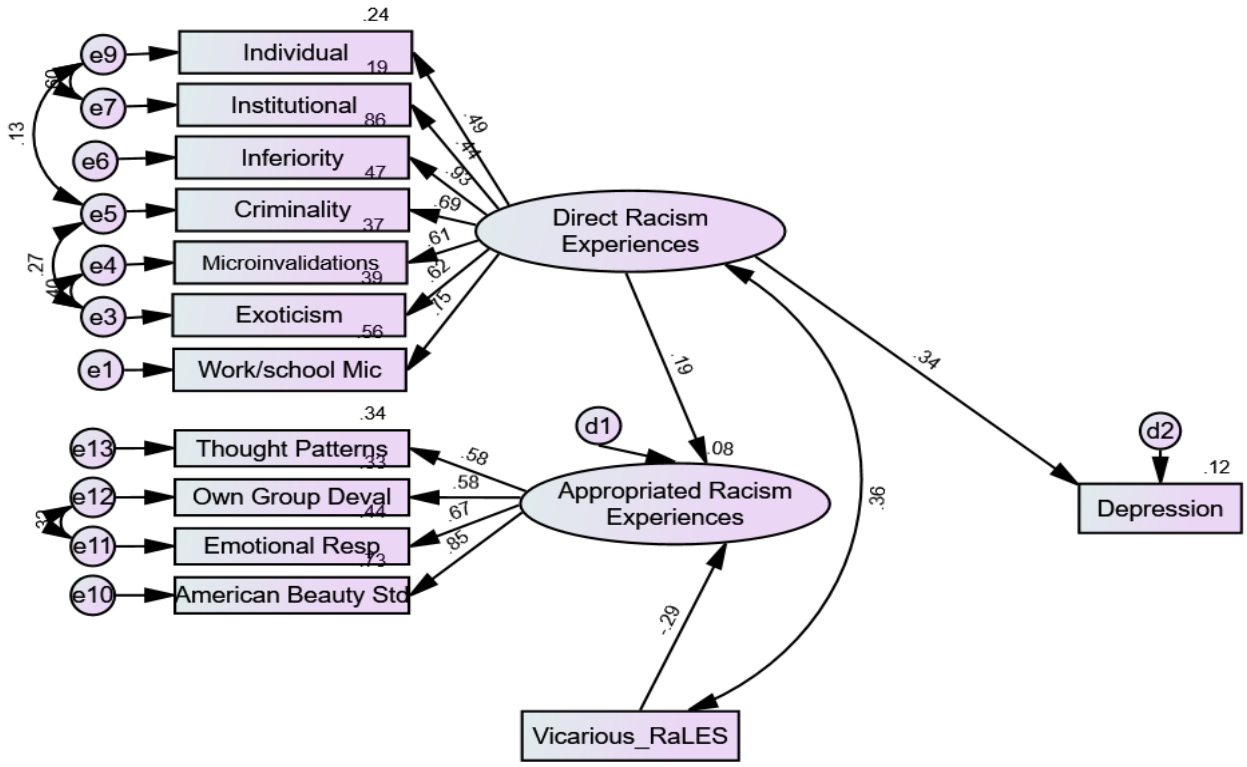
not support the appropriated racism hypothesized mediation pathway. Bootstrapping analyses with 2,000 samples confirmed the absence of a significant mediation pathway, with a point estimate of .056 and 95% CI of −.197 to .317.

Table 6

Fit Indices of SEMS 1–3, Depression

Fit Index	SEM 1	SEM 2	SEM 3
GFI	0.904	0.901	0.901
TLI	0.885	0.886	0.889
CFI	0.917	0.917	0.917
RMSEA	0.087	0.086	0.085

Figure 10
Respecified Structural Model: Racism Experiences and Depression



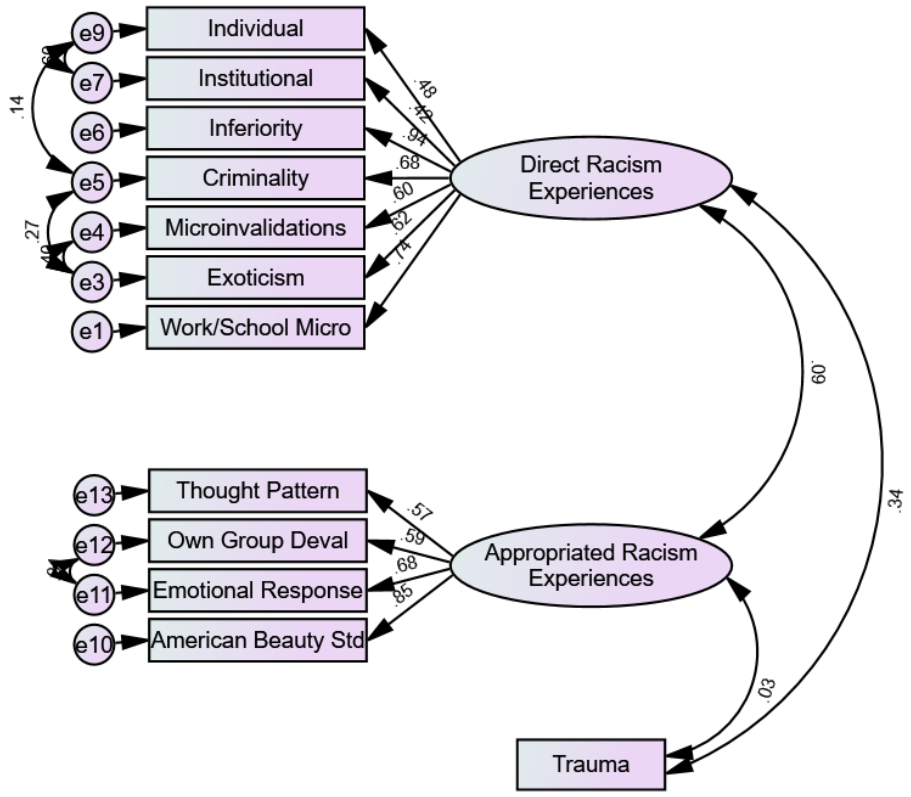
Note. Criminality=Assumption of Second-Class Citizen, Criminality; Work/School Micro=

Workplace/School Microaggressions; Beauty = American Standards of Beauty; Thought Patterns=Patterns of Thinking; Own Group Deval=Own Group Devaluation.

Trauma Structural Model

A two-step structural equation modeling strategy was used involving the separate estimation of the measurement model prior to the simultaneous estimation of the measurement and structural models. The model as configured appeared to represent an adequate fit to the data. Although the chi-square test was statistically significant, 125.71 (47, N=229), $p<.001$, this may be due to the sample size and not an indication that the model failed to fit the data. The GFI (.912), TLI (.90), CFI (.929), and RMSEA (.086) were in the adequate range after the model was respecified. Ultimately, the final model yielded coefficients relating the latent variables with their indicator variables that were reasonably robust, ranging from .42 to .94, and all were statistically significant ($p<.001$; see Figure 11). Statistically significant associations were present between direct racism experiences and trauma ($r=.34$, $p<.001$). However, no statistically significant relationships existed between direct racism experiences and appropriated racism experiences ($r=.09$, $p=.27$) or appropriated racism experiences and trauma ($r=.05$ $p=.38$).

Figure 11
Respecified Measurement Model, Trauma



Note. Measurement model for the model containing direct racism experiences, appropriated racism experiences, and trauma. Criminality=Assumption of Second-Class Citizen, Criminality; Work/School Micro= Workplace/School Microaggressions; Beauty = American Standards of Beauty; Thought Patterns=Patterns of Thinking; Own Group Deval=Own Group Devaluation.

