African American Women's Experiences of Race-Based Traumatic Stress

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UNIVERSITY OF MIAMI

AFRICAN AMERICAN WOMEN’S EXPERIENCES OF RACE-BASED TRAUMATIC STRESS

By

Amina Y. Simmons

A DISSERTATION

Submitted to the Faculty of the University of Miami in partial fulfillment of the requirements for the degree of Doctor of Philosophy

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RACE-BASED TRAUMATIC STRESS

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Assessments of racism are linked to increased risk of anxiety (Soto, Dawson-Andoh, & BeLue, 2011), depression (Lee & Turney, 2012), and increased symptoms of PTSD (Polanco-Roman, Danies, & Anglin, 2016), leading scholars to infer racism may be a type of traumatic stress (Carter, 2007; Helms, Nicolas, & Green, 2010). African American men and women report similar frequency and levels of racism-related stress (Jackson, Shestov, & Saadatmand, 2017; Kwate & Goodman, 2015) however, the impacts appear significant for Black women (Chyu and Upchurch, 2011; Jackson, Shestov, & Saadatmand, 2017). This exploratory study sought greater understanding of Black women’s experiences with racial stress and the impacts on their well-being. One hundred and thirty-five African American women between the ages 25-65 were recruited for the study. Mixed methods were used to examine the study variables of race-based traumatic stress, psychological well-being, and health service utilization. Results showed that Black women routinely seek health care and experience moderate levels of positive mental health but, racial stress is complex and multifaceted. Experiences of racism accounted for a significant portion of the difference in Black women’s current psychological well-being, suggesting the impacts of racial stress are enduring. Given
African American women’s experience of chronic racial stress more research is needed to understand how their brains are directing and processing stressful stimuli in order to bolster their well-being.

Keywords: Black/African American women, racial stress, trauma, well-being, health
DEDICATION

This dissertation is dedicated to every Black woman has and will continue to hold on to me throughout my journey. Mentors, othermothers, sisterfriends, my circle of we continues to expand. From the tops of our heads to the soles of our feet, I so completely in love and in awe of Black women. Y’all are the rainbows to my cloud; I am eternally grateful.
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# TABLE OF CONTENTS

| LIST OF FIGURES | ix |
| LIST OF TABLES | x |

## Chapter 1 INTRODUCTION
- Background of the Problem .................................................. 4
- Purpose of the Study ................................................................. 8
  - Aim I .................................................. 8
  - Aim II .................................................. 8
  - Aim III .................................................. 9
- Research Question I ................................................................. 9
- Research Question II .............................................................. 9
- Research Question III .............................................................. 9
- Significance of the Study .......................................................... 9

## Chapter 2 LITERATURE REVIEW
- Overview of Stress ................................................................. 10
  - Acute versus Chronic Stressors ............................................. 10
  - Cognitive Appraisal .............................................................. 11
    - Primary and Secondary Appraisal ....................................... 11
    - Controllability ................................................................. 12
    - Fear Learning ................................................................. 14
    - Emotions ................................................................. 15
  - Race-Based Stress and Trauma .............................................. 18
    - Racial Discrimination ..................................................... 19
    - Racial Harassment ........................................................... 20
    - Discriminatory Harassment ............................................... 21
  - Physiological Impacts of Stress ........................................... 22
    - Allostasis and Allostatic Load ........................................... 25
      - Cardiovascular System .................................................. 26
      - Metabolic System ...................................................... 27
      - Immune System ......................................................... 28
      - Central Nervous System ............................................... 30
  - Psychological Impacts of Stress ........................................... 36
    - Depressive Disorders ..................................................... 36
    - Anxiety Disorders .......................................................... 39
  - Trauma and Stress-related Disorders .................................... 41
  - Theoretical Framework .......................................................... 45
  - Approaches to Stress ........................................................... 45
LIST OF FIGURES

Figure 1  Average Psychological Well-being ........................................... 224
LIST OF TABLES

Table 1: Description of Measures................................................................. 225
Table 2: Background Characteristics of Participants...................................... 227
Table 3: Types of Racial Stress Events.......................................................... 231
Table 4: Settings of Racial Stress Events....................................................... 232
Table 5: Period of Life of Racial Stress Events.............................................. 233
Table 6: Most Memorable Event Racial Stress Event..................................... 234
Table 7: RBTSSS Subscale Scores and T-Scores............................................ 235
Table 8: Participants HSU Behaviors, General Use ....................................... 236
Table 9: Participants HSU Behaviors, Delayed Service Use........................... 238
Table 10: Participants HSU Behaviors, Specific Use...................................... 240
Table 11: Participants HSU Behaviors, Special Tests and Health Checks......... 241
Table 12: Regression Model with Total MHC Score as Predictor .................. 242
Table 13: Themes from Qualitative Interviews............................................ 243
Chapter One: Introduction

Introduction to the Problem

Diagnostic criteria suggest exposure to trauma does not always result in psychological injury (APA, 2013) and traumatology literature demonstrates discrepancies between trauma exposure and risk for poor mental health outcomes (Alegría et al, 2013). Though Black Americans have higher rates of PTSD, White Americans report greater exposure to trauma and scholars suggest exposure to racial discrimination may explain these differences (Alegría et al, 2013). A recent series of reports released by the Robert Wood Johnson Foundation (2017; RWJF) focusing on discrimination among marginalized groups in the United States found Black Americans reported the highest level of perceived discrimination (i.e. 92% endorsed discrimination directed at Black Americans) compared to LGBTQ individuals (90%) and other racial groups (i.e. Latinos, 78%; Native Americans, 77%; and Asian Americans, 68%). Articles critiquing the media attention surrounding the release of the reports comment, “the news coverage took to reporting the aggregate views of White respondents as the major news of this report...[but] the individual problems reported by White Americans are not of the same scale as reported by Black Americans” (Fulwood, 2017). Scholars reviewing the statistics suggest that increased racial tensions in the United States are reminiscent of the country’s racist history, and may trigger traumatic stress reactions for Black Americans (Corley, 2015).

The IndexUs report released in 2016 by the Black Women’s Health Imperative (BWHI) writes “[African American women] are not defined by disease, obesity, or poverty” (p.4). Utilizing data from the Black Women’s Health Study (BWHS)--the
largest, national, follow-up study documenting African American women’s health--the
*IndexUs* report presents a portrait of over 30,000 Black women who rated their health as “excellent or very good” (BWHI, 2016, p.3). The report provides resources and suggestions for improving the health of Black women and though the numbers are promising, the health disparities literature paints an entirely different picture for Black women. Belgrave and Abrams (2016) report, “African American women fare worse across every health indicator compared to women of other racial/ethnic groups” (p.723). The authors suggest the importance of addressing “historical inequalities” linked to these disparities in order to improve health equity for African American women (Belgrave & Abrams, p.730).

One form of historical inequality associated with poor health outcomes is racism (Carter, Lau, Johnson, & Kirkinis, 2017; Elias & Paradies, 2016; Pieterse, Todd, Neville, & Carter, 2012; Williams, Neighbors, & Jackson, 2003). In their meta-analysis, Carter, Lau, Johnson, and Kirkinis (2017) found the largest effects of racism on mental health, inferring that racism may contribute to stress reactions and subsequently, increase risk for stress-related diseases among racial/ethnic minorities (Orom, Sharma, Homish, Underwood, & Homish, 2017; Chae, Nuru-Jeter, Lincoln, & Jacob Arriola, 2012; Soto, Dawson-Andoh, & BeLue, 2011). Although African American men and women report similar frequency of everyday racism (Kwate & Goodman, 2015) and similar levels of stress related to racism (Jackson, Shestov, & Saadatmand, 2017), studies examining physiological markers of stress reveal increased cortisol (Jackson, Shestov, & Saadatmand, 2017) and higher allostatic load among African American women (Chyu and Upchurch, 2011; Geronimus, Hicken, Keene, & Bound, 2006), which suggests
gender differences in response to racial stress. Hill and Needham (2013) highlight that differences in the way mental health disorders are captured (e.g. self-report of symptoms) imply men and women express the same problems in different ways. Additionally, they suggest women’s mental health is often viewed through a lens of social disadvantage, such that women have less power as well as fewer opportunities and resources compared to men. The authors warn against equating men’s and women’s experiences, given that men and women may report different symptoms linked to similar stressors (e.g. racism) or disorders (e.g. depression). Hill and Needham (2013) recommend taking an intersectional approach to research, that seeks to understand why women express emotional distress with different symptoms and tend to have higher rates of affective disorders in response to stressful conditions.

Overall, the literature presents African American women’s physical and psychological well-being as disparate (Belgrave & Abrams, 2016; Black, Johnson, & VanHoose, 2015), suggesting experiences of racism may be predictive of poor health outcomes for African American women (BWHI, 2016; Neblett, Bernard, & Banks, 2016; Donovan & West, 2015; Donovan, Galban, Grace, Bennett, & Felicie, 2013; Hunn, & Craig, 2009). Moreover, scholars suggest the intersections of multiple marginalized identities (e.g. gendered racism), are more predictive of psychological distress among African American women (Lewis & Neville, 2015; Rosenfield, 2012; Szymanski & Stewart, 2010). Given the potential for both chronic and sudden race-related stress linked to the racial climate within the United States, these discrepancies demonstrate minimal understanding of African American women’s experiences of racial stress, which has implications for achieving health equity among this population.
Background of the Problem

Literature on stress and health demonstrate a positive correlation between stress exposure and risk for stress-related diseases (Ibrahim, Thearle, Krakoff, & Gluck, 2016; Rosenkranz, Venheim, & Padival, 2010; Rod, Grønbæk, Schnoehr, Prescott, & Kristensen, 2009). While acute experiences of stress can be adaptive, chronic stress exposure is linked to poor health outcomes and can lead to long-lasting genetic and neurological alterations in stress response (McEwen, Nasca, & Gray, 2016; McEwen, 2012; Bush, Obradović, Adler, & Boyce, 2011; Juster, McEwen, & Lupien, 2010; Calabrese, Molteni, Racagni, & Riva, 2009). Allostatic load refers to the impacts of chronic stress on health and the literature demonstrates higher allostatic load scores among racial/ethnic minority populations in the United States compared to White Americans (Howard & Sparks, 2016; Howard & Sparks, 2015; Chyu & Upchurch, 2011).

Controlling for other demographic variables (e.g. gender, socioeconomic status (SES)), the literature on racial/ethnic differences with regard to health outcomes is mixed. Moreover, people of color with multiple marginalized positions (e.g. low-income, women of color) may experience intersectional oppression (e.g. gendered racism), also linked to poor health outcomes (Brooks & al, 2015; Giurgescu & al, 2015; Jackson, Rowley, & Curry Owens, 2012; Perry, Pullen, & Oser, 2012; Rosenfield, 2012; Cummings & Braboy Jackson, 2008; Kamble & Boyd, 2008). Some scholars report however, that race/ethnicity exerts negative impacts on health outcomes independent of other demographic variables, providing evidence for racism as a type of stress (Siddiqi, Jones, Bruce, & Erwin, 2016; Davis & Welcher, 2013; Hinze, Lin, & Andersson, 2012).
The literature also demonstrates clear links between racial discrimination and diminished physical and psychological well-being (Carter et al., 2017; Polanco-Roman, Danies, & Anglin, 2016; Brondolo, Libretti, Rivera, & Walsemann, 2012; Johnston & Lordan, 2012; Lee & Turney, 2012; Pieterse, Todd, Neville, & Carter, 2012; Williams, & Mohammed, 2009). In fact, a recent meta-analysis found racial discrimination had the largest effect on mental health outcomes (Carter, Lau, Johnson, & Kirkinis, 2017), providing further evidence for racism as a form of stress. These indirect assessments of racism are linked to increased risk of anxiety (Soto, Dawson-Andoh, & BeLue, 2011), depression (Lee & Turney, 2012), and increased symptoms of PTSD (Polanco-Roman, Danies, & Anglin, 2016), leading scholars to infer that racism may be a type of traumatic stress (Carter, 2007; Helms, Nicolas, & Green, 2010).

Current diagnostic criteria for trauma and stress-related disorders does not consider race-based experiences of traumatic stress, although research demonstrates risk and prevalence for PTSD is greater among racial/ethnic minorities compared to non-Latino Whites (Alexander et al., 2017; Kaczkurkin et al., 2016; Alcántara, Casement, & Lewis-Fernández, 2013). Furthermore, though White Americans report greater exposure to trauma (Roberts, Gilman, Breslau, Breslau, & Koenen, 2011), prevalence of PTSD appears highest among African Americans (Alegría et al., 2013), which may also be linked to lower rates of recovery (Pérez Benítez, 2014). These discrepancies suggest traumatic experiences may be more impactful for African Americans and it can also be inferred that racism may play a role in the ability to cope with race-related traumatic stress. Calling attention to frameworks that seek to understand racism through the lens of trauma but lacking diagnostic tools to assess
psychological harm linked to racism, Robert Carter proposed the race-based traumatic stress model (2007; RBTS).

The RBTS model provides a nonpathological framework for understanding racial/ethnic minority clients’ experience of emotional pain linked to racism. Developed utilizing literature on racial discrimination and mental health, the model is parallel to the current diagnostic criteria, identifying classes of racism (i.e. avoidant-, hostile-, aversive-hostile racism) and associated symptoms clusters (e.g. depression, anger, avoidance, intrusion) to assist helping professionals in the assessment and treatment of race-related psychological harm (Carter, 2007).

From this framework, Carter and colleagues (2013) developed the Race-Based Traumatic Stress Symptom Scale (RBTSSS) as a tool for the assessment and treatment of emotional reactions to racism and racial discrimination. The RBTSSS was validated on both racially diverse and predominantly Black American samples, across gender (i.e. males vs. females, and socioeconomic status (i.e. low vs. high SES), and studies demonstrates support for both the construct and predictive validity of this measure (Carter & Muchow, 2017; Carter, Muchow, & Pieterse, 2017; Carter et al., 2013). Still early in its development, individual differences in race-based traumatic stress utilizing the RBTSSS has not yet been studied however, the literature on race-related stress and health provide evidence for the interactive effects of demographic variables on poor health outcomes linked to racism (Brown, Richardson, Hargrove, & Thomas, 2016; Greer, Laseter, & Asiamah, 2009).

Research provides evidence for gender variation in the experience of racism among African Americans (Jackson, Shestov, & Saadatmand, 2017; Kwate & Goodman,
African American women and men report similar frequency of everyday racism, but African American men report greater instances of major lifetime incidents of racism compared to African American women, specifically racial violence (Kwate & Goodman, 2015). These gender differences mirror the racial discrepancies in exposure and prevalence of PTSD between Black and White Americans, such that although African American men report greater frequency of exposure to race-related stress, African American women report worse health outcomes (Umberson, Williams, Thomas, Liu, & Thomeer, 2014; Greenman & Xie, 2008) and have higher allostatic load (Chyu & Upchurch, 2011). Scholars infer that these discrepancies may be linked to gender differences in type or constellation of stressors (Jackson, Shestov, & Saadatmand, 2017), perceived discrimination (Dambrun, 2007), and response to stress (Hill & Needham, 2013).

Frequency of stress exposure does not solely account for stress reactions linked to poor health outcomes; intensity and duration of stress are also critical factors. Chronic stress is linked to increased allostatic load (i.e. wear and tear due to stress) leading to changes in brain and bodily functions that increase vulnerability to stress-related diseases (McEwen, 2012). Compared to White Americans, Black Americans have greater probability of high allostatic load scores (Geronimus, Hicken, Keene, & Bound, 2006) and Black women have the highest allostatic load scores compared to all other racial/ethnic groups (Chyu and Upchurch, 2011; Geronimus, Hicken, Keene, & Bound, 2006). Geronimus and colleagues suggest living and attempting to cope in a “race-conscious society” may be taking a toll on Black Americans (2006, p. 832).
The 2012 murder of unarmed, African American teen, Trayvon Martin and subsequent not guilty verdict for murderer George Zimmerman, sparked a pattern of increased racial violence directed toward African Americans. In the article, *Race and Homicide in America, by the Numbers*, federal statistics demonstrate a twenty-two percent increase in the number of African American lives taken by White individuals from the year 2014 to 2015. Scholars suggest increasingly public racial tension, discrimination, and violence within the United States may affect African Americans’ health resulting in “collective anger, grief, and hopelessness” (Alang, McAlpine, McCreedy, & Hardeman, 2017, p. 662). Additionally, scholars encourage explicit acknowledgement of racism when addressing health disparities commenting, “undermining or disguising the impact of racism on racial health disparities enables the perpetuation of these inequities” (Jee-Lyn García & Sharif, 2015, p. e27).

**Purpose of the Study**

The purpose of this study is to document and explore African American women’s experiences of race-based traumatic stress, health service utilization, and psychological well-being through the following research aims:

**Aim I.** Document the experience of race-based traumatic stress, psychological well-being, and health service utilization among African American women through quantitative-dominant survey measures (i.e. web-based survey).

**Aim II.** Utilize statistical analyses to explore the relationship between race-based traumatic stress, psychological well-being, and health service utilization
Aim III. Utilize interpretative phenomenological analysis (IPA) to ground the quantitative data of African American women’s experience of racial trauma within their lived experienced. These research aims will enable us to answer the following research questions:

**Research Question I**: What are African American women’s experiences of race-based traumatic stress?

**Research Question II**: What is the current status of African American women’s psychological well-being?

**Research Question III**: What are African American women’s health service utilization behaviors?

**Research Question IV**: Is there a relationship between African American women’s experiences of race-based traumatic stress, psychological well-being, and health service utilization behaviors?

**Significance of the Study**

To date no study has utilized the RBTSSS to study RBTS among African American women. Given what the health disparities literature reports about poor health outcomes among African American women (Belgrave & Abrams, 2016), we can infer that racism may play a role in both African American women’s appraisal of stress and vulnerability to stress-related diseases. This study seeks to clarify if, and in what ways, race-based traumatic stress is linked to health service utilization and health outcomes among African American women and hopes to provide recommendations for helping professionals treating this client population.
Chapter Two: Literature Review

This following literature review provides an overview of stress including different types (i.e. acute versus chronic) and how we identity stressors (i.e. cognitive appraisal). In this section, I also introduce and define race-based stress and trauma and review the literature on the physiological and psychological impacts of stress.

Overview of Stress

Acute versus Chronic Stressors

Stress is a normal part of everyday life. Physical crises, like riding the tallest roller coaster at the theme park, or emotional crises, like arguing with your friend, activate our stress response. Stressors that are short-lived, minimally intense, and rarely pose a threat to our physical safety, like sitting in traffic or giving a major presentation, are classified as acute. Prolonged or repeated experiences of stress, like poverty or child abuse, are classified as chronic stress and vary in frequency and intensity. Expanding the accepted dichotomous view of stress, Sapolsky (2004) suggests humans experience three categories of stress: acute physical crises, chronic physical challenges, and psychological and social disruptions (p.6). In his book, Why Zebras Don’t Get Ulcers, Robert Sapolsky argues that unlike zebras, humans’ stress response is activated both in response to actual and anticipated threats to our well-being. While other mammals (e.g. zebras) can experience both acute and chronic physical stressors, psychological distress, or worry, is unique to humans. Our brains and bodies readily adapt to meet the everyday demands of life (i.e. acute stress) however, when we are frequently exposed to stressors, or consistently consumed by anxiety, there are significant impacts on both our physiological and psychological well-being.
Cognitive Appraisal

How we identify stressors is often linked to our perception, which may change throughout our experience of a stressful situation (O’Connor, Wilson, & Lawton, 2017; Diehl & Hay, 2010; Guterman, Lee, Taylor, & Rathouz, 2009; Folkman, 1984).

Cognitive appraisal is the process we use to identify something as stressful. Bessel van der Kolk writes, “The most important job of the brain is to ensure our survival,” (2014, p.55). Our brains engage in a complex set of interactions to elicit a response to the demands in our environment. In order to respond, we must assess the incoming sensory information. This process is called appraisal (Corbetta, Sylvester, & Shulman, 2009).

Appraisals represent constructed interpretations of events and situations and they serve as a framework for how individuals make sense of and respond to their experiences. Research demonstrates that humans identify and respond to stressors through two pathways: primary and secondary appraisals, though they are not mutually exclusive (Sarafino, 2008; Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986).

Primary and secondary appraisals happen concurrently and include their own sets of nuanced interactions between conscious and non-conscious processes. To better understand these two pathways, we can explore the literature on stress and cognitive appraisal from the top-down (from our thoughts to our senses).

**Primary and secondary appraisal.** Primary appraisal refers to the assessment of demands in our environment. This assessment yields one of three judgments (i.e. irrelevant, good, or stressful), and demands that are perceived as stressful are further assessed for their potential impact (i.e. harm-loss, threat, or challenge). Secondary appraisal refers to assessing whether we have the resources to meet the demands of our
circumstances, our ability to cope with a stressor. When we do not believe we have the resources to compete with the physiological and psychological demands presented to us (i.e. discrepancy), we may experience immense stress (Prati, Pietrantoni, & Cicognani, 2010; Sarafino, 2008; Yakhnich & Ben-Zur, 2008). How people make these judgments is influenced by characteristics of the individual person, situation, and the interaction between those characteristics (Sarafino, 2008). Controllability, previous experience, and the ability to regulate our emotions account for differences in our cognitive appraisal.

**Controllability.** The literature demonstrates an association between locus of control, an aspect of our personality, and our appraisal of events as stressful. A construct from social learning theory, locus of control describes the extent to which people feel in control of their lives and environment (Kormanik & Rocco, 2009; Rotter, 1966). A multidimensional concept, locus of control proposes a differential relationship between reinforcement and expectancy, specifically, reinforcement strengthens expectancy. Expectancy may be influenced by a variety of factors including: value of the outcome, self-efficacy, understanding and trust of the reward system, and avoidance of negative outcomes (Kormanik & Rocco, 2009). Viewed along a continuum, from internal to external, individuals with an internal locus of control believe that they exert (or at least have the ability to exert) a certain amount of influence over their world. Conversely, individuals with an external locus of control often believe they have little to no influence over their world; life is just happening to them. The less control you believe have over your life, the more stress you tend to experience, suggesting locus of control mediates the relationships between stress, health, and well-being. Individuals with an external locus of control tend to report greater stress, lower life satisfaction, and higher levels of illness,
but locus of control only partially mediated these relationships (Karaman, Nelson, & Cavazos Vela, 2017; Roddenberry & Renk, 2010; Hamlyn-Wright, Draghi-Lorenz, & Ellis, 2007). Although locus of control cannot fully explain why we experience stress, it can change the way individuals experience the impacts of stress. In fact, research demonstrates that individuals with a more internal locus of control experience fewer negative effects of stress (Watson, 2016; Gray-Stanley et al., 2010; Hay & Diehl, 2010).

Crucial to both the identification and impact of stressors, the literature provides some context to how our locus of control develops.