The first full SEM including the structural model explained 13.9% of the variance in trauma symptoms. Within this model both greater endorsement of direct racism experiences (β =.28, p=.03) and an increased frequency of vicarious racism (β=.17, p=.02) were uniquely associated with trauma symptoms. However, appropriated racism experiences (β=.04, p=.59) were not. The direct effect of direct experiences of racism on appropriated experiences of racism

(β =.19, p=.03) was statistically significant as was the direct effect of vicarious racism on appropriated racism experiences (β=−.29, p<.001). Finally, the correlation between direct racism experiences and vicarious racism experiences was statistically significant (r=.35, p<.001). The fit indices for this model (Table 7) suggested adequate fit, although the RMSEA indicated slightly less than adequate fit.

The second and final SEM (see Figure 12) freed up the least statistically significant path from the second model—appropriated racism experiences to trauma symptoms. The standardized path loadings and correlation remained the same. The fit indices for the second model were like the first and still suggested adequate fit (see Table 7). All path loadings were statistically significant as well as suggesting retention of the second model. The model explained 13.8% of the variance in trauma symptoms and 8.0% of the variance in appropriated racism experiences.

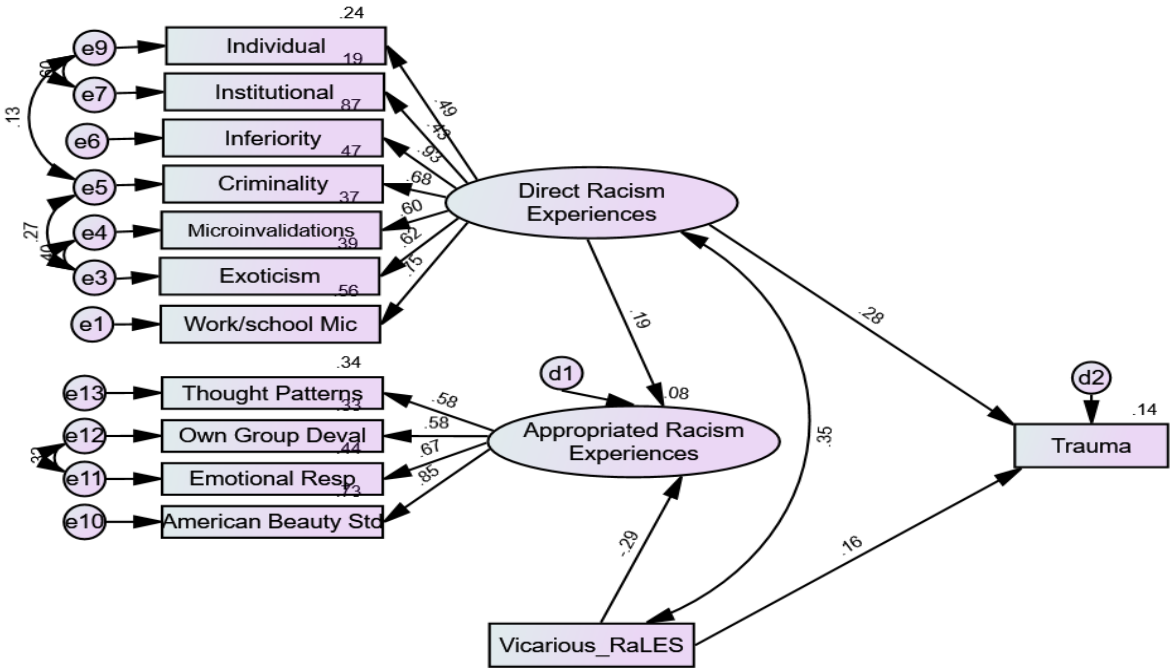
This second model did not support the hypothesis that direct, appropriated, and vicarious racism experiences would be directly and positively associated to trauma symptoms. While direct racism experiences and vicarious racism were positively associated to trauma symptoms, appropriated racism experiences were not. The hypothesis that direct and vicarious racism experiences would be positively correlated was supported. The hypothesis that direct and vicarious racism experiences would have a direct and positive effect on appropriated racism was not supported. While direct racism experiences was positively associated to appropriated racism experiences, vicarious racism had an inverse association to appropriated racism. The SEM did not support the appropriated racism hypothesized mediation pathway. Bootstrapping analyses with 2,000 samples confirmed the absence of a significant mediation pathway, with a point estimate of .056 and 95% CI of −.197 to .317.

Table 7

Fit Indices of SEMS 1 and 2, Trauma

Fit Index	SEM 1	SEM 2
GFI	0.904	0.904
TLI	0.886	0.889
CFI	0.918	0.919
RMSEA	0.087	0.086

Figure 12
Respecified Structural Model: Racism Experiences and Trauma



Note. Criminality=Assumption of Second-Class Citizen, Criminality; Work/School Micro= Workplace/School Microaggressions; Beauty = American Standards of Beauty; Thought Patterns=Patterns of Thinking; Own Group Deval=Own Group Devaluation.

Discussion

The current study aimed to add to the literature about existing models of racism-related experiences by creating an explanatory model that would operationalize direct, vicarious, and appropriated racism experiences. This study explored how these domains were associated and their impact on mental health variables. Finally, appropriated racism experiences were tested as a potential mediator of the relations between direct and vicarious racism experiences and mental health outcomes.

Mental Health Outcomes

Direct Racism Experiences and Mental Health Outcomes

Direct racism experiences, represented by subscales pertaining to individual racism, institutional racism, and racial microaggressions (Assumptions of Criminality, Assumptions of Inferiority, Microinvalidations, Exoticism, and Workplace/School Microaggressions) was positively associated to all mental health outcomes. These findings are well supported in the literature that links direct racism experiences and psychological distress for Black people, and for Black women specifically (Lewis, Williams, Peppers, & Gadson, 2017; Lewis & Neville, 2015; Thomas, Witherspoon, & Speight, 2008). Our data specifically highlight greater endorsement of environmental microaggressions (not included in the final structural models), microinvalidations, and assumptions of inferiority as informative of the salient types of direct racism our population has experienced and supports research about the gendered-racism distress link (Moody & Lewis, 2019; Syzmanskil & Lewis, 2016; Thomas et al., 2008). Intersectional theory would posit that these themes are salient due to the additive effects of racial and gender oppression. Examples of gendered racial microaggressions found in the literature that corroborates our results include the domain of silencing/invizibilizing and marginalizing Black women in workspaces (Lewis,

Mendenhall, Harwood, & Browne-Huntt, 2013), and believing Black women to be less intellectually capable than White people (Robinson-Wood et al., 2015).

These results are significant in that they show the deleterious impact that even so-called subtle forms of direct racism can have on Black women's mental health. Psychological literature has demonstrated that gendered racial microaggressions are positively associated with traumatic stress symptoms (Moody & Lewis, 2019). Our findings corroborate this research.