Theories about the antecedents of locus of control, also referred to as generalized control expectancies, suggest children’s early interactions with parents or primary caregivers influence the development of control expectancies (Carton & Nowicki, 1994; Rotter, 1966). Carton and Nowicki (1994) report that both consistency of parental behaviors and parental control of children’s behavior exert significant impacts on the development of control expectancies. Their review revealed that parents who provided their children with more autonomy and exercised consistency in reward and punishment behaviors, fostered the development of an internal locus of control (p. 38). Furthermore, the literature suggests an association between stressful early life experiences and children’s generalized control expectancies; the earlier stressful life events occur for children, the more external their locus of control (Carton & Nowicki, 1994). Freedom to explore and consistent messages from primary caregivers help children develop a sense of control over their world. Stressful early life experiences on the other hand, especially those involving parents and caregivers, contribute to the development of more external control expectancies, which in turn, impacts our experience of stress.
Supporting the Carton and Nowicki (1994) findings, Roazzi, Attili, Di Pentima, and Toni (2016) studied the impact of parental maltreatment and attachment style on children’s developing locus of control. Comparing victims of maltreatment (e.g. physical abuse, neglect, etc.) to a comparison group, they found maltreated children reported greater external locus of control. Even more interesting, their study demonstrated that as they get older, maltreated children exhibit greater external locus of control (Roazzi, Attili, Di Pentima, & Toni, 2016). The authors suggest that early and prolonged experiences of suffering (i.e. cumulative trauma) may prevent the development of a more internal locus of control. Control expectancies are thought to be most vulnerable to change during the early stages of life, given our lack of experience (Carton & Nowicki, 1994; Rotter, 1966). Unlearning powerlessness however, can be difficult depending on the nature of one's previous experiences.

**Fear learning.** Anxiety is a reaction to stress however, not everyone who experiences stress develops anxiety. Individual differences in how previous experiences shape our appraisals of stress can be examined through literature on classical conditioning. A learning theory proposed by John Watson, classical conditioning suggests learning new behaviors is about association. Therefore, individual differences in behavior are related to differential experiences in learning (Mcleod, 2014). Fear conditioning, a specific form of classical conditioning, where a previously neutral stimulus can elicit a fear response after being paired with aversive events, is one pathway for understanding how previous experiences can impact our appraisal (Cushman & Fanselow, 2010).
In a comprehensive overview of the etiology and maintenance of anxiety disorders, Mineka and Oehlberg (2008) integrated research on fear conditioning and associative learning to demonstrate individual differences in fear conditioning. The results suggest that fear conditioning is impacted by familiarity with the stimulus, controllability, and what happens after the conditioning experience. The more novel an unconditioned stimulus, the less control we perceive, and the subsequent experiences we have post-conditioning have the potential to strengthen the conditioned fear (Mineka & Oehlberg, 2008). Similarly interested in the development of anxiety, Britton, Lissek, Grillon, Norcross, and Pine (2011) conducted a review on the interactions between threat appraisal, fear learning, and attention. The authors suggest biased threat appraisals are learned and may manifest as “perturbed fear generalization gradients” (p.9). Fear generalization refers to the process whereby individuals associate their past fears with present stimuli, for example, people, places, or things (Dymond, Dunsmoor, Vervliet, Roche, & Hermans, 2015). Biased threat appraisals may indicate an overgeneralization of fear, impacting an individual’s ability to distinguish between safe versus threatening stimuli (Britton et al., 2011). How we learn about danger can bias our response, further enhancing our perception of certain stimuli as stressful or threatening. The association between fear learning and appraisal is further complicated when we consider the nuanced interaction between our cognitions and our emotions.

**Emotions.** The brain developed from the bottom up to ensure our survival (Van der Kolk, 2014). Appraisal and stress response processes represent a complex feedback system within each individual. Focusing on the more complex cognitive processes we engage to assess threatening stimuli, I reviewed the nuances in the literature on appraisal
from the top-down. At the bottom, we find our emotional brain. Responsible for kick-starting our physiological and behavioral responses to stress, the emotional brain is the evolutionarily oldest part of the brain, compared to the neocortex or rational brain (Van der Kolk, 2014). The first line of defense in the appraisal of threatening stimuli, the emotional brain consists of both the reptilian brain and the limbic system, also known as the mammalian brain. The reptilian brain is functional at birth and responsible for our basic needs: sleeping, eating, crying, etc. The limbic system, composed of a variety of brain regions, is responsible for monitoring danger and heavily shaped by our genetics, temperament, and early experiences. During threat detection, the emotional brain rapidly processes incoming sensory information (e.g. sight, smell, touch, etc.) and passes it along two pathways in the amygdala: the low road and the high road. Incoming sensory information is communicated directly from the thalamus to both the amygdala (i.e. the low road) and the frontal lobes (i.e. the high road) (LeDoux, 2000). Distinguishing these pathways from one another is the time it takes to receive the information. By a matter of milliseconds, incoming sensory information first reaches the amygdala then the frontal lobes (i.e. bottom-up).

The initial recipient, our amygdala, is where we first appraise stimuli as threatening however, it cannot do so alone. Automatically enlisting the help of the hippocampus, a part of the limbic system responsible for long-term memory (i.e. previous experience), the amygdala determines the emotional significance of the incoming information (i.e. threat appraisal). Van der Kolk (2014) describes the process like this, “If the amygdala senses a threat...it sends an instant message down to the hypothalamus
and the brain stem, recruiting the stress-hormone system and the autonomic nervous system (ANS) to orchestrate a whole-body response” (p.60).

Given that ensuring survival is the brain’s primary function, this appraisal process happens outside of our conscious awareness, until milliseconds later when our frontal lobes have a chance to catch up. Sensory information traveling along the high road, specifically the medial prefrontal cortex, is subject to deliberate and conscious appraisal. The amygdala is concerned with communicating a message of danger, preparing the body for action or escape (i.e. fight or flight or freeze). The frontal lobe, able to provide a more complex assessment of the stimuli, regulates the automatic alarm system by either confirming the presence of danger or deactivating the stress response. Emotions and cognitions work together to create an understanding of the demands in our environment, influencing how we respond to those demands.

The role of emotions in our appraisal of stress emphasizes our brain’s sensitivity to danger cues. Commenting on the fragile relationship between our emotional and rational brains, Van der Kolk (2014) writes, “when the limbic system decides something is a matter of life and death, the pathways between the frontal lobes and the limbic system become extremely tenuous” (p. 64). In other words, identifying what or why we are upset becomes more difficult to do once our stress response is activated. Characteristics of the stressful situations such as frequency, intensity, and duration moderate our biological response to threatening stimuli, distinguishing acute from chronic stress (Sarafino, 2008).
Race-Based Stress and Trauma

Law professor Destiny Perry writes, “race is a loaded and ubiquitous word, social category, and concept in American culture” (Peery, 2017, p.1821). Her comments capture how impossible it seems to define and summarize race—a social construct with no genetic basis and a complex history. The complexity of race stems from how the construct is used, for example, pairing one’s beliefs about race with prejudice and power to create oppressive or harmful experiences for people of color, also known as racism. Another complex term, scholars define racism as ideology, oppressive power, and institutional structures that can lead to physical and emotional harm for racial and ethnic minority group members (Brondolo, Libretti, Rivera, & Walsemann, 2012; Williams & Williams-Morris, 2000; Clark, Anderson, Clark, & Williams, 1999; Thompson & Neville, 1999; Jones, 1997; Omi & Winant, 1994). Additionally, critical race theorists describe racism as “an ingrained feature of our landscape,” suggesting that experiencing racial stress is relatively common for most people of color in the United States (Delgado & Stefancic, 2017; Rollock & Gillborn, 2011, p.2).

Racial/ethnic minority group members reactions to experiences of racism can range anywhere from mild irritation to intense panic attacks, and for some, racism evokes a trauma response (e.g. dissociation, intrusive thoughts, etc.). This variation reinforces suggestions from scholars like Robert Carter, to expand the current diagnostic criteria to include racism as a type of traumatic stress (Carter, 2007). Carter (2007) defines racism as a complex and dynamic phenomenon involving relationships between individuals, institutions, and the dominant culture. His scholarship distinguishes race-based traumatic stress (RBTS) from posttraumatic stress disorder (PTSD), such that RBTS
refers to “emotional trauma brought on by the stress of racism,” whereas PTSD criteria identifies traumatic stress as life threatening (APA, 2013; Carter, 2007, p. 25).

Acknowledging the breadth and range of experiences captured by most definitions of racism, including his own, Carter and colleagues “deconstruct” racism into three types or classes, racial discrimination, racial harassment, and discriminatory harassment. They suggest these classes help quantify experiences of racism, identify symptoms individuals report related to specific acts or experiences, and increase our understanding of links between racism and individual mental health outcomes (Carter, 2007).

**Racial Discrimination**

This class of racism is categorized as “avoidant racism,” and accompanied by “behaviors, thoughts, policies, and strategies that have the intended or accidental purpose or effect of maintaining distance or minimizing contact between dominant racial group and non-dominant racial group members” (Carter, 2007; Carter, Forsyth, Mazzula, & Williams, 2005). These instances of racial discrimination or “everyday racism” seek to “problematize” the beliefs and values of non-dominant cultural groups, keeping them “in their place” (Carter, 2007; pp. 76-77; Essed, 1991). Carter suggests acts of racial discrimination may look like denying the existence of racism, physical and symbolic violence (i.e. intimidation), or marginalizing non-dominant groups (e.g. using non-Latino Whites as the normative group) (2007, p. 77). Research on racial discrimination stress links emotional responses to poor mental health outcomes such as increased depression, anxiety, and higher rates of psychosis (Cokley et al., 2017; Polanco-Roman, Danies, & Anglin, 2016; Donovan, Galban, Grace, Bennett, & Felicie, 2013; Ertel et al., 2012; McKenzie, 2006), and much of the research linking racial discrimination to poor mental
health outcomes focuses primarily on African Americans. Though Carter (2007) notes this as a limitation to be considered, he also suggests given the historical context of Black and Native groups in the United States, experiences of discrimination may hold a particular emotional salience for these populations leading to race-related stress (p.77).

**Racial Harassment**

This class of racism is categorized as “hostile racism,” defined by “feelings, thoughts, actions, strategies, behavior, and policies” intended to communicate the non-dominant groups inferior or subordinate status (Carter, 2007, p. 77). Racial harassment sends both explicit and implicit messages that racism is permissible and often prevents racial/ethnic minorities from receiving legal recourse for experiences of harassment or “well-documented” community violence (Museus, Ledesma, & Parker, 2015; Archibong, & Sharps, 2013; Williams & Mohammed, 2013; Nopper, 2011; Carter, 2007). Carter, 2007, pp. 77-78). Crime and policing is one area where racial harassment is often clear and the literature documents increased rates of arrest, incarceration, and drug-related criminal offenses among racial/ethnic minority groups, specifically African American males (Gase et al., 2016; Becker, Meghani, Tetrault, & Fiellin, 2014; Brewer & Heitzeg, 2008; Ramchand, Pacula, & Iguchi, 2006). Brewer and Heitzeg (2008) assert, “mass criminalization and incarceration [lead to] collateral consequences [that] further decimate communities of color politically, socially, and economically,” suggesting racial harassment impacts individuals and communities (p. 628). Racial harassment in the form of institutional policies and practices also silences non-dominant group members by leveraging their well-being against their employment, education, or social participation, “the person is expected to grant the ‘favor’ of ignoring racism for the opportunity to work
or live,” (Carter, 2007, p. 78). Hostile racism experiences can include assaults that are physical, interpersonal, or verbal in nature and often lead to emotional reactions such as mistrust, anger, low self-esteem, rage, and disappointment (Smith, Hung, & Franklin, 2011; Carter, 2007).

**Discriminatory Harassment**

This class of racism is categorized as “aversive hostile racism,” defined by “thoughts, behavior, feelings, actions, or policies and procedures that have strong hostile elements” creating distance between dominant group members and people of color “once they have gained entry into an environment” from which they were previously excluded (Carter, p. 79). This class was derived from “combinations and complex mixtures” of both avoidant (i.e. racial discrimination) and hostile racism (i.e. racial harassment) and can occur at multiple levels (Carter, 2007, p. 79). For example, increased workplace drug-testing among racial/ethnic minority individuals suggests implementation practices may be racially-biased (Becker, Meghani, Tetault, and Fiellin, 2014).

Discriminatory harassment can also be subtle in nature (i.e. racial microaggressions) or even subconscious, like holding colorblind beliefs (Stepney, Sanchez, & Handy, 2015; Fairhurst, Ashcraft, Van Laer & Janssens, 2011; Ryan, Hunt, Weible, Peterson, & Casas, 2007). In fact, endorsement of colorblind attitudes is associated with greater White identity and greater endorsement of stereotypes (Ryan, Hunt, Weible, Peterson, & Casas, 2007). Likewise among minority individuals, racial microaggressions are linked to decreased self-esteem, feelings of disempowerment, and poorer physical health (Houshmand, Spanierman, & De Stefano, 2017; Nadal, Griffin,
Carter (2007) suggests these distinctions can assist helping professionals in the assessment of both race-based and traumatic stress (p.81). Utilizing classes also helps identify emotional reactions as symptoms linked to the various types of racist encounters, allowing for a more accurate assessment of psychological functioning. Psychological functioning and symptom report are the pathways clinicians and researchers use to diagnose and distinguish psychological disorders from one another, subsequently informing treatment. But the creators of the race-based traumatic stress framework suggest that diagnostic criteria often pathologize the client, viewing emotional reactions as dispositional whereas the effects of racism are situational (Carter, 2007). Emotional and psychological reactions to racist encounters are an adaptive response to what the brain and body experience as a threat to one's well-being. Pathologizing racial and ethnic minority responses to racism reinforces stereotypes embedded in the dominant culture (i.e. racial discrimination). Carter (2007) proposes race-based traumatic stress is a non-pathological model that seeks to understand the emotional pain or injury associated with experiences of racism.

**Physiological Impacts of Stress**

All stressful situations elicit a physiological response known as reactivity. Reactivity to stress is measured by comparing response to stress to a baseline (i.e. resting) measure of arousal (Sarafino, 2008). Evaluating the individual’s heart rate, galvanic skin response (i.e. sweat), and blood pressure are just a few of the ways in which researchers may attempt to capture our physiological response to stress (Sarafino, 2008; Sapolsky,
Research in the field of stress physiology, or the study of how the body responds to stressful events, outlines the biological processes that occur when our brains appraise an event as stressful.

Reactivity is our brain’s way of preparing our bodies to respond to the threat; “the body is aroused and motivated to defend itself” (Sarafino, 2008, p. 67). This physiological process is often referred to as the fight-or-flight response and was proposed in the 1920s by physiologist Walter Cannon (Sarafino, 2008). When our fight-or-flight response is activated our limbic system sends danger signals resulting in an increased secretion of stress hormones like epinephrine, cortisol, and adrenaline. These stress hormones are responsible for observed increases in heart rate and blood pressure and are also vital to maintaining our survival (Van der Kolk, 2014; Sarafino, 2008; Sapolsky, 2004). Cannon believed this process was the brain and body’s attempt to reestablish equilibrium, also referred to as homeostasis. A self-regulating process, homeostasis suggests when distinct biological set points are disturbed, our physiological systems engage in an internal interplay in order to reestablish those set points (Cicchetti, 2011; Sapolsky, 2004). Curious about the links between homeostasis and stress, in 1936 a Hungarian endocrinologist named Hans Selye, proposed a theory about how humans respond to and manage stress.

Selye named his theory general adaptation syndrome (GAS), defining it as the “generalized effort of the organism to adapt itself to new conditions” (Selye, 1998, p. 231). GAS theory suggests that exposure to stress results in consistent symptoms emerging in three stages: alarm, resistance, and exhaustion. The alarm stage refers to the activation of the HPA-axis, most similar to our fight-or-flight response (Sarafino, 2008;
Selye, 1998). By the end of this stage, which according to Selye can occur anywhere from “6-48 hours after the initial injury,” the body is fully engaged for self-defense (p.230). As a result of prolonged physiological arousal, the body moves into stage two, resistance, attempting to reestablish balance or adapt to the stressor. The third stage, exhaustion, refers to repeated or long-term exposure to severe stressors (Sarafino, 2008; Selye, 1998). Exhaustion is the process by which the immune system is weakened, the body’s resources are depleted, and resistance is limited. Selye also believed the exhaustion stage was where stress-related diseases emerge (Sarafino, 2008, Sapolsky, 2004).

Recent literature exploring stress physiology both supports and refines GAS theory. Bush, Obradović, Adler, and Boyce (2011) studied cumulative contextual stressors on the adrenocortical activation of a diverse sample of kindergarteners to determine whether chronic stressors (e.g. poverty, race, etc.) demonstrate a unique physiological response. The authors collected information about chronic stressors from participants’ parents and saliva samples from the children to assess their cortisol levels. Their results demonstrated strong positive correlations between cortisol levels and indicators of chronic stress, specifically: socioeconomic status, ethnicity, and adversity (p.1095). Correlations between cortisol and indicators of stress were consistently significant from Fall to Spring, suggesting that Selye was correct, chronic exposure to stressors consistently evokes the release of stress hormones.

Selye also observed that laboratory rats became sick after prolonged exposures to stressors. This observation led to the suggestion that exposure to a stressor of significant intensity, for a period of longer than three months, would result in a depletion of
resources to defend against the stressor (Sarafino, 2008; Selye, 1998). Bush, Obradović, Adler, and Boyce (2011) reported however, that the values of the correlations between cortisol and indicators of stress decreased from Fall to Spring. According to GAS theory, cortisol levels should have been depleted. This discrepancy suggests a different take on Selye’s theory, a concept called allostatic load.

**Allostasis and Allostatic Load**

Allostasis is when our bodies attempt to adapt to change and when exposed to stress our brains send signals to a variety of bodily systems that promote adaptation or allostasis (Borsook, Maleki, Becerra, & McEwen, 2012; Cicchetti, 2011; McEwen, 1998). Under conditions of chronic stress however, the process of allostasis can become more harmful than helpful (Sapolsky, 2004). Allostatic load refers to the “wear and tear on the body” when we are consistently engaged in a process of allostasis or adaptation (Borsook, Maleki, Becerra, & McEwen, 2012; Cicchetti, 2011; McEwen, 1998, p. 37). Allostatic load consists of three types of physiological responses: frequent stress, failed shut-down, and inadequate response (McEwen, 1998).

Frequent stress refers to physiological responses determined by the frequency and intensity of stressful experiences; the more frequent and intense stressful experiences we have, the more our bodies work to adapt to those changes. Type one allostatic load may lead to either failed shut-down (i.e. type two) or inadequate response (i.e. type three). Failed shut down refers to persistent activation of the stress response. When our stress response never turns off our bodies struggle to replenish the resources utilized to adapt to stress, creating a state of constant exhaustion. Inadequate response refers to a lack of activity from bodily systems that regulate stress. Failure to secrete adequate amounts of
stress hormones creates a cascade effect of dysregulation, as other bodily systems attempt to overcompensate. The most intense or sustained stressors rarely deplete our resources however, with increased allostatic load, we become more susceptible to a variety of stress-related diseases (Borsook, Maleki, Becerra, & McEwen, 2012; Sapolsky, 2004).

Risk for developing stress-related diseases occurs directly, through our body’s physiological response, and indirectly, through modification of our health behaviors (Sarafino, 2008). During the process of allostasis, McEwen (1998) suggests that although some of our physiological responses are strictly maintained (e.g. blood oxygen, pH level), other systems are more susceptible to changes in our environment or internal state. Changes in health behaviors or the physiology of our cardiovascular, metabolic, immune, and central nervous systems exhibit reactivity to both acute and chronic stress (p.37). Most useful when rapidly mobilized or halted when no longer necessary, these systems must adapt to both internal and external stressors. When our stress response cannot be sufficiently activated, slowed, or suppressed (i.e. allostatic load), the reactivity of these systems and the associated changes in health behavior can become harmful to us, increasing our vulnerability to stress-related diseases (Sarafino, 2008; McEwen, 1998).

**Cardiovascular system.** Cardiovascular reactivity refers to our physiological responses to stressors (Sarafino, 2008). Preparing our bodies for physical activity, exposure to stress results in cardiovascular reactivity, such as increased heart rate and blood pressure (Murphy, Cohn, & Loria, 2017; McEwen, 1998). Our cardiovascular system, consisting of the heart and a network of blood vessels is responsible for pumping blood, oxygen, and nutrients throughout the body (The Cardiovascular System, 2016). Chronic stress in childhood can exert permanent changes on the cardiovascular system,
leading to a variety of risk factors for cardiovascular disease such as increased body mass index (BMI), resting heart rate, and cortisol response (Murphy, Cohn, & Loria, 2017).

Longitudinal research also demonstrates that cardiovascular reactivity increases with age, resulting in an increased risk for the development of cardiovascular issues (Sarafino, 2008; Uchino, Holt-Lunstad, Bloor, & Campo, 2005). Exposure to chronic stress is also linked to increased risks for coronary heart disease (CHD), hypertension, and stroke (Murphy, Cohn, & Loria, 2017; Sarafino, 2008; McEwen, 1998). Other risk factors for these diseases often include individual’s weight and cholesterol, suggesting interactions between the cardiovascular and metabolic systems, which may increase our susceptibility to stress-related diseases (Sarafino, 2008).

**Metabolic system.** Designed to work as efficiently as possible, our physiological systems work together to ensure overall healthy functioning. Our metabolism, part of our digestive system, converts carbohydrates and fats into usable energy (i.e. calories) to “heat the body and fuel its activities” (Sarafino, 2008, p.46). Differences in body-size, age, gender, and stress exposure impact metabolic rate. Individuals with a healthy weight (as determined by BMI), males, younger folks, and individuals exposed to low levels of stress tend to have higher metabolisms than comparison groups (Sarafino, 2008). In response to stress, our metabolism slows down, conserving energy to defend against a threat (Mandal, 2013; Sapolsky, 2004; McEwen, 1998). Exposure to chronic stress results in persistent suppression of our metabolism, posing an increased risk for developing obesity, diabetes, and atherosclerosis (Sarafino, 2008; McEwen, 1998, p. 38). Literature on eating behaviors and nutrition is one area where scholars demonstrate the impact of stress on the metabolic system.
Research on stress and eating behaviors suggests stress can both increase and decrease food intake, a relationship moderated by the severity of a stressor (Serlachius, Hamer, & Wardle, 2007; Torres & Nowson, 2007). An association that appears strongest among women, frequency and severity of stressors are positively correlated with greater risk for weight gain (Serlachius, Hamer, & Wardle, 2007). Ibrahim, Thearle, Krakoff, and Gluck (2016) also found high perceived stress and high positive emotional eating (i.e. eating in response to positive emotions/situations) were correlated with increased weight gain, further supporting the link between stress, eating behaviors, and weight gain. One explanation for this connection is that increased stress results in an increased production of cortisol, a hormone responsible for appetite stimulation (Ibrahim, Thearle, Krakoff, & Gluck, 2016; Sarafino, 2008).

Moreover, stress also impacts what types of food individuals choose to consume. Chronic life stress is associated with greater preferences for nutrient-dense foods, like carbohydrates, fat, and sugar (Torres & Nowson, 2007). Diets high in fat and sugar can result in insulin resistance and increased cholesterol levels, increasing the risk for type 2 diabetes and atherosclerosis (Sarafino, 2008). Our metabolic system requires balanced nutrition to maintain our bodily functions. This literature suggests stress exerts its impact on our metabolic system through the pathway of nutrition, shifting when, how much, and what we choose to consume. In addition, imbalanced nutrition can also impact our immune system functioning, another system subject to adaptations resulting from exposure to stress.

**Immune system.** Compromised immune system functioning increases our vulnerability to infectious diseases (Morey, Boggero, Scott, & Segerstrom, 2015; Raqib
and Cravioto, 2009). Composed of organs, proteins, tissues, and cells located throughout the body, the immune system is responsible for protecting our bodies from damage when we encounter “pathogens” or disease-causing bacteria and viruses (Morey, Boggero, Scott, & Segerstrom, 2015; Sarafino, 2008). Antigens, proteins located on the surface of pathogens, trigger our immune system response through two interrelated processes: cell-mediated and antibody-mediated immunity. T-cells, the immune system’s soldiers, are grouped by function (e.g. helper, killer, suppressor, etc.) and engage in cell-mediated immunity by attacking infected cells directly (Sarafino, 2008). Antibodies focus on attacking the antigen (e.g. bacteria in the body), as opposed to the cell, representing antibody-mediated immunity (Sarafino, 2008; Kennedy, 2001).

During experiences of acute stress, our immune system introduces cells into the bloodstream to protect against potential infection or injury that may occur as we defend ourselves against a threat (Morey, Boggero, Scott, & Segerstrom, 2015). Similarly, acute stress response is also linked to increased production of pro-inflammatory cytokines, which help to kill pathogens and promote healing. Chronic stress has also been associated with increased inflammation however, this represents a dysregulation of the immune system. Exposure to chronic stress can “[activate] latent viruses,” resulting in consistent activation of our immune response, an energetically costly process (Morey, Boggero, Scott, & Segerstrom, 2015, p.1; Sapolsky, 2004). As with other systems, chronic stress dysregulates the immune system, increasing an individual’s susceptibility to stress-related diseases, and we may be particularly vulnerable to these effects during certain developmental periods (Morey, Boggero, Scott, & Segerstrom, 2015; Sarafino, 2008; Kennedy, 2001).
During both childhood and old age, our immune system is highly sensitive to disease and less effective at healing, effects that can be further exacerbated by stress exposure (Morey, Boggero, Scott, & Segerstrom, 2015; Sarafino, 2008). Early life stress has been linked to immune system dysregulation through increased production of pro-inflammatory cytokines (Morey, Boggero, Scott, & Segerstrom, 2015). Exposure to chronic stress in childhood, like bullying or sexual abuse, can lead to increased levels of latent virus antibodies and systemic inflammation in adulthood (Morey, Boggero, Scott, & Segerstrom, 2015).

Research also demonstrates that older adults exhibit heightened reactivity to stress and increased difficulty suppressing stress response (Vitlic, Lord, & Phillips, 2014; Hay & Diehl, 2010). Exposure to stress in this population also results in longer wound healing times, elevated levels of cortisol, and increased production of inflammatory cytokines, which can lead to immune system resistance (Morey, Boggero, Scott, & Segerstrom, 2015; Vitlic, Lord, & Phillips, 2014). Cytokines are small proteins released by immune cells that communicate with other bodily systems also impacted by stress exposure, for example, the central nervous system (Zhang & An, 2007; Ader, 2001).

Central nervous system. The brain and spinal cord comprise the body’s central nervous system, which is responsible for controlling our thoughts, movements, and interpreting our environment (Sarafino, 2008). We now know, based on research from disciplines such as neurobiology, psychiatry, and neuroendocrinology, that the brain is in fact the” target” of stress, (McEwen, 2013, p. 673; McEwen & Gianaros, 2011; Arnsten, 2009; Sarafino, 2008). When exposed to any sort of stimulus, the brain responds quickly, interpreting and determining the nature of the stimulus and what resources we have to
respond (i.e. appraisal). Stress appraisal mediates a variety of brain-body interactions through the process of allostasis including activation of the HPA axis, and adaptations in individual’s cardiovascular, immune, and metabolic systems (McEwen & Gianaros, 2011; McEwen, 1998). Research on brain plasticity demonstrates how stress impacts three specific parts of the brain, the hippocampus, amygdala, and prefrontal cortex, resulting in negative effects for an individual's’ health and well-being (McEwen, 2013; McEwen & Gianaros, 2011; Arnsten, 2009).

**Hippocampus.** Positioned in the medial temporal lobe, the hippocampus is implicated in memory, learning, and regulation of the HPA axis. Under conditions of stress, the glucocorticoid cascade hypothesis suggests the increased release of cortisol, a stress hormone biomarker, results in structural and functional changes in the hippocampus (McEwen & Gianaros, 2011; Sapolsky, Krey, & McEwen, 1986). High levels of or chronic stress results in neuronal remodeling such as shrinkage of hippocampal dendrites and reduced grey matter volume. This remodeling is linked to changes in gene expression and DNA transcription, suggesting stress-related effects may be heritable (McEwen, Nasca, & Gray, 2016; McEwen & Gianaros, 2011). These architectural changes in the hippocampus can also reduce information processing, decision making abilities, and create a “failure to terminate” response, dysregulating the activity in the HPA axis (McEwen & Gianaros, 2011). Although hippocampal morphology as a result of acute stress exposure appears reversible, exposure to chronic stress may exert permanent changes on the brain, impacting memory functions (McEwen, 2013; McEwen & Gianaros, 2011).
An inverted U shape is most often utilized to describe the relationship between stress and memory, suggesting optimal levels of stress can enhance memory, and stress levels that are too low or too high, impair functioning (McEwen & Morrison, 2013; Salehi, Cordero, & Sandi, 2010; de Quervain, Aerni, Schelling, & Roozendaal, 2009). Memory consolidation for emotionally arousing stimuli is enhanced during acute stress exposure, while memory retrieval is impaired (McEwen & Gianaros, 2011; de Quervain, Aerni, Schelling, & Roozendaal, 2009; Kuhlmann, Piel, & Wolf, 2005). In contrast to neutral stimuli, emotionally arousing stimuli can evoke behavior (i.e. fight or flight), suggesting interactions between the hippocampus and amygdala when exposed to stress (McEwen & Morrison, 2013; de Quervain, Aerni, Schelling, & Roozendaal, 2009).

**Amygdala.** In both humans and animals, the amygdala is responsible for memory consolidation, fear learning, and emotional regulation interacting with the hippocampus and other brain regions in complex ways (McEwen & Gianaros, 2011; Ressler, 2010; Rosenkranz, Venheim, & Padival, 2010). Depending on quality of activation (i.e. emotional arousal) in the amygdala, literature suggests differential impacts on implicit and explicit memory processes (Phelps & LeDoux, 2005). Generally speaking, emotionally arousing events are remembered better than neutral ones (van Giezen, Arensman, Spinhoven, & Wolters, 2005). However, increased activity in the amygdala is associated with stress-induced hippocampal plasticity, which can inhibit explicit memory and strengthen implicit memory (Arnsten, 2009). Additionally, compared to positive and neutral stimuli, fearful stimuli result in increased activation of the amygdala (Ressler, 2010), which can lead to both proactive and reactive responses to threat (Gorka, LaBar, & Hariri, 2016).
Proactive responses, such as active avoidance, prompt goal directed behavior in order to minimize exposure to threat and these responses are linked to both higher levels of anxiety and greater stress tolerance (Gorka, LaBar, & Hariri, 2016; Schlund, & Cataldo, 2010). Reactive responses, such as increased cardiovascular response or freezing behaviors, promote defense against a threat and these responses are linked to higher levels of impulsivity and aggression (Gorka, LaBar, & Hariri, 2016). Competing systems in the amygdala regulate expression of proactive and reactive responses, suggesting exposure to acute versus chronic stress may exert different structural and functional changes in the amygdala (Gorka, LaBar, & Hariri, 2016; Ressler, 2010; Schlund & Cataldo, 2010).

Acute stress exposure results in shrinkage of dendritic neurons, increasing the formation of emotionally salient memories (McEwen, 2012). Exposure to chronic stress results in decreased firing of inhibitory potassium ions, impairs the growth and development of nervous tissue (i.e. neurogenesis), and causes dendrite expansion in the basolateral amygdala (McEwen, 2012; Ressler, 2010). These deficits in the regulatory function of the amygdala due to chronic stress is associated with amygdala hyperreactivity or increased generalized emotional responses, such as fear and anxiety (Ursano et al, 2007). Amygdala hyperreactivity is found in individuals with early signs of cardiovascular disease and those suffering from mood and anxiety disorders like, depression and PTSD (McEwen, Nasca, & Gray, 2016; McEwen, 2012; Schlund & Cataldo, 2010; Ursano et al., 2007). Greater amygdala reactivity is also linked to neurochemical changes in the prefrontal cortex (PFC), a brain region particularly
susceptible to the impacts of stress (McEwen, 2012; McEwen & Gianaros, 2011; Arnsten, 2009).

Prefrontal cortex. The most evolved and last to develop, the prefrontal cortex (PFC) is responsible for higher order cognitive abilities like social and goal-directed behavior, executive functioning, and personality expression (McEwen & Morrison, 2013; Arnsten, 2009). The PFC is extremely sensitive and shifts rapidly when we are exposed to stress, exhibiting changes (i.e. deficits in executive functioning) after only one week or even a single exposure (Arnsten, 2009). Increased release of stress hormones in the PFC also shifts brain-body interactions from thoughtful, regulated responding, to rapid, intrinsic responses, which transfers control to the amygdala (Arnsten, 2009). This process is adaptive when individuals are in danger, strengthening fear conditioning and memory consolidation for emotionally salient stimuli but, these shifts also impact individuals’ decision-making abilities and inhibitory control (Arnsten, 2009). Exposure to chronic stress is associated with structural changes in the PFC such as reduced dendritic length, branching, and spine density, which can lead to deficits in attentional shifting and working memory (McEwen, Nasca, & Gray, 2016; Arnsten, 2009).

Development also plays an important role in the impact of stress on PFC functioning. Chronic and cumulative adversity in childhood is associated with reduced grey matter and impaired regulatory behavior, along with bodily effects such as elevated blood pressure and signs of obesity (McEwen & Morrison, 2013). Early life stress has also been linked to increased susceptibility and expression of psychosis biomarkers (McEwen & Morrison, 2013; Daskalakis, Oitzl, Schächinger, Champagne, & Ronald de Kloet, 2012; Pattwell et al., 2012). Additionally, communication between the PFC and
the amygdala shifts from positive to negative from childhood to adulthood (Gee et al., 2013), suggesting negative experiences may exert a greater impact throughout development. For example, chronic, uncontrollable stress (e.g. trauma) experienced early in life, impacts architectural development of the PFC and produces enduring effects into adolescence and adulthood (McEwen, Nasca, & Gray, 2016; McEwen & Morrison, 2013; Arnsten, 2009).

Vulnerable to stress as well as the impacts of aging, the interactions between the amygdala, hippocampus, PFC and other bodily systems are complex. Changes in these brain regions are associated with the development of a variety of mental health disorders, which is evidence of the impacts of stress on physiological and neurological systems that contribute to the development of psychopathology (McEwen, Nasca, & Gray, 2016; McEwen & Morrison, 2013; McEwen, 2012; McEwen & Gianaros, 2011; Arnsten, 2009).

In sum, the impacts of stress on our physiological systems are numerous. When exposed to changes in our physical and psychosocial environments, our bodies respond to those changes through complex and interconnected physiological mechanisms or allostasis (Cicchetti, 2011; McEwen, 1998). Allostasis can be adaptive, for example, activating our immune system to fight off a cold however, prolonged stress exposure results in increased allostatic load or “wear-and-tear” on the body (McEwen, 2004). Though adaptation is essential to human survival, persistent activation of our stress response has “negative, long-term effects that promote the illness” (Ellis & Del Giudice, 2014, p.1). Furthermore, McEwen (2004) suggests that “neural changes mirror the pattern seen in other bodily systems” (p.1), linking our physiological response to stress
(controlled by the brain) to the development of psychiatric disorders, such as depression and anxiety.

**Psychological Impacts of Stress**

Mood and anxiety disorders are most often implicated when discussing the impacts of stress on psychopathology (McEwen & Gianaros, 2011; McLaughlin et al., 2010; Calabrese, Molteni, Racagni, & Riva, 2009). Stress and its psychological sequelae are closely linked to the emergence of depression, anxiety, and PTSD. Furthermore, the reorganization of the *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5; American Psychiatric Association [APA], 2013) to include a section on “Trauma- and Stress-related Disorders”, may suggest a shift in the field toward understanding the unique impact of stress on the development of psychopathology.

**Depressive Disorders**

Formerly categorized under “Mood Disorders”, the DSM-5 revision separated depressive disorders from bipolar and other related disorders in terms of classification (APA, 2013). Depressive disorders share commonalities with respect to sadness, irritable mood, and various changes in somatic and cognitive functions however, are distinguished from one another other with regard to timing, duration, and etiology (APA, 2013, p.155). Major depressive disorder (MDD), referred to in the literature as depression, is the “classic condition” of this grouping, evidenced by distinct episodes at least two weeks in duration, with pronounced changes in affective, cognitive, and autonomic nervous system functioning (APA, 2013, p.155).

In the United States, the prevalence rate for MDD is 7% with differences in age and gender, suggesting higher rates among individuals 18-29 years old and up to three
times higher rates in females compared to males (APA, 2013, p. 165). Likelihood of onset is during puberty. Later in life onset is uncommon, and in the United States, incidence rates of MDD peak during the early twenties (APA, 2013, p. 165). Likelihood of experiencing recurrent depressive episodes decreases as length of remission increases however, individuals who previously experienced multiple, severe, or depressive episodes at young ages are at an increased risk for recurrence (APA, 2013, p.165).

Early onset appears to be a critical factor in the development of depressive orders. The literature suggests early life stress can exert “programming effects” on bodily systems that regulate stress, increasing the risk of developing psychopathology throughout the lifespan (Bandoli et al., 2017; McEwen & Morrison, 2013; McEwen, 2013; McLaughlin et al, 2010; Lupien, McEwen, Gunnar, & Heim, 2009, p. 434). The risk for developing MDD increases as adolescents approach puberty and adolescent girls appear to be at particularly high risk, suggesting associations between the onset of menstruation and development of depressive symptoms (Thapar, Collishaw, Pine, & Thapar, 2012; Andersen & Teicher, 2008; Birmaher & Brent, 2007).

Ironically, neurobiology literature on stress suggests estrogen exerts protective effects against the impact stress, which implies other factors, such as stress itself, may play a role in adolescent depression (McEwen, Nasca, & Gray, 2016). Literature linking early exposure to adverse or stressful experiences accounts for 54% of the risk for developing depression (Andersen & Teicher, 2008). Furthermore, stressful experiences such as child abuse, parental loss, or ongoing conflict are risk factors for both onset and recurrence of depressive episodes (Thapar, Collishaw, Pine, & Thapar, 2012; McLaughlin et al, 2010; Birmaher & Brent, 2007).
Studies of the life course of depressive disorders also demonstrate individuals with a specific genetic polymorphism (i.e. serotonin transporter 5HTT), exposed to early life stress (i.e. childhood maltreatment) are twice as likely to develop major depression, suggesting a gene by environment interaction may also play a role in the development of depressive disorders (Nugent, Tyrka, Carpenter, & Price, 2011; Lupien, McEwen, Gunnar, & Heim, 2009; Andersen & Teicher, 2008). These associations strongly suggest stress has enduring effects, which may heighten the risk of psychopathology in adolescence carrying over into adulthood.

Research supports links between exposure to stress in childhood and risk for depressive disorders in adulthood, demonstrating hyper-reactivity in the HPA axis of depressed adults who experienced abuse as children (Lupien, McEwen, Gunnar, & Heim, 2009). A recent study of US soldiers also demonstrated increased risk for major depression in soldiers who had experienced childhood maltreatment, further implying residual effects of stress in risk for mental health problems (Bandoli et al., 2017). Early life stress and genetic factors appear to exacerbate the effects of stressors in adulthood. Chronic stress in adulthood is associated with manifestation of latent effects of early life stress or maintenance of those effects, and increased levels of stress hormones over the lifespan is associated with both development of depressive symptoms and memory impairment (Lupien, McEwen, Gunnar, & Heim, 2009). Moreover, as individuals progress into old age the brain is less resilient to the impacts of stress, suggesting stress burden may exert a cumulative impact on the development of psychopathology.

In a longitudinal study on the development of MDD in a community-sample of aging women, Kasen, Chen, Sneed, and Cohen, (2010) found that multiple stressors, such
as marital stress and negative life events, results in elevated risk for depression in old age.
In particular, they found early high negative life events (i.e. measured starting at age 42) doubled the risk of developing late life MDD, which the authors suggest increases the risk for physical illness and exacerbates cognitive decline (Kasen, Chen, Sneed, & Cohen, 2010). Though onset and prevalence of depressive disorders is typically greater during adolescence, the literature demonstrates stressful experiences can increase risk for psychopathology throughout the lifetime (McEwen & Morrison, 2013; Kasen, Chen, Sneed, & Cohen, 2010).

**Anxiety Disorders**

Diagnostic criteria specify excessive fear and anxiety as key features of anxiety disorders, distinguishing fear as an emotional response to “real or perceived threat” and anxiety as “anticipation of future threat” (APA, 2013, p.189). This distinction suggests differences in physiological response to threat, such that fear may evoke arousal of the autonomic nervous system, whereas anxiety results in preparation for danger including cautious or avoidant behaviors (APA, 2013, p. 189). Decreasing in clinical significance and likelihood of onset with age, many anxiety disorders develop in childhood (APA, 2013). They often manifest as fear or anxiety responses that have surpassed developmentally appropriate periods and are distinguished from one another by the specific object or situation that evokes a fearful or anxious response (APA, 2013, p. 189).

Research on the lifetime prevalence of anxiety disorders suggests that specific and social phobias are the most common (i.e. 15.6% and 10.7% respectively), while generalized anxiety disorder (GAD) has a much lower lifetime prevalence of 4.3% (Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012). Diagnostic criteria
suggest specific phobias are most prevalent among adolescents, whereas GAD is more pronounced in adults and females are more likely to be afflicted than males (APA, 2013). Social anxiety disorder (SAD) seems to manifest at equal rates across the lifespan however, diagnostic criteria suggest an interaction between gender and development such that females are more likely to suffer from SAD than males, and these differences are more pronounced in adolescents and young adults (APA, 2013). The DSM-5 suggests lower overall prevalence rates however, specifies anxiety disorders as highly comorbid, which can present difficulties with regard to diagnosis (APA, 2013).

Comorbidity between these disorders is often underdiagnosed, particularly in community samples, where individuals may be more likely to present with physical or somatic complaints as opposed to psychological concerns (Hranov, 2007). Longitudinal data on prevalence and risk factors for comorbid depression and anxiety demonstrated that more than half of depressed individuals experience symptoms of comorbid anxiety, whereas less than a third of anxious individuals evidence comorbid depression (Almeida et al., 2012). Moreover comorbid depression and anxiety was identified as more “chronic and disabling” than either disorder alone, evidenced by lower rates of recovery (Almeida et al, 2012, p. 1630). The complex interplay between these disorders suggests one may be a precursor for the other and studies examining the relationship between stress and risk for development of psychopathology often assess for both (Bandoli et al., 2017; Michl, McLaughlin, Shepherd, & Nolen-Hoeksema, 2013; Almeida et al., 2012; Nugent, Tyrka, Carpenter, & Price, 2011).

Though diagnostic criteria suggest that prevalence of generalized anxiety decreases with age, the brain demonstrates diminished stress resilience in old age, which
may suggest stress increases the risk for late onset anxiety (APA, 2013; McEwen & Morrison, 2013). Research examining late onset GAD in elderly populations (i.e. 65 and older) report recent adverse life events, chronic physical or mental health conditions, and female gender, were principal predictors of late onset incidents (Zhang et al., 2015).

Most prevalent in childhood early life stress (ELS), such as adverse environments or family stressors, is also associated with risk for anxiety disorders, like GAD (Brandoli et al., 2017; Seib et al., 2017; McEwen & Morrison, 2013; Nugent, Tyrka, Carpenter, & Price, 2011; O’Connor, Rasmussen, & Hawton, 2010). Anxious individuals tend to exhibit bias threat appraisals early in life (Britton, Lissek, Grillon, Norcross & Pine, 2011). Children of anxious parents or family members are also at an increased risk for developing generalized anxiety, and anxiety disorders in childhood are predictive of both generalized anxiety and major depression in adulthood (Britton, Lissek, Grillon, Norcross, & Pine, 2011).

Treatment studies characterize generalized anxiety as highly comorbid, chronic (i.e. low rates of remission) and recurring, noting individuals can suffer for up to 20 years from the disorder (Katzman, 2009). Highly comorbid with other mental disorders, research examining generalized anxiety and posttraumatic stress symptoms following wartime trauma suggest stress exposure may be more closely linked to symptoms of posttraumatic stress disorder (Helpman, Besser, & Neria, 2015).

**Trauma and Stress-related Disorders**

The release of the DSM-5 introduced a new category, *Trauma and Stress-related Disorders*, suggesting an expansion of the diagnostic criteria related to stress and psychopathology. Diagnostic criteria suggest that stress and trauma are common
occurrences and the new category includes posttraumatic stress disorder (PTSD), formerly grouped under anxiety disorders, as well as acute stress disorder (ASD) and adjustment disorder. Resources from the National Center for PTSD suggest that 60% of men and 50% of women will experience at least one traumatic event in their lifetime (How Common is PTSD, 2016).

Discrepancies in risk and prevalence data suggest however, that not every individual who experiences a traumatic event will develop or be diagnosed with PTSD. In fact, diagnostic criteria report projected lifetime risk and prevalence for PTSD in the United States as 8.7% and 3.5%, respectively (APA, 2013). In contrast, research examining lifetime morbid risk and prevalence in mood and anxiety disorders suggest rates may be closer to 10.1% and 8% (Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012). The subjectivity of diagnostic criteria may account for these discrepancies, suggesting there are differences in the way practitioners label stressful experiences as traumatic (Van Hooff, McFarlane, Baur, Abraham, & Barnes, 2009), like when working with African American women.

Promoting health equity for African American women is the primary goal of the Black Women’s Health Imperative (BWHI). In their 2016 report, *IndexUS: What Healthy Black Women Can Teach Us About Health*, they focus on presenting a positive representation of Black women’s health however they also write, “while we may not be in mental health crisis mode, we are under a great deal of stress” (p.11). Along with encouraging Black women to explicitly share their experiences with healthcare providers, the *IndexUs* report also suggests considering Black women’s mental health in the current political context,
We acutely feel the pressure of family obligations, the demands of our work, economic pressures, and the expectations of us in our communities, not to mention just “being while Black” in a country where that seems increasingly problematic. Our experiences being Black and female nudge us to the edge of our capacity to cope (p.11).