Vicarious Racism and Mental Health. Vicarious racism was predictive of anxiety and trauma symptoms. While these results seem logical, there is little corroborating evidence in the literature. While Harrell (1997) found that vicarious racism was correlated with perceived stress and non-specific psychological symptomatology, literature quantifying the relationship between vicarious racism and mental health outcomes is scarce, and thus novel to this study. We have identified that indirect racism experiences are personally impactful and trigger psychological reactions. These results may implicate the role of racial identity—namely racial centrality, public regard, and private regard and a collectivist identity. We did not find a predictive relationship between vicarious racism and depression symptoms. This outcome is corroborated in research that focused on a youth population (Priest, Perry, Ferdinand, Paradies, & Kelaher, 2014). Despite this similarity, it is more likely due to systematic differences in how the construct was measured. Vicarious racism measures vary greatly in the literature and are often based on interviews. For our study, the lack of an association with depressive symptoms is remarkable. It can be hypothesized that perhaps the associations to anxiety and trauma indicate an overlap in symptoms, such that that the trauma symptoms endorsed are more anxiety-presenting (e.g., intrusive symptoms, avoidance symptoms, distorted cognitions and mood).

Appropriated Racism and Mental Health. Appropriated racism was not associated with

anxiety, depression, or trauma symptoms. The AROS (Campon & Carter, 2015) subscales were used as indicators of the appropriated racism experiences latent variable. While predictive validity for depression and anxiety in people of color was established during the AROS's scale development and validation, it was absent in our study. This could be due to several factors. For example, our sample comprises only Black women, whereas the AROS was normed on a multiracial group of people of all genders. The mean age of the population that the AROS was normed on was 35, ten years older than the population of this study. Perhaps discrepancies in results reflect a difference in the impact of development—emerging adulthood v. adulthood.

Psychological literature may indicate that the AROS (Campon & Carter, 2015) did not account for how appropriated oppression manifests in Black women. For example, the subscale Devaluation of One's Own Group was the most elevated of all the subscales—the rest were mildly elevated—and was the only domain of appropriated racism that was correlated with anxiety, depression, and trauma symptoms. James (2020) reported that applying measures of appropriated racism to multiple groups is problematic because the content and correlates of racialized experiences vary. He also argued that measures of appropriated racism ought to examine the intersectionality for same race groups. A measure of appropriated racism that examines the intersection of gender and appropriated racism perhaps more accurately captures the domain for Black women (Thomas, Witherspoon, & Speight, 2004). David, Schroder, and Hernandez (2019) posit that because of the diversity of appropriated racism experiences, quantitative measures do not capture the nuances of the domain as evidenced by quantitative results not statistically related to mental health variables when qualitative studies indicate the association.

Perhaps this is the case for our sample. The domain, Devaluation of Own Group, which

was positively associated with mental health outcomes describes feelings of uselessness, depression, and shame about racial group membership. It also reflects a desire to give up racial group membership in exchange for Whiteness. This is the only subscale of the AROS (Campon & Carter, 2015) which queries specifically about feelings. This may explain its positive association to mental health variables. Perhaps a qualitative study would have better captured a more intersectional and more specific domain of appropriated racism for Black women.

As a result of the lack of association with this factor and the mental health outcomes variables, the mediation role of appropriated racism in the relationship between direct racism experiences and vicarious racism and mental health outcomes was nonsignificant. Thus, the hypothesized model of racism-related experiences and mental health variables was not supported. However, just because this path model was not relevant for this particular study, does not render it useless. Perhaps with improved methodological tools this relationship could be better examined.

Direct Racism Experiences, Vicarious Racism, and Appropriated Racism Relationships

Direct racism experiences were positively associated to the appropriated racism experiences' latent variable and positively correlated to the exogenous vicarious racism variable in all three models. The positive association between direct racism experiences and appropriated racism experiences demonstrates the process by which the phenomenon of appropriated racism transpires. Appropriated racism is the internalization of a White supremacist ideology that in turn negatively impacts how an individual identifies with their race. Experiences of direct racism—personal exposure to acts of White supremacy or anti-Blackness—could harmfully influence one's understanding of their own racial identity. Our results reflect what is in the psychological literature, that people who experience more racism also tend to have higher levels of

appropriated racism (David & Okazaki, 2006b; Graham, West, Martinez, & Roemer, 2016).

The weak positive correlation between the direct racism experiences' latent variable and the vicarious measure indicates a linear relationship, such that a greater endorsement of direct racism experiences (e.g., microaggressions, institutional, individual) is related to the higher frequency of vicarious racism experiences. This relationship legitimizes that vicarious racism experiences are a distinct domain from direct racism experiences, in so much that this form of racism is experienced indirectly but still encompasses similar domains to direct racism experiences (e.g., occurring at individual, cultural, institution levels).

Vicarious racism was negatively related to appropriated racism experiences in all three models, such that more frequent vicarious racism experiences were associated with less appropriated racism, and the reciprocal. Thus, a respondent was more likely to endorse greater appropriated racism when they were infrequently exposed to other's racist experiences or less likely to endorse appropriated racism when they were more frequently exposed to others' racist experience. This finding is novel and does not exist in the psychological literature as far as can be ascertained. This result may indicate that there is a mediating or moderating effect not captured in the model that protects an individual from internalizing racism experiences that do not directly happen to them or enhances internalized racism experiences instead. Such possible constructs could be racial identity saliency and/or social support. Maduro et al. (2017) found that individuals who are sensitive to and concerned about racial discrimination and who also strongly identify with their racial group had stronger negative reactions (e.g., anxiety, depression, and hostility) to vicarious experiences of racism. The authors found that this relation was partially explained by repetitive worrisome thoughts about racist incidents happening to close others, labeled thought intrusions. Perhaps the negative association between vicarious racism and

appropriated racism in our study highlights this finding. Thought intrusions about the safety of others may be so disruptive to daily living that there is less emphasis on the self.

Perhaps personal threat may be a factor as well. An individual may perceive themselves as more capable of avoiding or managing a racist experience than a close other. They may believe that another's personal threat is greater than their own when facing such experiences. This can be corroborated by the role Black women play in the protection of other Black people of various intersecting identities. Black women have been at the forefront of racial justice movements often seeking racial equity and justice on behalf of many underrepresented groups (Roummell & James-Galloway, 2021). On a more personal level, Black women have continuously voiced concerns about being able to maintain the safety of their fathers, sons, brothers, and other important Black males in their lives (Dormire, Gary, Norman & Harvey, 2021). Racial saliency, thought intrusions, perceived personal threat, and gender roles, are all factors that could influence a negative relationship between vicarious racism and appropriated racism, and ought to be explored further.

Strengths

To our knowledge, this is the first study that seeks to examine the pathways of influence for direct, vicarious, and appropriated racism experiences and mental health outcomes. Despite considerable literature about direct racism experiences, there is very little quantitative data about the domains of vicarious racism and appropriated racism, and how these experiences impact the mental health of Black people using psychological correlates consistent with psychiatric symptoms rather than quality of life variables. In addition, our study attempted to examine the distinct mediation pathway of appropriated racism in relationship with other types of racism experiences and mental health outcomes. Despite lack of evidence to support the mediation

analyses, our findings provide insight into how different racism experiences influence and predict one another, as well as mental health symptomatology. This study also inadvertently only assessed Black women and provided a more nuanced understanding of racial-ethnic background of the participants than is observed in many quantitative studies. A Black women–only sample also highlighted the ways in which certain measures were reflective, or not, of Black women's experiences.

Limitations

This study's findings should be interpreted with caution considering several methodological limitations. First, our sample size was fair and may not have been robust enough to detect certain effects. Second, the exclusion of men and trans people in the study limited generalizability of our findings, in addition to reducing overall sample size. The limited number of Black men who participated in the study could reflect the low population of men, in general at the university (37%). It could also reflect a cultural mistrust that some Black people have about research (Scharff et al., 2010). Third, the modified EOD was a poor assessment of vicarious racism for our sample, given its inadequate reliability estimate. As a result of its exclusion, we lost an opportunity to expand on the construct that is vicarious racism and add to the literature about a standardized instrument of measurement. Fourth, while the sample of the final study comprised Black women, the intention behind the research was not specific to gender. Thus, in comprising the hypothesized structural model the intersection of gender was not considered in the selection of measures, which was a huge oversight and may have improved statistical outcomes. Taking into consideration measures that capture the intersection of race and gender would be an important future consideration. Finally, data were collected from March 2020 to November 2020, a period of racial reckoning, marked by the murders of Ahmaud Arbery,

George Floyd, Breonna Taylor, unrest in Kenosha, Black Lives Matter protests, a movement to defund the police, and the transformation of confederate/colonial spaces in Richmond and around the world. The awareness and impact of these experiences could have resulted in a history effect resulting in the influence of variables of interest. On the other hand, this research could merely reflect a snapshot of Black women's racism experiences and mental well-being during this historic time.

Implications

Implications of this study are significant for clinicians and researchers investigating how racism experiences influence health outcomes. Research significance includes adding to the body of literature that operationalizes the domains of vicarious and appropriated racism. This study also adds to the literature by providing data about Black women, an understudied population in psychological literature. Specifically, this study provides a more in-depth understanding of the psychological well-being of Black women beyond over-overemphasized quality of life correlates (e.g., life satisfaction, self-esteem). The psychiatric correlates of racism-related experiences are important to capture because of the implications for predicting the onset of disorder over more strongly and above stress (Cohen et al., 1995). This study also has clinical implications and demonstrates the ways in which racism experiences are impactful of mental health. Of note is the role that direct and vicarious racism experiences predict trauma symptoms in this population of Black women. It would behoove mental health clinicians, especially those who are trauma-informed providers and those who work with Black populations to be culturally aware of the ways in which navigating racial relationships at the individual, cultural, institutional, and even vicarious levels can be detrimental to Black women's mental health. Adopting a social justice theoretical framework within therapy practices that acknowledges racism experiences and knows

how to do interventions that are both relevant and respectful, is paramount. Clinicians should be able to explore the intersection of racism and gender with their Black women clients. They should be unafraid to identify racism experiences as traumatic or as anxiety or depression provoking. They should facilitate conversations with their clients assessing their perceived and actual safety in the spaces they enter, and aid clients in creating spaces that feel safe to them. Most importantly, clinicians should be working to reform how racist or discriminatory practices inform their own clinical practice. This could manifest as becoming a more culturally aware clinician, taking on more pro-bono Black clients, and adopting a multicultural and feminist lens when supervising practicum clinicians.

Recommendations

Results of this study should be used to inform future research exploring racism experiences and mental health outcomes in Black women. Future research should take into consideration the limited number of quantitative measures for appropriated racism and vicarious racism and ensure that these measures are normed using the population of interest, because as this study elucidated, appropriated racism experiences may be experienced differently based on the racial-ethnic identity of the person. This would add more tools to the methodological toolbox so to speak and increase specificity in statistical analyses. Similarly, quantifying racism-related experiences of Black women is an intersectional endeavor, and thus measures should be included that assess gendered racism. Researchers should also endeavor to find ways to alleviate concerns and establish trust with Black men whom they want to participate in their research, Finally, the structural models in this study did not assess how coping acts as a mediating and moderating variable. Future studies should explore the role of coping, racial saliency, gender, cognitions, and personal threat in the mitigation or enhancement of mental health outcomes.

References

Arbuckle, J. L. (2007b). Amos 16.0 User's Guide. Chicago: SPSS.

Banks, K. H., Kohn-Wood, L. P., & Spencer, M. (2006). An examination of the African American experience of everyday discrimination and symptoms of psychological distress. Community mental health journal, 42(6), 555-570.

Bentler, P. M., & Wu, E. J. (2005). EQS 6.1 for Windows. Structural equations program manual. Encino, CA: Multivariate Software.

Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. K., & Domino, J. L. (2015). The posttraumatic stress disorder checklist for DSM-5 (PCL-5): Development and initial psychometric evaluation. Journal of traumatic stress, 28(6), 489-498.

Brondolo, E., Gallo, L. C., & Myers, H. F. (2009). Race, racism and health: Disparities, mechanisms, and interventions. Journal of Behavioral Medicine, 32(1), 1–8. https://doi.org/10.1007/s10865-008-9190-3

Brody, G. H., Chen, Y. F., Murry, V. M., Ge, X., Simons, R. L., Gibbons, F. X., & Cutrona, C. E. (2006). Perceived discrimination and the adjustment of African American youths: A five-year longitudinal analysis with contextual moderation effects. Child development, 77(5), 1170-1189.

Brown, T. A., & Moore, M. T. (2012). Confirmatory factor analysis. Handbook of structural equation modeling, 361, 379.

Byrne, B. M. (2016). Structural equation modeling with Amos: Basic concepts, applications, and programming. Routledge.

Campón, R. R., & Carter, R. T. (2015). The appropriated racial oppression scale: Development and preliminary validation. Cultural Diversity and Ethnic Minority Psychology, 21(4), 497–

506. https://doi.org/10.1037/cdp0000037

Carter, R. T. (2007). Racism and Psychological and Emotional Injury: Recognizing and Assessing Race-Based Traumatic Stress. The Counseling Psychologist, 35(1), 13–105. https://doi.org/10.1177/0011000006292033

Carter, R. T., Forsyth, J. M., Mazzula, S. L., & Williams, B. (2005). Racial discrimination and race-based traumatic stress: An exploratory investigation. Handbook of racial-cultural psychology and counseling: Training and practice, 2, 447-476.

Carter, R. T., & Helms, J. E. (2002). Racial discrimination and harassment: A race based traumatic stress disorder. In American Forensic Examiners Conference, Orlando, FL.

Chae, D. H., Clouston, S., Martz, C. D., Hatzenbuehler, M. L., Cooper, H. L., Turpin, R., ... & Kramer, M. R. (2018). Area racism and birth outcomes among Blacks in the United States. Social Science & Medicine, 199, 49-55.

Chae, D. H., Lincoln, K. D., Adler, N. E., & Syme, S. L. (2010). Do experiences of racial discrimination predict cardiovascular disease among African American men? The moderating role of internalized negative racial group attitudes. Social Science & Medicine, 71(6), 1182-1188.

Clark, R., Anderson, N. B., Clark, V. R., & Williams, D. R. (1999). Racism as a Stressor for African Americans: A Biopsychosocial Model. American Psychologist, 54(10), 805–816. https://doi.org/10.1037/0003-066X.54.10.805

Clark, R., Coleman, A. P., & Novak, J. D. (2004). Brief report: Initial psychometric properties of the everyday discrimination scale in black adolescents. Journal of Adolescence, 27(3), 363–368. https://doi.org/10.1016/j.adolescence.2003.09.004

Cohen, S., & Rodriguez, M. S. (1995). Pathways linking affective disturbances and physical

disorders. Health Psychology, 14(5), 374.

David, E. J. R., & Okazaki, S. (2006). The Colonial Mentality Scale (CMS) for Filipino Americans: Scale construction and psychological implications. Journal of Counseling Psychology, 53(2), 241–252. https://doi.org/10.1037/0022-0167.53.2.241

David, E. J. R., Schroeder, T. M., & Fernandez, J. (2019). Internalized racism: A systematic review of the psychological literature on racism's most insidious consequence. Journal of Social Issues, 75(4), 1057-1086.