Linking stress and racism, The IndexUs report notes that fewer experiences of racism and discrimination are associated with better psychosocial health, and even low levels of chronic race-based stress, “can accumulate and cause symptoms similar to PTSD” (p. 14). Referring specifically to the diagnostic criteria, the BWHI suggests for Black women, “the symptoms of mental illness can look like something else altogether” (2016, p. 11).

Fear and anxiety are common responses to threatening stimuli however, clinical presentations after exposure to stressful or traumatic events are more closely linked to symptoms like anhedonia/dysphoria, anger/aggression, or dissociation (APA, 2013; Friedman, Resick, Bryant, & Brewin, 2011). Symptoms usually emerge within the first three months of traumatic exposure however, there is potential for delayed onset suggesting it can take months or years before individuals experience symptoms (APA, 2013). Furthermore, studies confirming the existence of delayed onset PTSD (i.e. DPTSD) suggest stressful experiences throughout the life course (e.g. pre- and post-trauma) may play a role in distinguishing long versus short-term onset (Horesh, Solomon, & Ein-Dor, 2013; Fikretoglu, & Liu, 2012; Horesh, Solomon, Zerach, & Ein-Dor, 2011).

Onset of PTSD can occur at any age, though diagnostic criteria suggest younger individuals may be at an increased risk (APA, 2013). Studies examining exposure to early life trauma in young children (i.e. birth to first grade) and development of PTSD found that greater sociodemographic risk, greater trauma exposure, and lower
developmental competence contributed to more severe PTSD symptoms (Enlow, Blood, & Egeland, 2013). Similarly in adolescents, elevated scores on measures of lifetime depression, trauma history, social support, and family conflict were associated with increased risk for PTSD following natural disasters (Danielson et al., 2017). Factors like gender and type of trauma, may mediate the development and clinical presentation of posttraumatic stress symptoms suggesting that PTSD is both complex and highly variable across groups (Gradus, 2017; APA, 2013; Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012; Galovski, Mott, Young-Xu, & Resick, 2010). Moreover, sociodemographic risk factors, like poverty or inadequate social support, are associated with greater risk for trauma exposure and increased risk for development of psychopathology (Enlow, Blood, & Egeland, 2013; Holt, Buckley, & Whelan, 2008).

Variability in risk and onset is also seen in rates of recovery from PTSD. More than half of adults diagnosed with PTSD achieve complete recovery in three months, while others may experience symptoms for as long as 50 years (APA, 2013, p. 277). What’s more, the literature demonstrates links between risk for symptoms of posttraumatic stress, recurrence, or intensification of symptoms and subsequent traumatic experiences, earlier age of onset, elevated physiological arousal, and persistent life stress, further highlighting the complexity of trauma (Gapen et al., 2016; Karam et al., 2014; APA, 2013).

In sum, the psychological impacts of stress can manifest in a variety of psychological disorders. Revisions and challenges to current diagnostic criteria suggest clear individual differences in the expression of psychological reactions to stress (APA, 2013; Carter, 2013). Differences in rates of mood and anxiety disorders as well as
trauma have been linked to gender, age, and race/ethnicity, implying that certain populations (i.e. African American women) could be at increased risk for the development of psychopathology. Furthermore, differences in trauma exposure (i.e. stress), risks or protective factors, and symptoms endorsement do not explain higher rates of PTSD among African Americans (Alegría et al., 2013), suggesting race may play a significant role in African Americans psychological response to stress.

Collectively, this literature documents the significant impact stress has on individuals and the importance of addressing such an impact in the lives of people. Moreover, examining the significant impact of racial stress is necessary, as it poses an additional layer of stress that Black women in the US face daily and contributes to poor health outcomes for this population.

**Theoretical Framework**

**Approaches of Stress**

Stress is a highly subjective term, for which researchers and clinicians alike struggle to provide a precise definition. In 1936, Hans Selye borrowed the term “stress” from physics, to describe, “the non-specific response of the body to any demand for change” (“What is stress?” 2017). Demands for change are called stressors, and they can be physical or psychological (Sarafino, 2008). Stressors vary in form and impact and are often characterized by elements such as intensity, duration, and type. Adaptive if experienced infrequently, and with minimal intensity (i.e. acute stress), stress that is persistent (i.e chronic stress) or extreme (i.e. traumatic stress) is maladaptive, exerting harmful impacts on our physiological and psychological systems (Ray, Gulati, & Rai, 2017; Ellis, Griffith, Allen, Thorpe, & Bruce, 2015; Borsook, Maleki, Becerra, &
Sarafino (2008) provides a brief summary of how health psychologists have come to understand and study stress by outlining three specific approaches: stimulus, response, and process (p. 62).

The “stimulus approach” focuses on identifying the physical or psychological demands in the environment that are contributing to one’s experience of stress. Lack of basic needs such as food and sleep, as well as a variety of psychosocial demands, like discrimination, contribute to our experience of stress (Neblett, Bernard, & Banks, 2016; Giurgescu, Engeland, Zenk, & Kavanaugh, 2013; Bush, Obradović, Adler, & Boyce 2011).

The “response approach” focuses on the individual’s reactions to stressors. Reactions are referred to as strain, and similar to demands can be both physiological or psychological (Sarafino, 2008). Our physiological reactions to stress often manifest immediately as increased heart rate or blood pressure and over time, or with prolonged exposure to stress, can lead to the development of chronic health issues like cardiovascular diseases (Chae, Nuru-Jeter, Lincoln, & Jacob Arriola, 2012; Johnston & Lordan, 2012; Sawyer, Major, Casad, Townsend, & Mendes, 2012).

Finally, the “process approach” seeks to understand stress by including stressors, strain, and the relationship between the individual and the environment (Sarafino, 2008; Folkman, 1984). In this approach, individuals are seen as “active agents” who engage in transactions (i.e. behavioral, cognitive, or emotional shifts) with their environment that influence the impact of a given stressor (Sarafino, 2008, p. 63). The association between
the individual and the environment suggests a bidirectional relationship between both how we identify and respond to demands for change.

Each approach uniquely contributes to our understanding of this dynamic, relational, and complex term. Therefore the proposed study will use a combination of these three approaches to define stress or, “the circumstance in which transactions lead a person to perceive a discrepancy between the physical or psychological demands of a situation and the resources of his or her biological, psychological, and social systems” (Sarafino, 2008, p.63).

**Phenomenological Frame**

Phenomenologists believe human experiences are inherently organized in a meaningful way. Moreover, some encourage researchers to “set aside” previous knowledge in order to “investigate what is experienced and how it is experienced” (Wertz, 2011, p. 125). This notion highlights two camps of phenomenologists, followers of Husserl and those who follow Heidegger, the founding fathers of phenomenology (Finlay, 2011; McConnell-Henry, Chapman, & Francis, 2007; Moustakas, 1994). Husserl’s followers, or researchers who align with descriptive phenomenology, seek to analyze and describe participants’ experiences in order to identify and articulate common features, as defined by those who have experienced the phenomenon (Finlay, 2011; Wertz et al., 2011; Moustakas, 1994). Phenomenologists who follow Heidegger, a student of Husserl, are identified as conducting interpretative phenomenology, or research aimed at analyzing and interpreting participants experiences, in order to comment on how participants make meaning of the phenomena under study (Finlay, 2011; McConnell-Henry, Chapman, & Francis, 2007).
Heidegger challenged Husserl's ideas about research seeking to provide a pure description of an experience, suggesting that anything individuals experience is also interpreted (McConnell-Henry, Chapman, & Francis, 2007). This distinction highlights differences between the two camps, particularly regarding the role of the researcher. Husserlian phenomenologists utilize techniques like “bracketing” or setting aside the researchers’ assumptions or preconceived notions about an experience, in order to “freshly reflect” on examples of the phenomena (Wertz, 2011, p.125). Heidegger’s followers believe however, that researchers’ previous knowledge is central to the practice of phenomenology as a research method, and suggest little distinction between how we come to know (i.e. epistemology) and what is real or exists (i.e. ontology) (McConnell-Henry, Chapman, & Francis, 2007). Interpretive phenomenological researchers acknowledge their presence in the participant’s world, using techniques like reflexivity, or providing the researcher’s stance and connection to the phenomena under study upfront (Finlay, 2011).

Despite their differences, scholar-practitioners note that the push for researchers to ascribe to a purely Husserlian or Heideggerian tradition may be an unnecessary, forced dichotomy (Finlay, 2011). Instead, phenomenological research methods can be viewed along a continuum, “with different researchers valuing more highly one or the other side” (Finlay, 2011, p. 110). The continuum perspective seems particularly relevant for the use of phenomenology within mixed methods research, where phenomenological inquiry is utilized to complement alternative methods (Mayoh & Onwuegbuzie, 2015). The current study will use a mixed methods phenomenological framework, with a specific focus on the Heideggerian side of the phenomenological continuum.
**Heideggerian phenomenology.** Heideggerian, or hermeneutic, phenomenology demonstrates a “shift in commitment away from description and towards interpretation” (Finlay, 2011, p. 109). In her book, *Phenomenology for Therapists*, Finlay (2011) outlines four tenets of hermeneutic phenomenology: “commitment beyond science toward humanities; explicit use of interpretation; reflexive acknowledgement of the researcher’s involvement; and emphasis on expressive presentation” (p. 111). The relational nature of Heideggerian phenomenology implies that, “research findings are co-created” in the dialogue between researcher and participant. This “intersubjectivity” however, is contingent upon the researcher’s ability to “attune empathically” to participant’s experience, calling attention the position of the researcher in relationship to the research project (i.e. researcher’s stance) (p. 113).

**Researcher’s Stance**

In alignment with Heideggerian phenomenological research methods, scholars (Visser, 2017; Nelson, 2005; Peshkin, 1988) suggest that explicit acknowledgment of researcher subjectivity contributes positively to one’s research agenda. Nelson (2005) suggests writing in the researcher’s subjectivity,

…can be considered a means of expanding or enriching one’s data sources; tracing one’s complex and fraught positionings vis-à-vis the research participants or the subject matter; or recognizing one’s own limitations as a researcher (p. 315).

Given both the value in the broader literature, and the core of researcher reflexivity to the practice of Heideggerian phenomenology, I will explicitly state my stance regarding the proposed research utilizing these advantages noted by Nelson (2005).

**Enriching one’s data source.** With regard to the proposed project, my identity as a Black American woman allows me ingroup status (Van Laar, Bleeker, Ellemers, &
Meijer, 2014) among African American women, which may facilitate recruitment of
research participants through social and professional networks. Additionally, my
experiences as a Black American woman, my prior research experiences, and my clinical
experiences with individuals of African ancestry serve as “expert knowledge” (Mayoh &
Onwuegbuzie, 2015), providing a unique closeness to both the research participants and
phenomena under study. This insider perspective has the potential to help build rapport
with participants and increase their sense of safety and willingness to be forthcoming
throughout the research process.

**Tracing complex or fraught positioning.** While my closeness to both the
participants and phenomena under study may be an asset to the proposed project, my
identity as a Black American woman also contributes to the motivation to conduct this
research. I explicitly acknowledge how my identity as a Black woman influences the
research agenda including choice of research questions and aims, methods, and data
analysis. To assist with decreasing the influence of my own subjectivity (i.e. previous
understandings, investment in research outcomes), scholars suggest intentional and
consistent reflection throughout each step of the research process (Finlay, 2011; 2003).

On the other hand, my position as an academic, researcher, and clinician also
influences the research agenda, given muddled relationship between the Black
community, academia, and psychology as both a discipline and practice. For many
African American women, these entities have historically failed at bringing to the
forefront the impact of racism within the Black community in a way that validates their
emotional pain (Simmons, 2017). My connection with psychology and the academy
highlights the power dynamic between participant and researcher, calling for me to be
mindful of and respond empathically to potential resistance from participants when I ask them to share their experiences of racial stress.

**Recognizing one’s own limitations.** Along the same lines, explicitly addressing the ways in which I contribute to the power dynamic within the research relationship provides me with an opportunity to address my own limitations, specifically my phenotype (i.e. fair skin and light eyes). Affording me privileges both within and outside of the Black community, in my experience, my racial identity and phenotype create confusion for others. Furthermore, in previous experiences conducting research with individuals of African ancestry, participants often make explicit their questions about my personal connection to the research agenda. As I move throughout the research process, I am mindful of how my privileged lens imposes limits to my understanding and interpretation the phenomena of interest (i.e. racial stress).

**Conclusion**

Cohen and Minas (2008) note “social positions of different populations put them at differential risk of stress” (p. 350), linking social determinants of health (e.g. gender, SES, and race/ethnicity) to increased vulnerability for psychopathology. The literature also suggests higher rates of trauma (e.g. PTSD) among people of color compared to non-Latino Whites (APA, 2013, p. 276) and African Americans appear to be at an increased risk compared to other racial/ethnic groups (i.e. non-Latino Whites, Asian Americans, Afro-Caribbeans, and Latinos) (Alegría et al., 2013). Disparities research reveal poor health outcomes particularly for African American women, and suggest a need for research that addresses social determinants of health to assist in achieving health equity for African American women (Belgrave & Abrams, 2016). The call to action for African
American women’s health is clear and the proposed study seeks to utilize mixed methods phenomenological research (MMPR; Mayoh & Onwuegbuzie, 2015) to document and explore African American women’s experiences of race-based traumatic stress, health service utilization, and psychological well-being.
Chapter Three: Methods

Methodological Framework

Spates (2012) refers to Black women’s daily realities as, “facing multiple forms of discrimination at once” (p.4). She also suggests psychological research as one domain where, historically, Black women’s experiences are pathologized and excluded. Highlighting the dynamic relationship between science (e.g. research) and racism, Spates (2012) argues Black women’s experiences cannot be explained using mainstream psychological knowledge and calls for research approaches that allow Black women to speak to their own experiences. Her call to action echoes Few, Stephens, and Rouse-Arnett (2003) who propose research should seek to validate knowledge, raise consciousness, and empower Black women. Taken together, these recommendations promote the use of non-traditional, multi-faceted research methods (Thomas, 2004), such as mixed methods research (MMR), when exploring the complexities of African American women’s experiences. The current exploratory study adhered to this recommendation.

**Mixed methods research.** Tashakkori & Creswell (2007) define mixed methods research (MMR) as, “research in which the investigator collects and analyzes data, integrates the findings, and draws inferences using both qualitative and quantitative approaches or methods in a single study” (p. 4). MMR comes to life by challenging monolithic research practices and integrating eclectic techniques. An ever-evolving approach, many scholars (Castro, Kellison, Boyd, & Kopak, 2010; Leech & Onwuegbuzie, 2009; Onwuegbuzie & Collins, 2007; Teddlie & Yu, 2007) have outlined various typologies of MMR designs, providing both guidance, and a healthy debate about
“core characteristics” of the MMR approach (Teddlie & Tashakkori, 2012). In fact, Teddlie and Tashakkori (2012) assert that the time has come for contemporary mixed methods researchers to, “develop a core identity of commonly understood characteristics and principles” (p. 783).

**Concurrent mixed methods research.** Concurrent MMR designs are characterized by simultaneous qualitative and quantitative data collection in order to increase efficiency and provide “multiple angles” to explore and understand the research problem (Table 1, Creswell & Zhang, 2009, p. 615). Though some concurrent designs are fully mixed with respect to the integration of qualitative and quantitative methods across the research study, other studies are partially mixed (Leech & Onwuegbuzie, 2009). Concurrent partial MMR designs include separate, yet simultaneous data collection, resulting in an integration of the two data sources during interpretation (Creswell & Zhang, 2009, Leech & Onwuegbuzie, 2007). Additionally, concurrent partial designs allow for more efficient data collection and intuitive analysis, one of the advantages of concurrent MMR designs highlighted by Creswell and Zhang (2009). It could be argued that efficiency and intuition speak to some of the core characteristics of MMR research; one example is methodological eclecticism (Teddlie & Tashakkori, 2012). Methodological eclecticism refers to the creative selection and integration of qualitative, quantitative, and mixed strategies to, “thoroughly investigate the phenomena of interest” (Teddlie & Tashakkori, 2012, p. 776). Considering these advantages, the current study used concurrent partial MMR methods.

**Mixed methods phenomenology (MMPR).** To address gaps in the psychological literature on Black women’s health Spates (2012) recommends,
“allow[ing] Black women themselves to contribute” to the conversation (p. 6), aligning well with phenomenological research, which seeks to provide, “meaning-oriented, descriptive knowledge” (Wertz et al., 2011). Mixed descriptive phenomenology aims to identify common features of a phenomenon to describe its “essence” or “structure” (Mayoh & Onwuegbuzie, 2015, p. 96). Descriptive phenomenologists utilize bracketing (Overgaard, 2015) or setting aside assumptions, in order to reduce the researchers’ influence on the data (Mayoh & Onwuegbuzie, 2015). This approach results in a focus on “general characteristics rather than individual experiences” in order to, “focus on the experience alone” (Tuohy, Cooney, Dowling, Murphy, & Sixmith, 2013, p. 18).

Mixed interpretive phenomenology aims to explicitly describe, understand, and interpret humans’ actions and behaviors (Mayoh & Onwuegbuzie, 2015), through the context of their realities (Tuohy et al., 2013). Smith and Osborn (2008) argue that interpretative phenomenology is “concerned with an individual’s personal perception or account of an object or event, as opposed to an attempt to produce an objective statement” (p. 53). Interpretive phenomenology places a reduced emphasis on phenomenological attitude (i.e. objectivity) (Finlay, 2009), and instead views the “researcher’s subjectivities” as “expert knowledge,” contributing to meaning-making throughout the research process (Mayoh & Onwuegbuzie, 2015, p.97). The current study used mixed interpretative phenomenological research methods in order to provide a clearer picture, and more meaningful documentation of African American women’s experience of racial stress.
Research Design

As the MMPR approach becomes more popular, scholars critique MMPR researchers for offering limited justification for mixing phenomenology and alternative methods (Mayoh & Onwuegbuzie, 2014). Exploring the implementation of MMPR in empirical studies, Mayoh and Onwuegbuzie (2014) propose five purposes of mixing phenomenology with an alternative method: grounding, framing, orientating, confirming, and layering (pp.10-11). The current study used grounding as justification for mixing phenomenology with quantitative methods.

Grounding refers to MMPR that collects, “rich experiential data in order to ground the quantitative data within the lived-experience of participants” (Mayoh & Onwuegbuzie, 2014, p.10). This approach utilizes the strengths of phenomenological inquiry to “offset the weaknesses of alternative methods,” resulting in “more expressive and significant findings” (Mayoh & Onwuegbuzie, 2014, p.10; Robbins & Vandree, 2009). The current study used a grounding approach to MMPR to provide a clearer picture and more meaningful documentation of African American women’s experience of racial stress as a form of trauma.

Given the scope of this exploratory study, the current project ran in two phases: quantitative (i.e. phase one) and qualitative (i.e. phase two); the methods are organized with regard to phases. In the current study, I prioritized recruitment of participants and data collection for phase one (i.e. survey data) and then concurrently proceeded with phase two data collection (i.e. interview data). Recruitment for phase one began in March 2018 and recruitment for phase two began once the minimum number of participants (N=10; Creswell, 2013) indicated interest in phase two, approximately mid-
May 2018. Recruitment for both phases and data collection for phase one (i.e. quantitative) ended in June 2018. Data collection for phase two (i.e. qualitative) ended in July 2018.

**Quantitative Phase**

**Power analysis**

Traditional quantitative methods prioritize generalizability of study findings, goals to achieve a study sample that is representative of the population is often linked to sample size (Gravetter & Forzano, 2009; Teddlie & Yu, 2007). Researchers often use statistical power to achieve these goals and determine the probability that “a difference that exists in reality will be found in a particular study” (Goodwin, 2008, p.154). Alpha level, effect size, and sample size all exert effects on statistical power however, sample size is the only component directly controlled by the researcher. Increasing study sample size results in increased power or decreased probability type II error (Gravetter & Wallnau, 2007). Scholars suggest conducting an “a priori” estimate of study sample size, increasing statistical power, in order to reduce both the risk of random errors (Farrokhyar, Reddy, Poolman, & Bhandari, 2013) and conducting lengthy “unpowered” studies (Beck, 2013, p.2334).

For the current study, I conducted an priori sample size estimation (Beck, 2013), using power analysis software (i.e. G*Power) to estimate the minimum sample size. G*Power estimates for the current study recommended a sample size of 1294 (small effect, r=0.1), 139 (medium effect, r=0.3), and 47 (large effect, r=0.5) participants to maintain adequate power. Before data collection ended for phase one, a second power analysis was conducted to determine the close date for the survey. This second power analysis yielded lower G*Power estimates, recommending a sample size of 1077 (small
effect, $r=0.1$), 115 (medium effect, $r=0.3$), and 38 (large effect, $r=0.5$) participants to maintain adequate power. The discrepancies between the power analyses could be due to researcher error in the steps for power analysis (see Appendix J for steps).

**Sample size.** Beck (2013, p.2334) suggests aiming for a sample size “slightly above” the G*Power estimate and resources permitting, also recommends using the estimated sample size from the smallest effect size (i.e. $r=0.1$). Given the time limitations of the current study, the estimated sample size associated with the smallest effect size (i.e. 1294 participants) was neither feasible nor efficient (Teddlie & Yu, 2007). The current study combined the suggestions of these scholars (Beck, 2013; Teddlie & Yu, 2007) and aimed for a sample size that was both attainable and above the estimate provided by G*Power for a medium effect ($r=0.3$). One hundred and eighty individuals consented to participate in quantitative phase ($N=180$) and more than half were eligible to participate ($N = 135$).

**Participant Demographics**

**Inclusion/exclusion criteria.** To be eligible to participate in the study, participants had to: self-identify as a Black American or African American woman between the ages of 25-65 years old. Participants consented to participate using an electronic signature and then were asked to complete three eligibility questions (i.e. race, biological sex, and age range) in order to continue with the survey. One hundred and eighty participants ($N=180$) consented to participate in the online survey. Participants ($N=22$) who did not complete the eligibility questions or participants ($N = 23$) who did not meet the eligibility criteria (i.e. identified as male or intersex, selected more than one choice for race, reported their age as less than 25 or older than 65) were excluded from
further analysis (N = 45). All participants who met the eligibility criteria, that is they self-identified as a Black American or African American female, between the ages of 25 - 65 years old, were allowed to proceed with the remainder of the online survey.

**Participant characteristics.** One hundred and thirty-five African American women met the eligibility criteria for participation in the study (see Table 2 for background characteristics of the sample). The participants ranged in age from 25 to 62, with a mean age of 36.8 years. Household size, not including the participant, ranged from zero to seven people, with an average household size of two people. The majority of participants (93.3%) reported being born in the United States and indicated the same for both their mother (87.4%) and their father (83.7%). Participants’ geographic location included all four major U.S. regions and some women were located outside of the U.S. (1.5%). The majority of participants reported their geographic location as the South Atlantic U.S. (41.9%) and only one participant was from the East South Central U.S. Most participants in the sample identified as heterosexual/straight (83%) and reported their relationship status as single (37.8%) or married (23%). Ninety-one percent of the sample reported voting in the last election and the majority of participants denied U.S. military service (96.3%).