Doerner, J. K., & Demuth, S. (2010). The independent and joint effects of race/ethnicity, gender, and age on sentencing outcomes in US federal courts. Justice Quarterly, 27(1), 1-27.

Dormire, S. L., Gary, J. C., Norman, J. M., & Harvey, I. S. (2021). Insights into fear: A phenomenological study of Black mothers. Journal of Advanced Nursing, 77(11), 4490-4499.

Dovidio, J. F., & Gaertner, S. L. (2004). Aversive racism. Advances in experimental social psychology, 36, 4-56.

Dominguez, T. P., Dunkel-Schetter, C., Glynn, L. M., Hobel, C., & Sandman, C. A. (2008). Racial differences in birth outcomes: the role of general, pregnancy, and racism stress. Health psychology, 27(2), 194.

Essed, P. (1991). Understanding everyday racism: An interdisciplinary theory (Vol. 2). Sage.

Fanon, F. (1963). The Wretched of the Earth, trans. Richard Philcox (New York: Grove, 2004), 239.

Fanon, F. (1967). Black skin, white masks, trans. Charles Lam Markmann (New York: Grove, 1967), 109, 98.

Gibbons, F. X., O'Hara, R. E., Stock, M. L., Gerrard, M., Weng, C. Y., & Wills, T. A. (2012).

The erosive effects of racism: reduced self-control mediates the relation between perceived racial discrimination and substance use in African American adolescents. Journal of personality and social psychology, 102(5), 1089.

Graham, J. R., West, L. M., & Roemer, L. (2013). The experience of racism and anxiety symptoms in an African-American sample: Moderating effects of trait mindfulness. Mindfulness, 4(4), 332-341.

Graham, J. R., West, L. M., Martinez, J., & Roemer, L. (2016). The mediating role of internalized racism in the relationship between racist experiences and anxiety symptoms in a Black American sample. Cultural Diversity and Ethnic Minority Psychology, 22(3), 369.

Greer, T. M., Laseter, A., & Asiamah, D. (2009). Race-Related Stress and Mental Health Symptoms for African Americans. Psychology of Women Quarterly, 33, 295–307.

Greene, M. L., Way, N., & Pahl, K. (2006). Trajectories of perceived adult and peer discrimination among Black, Latino, and Asian American adolescents: Patterns and psychological correlates. Developmental Psychology, 42, 218–238. doi:10.1037/0012-1649.42.2.218.

Greer, T. M., & Spalding, A. (2017). The role of age in understanding the psychological effects of racism for African Americans. Cultural diversity and ethnic minority psychology, 23(4), 588.

Griffith, D. M., Mason, M., Yonas, M., Eng, E., Jeffries, V., Plihcik, S., & Parks, B. (2007). Dismantling institutional racism: theory and action. American Journal of Community Psychology, 39(3-4), 381-392.

Hair, J.F., Black, W.C., Babin, B.J., & Anderson, R.E. (2010). Multivariate Data Analysis.

Seventh Edition. Prentice Hall, Upper Saddle River, New Jersey.

Harrell, S. P., Merchant, M. A., & Young, S. A. (1997). Psychometric properties of the racism and life experiences scales (RaLES). Unpublished manuscript.

Harrell, S. P. (2000). A multidimensional conceptualization of racism-related stress: Implications for the well-being of people of color. American journal of Orthopsychiatry, 70(1), 42-57.

Harrell, S. P. (2011). Writing your way to peace and power: Empowerment journaling as a pathway to healing and growth. Surviving sexual violence: A guide to recovery and empowerment, 328-348.

Harrell, J. P., Hall, S., & Taliaferro, J. (2003). Physiological responses to racism and discrimination: An assessment of the evidence. American Journal of Public Health, 93(2), 243–248. https://doi.org/10.2105/AJPH.93.2.243

Hilmert, C. J., Dominguez, T. P., Schetter, C. D., Srinivas, S. K., Glynn, L. M., Hobel, C. J., & Sandman, C. A. (2014). Lifetime racism and blood pressure changes during pregnancy: Implications for fetal growth. Health Psychology, 33(1), 43.

Howard, S., & Sommers, S. R. (2017). Exposure to White religious iconography influences Black individuals' intragroup and intergroup attitudes. Cultural Diversity and Ethnic Minority Psychology, 23(4), 508.

Hu, L. T., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. Structural equation modeling: a multidisciplinary journal, 6(1), 1-55.

Huynh, V. W. (2012). Ethnic microaggressions and the depressive and somatic symptoms of Latino and Asian American adolescents. Journal of youth and adolescence, 41(7), 831-846.

James, D. (2020). Health and health-related correlates of internalized racism among racial/ethnic minorities: A review of the literature. Journal of racial and ethnic health disparities, 7(4), 785-806.

Jones, C. P. (2000). Levels of racism: a theoretic framework and a gardener's tale. American journal of public health, 90(8), 1212.

Jones, J. M. (1972). Prejudice and racism. Menlo Park. CA: Addison-Wesley.

Jones, J. M. (1997). Prejudice and racism. McGraw-Hill Humanities, Social Sciences & World Languages.

Kenny, D. A. (2015). Measuring model fit.

Kline, R. B. (2015). Principles and practice of structural equation modeling. Guilford publications.

Klonoff, E. A., Landrine, H., & Ullman, J. B. (1999). Racial discrimination and psychiatric symptoms among Blacks. Cultural Diversity and Ethnic Minority Psychology, 5(4), 329.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. Journal of general internal medicine, 16(9), 606-613.

Lee, D. B., Neblett Jr, E. W., & Jackson, V. (2015). The role of optimism and religious involvement in the association between race-related stress and anxiety symptomatology. Journal of Black Psychology, 41(3), 221-246.

Lewis, J. A., Mendenhall, R., Harwood, S. A., Browne Huntt, M. (2013). Coping with gendered racial microaggressions among Black women college students. Journal of African American Studies, 17, 51-73. doi:10.1007/s12111-012-9219-0

Lewis, J. A., & Neville, H. A. (2015). Construction and initial validation of the Gendered Racial Microaggressions Scale for Black women. Journal of counseling psychology, 62(2), 289.

Lewis, J. A., Williams, M. G., Peppers, E. J., & Gadson, C. A. (2017). Applying intersectionality to explore the relations between gendered racism and health among Black women. Journal of counseling psychology, 64(5), 475.

Lewis-Coles, M. E. L., & Constantine, M. G. (2006). Racism-related stress, Africultural coping, and religious problem-solving among African Americans. Cultural Diversity and Ethnic Minority Psychology, 12(3), 433–443. https://doi.org/10.1037/1099-9809.12.3.433

Mason, T. B., Maduro, R. S., Derlega, V. J., Hacker, D. S., Winstead, B. A., & Haywood, J. E. (2017). Individual differences in the impact of vicarious racism: African American students react to the George Zimmerman trial. Cultural Diversity and Ethnic Minority Psychology, 23(2), 174.

McConahay, J. B. (1986). Modern racism, ambivalence, and the modern racism scale.

Mickelson, K. D., & Williams, D. R. (1999). The prevalence, distribution, and mental health correlates of perceived discrimination in the United States. J Health Soc Behav, 40, 208-230.

Miliora, M. T. (2000). Beyond empathic failures: Cultural racism as narcissistic trauma and disenfranchisement of grandiosity. Clinical Social Work Journal, 28(1), 43–54. https://doi.org/10.1023/A:1005159624872

Moody, A. T., & Lewis, J. A. (2019). Gendered racial microaggressions and traumatic stress symptoms among Black women. Psychology of Women Quarterly, 43(2), 201-214.

Nadal, K. L. (2011). The Racial and Ethnic Microaggressions Scale (REMS): construction, reliability, and validity. Journal of Counseling Psychology, 58(4), 470.

Neville, H. A., Awad, G. H., Brooks, J. E., Flores, M. P., & Bluemel, J. (2013). Color-blind racial ideology: Theory, training, and measurement implications in

psychology. American Psychologist, 68(6), 455.

Neville, H. A., & Pieterse, A. L. (2009). Racism, White supremacy, and resistance: Contextualizing Black American experiences.

Odafe, M. O., Salami, T. K., & Walker, R. L. (2017). Race-related stress and hopelessness in community-based African American adults: Moderating role of social support. Cultural Diversity and Ethnic Minority Psychology, 23(4), 561.

O'Keefe, V. M., Wingate, L. R., Cole, A. B., Hollingsworth, D. W., & Tucker, R. P. (2015). Seemingly harmless racial communications are not so harmless: Racial microaggressions lead to suicidal ideation by way of depression symptoms. Suicide and Life-Threatening Behavior, 45(5), 567-576

Oliver, W. (2001). Cultural racism and structural violence: Implications for African Americans. Journal of human Behavior in the Social Environment, 4(2-3), 1-26.

Paradies, Y. (2006). A systematic review of empirical research on self-reported racism and health. International Journal of Epidemiology, 35(4), 888–901. https://doi.org/10.1093/ije/dyl056

Pittman, C. T. (2011). Getting mad but ending up sad: The mental health consequences for African Americans using anger to cope with racism. Journal of Black Studies, 42(7), 1106-1124.

Pierce, C. (1970). Offensive mechanisms. The black seventies, 265-282.

Pierce, C. (1974). Psychiatric problems of the Black minority. American handbook of psychiatry, 2, 512-523.

Pierce, C. M. (1975). Poverty and racism as they affect children. In I. Berlin (Ed.), Advocacy for child mental health (pp. 92-109). New York: Brunner/M

Pierce, C., Carew, J., Pierce-Gonzalez, D., & Willis, D. (1978). An Experiment in racism: television. Television and education. Sage, Beverly Hills, CA.

Priest, N., Perry, R., Ferdinand, A., Paradies, Y., & Kelaher, M. (2014). Experiences of racism, racial/ethnic attitudes, motivated fairness and mental health outcomes among primary and secondary school students. Journal of youth and adolescence, 43(10), 1672-1687.

Poolokasingham, G., Spanierman, L. B., Kleiman, S., & Houshmand, S. (2014). "Fresh off the boat?" racial microaggressions that target South Asian Canadian students. Journal of Diversity in Higher Education, 7(3), 194.

Priest, N., Perry, R., Ferdinand, A., Paradies, Y., & Kelaher, M. (2014). Experiences of racism, racial/ethnic attitudes, motivated fairness, and mental health outcomes among primary and secondary school students. Journal of youth and adolescence, 43(10), 1672-1687.

Pyke, K. D. (2010). What is internalized racial oppression and why don't we study it? Acknowledging racism's hidden injuries. Sociological Perspectives, 53(4), 551-572.

Ridley, C. R. (1995). Overcoming unintentional racism in counseling and therapy. Thousand Oaks, CA: Sage.

Robinson-Wood, T., Balogun-Mwangi, O., Fernandes, C., Popat-Jain, A., Boadi, N., Matsumoto, A., & Zhang, X. (2015). Worse than Blatant Racism: a phenomenological investigation of microaggressions among black women. Journal of Ethnographic & Qualitative Research, 9(3).

Roumell, E. A., & James-Gallaway, A. D. (2021). Social movements, community education, and the fight for racial justice: Black women and social transformation. New Directions for Adult and Continuing Education, 2021(170), 21-31.

Scharff, D. P., Mathews, K. J., Jackson, P., Hoffsuemmer, J., Martin, E., & Edwards, D. (2010). More than Tuskegee: understanding mistrust about research participation. Journal of health care for the poor and underserved, 21(3), 879.

Schwalbe, M., Holden, D., Schrock, D., Godwin, S., Thompson, S., & Wolkomir, M. (2000). Generic processes in the reproduction of inequality: An interactionist analysis. Social forces, 79(2), 419-452.

Schulz, A. J., Gravlee, C. C., Williams, D. R., Israel, B. A., Mentz, G., & Rowe, Z. (2006). Discrimination, symptoms of depression, and self-rated health among African American women in Detroit: results from a longitudinal analysis. American journal of public health, 96(7), 1265-1270.

Sears, D. O., Henry, P. J., & Kosterman, R. (2000). Egalitarian values and the origins of contemporary American racism. Racialized politics: The debate about racism in America, 75-117.

Smith, W. A., Hung, M., & Franklin, J. D. (2011). Racial battle fatigue and the miseducation of Black men: Racial microaggressions, societal problems, and environmental stress. The Journal of Negro Education, 63-82.

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. Archives of internal medicine, 166(10), 1092-1097.

Steffen, P. R., McNeilly, M., Anderson, N., & Sherwood, A. (2003). Effects of perceived racism and anger inhibition on ambulatory blood pressure in African Americans. Psychosomatic medicine, 65(5), 746-750.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: implications for clinical practice. American psychologist, 62(4), 271.

Sue, D. W., Capodilupo, C. M., & Holder, A. (2008). Racial microaggressions in the life experience of Black Americans. Professional Psychology: Research and Practice, 39(3), 329.

Szymanski, D. M., & Lewis, J. A. (2015). Race-related stress and racial identity as predictors of African American activism. Journal of Black Psychology, 41(2), 170-191.

Szymanski, D. M., & Lewis, J. A. (2016). Gendered racism, coping, identity centrality, and African American college women's psychological distress. Psychology of Women Quarterly, 40(2), 229-243.

Tabachnick, B. G., Fidell, L. S., & Ullman, J. B. (2007). Using multivariate statistics (Vol. 5, pp. 481-498). Boston, MA: Pearson.

Tappan, M. B. (2006). Reframing internalized oppression and internalized domination: From the psychological to the sociocultural. Teachers College Record, 108(10), 2115.

Taylor, J. (1990). Relationship between internalized racism and marital satisfaction. Journal of Black Psychology, 16(2), 45-53.

Taylor, J., & Turner, R. J. (2002). Perceived discrimination, social stress, and depression in the transition to adulthood: Racial contrasts. Social Psychology Quarterly, 213-225.

Torres, L., Driscoll, M. W., & Burrow, A. L. (2010). Racial microaggressions and psychological functioning among highly achieving African-Americans: A mixed-methods approach. Journal of Social and Clinical Psychology, 29(10), 1074-1099.

Thomas, A. J., Witherspoon, K. M., & Speight, S. L. (2004). Toward the development of the stereotypic roles for Black women scale. Journal of Black Psychology, 30(3), 426-442.

Thomas, A. J., Witherspoon, K. M., & Speight, S. L. (2008). Gendered racism, psychological distress, and coping styles of African American women. Cultural Diversity and Ethnic Minority Psychology, 14(4), 307.

Truong, K. A., Museus, S. D., & McGuire, K. M. (2016). Vicarious racism: A qualitative analysis of experiences with secondhand racism in graduate education. International Journal of Qualitative Studies in Education, 29(2), 224-247.