**Socioeconomic status.** The participants’ highest level of education or degree received ranged from high school/GED equivalent to professional degree, with the most participants reporting completion of their master’s degree (57.8%). The majority of the sample endorsed working as paid employees (87.4%) and household income ranged from less than $10,000 to $150,000 or more. Equal numbers of participants (N=16) reported their income range as within either the $30,000 to $39,999 (11.9%) or $50,000 to
$59,999 (11.9%) ranges. Of note, the sample for the current study was highly educated and gainfully employed (i.e. common protective factors), and caution should be taken when generalizing the results of this study to other populations of African American women in the United States.

**Measures**

**Psychological well-being.** This study used the Mental Health Continuum Short Form (MHC-SF) to document participants’ psychological well-being. The MHC-SF is a 14-item measure that collects information about individuals’ positive symptoms and life functioning, utilizing subscales of emotional, psychological, and social well-being (Keyes, 2009; 2002). The MHC-SF is composed of the “most prototypical items representing the construct definition for each facet of well-being” (Keyes, 2009, p.1) from the MHC long-form (40-items, MHC-LF). Participants were asked to indicate the frequency of positive symptoms “during the past month” utilizing a six-point Likert scale for each item: 0 (never), 1 (once or twice), 2 (about once a week), 3 (about 2 or 3 times a week), 4 (almost every day), 5 (every day). In the current study, 116 participants completed the full MHC-SF and reliability analyses indicated good internal consistency ($\alpha = .924$).

The current study used continuous scoring to analyze participant responses on the MHC-SF. Responses were summed across all 14 items and then the average was taken to produce a mental health continuum score for each participant.

**Health service utilization.** The current study used the Access to Health Care and Utilization (AAU) portion of the National Health Interview Study (NHIS) questionnaire to document participants’ use of health-related services within the last 12 months. The
NHIS is an ongoing project run through the National Center for Health Statistics (NCHS), a branch of the Centers for Disease Control and Prevention (CDC). Data collection with the NHIS started in 1957 and is collected annually on four “core” components (i.e. household composition, family core, child core, and adult core); supplemental data that varies from year to year (NHIS Manual, 2017c; NCHS, 2017).

The NHIS measures health trends and progress toward national health objectives through confidential, standardized interviews with respondents who are selected through partnership with the U.S. Census Bureau (NHIS, 2017a). NIHS data and questionnaires are “in the public domain” and do not require permission for use (NCHS, 2017).

Psychometric properties for the NHIS are currently unavailable however, the 2016 NHIS Survey Description report notes, “The content of the NHIS questionnaire is revised periodically, with the last major revisions occurring in 1982 and 1997” (NCHS, 2017, p. 10). Questionnaires ask respondents about a “broad range of health topics” (NCHS, 2017, p.7) and NHIS items appear to be clear, explicit, and general enough to be useful with diverse populations in the United States (e.g. African American women).

The AAU is a section of the adult core questionnaire and consists of 107 items on health service access and utilization. Following recommendations from Beatty (2014) about using questions from previously administered questionnaires of health service use, 46 items were selected from the AAU for administration in this study. When necessary, item wording or order of administration was adapted to assure consistency with the study research questions (i.e. documenting health service use among African American women). In the current study, 114 participants provided information about their health service utilization. Items were grouped using the following categories: general use,
delayed service use, specific use, and special tests and health checks and some included subcategories (e.g. logistics, specific provide type, etc).

**General use.** Items in this category gather general information about participants’ use of health services when sick, needing advice about their health, and when seeking preventative care. The response format for use of health services was multiple choice, with four options: 1 (yes), 2 (no), 7 (refused), or 9 (don’t know). Participants were also asked to specify the kind of health service location used when seeking care and the response format was also multiple choice, with eight options for kind of health service location items: 1 (clinic or health center), 2 (doctor's office or HMO), 3 (hospital emergency room), 4 (hospital outpatient department), 5 (some other place), 6 (doesn't go to one place most often), 7 (refused), or 9 (don’t know).

**Delayed service use.** Healthcare patients report delaying the use of health services for a variety of reasons. Items within this category assessed logistics reasons for delaying service use, types of services delayed due to lack of affordability, and issues related to prescription medication adherence for participants within the last 12 months.

**Logistics.** Common logistical reasons for delaying service use included being unable to get through on the telephone, unable to get an appointment soon enough, having to wait too long once at the doctor’s office, doctor’s offices closed during patient availability, and lack of transportation.

**Affordability.** Common services delayed due to lack of affordability included dental care, mental health care or counseling, obtaining eyeglasses, filling prescriptions, seeing a specialist, or receiving follow-up care.
Prescription medication adherence. Common adjustments patients make to their prescription medication protocol to save money included skipping doses, taking less medicine, delaying filling prescriptions, asking doctors for lower cost medication, buying prescriptions from another country, and using alternative therapies.

Specific use. Items within this section assessed participants’ specific use of healthcare services including types providers visited and locations where they received healthcare within the last 12 months.

Provider type. Common providers visited for health care services include dentists, mental health professionals, optometrists, foot doctors, chiropractors, allied health professionals, nurse practitioners or physician’s assistants, women’s health doctors, specialty healthcare professionals, and general practitioners.

Service location. Options for service locations included hospital emergency rooms, patient homes, doctor’s offices, and health clinics.

Special health checks and tests. Items within this section assessed any specific health checks participants received over varying periods of time (i.e. within the last 10 years, within the last 12 months) including non-required vaccines, blood tests, and conversations with healthcare providers regarding individual health behavior (e.g. smoking).

Nonrequired vaccines. Immunization/vaccine recommendations vary by age, gender, and health risk factors. Requirements and exemptions are decided by state health departments, based on recommendations for the Centers for Disease Control (CDC). In 2018, CDC recommended immunizations for adult women between 25-65 years old included vaccinations often received during childhood (i.e. Tdap, MMR, Varicella,
Hepatitis A, and Hepatitis B) and vaccinations received during in adulthood (i.e. flu, Shingles, pneumonia, and HPV).

Health checks and screens. Health care providers may recommend or request health screens or have conversations about health behaviors based on patient age, gender, as part of routine health assessment, or due to health risk factors.

Racial stress. The Race Based Traumatic Stress Symptom Scale (Carter et al., 2013) was used to assess participants’ experiences of racial stress (i.e. memorable event of racism) and emotional or psychological stress reactions related to those experiences.

Experiences of racial stress. Participants were asked to provide descriptions of up to three memorable events with racism, along with the setting, geographic location, and period of life during which each event occurred. Participants were also asked to select the most memorable experience of the descriptions provided and use that event as a reference point when answering the remaining questions. Using the most memorable event participants were asked to specify how often (i.e. never, only once, a few times, several times, or all the time) they experienced that event during each period of life (i.e. childhood, adolescence, adulthood, or later adulthood).

Endorsement of race-based traumatic stress. Participants also used the reference point event to answer yes/no questions about if the event was emotionally painful, sudden, and/or uncontrollable (i.e. criteria for traumatic stress). Endorsing events “yes” to the criteria for trauma stress was the first indicator that race-based traumatic stress may have occurred (Carter & Sant-Barket, 2015).

Reactions to racial stress. Using the one event as a reference point, participants were also asked to indicate frequency of 52 emotional reactions (i.e. symptoms) related to
the event both immediately after (i.e. within one month of the event) and during the time of the study (i.e. thinking about the event presently). Frequency of symptoms was reported using a five-point Likert scale for each item, with the following options: 0 (does not describe my reaction), 1 (infrequent), 2 (sometimes), 3 (frequently), and 4 (this reaction would not go away). Participants also used a yes/no format to answer if other noticed a change in them for each reaction item. The 52 reaction items cluster together to form seven symptoms scales (Carter & Sant-Barket, 2015; Carter et al., 2013), and in the current study, reliability analyses were conducted on all seven symptom subscales for the after items and the recent items. The RBTSSS seven symptom subscales demonstrated good internal consistency with high Cronbach’s alphas ($\alpha = .8+$) for the after and recent items (see Appendix K for reliability alpha levels).

Participants received a score for each of the seven symptom scales. Symptom scale scores are summed and then converted to $z$-scores. Scores were then converted to $T$-scores using the sample mean for each symptom scale. Participants received a $T$-score for both the right after and more recent reaction scale items. $T$-scores on one or more symptom scales at 60 or higher, were considered elevated and suggest experiencing race-based stress (i.e. non-traumatic) or race-based traumatic stress. Participants who had three or more elevated symptom scales and reported memorable events as uncontrollable, sudden, and emotionally painful met the criteria for race-based traumatic stress (Carter & Sant-Barket, 2015). Participants who endorsed criteria for traumatic stress and had one or two elevated symptom scales and met the criteria for race-based stress (Carter & Sant-Barket, 2015).
Procedure

Recruitment. After approval from the Institutional Review Board (IRB), recruitment for the quantitative phase of the study started, followed by selection of participants for the qualitative phase. A convenience sample of African American women was provided with a web-link to the survey measure that was distributed to the researcher’s network through email and social media platforms (i.e. Facebook, Twitter), to personal and professional contacts of the primary researcher (e.g. former colleagues at other institutions) and community organizations serving African American women and girls (e.g. Urgent Inc.). Participants were also encouraged to pass along information to their personal and professional networks throughout the data collection process. Recruitment emails and social media postings described the study’s inclusion criteria and the purpose of the study, to document African American women’s experiences of race-based traumatic stress, psychological well-being, and health service utilization (see Appendix B). Recruitment materials also included researcher contact information and hyperlinked recruitment flyer (see Appendix C). Recruitment for the quantitative phase of the study followed recommendations for adapting snowball sampling procedures in order to gain access to “members of traditionally underserved or vulnerable populations” (Sadler, Lee, Lim, & Fullerton, 2010, p. 369), for example, connecting with leaders of support groups (e.g. Black Women in Higher Education, FB group) and organizations for African American women (e.g. National Council of Negro Women; NCNW) to recruitment potential participants.
Survey procedure. To increase reliability the current study used recommendations for improving the quality of Web-based surveys offered by Eysenbach (2004).

Consent process. Upon arriving at the survey platform participants viewed the informed consent page, including a brief description of the study’s purpose, design, and potential benefits and risks associated with participating in the study (see Appendix D). Participants were also informed of their right to withdraw participation at any point during the study, that they would not be compensated for their participation, and provided with contact information for the primary investigator and the IRB and Office of Human Subjects at the University of Miami. The informed consent page also included a labeled hyperlink allowing participants to print a copy of the consent, which included mental health resources, for their records. After endorsing three statements demonstrating an understanding of the informed consent, participants were asked to provide a digital signature consenting to participate. Individuals who provided consent moved on to eligibility criteria. Individuals who declined to provide consent were redirected to a webpage thanking them for their interest in the study.

Eligibility criteria. After giving consent, participants were asked to self-identify their racial identity, biological sex, and age range (i.e. eligibility criteria). Participants who were between the ages of 25-65 years of age, endorsed being female, and who selected Black or African American were allowed to proceed with the remainder of the survey. Individuals who did not meet the eligibility criteria were redirected to a webpage notifying them they did not meet the inclusion criteria and thanking them for their interest.
Participants proceeding with the remainder of the survey completed the measures in the following order: demographic information, Mental Health Continuum Short Form (MHC-SF), selected items from the Access to Care and Utilization (AAU) portion of the NHIS, and finally the Race Based Traumatic Stress Symptom Scale (RBTSSS). The web-based survey included the measures outlined in Table 1. After completing the RBTSSS measure, participants were directed to a page offering the opportunity to express interest in an interview (i.e. phase two). Participants were informed that follow-up participation was not required, interviewees would be selected at random by the research team, and their contact information would remain confidential and unlinked to their responses to the survey items. Participants expressing interest in phase two were redirected to a web survey asking them to provide their contact information. Participants who declined interest in the qualitative phase of the study were redirected to a page thanking them for their participation in the study and providing them with another opportunity to print the informed consent including mental health resources.

**Concurrent phase two recruitment.** Participants who indicated interest in the qualitative phase of the study were redirected to a separate survey and asked to provide their name, email address, phone number, and indicate best times to call (i.e. morning, afternoon, evening). Prospective interviewees were also informed that interview selections would be conducted at random and if were selected for an interview they would be contacted directly by a member of the research team for follow-up. After providing contact information, participants were directed to a page thanking them for their participation in the study and providing them with another opportunity to print the informed consent including mental health resources.
Qualitative Phase

Sample Size

In a review of sample size patterns among qualitative approaches, Mason (2010) reported studies including 10, 20, 30, and 40 participants were most common across approaches. Specifically for phenomenological research, Mason (2010) reported a range of 7-89 participants (i.e. low vs. high), with average number of 25 participants (Table 1). Creswell (2013) notes phenomenologists have recruited anywhere from “1 up to 525” participants and recommends recruiting anywhere from “5 to 25” participants for phenomenological research (p. 157). Given the current study’s time limitations, scholars recommendations regarding efficiency in MMR (Teddlie & Yu, 2007), and the incompatibility of applying saturation to phenomenological research methods (Saunders et al., 2017; van Manen, Higgins, & van der Riet, 2016), I aimed to obtain a qualitative sample of 10-12 interview participants, within the range specified by Creswell (2013).

Before contacting prospective interviewees, I consulted with my faculty committee regarding the sample size and received confirmation to conduct at most 12 interviews.

From late May 2018 to July 2018, I completed a total of 12 individual interviews.

The participants. Twelve self-identified Black American women participated in this phase of the study. The individual interview participants ages ranged from 25 - 65 years of age and all women were born within the United States. All but one of the women resided in the U.S., and every participant revealed that she had experienced racial stress. Each participant was asked to select a pseudonym for herself in order to help maintain anonymity, which is provided at the end of each quote. Though precautions were taken to protect participants’ identities by also de-identifying names of others,
specific locations, and/or job titles within each transcript, many of the women raised concerns about being identified by their experiences. Thus, given the focus of this research as well as the real and justified fear of repercussions, I decided not to provide written, detailed descriptions of the interview participants.

Procedure

Interview set-up. When a participant’s name was generated using the random selection formula, I contacted them via their preferred method. Email was the most preferred in this study. In the first email, I thanked the participant for being a part of phase one and asked them to confirm their interest in phase two. If interested, I asked participants to reply and share their location (city, state) and general availability (e.g. Wednesday from 5pm to 7pm) to help determine the best method for interview (e.g. Skype, in-person, phone, etc.). An electronic copy (i.e. pdf) of the consent form was also attached to the initial contact email. I reminded participants that the consent form would be reviewed before the start of the interview and encouraged them to ask me any questions beforehand. I sent participants who did not respond to the initial contact email, a follow-up email once a week for two weeks. If a participant did not respond by the end of the third week (N = 2), I marked them as “no response,” and selected another participant for interview using the random selection formula in Microsoft Excel. Outside of the non-response emails, no participants responded to the contact email explicitly declining interest in phase two.

For participants confirming interest in interviews, I used their general availability to create an online scheduling poll (i.e. Doodle). I responded with the Doodle link and asked them to select their preferred date and time for an interview. Once the Doodle poll
was completed, I sent each participant a confirmation email including the date, time, and method (e.g. Skype, phone) of their interview. I also provided my contact information (e.g. Skype username), asked them to provide the same and I closed the email with some additional information about the interview process (see Appendix for sample email). I also worked with some participants via email to answer questions regarding scheduling and to accommodate participant interview preferences (i.e. phone vs. Skype) as best as possible.

The day before each interview I sent reminder emails to participants to confirm their interview date and time and request any additional information needed (e.g. Skype username). Participants who missed their interview (e.g. due to other commitments) were provided with an additional Doodle poll, based on their previously provided availability, to reschedule their interview. Skype was the primary method used for conducting interviews (N = 10); two interviewees preferred the phone (N = 2), and no interviews were conducted in-person. All interviews were conducted in the same location in my home (i.e. living room) and I also tried to maintain consistent personal characteristics across interviews (e.g. hairstyle, clothing, etc.).

**Interviewee selection.** Once the minimum number of participants (N=10; Creswell, 2013) indicated interest in phase two, I exported the contact information from Qualtrics and imported the information into a Microsoft Excel document stored on a secure, password protected external hard drive. Participants were assigned random numbers and selected on a weekly basis using formulas for random number assignment and selection in Microsoft Excel. I repeated this process once a week until the target number of interview participants confirmed and completed interviews with me (N=12).
All prospective interviewees had an opportunity to be considered for interview participation (i.e. were a part of the weekly random selection) with the exception of interviewees who were already selected (i.e. duplicates).

**Interview questions.** In the current study I followed the interpretative phenomenological analysis (IPA) framework provided by Pietkiewicz and Smith (2014) for conducting “semi-structured, in-depth interviews” with participants (p.10). Pietkiewicz and Smith (2014) suggest semi-structured interviews allow participants and researchers to “dialogue in real time” while also allowing, “flexibility for original and unexpected issues to arise” (p.10). They suggest establishing rapport and preparing an “interview plan” (see Appendix L) with both “open and expansive” questions and “prompts” in the event participants think questions are too “abstract” (p. 10). Pietkiewicz and Smith (2014) report duration of semi-structured interviews is typically “one hour or longer” and highlight the necessity of both audio-recording and transcribing interviews verbatim (p. 11).

**Interview procedure.** On the day of the interview, I contacted participants at the time of the interview, unless receiving accommodation requests from the participant (e.g. needing five more minutes to get settled). Upon connecting I greeted the participant and thanked her for being a part of the research. I informed each participant she was not being recorded and engaged in brief small talk (i.e. “How are you?”) before providing her with the link to the informed consent. I sent each interviewee the link to a qualtrics survey with the qualitative phase informed consent (see Appendix E) based on the participant’s preference (i.e. Skype messenger, email, text). While reviewing the consent to together, I highlighted sections regarding their rights to withdraw participation and the
mental health resources provided within the risks and discomforts section. After answering any questions participants had, I reminded them of the electronic copy of this document attached to the initial contact email and encouraged them to ask me questions throughout the interview if necessary. I then asked them to type their first and last name, provide an electronic signature using their mouse or trackpad, and submit the consent survey. I confirmed receipt of the participant’s signed consent form by checking the Qualtrics database before starting each interview.

Once confirmed, I reminded interviewees about confidentiality and asked them to select a pseudonym to be their identifier for the files, transcript, and within the dissertation results. I made note of the participant’s pseudonym in their interview procedure document and in my researcher’s journal. My researcher’s journal is a paper journal where I took notes during the interview with the participant’s permission. No participants expressed discomfort with note-taking and I assured them that the researcher’s journal was only for me. Finally, I asked the interviewee for permission to turn on the audio recorders and begin the interview. All interviewees (N = 12) consented to participate in the interview.

The duration of each interview ranged in length, with the longest interview lasting for 1 hour 38 minutes, and the shortest interview lasting for 31 minutes. I began the interview by asking each participant to answer the question, “Tell me a little bit about yourself?” After gaining some background information about the participant, I proceeded with the first question, “Can you tell me about your experiences of racial stress?” (see Appendix L). As the interview proceeded, I followed up with questions relevant to their shared experiences (e.g. “Can you say more about…”), and other interview
questions/prompts that participants had not already addressed (e.g. “What did that feel like in your body?”). Before turning off the recorders, I offered participants the opportunity to ask me any questions and once answered, asked their permission to turn off the recorders, concluding the interview.

At the conclusion of the interview, I thanked each interviewee for her participation and reminded each about the mental health resources provided on her copy of the informed consent. I also asked participants which retailer (e.g. Amazon, Target, Walmart) they would prefer for their $10 e-gift card and asked them to confirm how they wanted to receive the gift card (e.g. email or text message). Within seven days of the interview date I purchased and sent a $10 e-gift card to each participant from their retailer of choice. After sending the gift card via the retailer’s website, I sent each participant a confirmation and thank you email, informing them of the anticipated date and time they would receive their card (i.e. typically 5pm EST on the date of purchase). I also encouraged interviewees to reach out to me with any issues redeeming the cards.

**Study Materials**

All interviews were audio-recorded utilizing two digital recording devices (i.e. Sungluber Digital Voice Recorder; Lemego Digital Voice Recorder). Each participant also had her own folder labeled with her pseudonym, which included two audio recordings of her interview, one interview procedure document, and one transcript document. Immediately following each interview, I transferred the audio recordings to a secure, password protected, external hard drive. Audio files were saved in an mp3 format and labeled with the participants’ pseudonyms and dates of the interviews. Participants’ selected pseudonyms also served as the label for the folder and their “name” throughout
the transcription document. Once I transferred the audio files to participants’ respective folders, the recordings were tested for playback and then deleted from the digital audio recorders. I transcribed each individual interview verbatim, in the order that they were conducted, and the transcripts were saved in the participant’s folder on a secure, password protected, external hard drive. All interview data were treated as research information.
Chapter Four: Results

Quantitative Results

Phase one of this study examined the following research questions:

Research Question I. What are African American women’s experiences of race-based traumatic stress?

Experiences of racial stress. Ninety participants provided a qualitative description of at least one memorable event of racism in their lifetime. The most frequently reported memories across all three events were multiple experiences of harassment and discrimination (31.1%) and verbal assaults (21.1%) (see Table 3). School (43.3%) was the most frequently reported setting for events, followed by work (20%) (see Table 4). Across all three events, adulthood was the most frequently reported period of life where participants experienced racial stress (see Table 5). More than half of participants (N=62) indicated the first experience of racial stress described was the most memorable experience (see Table 6).

Endorsement of race-based traumatic stress. The majority of participants endorsed memorable events as out of their control (N=76), unexpected (N=75), and a negative experience (N=89). Forty-six percent of participants endorsed all three criteria for race-based traumatic stress.

Reactions to racial stress. The average scale scores and range of T-Scores for each subscale of the Race Based Traumatic Stress Symptom Scale (Carter et al., 2013) are presented by scale in Table 7. Right after the event, self-esteem T-scores were the most elevated and more recently when remembering the event, avoidance T-scores were
the most elevated. Intrusion T-scores were the lowest both right after and more recently remembering the racially stressful event.

**Research question II.** What is the current status of African American women’s psychological well-being?

*Psychological well-being.* Mental Health Continuum Short Form (MHC-SF; Keyes, 2009; 2002) total scale scores ranged from 0.57 to 5.00 (see Figure 1), with a mean mental health continuum score of 3.18 \((SD = .93)\).

**Research question III.** What are African American women’s health service utilization behaviors?

*Health service utilization.* Endorsements for health service utilization behaviors among the current sample are presented in Tables 8-11.

*General use.* The majority of participants \((67.8\%)\) reported visiting a doctor or healthcare professional within the last six months and 64.9% of participants reported there is one place they typically visit when sick or needing advice about their health. When sick or needing health advice, most participants sought care at doctor’s offices \((78.5\%)\), followed by seeking care at health clinics \((17.2\%)\). Similarly, 88.6% of participants reported seeking routine or preventative care, at the same location they visit when they are sick. About thirty-five percent of participants reported changing the location where they seek services within the last 12 months, and almost half of those participants \((47.5\%)\) reported changes were due to health insurance.