Utsey, S. O. (1999). Development and validation of a short form of the Index of Race-Related Stress (IRRS)-Brief Version. Measurement and evaluation in Counseling and Development, 32(3), 149.

Utsey, S. O., Abrams, J.A., Opare-Henaku, A. , Bolden, M.A., & Williams, O. (2014). Assessing the Psychological Consequences of Internalized Colonialism on the Psychological Well-Being of Young Adults in Ghana. Journal of Black Psychology. https://doi.org/10.1177/0095798414537935

Utsey, Shawn O., Lanier, Y., Williams, O., Bolden, M., & Lee, A. (2006). Moderator effects of cognitive ability and social support on the relation between race-related stress and quality of life in a community sample of Black Americans. Cultural Diversity and Ethnic Minority Psychology, 12(2), 334–346. https://doi.org/10.1037/1099-9809.12.2.334

Walker, R. L., Salami, T. K., Carter, S. E., & Flowers, K. (2014). Perceived racism and suicide ideation: Mediating role of depression but moderating role of religiosity among African American adults. Suicide and Life-Threatening Behavior, 44(5), 548-559.

Williams, D. R., & Mohammed, S. A. (2009). Discrimination and racial disparities in health:

evidence and needed research. Journal of behavioral medicine, 32(1), 20-47.

Williams, D. R., & Mohammed, S. A. (2013). Racism and health I: Pathways and scientific evidence. American behavioral scientist, 57(8), 1152-1173.

Williams, D., & Williams-Morris, R. (2000). Racism and mental health: The African American experience. Ethnicity & health, 5(3-4), 243-268.

APPENDICES

Appendix A

RESEARCH PARTICIPANT INFORMATION SHEET

Study Title: Racism Experiences and Mental Health: An Examination of Direct, Vicarious, and Appropriated Racism Experiences on Mental Health Symptom Expression

VCU Investigators:
Shawn Utsey, Ph.D., Counseling Psychology; Chair, African American Studies
Christina Barnett, M.S., Counseling Psychology Doctoral Candidate

Purpose and Participation:
You are being invited to participate in a research study. Your participation is voluntary. The purpose of this research study is to understand the relationships between racism experiences and mental health symptom expression. This study will help us gain more nuanced insight into these relationships. You will be asked to take a survey and answer questions about racism experiences you may have encountered and your own mental well-being.

Payment for Participation:
If you are a VCU student participating via SONA, you will receive .25 research credits for each 15 minutes you spend participating in a study. This study is worth 1.5 SONA research credits.

All participants will be eligible to enter a raffle to win one of three gift cards at the end of the study.

Questions:
If you have any questions, concerns, or complaints about this study now or in the future, please contact:

Shawn Utsey, Ph.D.
(804) 828-1144
soutsey@vcu.edu

Christina Barnett, M.S.
barnettc@mymail.vcu.edu

If you have general questions about your rights as a participant in this or any other research, or if you wish to discuss problems, concerns or questions, to obtain information, or to offer input about research, you may contact:

Virginia Commonwealth University Office of the Vice President for Research and Innovation
800 East Leigh Street, Suite 3000, Box 980568, Richmond, VA 23298
(804) 827-2157

VCU Office of Research website

Do not begin the study unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

Appendix B

Survey Measures

Demographic Questionnaire

Please answer the following demographic questions.

1. What is your gender?
   - Genderqueer/nonbinary
   - Transgender man
   - Transgender woman
   - Man
   - Woman
   - Other

2. What is your age? (number)

0 10 20 30 40 50 60 70 80 90 100 110

Age:

3. What is your race. Select all that apply

- American Indian/Native American
- Alaska Native
- Asian
- Black
- Latinx
- Middle Eastern
- Native Hawaiian
- North African
- Pacific Islander
- White
- Other

a. If 'other' was selected please type in how you identify your race, below:

_____

4. Please select what part(s) of the world your family (both sides) is from?
   - North, Central, and/or South America
   - Caribbean
   - Europe
   - Africa and/or Islands of Africa
   - Middle East
   - Asia
   - Pacific Islands and/or Oceania

   Write in countries of origin:

5. I am a citizen of the United States
   - Yes
   - No

6. Highest level of Education
   - None
   - Some high school
   - High school degree or equivalent
   - Some college, no degree
   - Associate degree
   - Bachelor's degree
   - Master's degree
   - Professional degree/doctorate

7. Employment
   - Student
   - Employed full-time
   - Employed part-time
   - Seeking opportunities
   - Retired

Anxiety Symptoms: GAD-7

Response Options:
0=Not at all sure; 1=Several days; 2=Over half the days; 3= Nearly every day

1. Over the last 2 weeks, how often have you been bothered by the following problems?
2. Feeling nervous, anxious, or on edge
3. Not being able to stop or control worrying
4. Worrying too much about different things
5. Trouble relaxing
6. Being so restless that it's hard to sit still
7. Becoming easily annoyed or irritable
8. Feeling afraid as if something awful might happen

Depression Symptoms: PHQ-9

Response Options:
0=Not at all sure; 1=Several days; 2=Over half the days; 3= Nearly every day

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

Trauma Symptoms: PCL-5

Response Options:
0=Not at all sure; 1=Several days; 2=Over half the days; 3= Nearly every day

1. Repeated, disturbing, and unwanted memories of the stressful experience?
2. Repeated, disturbing dreams of the stressful experience?
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?
4. Feeling very upset when something reminded you of the stressful experience?
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?
6. Avoiding memories, thoughts, or feelings related to the stressful experience?
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?
8. Trouble remembering important parts of the stressful experience?
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?
10. Blaming yourself or someone else for the stressful experience or what happened after it?
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?
12. Loss of interest in activities that you used to enjoy?
13. Feeling distant or cut off from other people?
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?
15. Irritable behavior, angry outbursts, or acting aggressively?
16. Taking too many risks or doing things that could cause you harm?
17. Being “super alert” or watchful or on guard?
18. Feeling jumpy or easily startled?
19. Having difficulty concentrating?
20. Trouble falling or staying asleep?

IIRS-B

The following questions are intended to sample some of the experiences that Black people have in this country because of their "blackness." There are many experiences that a Black person can have in this country because of their race. Some events happen just once, some more often, while others may happen frequently. Below you will find listed some of these experiences for which you are to indicate those that have happened to you. Please select the reaction you had to the event at the time it happened. Do not leave any items blank. If an event has happened more than

once refer to the first time it happened. If an event did not happen select, this never happened to me," and go on to the next item.

Response Options:
0= This never happened to me; 1=This event happened but did not bother me; 2=This event happened, and I was slightly upset; 3=This event happened, and I was upset; 4=This event happened, and I was extremely upset.

1. You notice that crimes committed by White people tend to be romanticized, whereas the same crime committed by a Black person is portrayed as savagery, and the Black person who committed it, as an animal.
2. Salespeople/clerks did not say thank you or show other forms of courtesy and respect (i.e., put your things in a bag) when you shopped at some White/non-Black owned businesses.
3. You notice that when Black people are killed by the police the media informs the public of the victim's criminal record or negative information in their background, suggesting they got what they deserved.
4. You have been threatened with physical violence by an individual or group of White/non-Black people.
5. You have observed that White kids who commit violent crimes are portrayed as "boys being boys," while Black kids who commit similar crimes are wild animals.
6. You seldom hear or read anything positive about Black people on radio, TV, newspapers, or in history books.
7. While shopping at a store the salesclerk assumed that you couldn't afford certain items (i.e., you were directed toward the items on sale).
8. You were the victim of a crime and the police treated you as if you should just accept it as a part of being Black.
9. You were treated with less respect and courtesy than Whites and other non-Black people while in a store, restaurant, or other business establishment.
10. You were passed over for an important project although you were more qualified and competent than the White/non-Black person given the task.
11. White/non-Black people have stared at you as if you didn't belong in the same place with them, whether it was a restaurant, theater, or other place of business.
12. You have observed the police treat White/non-Black people with more respect and dignity than they do Blacks.
13. You have been subjected to racist jokes by White people/non-Black people in positions of authority and you did not protest for fear they might have held it against you.
14. While shopping at a store, or when attempting to make a purchase you were ignored as if you were not a serious customer or didn't have any money.
15. You have observed situations where other Black people were treated harshly or unfairly by Whites/non-Black people due to their race.
16. You have heard reports of White people/non-Black people who have committed crimes, and in an effort to cover up their deeds falsely reported that a Black man was responsible for the crime.

17. You notice that the media plays up those stories that cast Black people in a negative way (child abusers, rapists, muggers, etc. [or as savages] Wild Man of 96th St., Wolf Pack, etc.), usually accompanied by a large picture of a Black person looking angry or disturbed.
18. You have heard racist remarks or comments about Black people spoken with impunity by White public officials or other influential White people.
19. You have been given more work, or the most undesirable jobs at your place of employment while the White/non-Black person of equal or less seniority and credentials is given less work, and more desirable tasks.
20. You have heard or seen other Black people express the desire to be White or to have White physical characteristics because they disliked being Black or thought it was ugly.
21. White people or other non-Black people have treated you as if you were unintelligent and needed things explained to you slowly or numerous times.
22. You were refused an apartment or other housing; you suspect it was because you are Black.

REMS

Indicate the number of times that a microaggression occurred in the past 6 months by selecting one of the following:

0=I did not experience this event in the past six months; 1=I experienced this event 1-3 times in the past six months; 2=I experienced this event 4-6 times in the past six months; 3=I experienced this event 7-9 times in the past six months; 4=I experienced this event 10 or more times in the past six months

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 color-blind.
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 U.S.
21. Someone assumed that I would not be educated because of my race.
22. Someone told me that I was "articulate" after they 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 their 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.

AROS

Please indicate the extent to which you agree or disagree with the following statements:

1=Strongly disagree; 2=Disagree; 3=Somewhat disagree; 4=Neither agree nor disagree; 5=Somewhat agree; 6Agree=Strongly agree

1. Good hair (i.e., straight) is better.
2. I feel critical about my racial group.
3. Although discrimination in America is real, it is definitely overplayed by some members of my race.
4. I don't really identify with my racial group's values and beliefs.
5. I feel that being a member of my racial group is a shortcoming.

6. I prefer my children not to have broad noses
7. I find people who have straight and narrow noses to be more attractive.
8. I find persons with lighter skin-tones to be more attractive.
9. I wish I could have more respect for my racial group.
10. People of my race shouldn't be so sensitive about race/racial matters.
11. I wish I were not a member of my race.
12. In general, I am ashamed of members of my racial group because of the way they act.
13. I wish my nose were narrower.
14. Sometimes I have a negative feeling about being a member of my race.
15. People take racial jokes too seriously.
16. I would like for my children to have light skin.
17. There have been times when I have been embarrassed to be a member of my race.
18. White people are better at a lot of things than people of my race.
19. It is a compliment to be told, "You don't act like a member of your race".
20. When I look in the mirror, sometimes I do not feel good about what I see because of my race.
21. Whenever I think a lot about being a member of my racial group, I feel depressed.
22. Interacting with other members of my race, I often feel like I don't fit in
23. Because of my race, I feel useless at times.
24. I wish I could have more respect for my racial group.
25. People of my race don't have much to be proud of.

RaLES

Listed below are different types of race-related experiences that some people have. Using the options in the drop-down menu, please choose the response that best indicates HOW OFTEN you had the experience described and the AMOUNT OF STRESS you felt DURING THE PAST YEAR.

Response options: 0=Never; 1=A few times; 2=Monthly; 3=Weekly; 4=Daily

1. Race-related conflict between you and someone of a different race/ethnicity
2. Others expecting you to be, or treating you like, stereotypes of your racial/ethnic group
3. Hateful or mean-spirited behavior directed towards you
4. Violent or life-threatening personal experiences (e.g., assaults)
5. A racially hostile atmosphere at your job, school, or neighborhood
6. Ongoing conditions in your life that are in some way related to racism (e.g., being unemployed)
7. Violation of your civil rights (e.g., job or housing discrimination)
8. Others saying or inferring that you are oversensitive, paranoid, or exaggerate concerns about racism
9. Witnessing racial discrimination or prejudice directed toward someone else
10. Hearing about someone else's experience of discrimination or prejudice
11. Seeing negative, offensive, or insulting stereotypes of your racial/ethnic group in the media (news, TV, movies, social media, etc.)
12. Observing policies or practices at work, school, or in businesses that exclude or negatively affect people of your racial/ethnic group
13. Observing limited participation in decision-making, opportunities, or access to resources for people of your racial/ethnic group (i.e., "ol' boys' network")
14. Observing legislative processes or political activities (national, local) that negatively affect people of your race/ethnicity
15. Observing problems or racial disparities in different areas of life for people of your race/ethnicity (i.e., economic, health, employment)
16. Significant racial tensions or conflicts in your community, city, or town
17. Experiencing microaggressions such as being ignored in a conversation, treated suspiciously, your opinions dismissed, or asked a racially offensive question
18. Racial prejudice or discrimination experienced by close friends or family members.
19. Seeing the lingering effects of historical traumas experienced by your racial/ethnic group (e.g., slavery, genocide, displacement, colonial occupation, etc.)
20. Observing ways that some members of your racial/ethnic group collude with racism by endorsing stereotypes or expressing negative prejudice against their own group.

Modified EOD

This next set of questions asks about people who are close to you who may have been discriminated against or treated poorly due to their race or color.

1. Do you feel that someone close to you has been discriminated against or treated poorly because of his or her race, ethnicity or color?

- Yes
- No

Please tell us more about the person or people you are close to who have been discriminated against, and where it happened. First, write in the person's relationship to you and their race/ethnicity. Next, check all the boxes that apply to where it occurred. Use as few or as many of the lines and boxes as you need.

Person #1
Relationship to you: _____ Person's Race/Ethnicity: _____

Where the unfair treatment happened (please check a box or boxes):

- At school or college
- Getting hired or getting job
- At work
- Getting housing
- Getting medical care
- Getting service in a store or restaurant
- Getting credit, a bank loan or a mortgage
- On the street or in a public setting
- From the police or in the courts

Person 2-8

Vita

Christina M. Barnett was born on March 9, 1989, in New Haven, CT. She graduated from McDonogh School in Owings Mills, MD in 2007. She received her Bachelor of Arts in African American Studies and Psychology from Wesleyan University, Middletown, CT, in 2011. She taught SAT prep in Accra, Ghana for two years after graduating from college. She later served as a Program Coordinator at Street Law, Inc., working with their legal community partnership programs. She simultaneously provided ABA services to a children on the autism spectrum. She received her Master of Science in Psychology from VCU in 2017. While completing doctoral coursework, Christina acted as a Research Assistant, Teaching Assistant, and served on the departmental committee of Equity, Diversity, and Inclusion. She completed a predoctoral internship in clinical psychology with Howard University Counseling Services in Washington, DC.