*Delayed service use.* The most common reason participants reported delaying the use of health services was because they were unable to get an appointment soon enough \((32.1\%)\), followed by 13.4% of participants reporting doctor’s offices being closed when
they were available. Dental care (30.4%) was the most common service delayed, followed by mental health care or counseling (25.9%). Almost sixty-three percent of participants reported being prescribed medication by a doctor or healthcare professional and the most common adjustment was using alternative therapies (30%), followed by delaying filling her prescriptions (24.3%), and asking for lower cost medicine (24.3).

Specific use. Most participants reported seeing dentists (62.2%) or general practitioners (62.2%) within the last 12 months, followed by women’s health doctors (60.4%). Doctor’s offices (80.9%) were the most common location for participants seeking care, followed by health clinics (41.3%), and hospital emergency rooms (20.9).

Special health checks and tests. In the current study, most participants reported receiving a tetanus shot within the last 10 years (71.8%) as well as the Hepatitis B (62.7%) and Hepatitis A (47.3%) vaccines at some point in their lifetime. Ninety-one percent of participants reported having their blood pressure checked by a healthcare professional within the last 12 months. More than half of participants also reported the following health screens: Pap smear (68.8%), blood cholesterol check (66.1%), and fasting test for diabetes (50.5%). Almost half of participants (47.7%) report having a conversation about their diet within the past 12 months.

Research question IV. Is there a relationship between African American women’s experiences of race-based traumatic stress, psychological well-being, and health service utilization behaviors?

Multiple Regression. Multiple regression analyses were used to answer the research question about the relationship between African American women’s experiences
of race-based traumatic stress, psychological well-being, and health service utilization behaviors.

**Power.** A priori power analyses recommended obtaining a sample size of 1294 (small effect, r=0.1), 139 (medium effect, r=0.3), or 47 (large effect, r=0.5) participants to maintain adequate power for multiple regression. Though our sample size was close to the recommended suggestion for a medium effect (N=135), the model I used was large (i.e. seven independent variables) relative to our sample size.

**Multicollinearity.** The initial model was run using all seven dimensions however, multicollinearity issues were found as well the power issues demonstrated earlier. The Hypervigilance subscale was highly correlated (r ≥ 0.70) with the other RBTSSS subscales, particularly the Anger (r = 0.80) and Physical (r = 0.83) subscales. At that point, it was decided to remove Hypervigilance from the model based on the results of the multicollinearity analysis, particularly the correlation with the Physical and Anger subscales, resulting in a final model containing six subscales.

**Racial stress and psychological well-being.** Multiple regression analyses were used to test if six dimensions of race-based traumatic stress (i.e. Depression, Intrusion, Anger, Physical, Self-esteem, Avoidance) right after a stressful event significantly predicted Black American women’s current psychological well-being. The results of the regression were significant, indicating that the six dimensions explained 11.5% of the variance (R² =.12, F(6,109)=2.36, p<.05) in psychological well-being. It was also found that both the Intrusion (β = .022, p =.06) and Anger (β = -.025, p =.06) subscales approached significance when predicting current psychological well-being.
Overall, the African American women in the current study reported multiple, complex experiences of racial stress that increased their negative view of themselves and their avoidance behaviors. They experienced positive mental health two to three times per week and given that the current sample was highly educated and gainfully employed, the majority also reported using healthcare services regularly. Statistical analyses also demonstrated that racial stress had a significant and enduring impact on the psychological well-being of African American women in the current exploratory study.

**Linking Phase One and Two**

The quantitative data from phase one tells a complex story, understandably so, given the complexity of racial stress. To further amplify the voices of Black American women I also collected qualitative data (i.e. phase two) from some of the women who participated in phase one. Phase two provides some additional context about how African American women understand their experiences of racial stress and how these experiences relate to support-seeking behaviors.

**Qualitative Results**

Phase two was the qualitative portion of this study, where data were collected through individual interviews with participants from phase one. Through questions examining experiences of racial stress, 12 self-identified African American women recalled their experiences of racial stress, initial and subsequent reactions, and their experience of sharing with the researcher. In this section of the results I will use quotes from the participants’ narratives to highlight consistent themes that emerged across Black American women’s experiences of racial stress.
Presented in successive order, Pietkiewicz and Smith (2014) recommend total immersion in the qualitative data through re-reading transcriptions and replaying audio recordings. In the current study, I transcribed interviews verbatim and reviewed the interview transcripts and audio files multiple times, making exploratory comments about the data. This process can be challenging for researchers and IPA scholars suggest researchers engage in “critical self-awareness of their own subjectivity...and to be conscious of how these impact the research” (Finlay, 2008, p. 17). Researcher awareness was achieved through a continual process of reflexivity in which I, as the researcher, “shifted back and forth,” acknowledging my personal assumptions while also remaining open and curious to participants’ experiences (Finlay, 2009, p. 13). Pietkiewicz and Smith (2014) also suggest that discovering emergent themes involves shifting between “emic and etic” perspectives (p. 11). Multiple readings allowed me to “step into the participant’s shoes” (Pietkiewicz & Smith, 2014, p.11). One IPA technique I used to help discovering emergent themes was the hermeneutic circle (Tuohy, Cooney, Dowling, Murphy, & Sixmith, 2013; Reeder, 1998).

**Hermeneutic circle.** Based on Heideggerian philosophy, Reeder (1998) provides a model for use of the hermeneutic circle and defines the process as, “where the interpreter moves back and forth between the whole and its parts” (p. 66). Providing a structure for this process, Reeder (1998) suggests there are “four moments” of engaging the hermeneutic circle (i.e. inscription, anticipation, interpreting, and signification). Consist with Heidegger’s philosophy of “being-in-the-world,” Reeder (1998) suggests interpreters may enter the circle at any point, however, he recommends beginning with inscription.
**Inscription.** Another word for experience, Reeder (1998) suggests inscriptions are “imprints left in the body” that are “unavailable to introspection” (p. 67). Moreover, he suggests experiences must be interpreted to be accessible, so I used this concept to help me interpret participants’ experiences of racial stress by identifying for example, actions or “interactions with the Other” (i.e. individuals, social institutions) that brought me closer to an understanding of how African American women experience racial stress.

**Anticipation.** The moment of anticipation within the hermeneutic circle is equated with intuition or gut feelings, moments of understanding that are present yet, incomprehensible to an individual. Reeder (1998) calls anticipation “the realization in advance of something which is not yet in existence,” commenting again on the necessity of interpretation in order to make meaning (p. 68). In the current study I used anticipation as a way to facilitate interpretation of the African American women’s experiences of racial stress.

**Interpretation.** Reeder (1998) suggests interpretation is a dynamic process when he comments, “the instance of interpreting coincides with interpreting itself” (p.68). He elaborates on the process, noting that interpretation is always “informed” otherwise interpretations would be “arbitrary” and without meaning. Within the hermeneutic circle, meaning is seen as “demanding to be interpreted and come to speech,” implying that participants speak about their experiences with intentionality, and that the meanings associated with these experiences guide interpretation by the researcher (Reeder, 1998, p. 68). In the current study, I used meanings communicated through participant experiences to “inform and guide” my interpretation (Reeder, 1998, p. 68).
**Signification.** Reeder (1998) defines this moment of the hermeneutic circle as a “gift in return” (p. 69). This concept is similar to the therapeutic concept of insight (i.e. acquiring a new understanding) and “[offers] the opportunity to be in the world in decisive ways” (Reeder, 1998, p. 69). Not to be misunderstood as a static or final process, Reeder (1998) notes signification is about meaning and that the goal of meaning is “to be in motion” (p. 69). In the current study, I used signification as an indication of gaining insight into African American women’s experience of racial stress, while also being mindful to continue moving within the hermeneutic circle. Use of the hermeneutic circle assisted with bringing me into the “intersubjective space” (Finlay, 2009, p. 13) which increased my reflexivity and allowed for me to confidently transform my notes into themes.

Relationships and clustering was the final step of IPA suggested by Pietkiewicz and Smith (2014) used in this study. Following their recommendations, I compiled themes from entire transcripts before looking for clusters and removed themes that did not align with the emerging structure of the phenomenon. Then, I combined similar emergent themes to create clusters representative of the “emergent structure” (Pietkiewicz & Smith, 2014, p. 12) of African American women’s experiences of racial stress (see Appendix N analysis graphic).

I set out to answer four research questions regarding African American women’s experiences of race-based traumatic stress, psychological well-being, and health service utilization behaviors, but Black American women’s lived experiences of racial stress are complex and multi-faceted. To honor African American women’s experiences as truth, I did not attempt to force participants’ narratives to fit the proposed research questions.
Data analysis revealed four themes (i.e. racial stress is constant, the impact of racial stress is not a choice, response to racial stress is strategic, and support through sisterhood), divided into three categories (i.e. experience of racial stress, reaction to racial stress, and coping with racial stress) that relate to the focus areas of this research. The themes are presented in temporal sequence to reflect the additive complexity of the Black American women’s experiences of racial stress and also include salient subthemes. The themes and their associated subthemes are described below (see also Table 13).

**Experience of Racial Stress**

**Racial stress is constant.** A consistent message throughout the participants’ narratives was their experience of racial stress as a constant in their lives. All of the women disclosed experiencing racial stress at a young age, in both in- and out-group settings, whether or not they were cognizant at the time about what was happening. African American women also described racial stress as inherent to the Black experience, highlighting their heightened awareness of their racial identity, the weight of these constant experiences, and feeling exhausted by existing as a Black person within the United States.

Amari, for example, made a parallel between her awareness of her racial identity and her description of the U.S. as a White-dominant space.

...Your whole existence as a Black person, you’re always livin’ in a… in a… country that is…ran by White people for White people. Like you’re always under a constant… racial stress. …’Cause you’re always constantly aware. I feel like… having to constantly be aware of your color… is, is to live in a constant state of stress. So, yeah. (Amari)

Amari goes on to describe racial socialization practices and points out that Black people have been “conditioned” to live in a constant state of stress.
Her thoughts connect to a reflection that another participant, Kehlani, shared about the weight of existing as Black woman at work.

Like I walk into work and I walk into work like a hundred...**my full self** (emphasized words). Like I’m a Black...I’m a Black woman... so that’s gonna go with me all the time and everything that comes along with being a Black woman. Versus like coworkers who... they don’t have those intersecting identities so they don’t necessarily haveta... carry all the things that I’m carrying... you know when they go to work or when they go to the store or whatever. [exhales] But maybe [exhales] it’s a lot of...**prac-tice** (emphasized word) unfortunately? With carrying this... this type of... **bur-den** (emphasized word)? I don’t know if I really like that word but... just carrying **THIS** (emphasized word). And understanding that I don’t really have the luxury of... kind of...I don’t wanna say dealing with it. But I just don’t have the luxury of... like... it deterring me from what I need to do. *(Kehlani)*

Kehlani communicates some ambivalence about her use of the word burden however, her experience also mirrors the exhaustion that another woman, Brittani, shared when describing her experience of racial stress to her partner.

And he wants ta get ta like, “Well you know, what’s going on? Why are you so stressed? Why are you so depressed?” And I was like, **“BABY I’M BLACK!”** (emphasized word). THAT’S WHY I’M STRESSED.” And he was like, “... Oh.” I was like, “There’s not a significant event. There’s not a... something that someone said ta me.” It’s like **LITERALLY JUST EXISTING... as Black... is exhausting** (emphasized word). ... It’s just like... this is just my **daily** (emphasized word) experience. *(Brittani)*

There were a variety of specific, indirect, and direct instances of racial stress that Brittani and the other participants recalled during the interviews but, Brittani’s narrative reinforces the constancy of the overall experience of racial stress for Black American women.

**Reaction to Racial Stress**

**The impact of racial stress is not a choice.** Given the constancy of racial stress, it was no surprise that the next most salient theme related to the African American women’s automatic reactions to those experiences. Participants recalled a complex
mixture of feelings, thoughts, and bodily responses to racial stress but, appeared most
cognizant of their emotional reactions. Black American women described a range of
emotions like surprise, worry, exhaustion, hopelessness, and the most frequently
remembered emotion, anger.

Melissa, for example, recalled an experience of sitting with the few other Black
students at her predominantly White high school, and being asked by her White peers
during a lunch time assembly to help start the “Ebonics club.”

...And they looked directly at our table and we look at each other like, “You’ve
gotta be fucking (emphasized word) kidding me?” They’re like, “Yeah and you
guys could help us with that.” And I’m like, I’ll be damned if I help you with this
ignorant shit. In my mind, when I see that type of like dumb shit, I felt like I
needed to respond more aggressively. Like, Hell no. Fuck you and fuck him, I’m
not gon’ do this dumbass club. What even gives you the audacity to ask me that
stupid shit? Like also, that’s not the way I talk don’t assume shit about me, like
DON’T (emphasized word). It just be dumb shit, I’m just like gotdammit y’all
are dumb. So I would just get really angry, right. Just like, angry. (Melissa)

Melissa went on to describe the complexity of emotions that experience brought up,
highlighting embarrassment about being targeted and frustration about not being able to
control her emotional reaction to the situation.

Similar to Melissa’s frustrations about lack of control, Jane described her
emotional reaction to walking into a breakroom and hearing a White supervisor referring
to other Black students as “n-words.”

...what he was saying was problematic to be saying it. But the fact...it almost
made me more angry that he was like, “Oh I’m not talkin’ about you.” Back back
back back to n-word. I’m like, ugh. Ugh! It’s so in...okay, it was still insulting. ...It
was still... like… ugh [sighs], I dunno. I dunno. [long pause]... I dunno, that
was just… because then it made me ta…I… that was one time where I felt like I
shoulda said something. But I was so shocked (emphasized word), I didn’t…I
didn’t even say anything. You know what I mean? Like I was so…
SURPRISED, by the way he was talking. And that he was just… like no
hesitation no… ugh [sighs], I dunno. I was just so shocked by that. And again
looking back on it, I feel like that would’ve been a teaching moment to say, “You
may **not** (emphasized word) have been talking about me. But you’re calling...you’re using a racial slur... against other Black people. And **that’s** (emphasized word) inappropriate. So it...it doesn’t matter if you’re talking about me.” *(Jane)*

Jane’s experience demonstrates the uncontrollable impact of racial stress on African American women’s emotional and cognitive processes. Furthermore, her reflection about it as a “teaching moment” communicates what many other participants shared about how their reactions to racial stress have changed over time.

For example, when asked about her mood when experiencing instances of racial stress Troi shared how her anger reaction to racial stress has decreased with age.

I don’t think I experience anger anymore. I think that was something I experienced when I was younger...especially when I was attending the...my...my undergraduate institution. And trying to think about what it meant to be one of eleven Black people in my class...and one of 37 in my school. ...And what it meant for me to learn to code-switch immediately and for me to learn how to... navigate my emotions as they’re being read immediately in the moment. *(Troi)*

Troi attributes much of her anger response to her environment however, she also comments on the parallel process of having an emotional experience that others are both witnessing and interpreting for themselves.  

**Response to racial stress as strategic.** Troi’s comments are a perfect transition into the next theme about Black American women’s behavioral response to racial stress. Different from automatic reactions, African American women in this study clarified that their behavioral responses to racially stressful situations are often strategic. Participants expressed a desire to reduce potential negative consequences, keeping in mind both their positionality within certain spaces and the assumptions others have about Black women.

From the last example, Troi goes on to describe her thought process regarding the strategy of her response.
...So even if I’m experiencing a moment of racial stress, I can’t necessarily react negatively in that moment (emphasized word). I can’t necessarily play… sort of… any kind of reaction that may give away my internal disposition… be-

CAUSE (emphasized word), I feel like that (emphasized word) in and of itself can be used… in a way that does not help the situation come to a resolution. (Troi)

Troi’s use of language such as “play” and “give away my internal disposition,”

communicate what other participants also shared about making active decisions to respond to racial stress in ways that attempted to prevent further harm.

Similarly, Nick was asked to describe how she responded to frequent experiences of her son being falsely accused of misbehavior and ostracized from his peers in their predominantly White neighborhood.

I was...I’m not like a rowdy person or anything like that. I’m a pretty calm person. BUT (emphasized word) when it comes to my children [laughs]...I mean I can get a little, you know. But I still didn’t. I kept my composure but… it hurted me more than anything because I was like seeing my child (emphasized word)...would literally look out the window and just watch him play. And I can obviously (emphasized word) see, you can obviously (emphasized word) see where it would be division when he’s outside playin’ wit the… the White kids. (Nick)

Although Nick was aware of her frustration and hurt linked to the mistreatment of her child, she also prided herself on maintaining an outward appearance that was congruent with her sense of herself as a “calm person.” Nick demonstrates how in certain instances Black American women’s outward appearance may be incongruent with their internal emotional experience.

Nick and Troi’s narratives also demonstrate how internalization is a strategic response to racial stress when Black American women are in positions where their ability to express themselves fully is limited. For example, Dena described navigating an
experience at work where she was being undermined by White individuals who also contribute financially to her department.

I don’t think I ever came across as the angry Black woman… You know the stereotypical. It didn’t go to that level. I had to be much more strategic… about it (emphasized word) because… the same people I was fighting against are also the same people who [laughing] help fund my grant for my division so… so it was very, very stressful. (Dena)

Dena went on to describe her growing mistrust of the individuals and how her anger regarding the situation manifested in her body.

And so… during that time… I mean I was so off put. And it was from people who I… you know I kinda feel like this is a choir, you know? We’re all on the same page. We may serve… different populations but we’re all on the same page in general. And… I felt like stabbed in the back around… this particular issue. I was angry. [exhales loudly] But I usually… internalize that. So I had [laughs]… my heart rate would go up to like 90 over 100, just getting an email about the subject. (Dena)

Dena laughed while sharing this with me but, as a result of this experience she was also prescribed antihypertensive medication to assist with regulating her blood pressure. Her strategic response was helpful in the short-term, but not without consequences.

**Coping with Racial Stress**

**Support through sisterhood.** Developing strategic responses to constant racial stress is also linked to the ways African American women are attempting to cope with their experiences. Every participant recalled moments of reaching out to her community for support, particularly other Black women. Talking through experiences of racial stress with others who share both similar identities and experiences was integral to Black American women feeling seen and having their narratives accepted as truth.

Sandra, for example, recalled how support from other Black women helped her cope with racial stress in lieu of therapy.
...I really believe in like sistercircles, you know? [laughs] So do I necessarily go to a therapist when things get hard? No. But I have two homegirls that I call on...on three-way and we work it out. RIGHT? Like… because they know, right? Like they’ve reflected on the same things that I do, so to know… yeah but that can be really healing. Ta have people listen and be like, “Yes girl. Yes ALLA THAT [lowers voices to a whisper] [laughing] ALLA THAT IS REAL….(Sandra)

The validation Sandra experienced through her connections with other Black women were critical for her healing process. At the same time she and other participants described how challenging it can be to seek support given Black women’s roles.

You know so like… there was no other… I dunno. AND [lowers voices to a whisper], I was the person that people would come to when things are hard. And that’s your role, [lowers voices to a whisper] for you ta heal them. So yeah… (Sandra)

...You know we’re the backbone of the community. You know everyone relies on us. You know I’m the strong (emphasized word) friend. Like I can’t…I can’t have a weak day. (Brittani)

For almost all of the participants navigating their roles as healers and others’ source of strength posed unique challenges when attempting to seek support for themselves. Along with the pressure to be strong, some of the women also discussed stigma related to help-seeking including fear of judgment and shame.

You know there is a stigma. You know? You kinda haveta keep it to yaself because like… Because I think like… even my family, if they knew… during that time frame and range… they might tell, they had loose lips. It may come up in a conversasion, “Well ya know… Kombi is takin’ Zoloft. That’s really her problem.” You know? … You know I was always worried about… you know if I go into dat building will summa my friends see me go into dat building? You know, like that. … It wasn’t something that… you know you really wanna tell people about. (Kombania)

Kombania went on in her interview to describe the importance of feeling safe to reach out for help. Additionally, concerns about how her community would perceive her reinforce
what all of the participants acknowledged, Black women need to know it is okay to reach out for support.

Normalizing support seeking was also something participants noted as a helpful for expanding Black women’s options for adaptive coping. One participant, Javiere provided examples of using social media to encourage other Black women in her field.

There was a doctoral student that I followed and she was like,”Gettin’ ready ta study. Got my snacks ready.” And she had like gummy bears and somethin’ somethin’ somethin’. And I just left like a cute lil message I was like, “Next time I wanna see a apple on that table.” [laughter] And she was like, “You are RIGHT SIS!” I mean this is just how you… you know just gently nudge a person. You know ah mean? I wasn’t trying ta be just all, you know just… talkin’ down to her or judgin’ her. I was just tryna bring it up in a cute lil way, you know? (Javiere)

Emma also recalled using her experience in therapy to encourage others.

You know, I’m just super [laughing], I’m very Evangelical about those sort of things because I’m very… like I feel like as Black women we have… struggled so much in society to… to lift up our men, to save our communities, to… you know, wear so many hats. And...and this forced strength (emphasized word), I think has put a lot of us in a position where… we are help, so we don’t really know where to get it. (Emma)

Acknowledging Black women’s immense responsibility to others, the women in this study agreed that getting permission from other Black women to take care of themselves was critical to their well-being.

‘Cause I feel that sometimes somebody might be at the endda their rope and then they come across this page and read summa the things that people have said about how they made it through and they’ll say, “Ok. Imma give it another try.” You know ah mean? (Javiere)

Overall, the African American women who participated in this study reported cognitive, emotional, and physiological impacts as a result of the constant racial stress they experience. The impacts were noted as out of their control however, their behavioral responses to these experiences were often strategic and intended to reduce the potential
for additional negative consequences. Furthermore, the women in this study also shared how Black American women’s roles as healers within communities can limit their ability to reach out to healthcare professionals for support, finding more safety and comfort in community with other Black women.
Chapter Five: Discussion

The current study aimed to explore and document Black American women’s lifetime experiences of race-based traumatic stress, the status of their psychological well-being, and their health service utilization behaviors over the last 12 months. Overall, the results indicate that although African American women are resilient, they also feel physically and emotionally burdened by racial stress. The participants reported racial stress as constant and the majority of the experiences described were complex and multifaceted. Happening most frequently during adulthood and in work or school environments, many of the participants also characterized racial stress as sudden or unexpected, negative, and out of their control; the criteria used to identify trauma. These experiences elicited a range of automatic physiological, cognitive, and emotional reactions and were accompanied most often by negative self-esteem and avoidance behaviors.

The African American women in the current study reported experiencing positive mental health two to three times a week, but many of the participants also communicated concerns about the status of Black women’s mental health, particularly regarding the expectations placed on African American women to perform strength and remain steadfast in the face of hardship. The participants expressed a need for increased attention to the fullness of Black women’s humanity and a desire to engage with other African American women in spaces where they could be seen, be heard, and feel validated. The majority of the participants reported seeing their general practitioners or women’s health doctor within the last year for routine check-ups and preventative care. Though it was unclear if the healthcare visits were directly related to experiences of racial
stress, participants did report seeking health care services related to physiological reactions to stress (i.e. increased blood pressure, migraine headaches, chronic pain). Mental health care was one of the most commonly delayed services, and understandably so given that participants shared challenges finding therapists of color, as well as concerns about a White therapist’s ability to validate their experiences. Nonetheless, many participants reported openness to seeking therapy and felt comfortable sharing their experiences with others to encourage mental health treatment seeking. The significance and implications of these results for clinical practice and research are provided below along with some recommendations for future study.

**Race-Based Traumatic Stress among African American Women**

**Experiences.** The majority of the experiences of racial stress described in this study were categorized as multiple experiences of harassment and discrimination, consistent with previous literature that reports African American women experience various forms of racial discrimination including interpersonal, institutional, and internalized racism (Nuru-Jeter et al., 2009). African American women in this study provided examples of direct or overt experiences like verbal assaults or being denied access or service, and indirect or covert experiences of being stereotyped or navigating hostility in different environments. The majority of the instances described in this study took place at school or work, which is also consistent with studies that found Black women who are educated (i.e. college degree or higher) or employed full-time experience greater exposure to racism (Parker Dominguez, Ficklin Strong, Krieger, Gillman, & Rich-Edwards, 2009; Kwate & Goodman, 2015). Though higher education and gainful employment are often seen as protective factors against stress, for African American
women not seeing yourself represented in spaces that individuals are often required to
inhabit can be both frustrating and disheartening. Some scholars suggest that social
identity threat may be contributing to racial disparities in workplace hiring and promotion
practices as well as diminished satisfaction and well-being of ethnic minority employees
(Emerson & Murphy, 2014). Social identity threat theory suggests different social groups
experience the same environment in “psychologically distinct ways” due to historical
context (Emerson & Murphy, 2014, p. 508). Though the Black women in this study were
highly educated, qualified, and held a wealth of knowledge and experience, the past and
current inequities within the United States workforce represent a legacy that
psychologically they cannot escape.

In addition to pervasive institutional discrimination, African American women in
the current study also highlighted subtle experiences of racial discrimination, which for
some can be particularly challenging to discern (Sue et al., 2008). Scholars suggest an
individual’s racial group membership impacts their perception of racial discrimination
and Whites are also more likely than Blacks to endorse colorblind ideology (Offermann
et al., 2014; Ryan, Hunt, Weible, Peterson, & Casas, 2007). Connecting the two, in a
study of colorblindness and perceptions of subtle racial discrimination at work, Offerman
et al., (2014) found that non-Hispanic Whites who endorsed higher colorblind
worldviews were less likely to perceive racial microaggressions. Moreover, colorblind
worldviews were significantly more pervasive among Whites with regard to institutional
discrimination and issues of blatant racism (Offerman et al., 2014). Consistent with my
findings, African American women shared not having their presence and contributions to
class discussions or work meetings acknowledged and also reported feeling invalidated
when challenging colleagues’ subtle racist attitudes. In a recent HuffPost article, Shante (2018) touches on what many of the women in this study shared about “transform[ing] into a watered-down version of myself to ensure I am palatable,” reinforcing how work, school, and other often majority White environments are exhausting for Black women.

**Frequency.** The more chronic a stressor is the more likely an individual is to experience exhaustion (McEwen, 2012) and the Black women in this study endorsed racial stress as constant; a part of their daily lived experience. This is consistent with previous work examining African American women’s experiences of racial and gender discrimination that found 97 percent of Black women are aware of racism and sexism directed at them, and 80 percent have personal experiences with these types of discrimination (Jones & Shorter-Gooden, 2003, p.6). The majority of the memorable experiences described in the current study happened in adulthood however, many of the women also recalled experiences of racial stress during childhood and adolescence. The participants noted that simply existing as a Black person in the United States is a form of racial stress and it is not surprising that many of the salient experiences recalled were also the most recent ones, given the increasingly tense sociopolitical climate within the U.S.

The most recent Intelligence Report from the Southern Poverty Law Center (SPLC) reported a total of 1,020 hate groups in 2018 and also noted a near 50 percent increase in White nationalist groups during the same year. The report also deemed 2018 the “deadliest year” highlighting numerous homicides within the U.S. carried out by individuals “who were motivated by or attracted to far-right ideologies” (p.6). The potential for African American women to experience either direct or indirect racial stress is at an all-time high, and research suggests shifting social norms since the 2016
presidential election. Crandall, Miller, and White (2018) conducted parallel studies exploring individuals’ levels of prejudice and knowledge of social acceptability of prejudice before and after the 2016 election. They found both an increase in tolerance for prejudice and that participants typically rated themselves as less prejudiced after the election (p. 189). The authors note that individuals use social norms to regulate their behavior, suggesting that the shifting social norms may be contributing to increases in bias-related incidents (Crandall, Miller, & White, 2018). African American women are carrying the weight of generations of mistreatment of Black folks within the United States. Given the distinct and measurable increases in bigotry within the last three years, it is important to attend to Black women’s reactions and responses to racial stress.

**Reactions and responses.** African American women in this study reported a variety of automatic physical, cognitive, and emotional reactions to their experiences of racial stress. The most common reactions reported were emotional, in particular the feeling of anger. Black women’s anger continues to be seen as pathological, even though literature over decades documents anger as a basic emotion that is distinct, built into the nervous system, and serves a particular purpose linked to survival (Ekman, 1999; Levenson, 2011; Williams, 2017). The Angry Black Woman stereotype is one that haunts African American women, encouraging them to suppress and deny their valid emotional experience (Hayes, 2012). Corbin, Williams, and Garcia (2018) sum up the literature on angry Black women like this, “the net result is a figure whose justified angry responses are malignned and dismissed” (p. 628). They suggest that the Angry Black Woman stereotype is one of the silencing images that “promotes or enhances racial battle fatigue” (p.639). Racial battle fatigue is a term coined by William Smith that describes
the “physiological, psychological, and behavioral strain exacted on racially marginalized and stigmatized groups and the amount of energy they expend coping with and fighting against racism” (Smith, 2008, p.617).

Some psychologists suggest that Black women’s expression of anger is associated with feelings of powerlessness, particularly for African American women who lack valuable resources such as income, education, and employment (Gonzalez-Prendes & Thomas, 2011, Thomas & Gonzalez-Prendes, 2009). However, the Black women in this study were highly educated, gainfully employed, and reported moderate incomes. Powerlessness may be part of the narrative for some Black women, but hooks (1995) suggests that psychologists’ distillation of Black anger as powerlessness does not “urge the larger culture to see Black rage as something other than sickness, to see it as a potentially healthy, potentially healing response to oppression and exploitation” (p.2).

Given the constant experience of racial stress the African American women in my study reported, it is unrealistic to expect them not to feel angry. Pathologizing Black women’s anger further invalidates their experience, another form of race-related stress, increasing their vulnerability to stress-related diseases and diminished psychological well-being.

Speaking of diminished psychological well-being, in this study negative self-esteem was highest right after experiencing a racially stressful event, suggesting that experiences of racial stress result in African American women questioning their value and their worth. Negative self-esteem or diminished self-worth is one of the diagnostic criteria for numerous disorders within the DSM (Schwartz, 2013) and the National Alliance on Mental Illness (Gold, 2016) suggests that low self-esteem contributes to poor relationships, addiction, depression, and anxiety. Additionally, African American
women’s negative self-esteem due to racial stress may also be linked to their ability to shift between their automatic reactions and strategic responses to these experiences. The women in my study were expected to regulate their emotional reactions to racial stress while simultaneously responding in a manner that did not hinder their attention to their home, school, and work responsibilities. This experience for African American women in my study is consistent with literature that suggests Black women feel trapped between their justified anger and their ability to perform strength in the face of injustice (Corbin, Williams, & Garcia, 2018). Furthermore, these conflicting expectations fail to acknowledge the fullness of African American women’s humanity, resulting in “uncompensated emotional labor” (Williams, Bryant, & Carvell, 2019, p.4).

The pressure placed on African American women to successfully meet these incongruent and unrealistic expectations has the potential to manifest as numbing or avoidance. True for many of the women in the current study, avoidance scores were the highest when asked about their reactions to remembering a racially stressful event. In the Encyclopedia of Trauma, avoidance is defined as a “conscious and intentional strategy for regulating distressing emotional states” (Reyes, Elhai, & Ford, 2008, p. 142). Some avoidance behaviors appear more obvious, like when participants reported staying away from stores where they were racially profiled, and some are more discrete, like smiling while dissociating during a staff meeting where your ideas and voice are consistently overlooked. Jarring, painful, and uncontrollable, for the African American women in this study racial stress was inherent to their existence as Black women, suggesting that avoidance is a sign of their exhaustion. This response can be further understood through the lens of trauma. Reyes, Elhai, and Ford (2008) highlight avoidance as a “diagnostic
feature of posttraumatic stress disorder (PTSD)” (p.142) and the majority of women in
our study also endorsed racially stressful events as either negative, out of their control, or
unexpected; the criteria for trauma. Helpful in the short-term, avoidance is well-
documented in the literature as a maladaptive long-term coping strategy (Bishop, Ameral,
& Reed, 2017; Dulin & Passmore, 2010; Reyes, Elhai, & Ford, 2008) which has
implications for African American women’s psychological well-being.

In sum, experiences of racial stress are constant for Black women and the impacts
seem unavoidable. Starting as early as childhood, African American women encounter
racial stress in a variety of settings, and they are expected to respond in ways that allow
others to feel comfortable, even at the expense of their well-being. Dismissed or shamed
when expressing anger about the pain of racism, the limitations placed on Black women’s
humanity contributes to a cycle of racial stress which leads to both physical and
psychological exhaustion.

**African American Women’s Psychological Well-being**

Within the last twelve months, Black women in this study reported experiencing
positive mental health (i.e. emotional, social, and psychological well-being) on average
two to three times per week. This finding suggests that African American women are
undoubtedly resilient, which is encouraging given the constant experience of racial stress
for this population. Moreover, this finding also stands out because much of the recent
research linking racial stress to psychological well-being consistently reports poor mental
health outcomes for African Americans (Carter, Lau, & Johnson, 2017; Donovan,
Galban, Grace, Bennett, & Felicié, 2012; Perry, Harp, & Oser, 2013). Part of what might
explain the discrepancy between the current study and other research has to do with how we frame mental health and what questions are being asked.

Mental health is most often equated with the presence or absence of mental illness (Keyes, 2009, 2007). Interestingly enough, the World Health Organization (WHO) defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (World Health Organization [WHO], 2014). WHO (2014) explicitly states their commitment to positive mental health and the organization goes on to note that health is, “...not merely the absence of disease or infirmity.” Similarly, the focus of most health research is to understand and reduce distress, resulting in outcomes and findings that focus primarily on symptoms and illness (MacLeod, 2012). Nonetheless, scholars continue to suggest the importance of approaching mental health research from a “well-being enhancing” as opposed to a “distress reducing” standpoint (Franken, Lamers, Ten Klooster, Bohlmeijer, Westerhof, 2018; Hennessy, Patrick, & Swinbourne, 2018, Keyes, 2007; MacLeod, 2012, p. 279).

Well-being enhancing approaches acknowledge that few psychological problems fit within an acute treatment model, lending to a more comprehensive picture of patient experiences (Franken, Lamers, Ten Klooster, Bohlmeijer, Westerhof, 2018; MacLeod, 2012). This shift is particularly important when engaging in research with Black women who are traditionally framed within the literature as “anomalies” that are innately deviant and pathological (Few, Stephens, & Rouse-Arnett, 2003; Reid & Kelly, 1994, p.477; Slatton, 2018). African American women are well-aware of their struggles, so over
attending to these within the research may actually be counterproductive. For example, in a study about an HIV prevention campaign for Latina and Black women, participants reported they “did not want to read negative messages” or see stigmatized representations of women from their communities (Colarossi, Hazel, Collier, DeSouza, & Pappas, 2016, p. 236). Instead, African American women may benefit more from research and health marketing that encourages them to examine their wellness, similar to what Franken et al. (2018) notes about “patients appreciat[ing] well-being as an important outcome of treatment” (p.2188). The Black women in this study noted the importance of engaging with other African American women with similar struggles in order to trade coping skills and as one participant commented, “gently nudge” each other along. Many of the participants also asked me directly how I and other Black women cope with racial stress, indicating their focus on improving their wellness.

Congruent with the resilience demonstrated by the African American women in the current study, there is also some research highlighting puzzling differences in mental health among Black and White Americans. Aptly named the Black-White health paradox, health researchers continue to find that even in the face of chronic psychosocial stress (e.g. racial discrimination) Black Americans have equitable, and in some cases better, mental health than White Americans (Keyes, 2009; Mouzon, 2017). As previously discussed, part of this discrepancy is based on what researchers define as mental health and to date, only one study by Keyes (2009) actually captures positive mental health among Black Americans. The primary focus of the Keyes (2009) study is the Black-White health paradox and the author highlights potential mechanisms for this
demonstrated resilience such as religious involvement, generativity, racial socialization, and group identification.

Research on religiosity as a protective factor of psychological well-being for African Americans is mixed (Lee & Zhang, 2018; Lester & Walker, 2015), suggesting religious involvement is helpful for some and not so much for others. Additionally, Mouzon (2017) explored religious involvement related to the Black-White health paradox and found that even though African Americans report higher levels of religious involvement compared to White Americans, those differences did not explain the mental health paradox. Black women in the current study identified their faith practice as one of many adaptive coping strategies they utilize to manage racial stress. What appeared most salient however, was the sense of community African American women gained in congregations that were either predominantly Black or actively engaged in social justice work.

Related to social justice work is the term generativity, which refers to the adult life stage where individuals aim to leave their legacy by demonstrating concern for and engagement with future generations (MacLeod, 2018; Pratt, 2013). Research on generativity demonstrates positive associations between generative concern, psychological well-being, and life satisfaction (Hart, McAdams, Hirsch, & Bauer, 2001; Keyes, 2009; Ryff & Keyes, 1998). Additionally, in a comparison of White and African American adults, Hart et al. (2001) found higher levels of generative concern and acts among African Americans. This research is consistent with the stories of the Black women in the current study, who outlined the sense of responsibility they feel toward the Black community, in particular African American youth. Women in this study gave
examples of intentionally providing school-age youth with books that included children of color and stepping in when Black youth were being unfairly treated, modeling how to identify and address racial microaggressions. Even the elder women in the current study shared their history of and continued engagement with social justice movements, confirming research that suggests neither age nor perceived health prevent African American women from attending political meetings or rallies (Farmer & Piotrkowski, 2009). Historically lost in what Hribar (2013) refers to as the “master narrative,” which highlights males, African American women continue to harness their power to fight racial injustice (p.96). In 2013, three Black women started the Black Lives Matter movement and in 2018, more than 20 Black women were elected to serve in Congress, a first in U.S. history (Lockhart, 2018).

Generativity also plays a major role in how individuals approach parenting. Hart et al., (2001) found for African American parents being a role model and source of wisdom for their children was crucial. Similarly, all the mothers in the current study referenced how their civic, social, and political engagement was in service of their children’s well-being. This finding is consistent with research demonstrating African American mothers’ commitment to “interrupting patterns of inequality” (Appling, Haskins, & Daigle, 2018; Fuentes, 2013, p.317) and also speaks to the importance of Black women’s roles with regard to racial socialization of African American children.

Racial socialization refers to how parents prepare their children to experience life as a part of their racial group and engage with others from different racial or ethnic backgrounds (Edwards & Few-Demo, 2016; Hughes & Johnson; 2001). African American women in the current study described early experiences of racial stress,
primarily in educational settings, where they were called racial slurs, stereotyped by White administrators as stupid or troublemakers, and in some cases exposed to racial violence. Many of the women also expressed anger and frustration about lack of parental preparation and protection from the harm incurred from those interactions. Unsure of how to navigate those instances, Black women in this study channeled their frustrations about their own experiences into direct conversations with children in their families and communities about perceptions of Black Americans in the United States. Consistent with the literature, African American women in their roles as primary caregivers, teachers, aunties, mentors, and othermothers are faced with the task of mitigating racialized messages Black youth receive about themselves (Edwards & Few-Demo, 2016; Malone Gonzalez, 2019). Black women use these conversations as opportunities to counter negative messages, and also prepare African American youth to navigate instances that could have detrimental consequences if not handled strategically. For example, the mothers in the current study who were parenting Black boys shared how they attempt to balance their fears with conversations preparing their sons for difficult encounters, particularly with law enforcement. Interestingly, Malone Gonzalez (2019) suggests that centering Black boys actually reinforces that Black women and girls are not as vulnerable, which may explain the lack of preparation the African American women in our study received. An expanded understanding of vulnerability to racial stress is needed both within the research and the Black community. Therefore it is not clear in the current study if racial socialization explains resilience among African American women.

Group identification is the final mechanism of resilience Keyes (2009) explores and it also appears to be a primary source of Black women’s resilience in the midst of
racial stress. Group identification or one’s sense of belonging and connection to a social group can be an important source of pride and self-esteem (MacLeod, 2008). For African Americans, high racial group identification is associated with positive group evaluation, can buffer the negative impacts of racial discrimination, and is also linked to greater self-esteem and fewer depressive symptoms (Chae, Lincoln, & Jackson, 2011; Highes, Kiecolt, Keith, & Demo, 2015). Specifically for Black women, scholars highlight social support as an important factor for African American women’s well-being (Bronder, Speight, Witherspoon, & Thomas, 2014; Linnabery, Stuhlmacher, & Tower, 2014). This research is consistent with the current study, where African American women identified social support, particularly from Black women, as one of the most helpful ways of managing racial stress. Engaging with other Black women provided opportunities to openly share stories, have their experiences validated and accepted as truth, and use these interactions to trade coping strategies and recommendations for professional help-seeking.

As valuable as these relationships are for Black women, Bronder et al., (2014) note that social support can sometimes be a “double-edged sword,” that creates additional pressure and responsibility for African American women (p. 121). Black women in the current study confirmed this finding as well, describing how differences in socialization regarding Black womanhood and difficulties navigating controlling images (Collins, 2000) impact their ability to be vulnerable with and receive care from others, especially other African American women. For example, one woman tearfully described feeling unsure if it was okay to accept a hug from her daughter on a particularly difficult day. Acknowledging her efforts to model a loving dynamic and encourage her daughter to
seek support when she needed it, this participant wanted to protect her daughter from her pain and felt wary about accepting care because of her role as the mother. Black women in this study also shared about how their resilience is often used to negate their vulnerability. One participant commented in frustration, “I don’t wanna be strong!” She explained how the Strong Black Woman myth reinforces that African American women must carry their burdens alone. Other participants used the same burden carrying imagery, and when asked about that experience one woman commented, “You know when you been carrying something so long your body just adjusts to the weight.”

Unfortunately, the health disparities literature actually suggests that African American women’s bodies do not in fact, adjust to the weight.

Belgrave & Abrams (2016) report that “across almost every health indicator African American women fare worse than women in other racial or ethnic groups” (p.723). Moreover though the Black-White health paradox suggests at least moderate rates of mental health among Black Americans, Alegria et al. (2013) reports higher lifetime prevalence rates of PTSD among African Americans, and the rates of physical illness and mortality among this population are still quite high (Belgrave & Abrams, 2016; Keyes, 2009). Black women are indeed carrying the burden of racial stress, which is contributing to their allostatic load and putting them at increased risk for stress-related diseases.

**Health Service Utilization among African American Women**

According to the Centers for Disease Control [CDC] 2015 report the leading cause of death for Black women across all ages was heart disease, and compared to women of other races, the rates of heart disease among Black women were the highest.
Although stress may not be the direct cause of heart disease among African American women, stress, especially chronic stress increases the risk for stress-related diseases such as diabetes and high blood pressure. The CDC does a comprehensive job of capturing the health concerns across many identity groups (i.e. race, age, gender) however, very little is known about African American women’s use of health care services.

In the current study, Black women were asked to share their use of healthcare services within the last year, and the majority of the women reported routinely going to the doctor for health concerns or preventative care. This finding is consistent with data on African American treatment seeking behaviors, like the 2017 National Health Interview Survey (NHIS) that reported 69% of African Americans had contact with a doctor within the last six months (Blackwell & Villarroel, 2018). In addition, Shippee, Schafer, and Ferraro (2012) found that of the Black Americans who participated in the National Survey of Midlife Development in the United States (MIDUS), 88% reported physician use within the last year. Additionally, recent research exploring frequency of health care visits among African American women found Black women visit health care providers on average two to five times per year (Smith, Tucker, Arthur, Wippold, & Tran, 2017). The literature suggests that African American women are seeking healthcare treatment with some consistency, so what then might account for the increased rates of morbidity among this population?

Prevention and early intervention help reduce rates of illness and typical healthcare barriers are low-income and/or lack of insurance. Women in the current study did report delays in seeking healthcare services however, the majority of participants were gainfully employed and enrolled in health insurance plans. For African American
women in this study, one of the primary concerns impeding health care treatment seeking was little to no access to healthcare providers of color, with a clear preference for Black doctors when possible. This finding is interesting given the mixed research on provider preferences among Black women. Dale, Polivka, Chaudry, and Simmonds (2010) explored important factors in choosing a health care provider for young (i.e. 19-24yo) African American women and found gender was more important than race. Cunningham, Sohler, Korin, Gao, and Anastos (2007) found that although the Black and Hispanic women in their study reported overall mistrust of the healthcare system, more trust was associated with having a White health care provider. Finally, Nicolaidis et al., (2010) found that African American women in their study reported a “deep mistrust” of the healthcare system as a “White” system (p.1470). Armstrong, Hughes-Halbert, and Asch, (2006) suggest overemphasizing patient preferences can be misleading when exploring racial disparities in health, noting the importance of understanding the intricate connections between individual preferences and systemic inequality. They identify poverty, communication, culture, and trust as key factors linking patient preferences to systemic inequality and they also suggest that differences in preference are actually “reactions to correctable imbalances in the healthcare system” (Armstrong, Hughes-Halbert, & Asch, 2006, p.951).

Provider bias and experiences of discrimination when seeking healthcare services are examples of correctable imbalances, and in the current study, African American women described previous experiences of discrimination that decreased their willingness to seek healthcare services from White providers. Malat and Hamilton (2006) found a similar connection between providers’ race and discrimination, where greater preference
for same-race provider was linked to beliefs that discrimination was frequent in different-race doctor-patient dyads. Previous experiences, including awareness of historical inequality, often contribute to the beliefs we develop which can also impact our behaviors. For example, Sacks (2017) suggests that Black women’s anticipation of bias and stereotyping when seeking health care impacts their behaviors in those settings. In her study, Sacks (2017) found that middle-class African American women were both aware of pervasive stereotypes about Black women and found it important to adopt “certain behaviors to mitigate discrimination” (p. 8). Consistent with the narratives of the African American women in the current study, participants in Sacks (2017) study reported strategic behavioral modifications such as changing their style of dress, encouraging providers to recognize their personhood, and using pre-appointment research to demonstrate their legitimacy as a patient. Given the context that Black women are responsible for reducing the impact of negative experiences with healthcare providers by changing their behaviors, delays in treatment seeking among African American women in the current study become easier to understand. Moreover, these intentional adjustments place an additional burden on Black women, increasing their allostatic load.

Allostasis is the dynamic process of adjusting to stressors and allostatic load refers to the impact on our brain and body as a result of these adjustments (Cicchetti, 2011; McEwen & Gianaros, 2011; McEwen, 1998). Research on racial differences in allostatic load often compares White Americans to racial/ethnic minority groups in the United States, specifically focusing on the consistent and stark differences in health between Black and White Americans. This focus appears linked to what some scholars refer to the as “Hispanic Paradox” (p.422) or that Hispanic populations demonstrate
“lower or similar mortality rates” (p.56) when compared to non-Hispanic Whites (Howard & Spark, 2016; Santos-Lozada & Daw, 2018). That being said, research consistently find higher rates of allostatic load among African Americans (Duru, Harawa, Kermah, & Norris, 2012; Howard & Sparks, 2016; Santos-Lozado & Daw, 2018; Taylor, McFarland, & Carr, 2018; Tomfohr, Pung, & Dimsdale, 2016; Upchurch et al., 2015). Moreover, the research on allostatic load among Black women (Chyu & Upchurch, 2011; Duru et al., 2012; Geronimus, Hicken, Keene, & Bound, 2006; Upchurch et al., 2015) is consistent with what Allen et al., (2019) reports that, “African American women are disproportionately burdened by the simultaneous dysregulation of multiple physiologic systems” (p.225).

Disproportionate burden is a perfect way to describe the responsibilities placed on Black women seeking healthcare treatment. Moreover, relying on African American women’s resilience and ability to adapt to stress as buffers for negative treatment seeking experiences, may actually be contributing to a problematic process where their stress response is being activated when attempting to seek care.

In my article on Black women, stress, and therapy, I use anecdotes about women seeking care to encourage dialogue, and challenge readers to consider the link between negative experiences (i.e. stress) and treatment seeking behaviors (Simmons, 2017). I provide context about the evolution of psychological stress among humans and suggests that for an African American woman seeking care even the anticipation of threat, like worrying her experience will be invalidated, can activate her stress response. Focused primarily on mental health treatment for Black women, my conceptualization of the treatment seeking process is consistent with my findings from the current study, where
mental health treatment was the second most common delayed service after dental care (Simmons, 2017). African American women in the current study expressed openness to treatment seeking (i.e. therapy), and some participants shared particularly positive experiences in therapy. At the same time, even the women with positive experiences described previous negative interactions with White clinicians, contributing to their increased wariness when seeking healthcare services. Consistent with the literature highlighting the usefulness of informal supports, alternative medicine, and non-medical settings for African Americans (Hines, Cooper, & Shi, 2017; Pullen, Perry, & Oser, 2014; Shippee, Schafer, & Ferraro, 2012; Ward, Clark, & Heidrich, 2009), most participants in the current study reported the use of alternatives, particularly social support networks, to manage racial stress. Above all else, support from other Black women provided connection, understanding, and opportunities to share resources for healing. It is through this lens of connection that I understand the final topic explored in the current study, the relationship between race-based traumatic stress, psychological well-being, and health service utilization among African American women.

**Connecting the Pieces**

In the current study, African American women’s memorable experiences of racism accounted for a significant portion of the difference in their current psychological well-being. This is consistent with the literature that demonstrates racial discrimination has negative impacts on mental health (Donovan et al., 2012; Elias & Paradies, 2016; Ertel et al., 2012; Miller, Rote, & Keith, 2013; Molina & James, 2016; Soto, Dawson-Andoh, & BeLue, 2011). Additionally, reactions to racial stress linked to anger and intrusion accounted for the biggest differences in African American women’s
psychological well-being, suggesting that neither denial nor emotional suppression are effective ways of managing racial stress for Black women. This is consistent with research that demonstrates the positive impact of active coping with racial stress on mental health outcomes. Polanco-Roman, Danies, and Anglin (2016) found that use of active coping strategies to manage racial discrimination was negatively associated with dissociative symptoms. Similarly, Greer (2011) found that cognitive-emotional debriefing, defined as “distraction, venting, and processing stressful incidents with others” (p.223), helped to decrease anxiety-symptoms in a sample of African American women experiencing race-related stress. These findings reinforce how important and valuable it is for Black women to have a space to share and process their experiences of racial stress, as authentically as possible.

In both phases of the current study, Black women provided thoughtful responses to questions and many participants reported having “ah-ha” moments, where memories or emotions they tried to erase or avoid resurfaced as a result of our interaction. While sharing their experiences, the women laughed, raised their voices, cried, cursed, and gestured often with their hands and faces. Almost every woman interviewed described feeling surprised by their physiological and emotional activation during both phases of the study, and every participant reported feeling relieved at the end of our conversation. When asked to provide their experience of what it was like to share their stories specifically with me, another Black woman, participants commented on my demeanor using descriptors like, “genuine” and “disarming.” The African American women in this study also noted that I encouraged them to think more intentionally about their experiences of racial stress from a holistic perspective (i.e. mind, heart, and body), while
still allowing them to define the experience for themselves and respecting their various levels of comfort with sharing. Finally, participants reported appreciating my willingness to openly answer questions about my identity as a Black woman, researcher, clinician, and scholar, connecting that to their increased willingness to trust me with their stories. My position when engaging with Black women is consistent with literature suggesting that African American women benefit from mental health frameworks that are integrated, holistic, and attend to both individual and societal stressors exacerbated by experiences of oppression (Jones & Guy-Sheftall, 2015). Space for Black women to be known, loved, and accepted just as they are is necessary for their well-being, which has implications for healthcare providers and researchers hoping to serve African American women.

**Implications for Healthcare Practice**

In order for Black women to receive adequate care and support, healthcare professionals must broaden their understanding of health and well-being to include racial stress, approach African American women from a place that highlights their strengths, and account for how previous experiences of racial stress within the healthcare system impacts their current willingness and experience of treatment seeking.

Providers working with Black women must make a conscious effort to ask about experiences of racism when assessing for client stress. Information about stress collected during intakes or first visits are often siloed or seen as separate issues, but race impacts how African American women experience a variety of life moments like motherhood and parenting, professional development, and engaging with support networks. Allen et al., (2019) reports that, “African American women are disproportionately burdened by the simultaneous dysregulation of multiple physiologic systems” (p.225), suggesting that the
combination of racial stress with other stressors is indeed contributing to diminished health among Black women. Additionally, the literature (Duru, Harawa, Kermah, & Norris, 2012; Howard & Sparks, 2016; Santos-Lozano & Daw, 2018; Taylor, McFarland, & Carr, 2018; Tomfohr, Pung, & Dimsdale, 2016; Upchurch et al., 2015) reports high rates of allostatic load among African American women, and allostatic load refers to the impact on our brain and body as a result of adjusting to stressors in our lives (Cicchetti, 2011; McEwen & Gianaros, 2011; McEwen, 1998). If healthcare professionals know that Black American women are experiencing racial stress on a daily basis, the question becomes, what are those experience like for them? Does it cause distress? What does that distress look like for that particular Black woman (e.g. physical, emotional, cognitive)? Asking direct, open-ended questions about racial stress communicates that the African American woman is seen and heard.

Prior to providing recommendations for additional care, it is also important to acknowledge Black American women’s resilience and assess for how they are coping with their experiences. This challenges healthcare professionals to use a strengths-based approach when working with Black women, which Walton and Oyewuwo-Gassikia (2017) suggests, “provides a pathway to delivering services that are grounded in the lived experiences of Black women” (p. 471). Providers should actively praise the use of adaptive coping strategies and also ask themselves if coping tools that appear maladaptive are culturally congruent? Coping is linked to how individuals appraise stressors and that appraisal is linked to the resources individuals believe they have accessible to them to manage the stressor (Everett, Hall, & Hamilton-Mason, 2010; Simmons, 2017, Sapolsky, 2003). Black women are already stretched pretty thin, so
coping strategies that require additional time, energy, or financial resources may be incompatible with African American women’s current roles and responsibilities. Providers should work collaboratively with Black women to assess their current support resources, which communicates that their narratives can be used to provide individualized care that actually fits each woman’s experience. Moreover, when offering alternate recommendations using accessible language to explain how certain coping strategies may be unsustainable or exacerbate a Black woman’s distress has the potential to empower African American women to make different choices about coping on their own terms.

Finally, health professionals must account for both current and historical patterns of bias and discrimination aimed at African American women seeking care, like, “ongoing struggles with poor communication, cultural incompetence, and lack of trustworthiness” (Armstrong, Hughes-Halbert, & Asch, 2006, p.953; Noonan, Velasco-Mondragon, & Wagner, 2016; Sacks, 2018). African American women, including the participants in the current study, are consistently misdiagnosed, assumed incompetent, and ignored when sharing their physical and emotional pain with healthcare professionals (McMillian Cottom, 2019; Meara, 2018; Sack, 2018). Furthermore, a study examining differences in interactions with African American patients found that compared to conversations with African American men, White male doctors are less likely to talk about prevention and health promotion with African American women (DiMatteo, Murray, & Williams, 2009). Findings like this are particularly disturbing given that the number of White healthcare providers in the U.S. is quite high compared to the number of African American healthcare providers (68% vs. 6%) (U.S. Census Bureau, 2016). These examples of discrimination contribute to Black women’s perception of the U.S.
healthcare system as a “White system” (Nicolaidis et al., 2010) and reinforces their preference for providers of color, specifically other African American women.

Black women need healthcare professionals that can relate to or understand their experiences. If that means connecting with another Black woman, then non-Black providers should honor that request and help guide African American women to the resources and agencies where their needs can be met. Developing partnerships with organizations led by Black women healthcare professionals (e.g. Therapy for Black Girls, Black Women’s Health Imperative) has the potential to increase African American women’s access to care, and knowledge about these organizations is critical information that should be disseminated widely. African American women’s willingness to take recommendations from trusted others (i.e. other Black women), also challenges healthcare professionals to modify their health promotion, prevention, and outreach efforts to incorporate more groups for Black women. Every woman in the current study described how valuable being a part of a community of Black women was to her well-being, and the literature also demonstrates the effectiveness of groups for this population. In fact, support groups for Black women have been shown to improve physical health outcomes (Diallo, Moore, Ngalame, White, Herbst, & Painter, 2010; Jennings et al., 2013), mental health outcomes (Jones, Ahn, & Chan, 2016; Jones & Warner, 2011, Kohn, Oden, Munoz, & Robinson, 2002; Norris & Mitchell, 2014) and African American women’s ability to cope with racial stress (Davis, 2018; Hall, Everett, Hamilton-Mason, 2012).

**Counseling psychologists.** In addition to the aforementioned recommendations, which are critical for any provider (i.e. physical or mental health) serving Black women, I
want to offer some recommendations specific to counseling psychologists. The first being that we must actively resist anti-Black racism by increasing our awareness, knowledge, and understanding of the racial oppression experienced by Black women. African American women in the current study spoke about how frustrating and exhausting it feels to occupy classroom, work, and personal spaces where others remained ignorant about the most recent instance of violence inflicted upon Black bodies.

In order to better understand the physical, emotional, or cognitive state our Black female client, research participant, or student might be in when she enters a space, we must be willing to notice and acknowledge her experiences. This could range from updating ourselves with the current narratives being disseminated throughout social media about African American women to partnering with APA divisions working to improve the lives of Black women (i.e. Division 35, section 1 or Division 45). This recommendation echoes the sentiments of Hargons et al. (2017) who prompt counseling psychologists to be actively engaged with what they describe as the “urgent social justice issues of our time” (p. 874). The authors are referring to how anti-Black racism is so normalized (e.g. consistent killing of unarmed Black people) and the emergence of the Black Lives Matter movement.

Hargons and colleagues encourage counseling psychologists to live up to our stated values of “multiculturalism, social justice, and advocacy,” (p. 873). Likewise, they critique counseling psychologists for our slow and inconsistent reactions to “unexpected instances of violence against Black people,” (Hargons et al., 2017, p. 880). These types of responses are misaligned with our values. On an individual and collective level, we
must be unafraid to explicitly address anti-Black racism, especially when working with Black women.

Along with being seen, explicitly confronting social justice issues also provides African American women with permission to talk about and address issues of race and racism within the spaces we occupy together. For example, one participant in the current study reported feeling unsure if it was okay to bring up race with her White clinician and she questioned the clinician’s training around issues of race and culture. Counseling psychologists must understand the complex power dynamics that can leave African American women feeling further marginalized when the onus to address race is left to them. We must be prepared to bring race into the room, especially non-Black psychologists who may have a different experience of race and racism. From the first interaction, we have the opportunity to ask questions like, “I’m not a Black woman, how might it feel to work with me?” or “What might it be like to share your experiences as a Black woman with me?” These questions acknowledge difference in lived experience and allow African American women to address potential concerns that may impact their authentic expression.

This recommendation is also consistent with the Mallott and Schaefle (2015) who write, “counselors need to initiate discussions about race and racism throughout their time with clients of color to indicate comfort with and willingness to discuss such topics” (p. 363). Comfort and willingness to address issues of race may come more naturally for some however, it is the responsibility of counseling psychology training programs to boost the efficacy of their trainees with regard to multiculturalism, social justice, and advocacy.
Counseling psychology training programs must be committed to designing and implementing a curriculum that helps trainees further their understanding of what our values look like in practice, in particular social justice. Pieterse, Evans, Risner-Butner, Collins and Mason (2009) reviewed syllabi and course descriptions for counseling training programs and found social justice and multiculturalism are often blended together in ways that make it difficult to “operationalize” social justice objectives (p. 108). They suggest acknowledging the overlap with multiculturalism however, identifying the two as distinct constructs to reduce confusion among trainees (Pieterse, Evans, Risner-Butner, Collins & Mason, 2009). Counseling psychology faculty might find it useful to review the terminology they use when discussing issues of racism and also directly assess the development of advocacy skills by conducting trainee role plays related to current social justice issues. Faculty demonstrations of how counseling psychologists can engage in social justice work is critical for trainee development. In fact, Beer, Spanierman, Greene, and Todd (2012) interviewed counseling psychology trainees and found that faculty serve as “important sources of support and role models in creating an environment supportive of social justice” (p.128). This modeling is important to counseling psychology trainees personal and professional development, which brings me to my final recommendation.

Although trainees report that their programs overall could be doing more, many report their programs match and promote their individual commitment to social justice (Beer et al., 2012). Many counseling psychology training programs are providing trainees with opportunities that mirror the values of the field. Trainees report engaging in social justice training activities that are not explicitly labeled or categorized as social
justice work (Beer et al., 2012). I recommend counseling psychology training programs be clearer and more explicit in naming these opportunities as social justice skill development. Training programs that are using interventions successfully could be a model for other programs that hope to revise their curriculum (Pieterse et al., 2009), which can build our capacity to better serve populations like African American women. One example of a successful training program naming their social justice skill development is outlined in Motulsky, Gere, Saleem, and Trantham (2014). The authors describe teaching itself as an opportunity to build trainees social justice skills through critical analysis where students, “can identify systemic institutional, social, and professional structures that perpetuate and maintain harmful practices” (Motulsky et al., 2014, p. 1063). They suggest that this awareness can deepen trainees understanding of social justice issues and challenge them to “become change agents in their professional roles” ((Motulsky et al., 2014, p. 1063). Black women need change agents, counseling psychologists who will listen to and honor their experiences of racial stress.

In sum, honoring the experiences of African American women appears to be the pathway to providing quality care. Providers must openly address the intersectional nature of racism as a part of Black women’s experiences of their physical and psychological health and approach this population from a strengths-based model of care that prioritizes collaboration and shared-decision making (Hawley & Morris, 2017; Peek et al., 2016; Peek et al., 2010). Given the prevalence of systemic racism within the U.S. healthcare system (Feagin & Bennefield, 2014), hiring Black female healthcare professionals or creating a comprehensive referral list through partnerships with organizations led by African American healthcare professionals are also ways that non-
Black providers can honor African American women who wish to seek care from Black female providers. Lastly, counseling psychologists must remember our values when working with African American women. We must increase our awareness of Black women’s racial stress, respond with a sense of urgency, and we must prepare our trainees to be change agents who are committed to social justice.

**Implications for Researchers**

Scholars report that African American women’s voices are often left out of research conversations and those that are included fail to represent the diverse (i.e. intersectional) experiences within the Black community (Huang & Coker, 2010; Spates, 2012). Since research often informs the development of models of care, the underrepresentation of African American women is decidedly problematic. Common barriers to African American women’s participation include the logistics of research participation (e.g. time commitment.), lack of knowledge about research topics or opportunities, and concerns about the use of research (e.g. researcher motives, confidentiality, etc.) (Coker, Huang, & Kashubeck-West, 2009; Howell, Bickell, Martin, Negron, & Balbierz, 2013; Huang & Coker, 2010; Luebbert & Perez, 2016; Murphy & Thompson, 2010). Scholars (Coker, Huang, & Kashubeck-West, 2009; Howell et al., 2013; Huang & Coker, 2010; Speights, Nowakowski, De Leon, Mitchell, & Simpson, 2017) specifically provide guidelines to promote recruitment and retention of African American women in research, many of which focus on building relationships with Black women. In the current study, the use of community-based recruitment strategies, culturally sensitive research methods, and facilitating access to the academy appeared to increase participant engagement in the research process.
Community-based recruitment strategies. My article on Black women’s experience of treatment-seeking also talks about the power of the Black women’s connections with one another (Simmons, 2017). I decided early on to intentionally recruit participants for the current study using groups and organizations that are fostering connections between women of color, specifically African American women. Researchers must familiarize themselves with local and national community organizations serving African American women, which can be achieved through internet searches and personal connections. Initial contact with leaders should start by asking permission to engage with the members of the organization and researchers should be transparent and available to directly address fears, concerns, or issues of trust, which the literature suggests improves rapport when working with African American women (Coker, Huang, & Kashubeck-West, 2009; Huang & Coker, 2010). For the current study, preliminary interactions with community and organizations leaders ranged from brief email exchanges to in-depth phone calls explaining my research process, motives, and personal connection to the work. Being open and transparent during these interactions increased leader’s willingness to disseminate my recruitment materials to Black women in their community, and these connections also prompted leaders to provide me with additional recommendations for recruitment. This is consistent with Sadler, Lee, Lim, and Fullerton (2010) who write about using affinity and social groups as an adapted sampling method to increase the presence of vulnerable or hard-to-reach populations in research.

Additionally, scholars note that African American women are more likely to participate in research that can clearly outline benefits for the community (Huang &
Researchers who wish to recruit and retain African American women in their research must be forthcoming about how the research will benefit the larger community of Black women, beyond adding to the academic literature, which is rarely accessible to the community. Informing participants about my various roles as a researcher, clinician, and scholar allowed me to speak humbly and openly about how the current study is an ongoing project birthed out of my interactions with Black women and engagement with the academic literature. I demonstrated how I intended to apply the research in my clinical work serving African American women, and offered participants opportunities to provide feedback about the research questions, motives, and future directions. This was an easier task to accomplish during one-on-one interactions with participants in the qualitative phase however, I also solicited feedback during initial interactions with leaders during the quantitative phase. These strategies reinforce the importance of including Black women’s voices throughout the research process and model other scholars recommendations for using participatory approaches when engaging in health equity research (Ceasar et al., 2017; Huang & Coker, 2010; Speights et al., 2017; Wallerstein & Duran, 2010;).

Culturally-sensitive research methods. In their chapter, Applying Intersectionality Theory to Research on Perceived Racism, Lewis and Grzanka (2016) define intersectionality as, “an analysis of the systems of oppression and social constructions of race, class, and gender” (p.21). They caution against creating a hierarchy of oppressions, encouraging researchers to utilize methods that “rethink” the psychological constructs, categories, and definition of race and racism (Lewis & Grzanka, 2016, p.42). Engagement African American women in research must then also
involve using methods that allow for Black women to speak their truth. This became more evident as I began collecting data for the qualitative phase of the current study.

Participants often joked about the disclaimers about potential emotional discomfort outlined in the informed consent however, they described feeling “surprised” by the emotionality that the survey questions evoked. This feedback from the phase two participants increased my understanding of both missing data and the multi-faceted written descriptions of memorable experiences of racism collected during the quantitative phase. After providing a written description some participants decided not to complete the survey measure, which could be linked to having a strong emotional response and no one to process that with in the moment. Additionally, some of the descriptions included frustrated comments about being asked to choose a memorable event and some participants even disclosed risk, like experiencing suicidal ideation as a result of racial stress. Talking about experiences of racial stress, traumatic or otherwise, can activate participants emotionally, cognitively, and physiologically in unexpected ways. Although the measure used to assess race-based traumatic stress was developed by researchers who prioritize cultural sensitivity, when gathering information about African American women’s experiences researchers must do more than administer a self-report measure, which is consistent with literature supporting the use of narrative or qualitative methods when engaging African American in research (Coker, Huang, & Kashubeck-West, 2009; Huang & Coker, 2010).

In the current study, the addition of the qualitative interviews allowed Black women to actually verbalize their experiences to another individual and receive affirmation that I was listening through nonverbal (e.g. head nods) and verbal cues (e.g.
saying “mhmm”). These cues also mirror Black women’s dynamic communication style, which was appropriate given that I, the primary investigator, also identify as a Black woman. The interviews also provided participants with a chance to intentionally reflect on their life experiences and many women had “ah-ha” moments where they recalled instances of racial stress they had “completely forgotten.” Building rapport and trust through the interview interaction appeared to increase the participants’ comfort and willingness to be vulnerable with me, which can be challenging to accomplish when using solely quantitative or survey methods. Providing a space for Black women to share their stories through open-ended interviews also supports the literature suggesting that we must “honor the various ways of knowing” among African American women (Coker, Huang, & Kashubeck-West, 2009, p. 162; Huang & Coker, 2010).

Finally, the use of mixed methods was also a research strategy that appeared to be more culturally sensitive. It felt important to provide African American women with multiple opportunities and modalities to speak about their lived experiences. The addition of phase two provided context for the quantitative data, particularly with regard to African American women’s reactions and responses to racial stress. For example, many of the participants commented, “I’ve never thought about it like that before,” when asked to describe how experiences felt in their body. They were able to use language that fit their level of understanding and awareness, which can be matched as needed with terms or physiological symptoms demonstrating how racial stress manifests for Black American women. The use of mixed methods also communicated to participants in the current study that this was, and is, an ongoing conversation about African American women’s health and well-being. Their abundant response communicated that Black
women are both interested and willing to share their experiences, which encourages researchers to put more effort into bridging the gap between the community and the academy (Spates, 2012).

**Facilitating access to the academy.** One way I am attempting to facilitate African American women’s engagement and access to research is through a new website, sistahsspeak.com. Sistah’s Speak advertises opportunities for Black women to participate in research and also includes a resource library with book recommendations, e-news, and research articles about African Americans physical, mental, and spiritual health. Many of the current research projects advertised also have primary investigators that are Black women. This helps add an additional layer of trust and mirrors what Black women in the current study shared about sistahs supporting each other through their connections. Scholars and researchers can help contribute to sites like Sistah’s Speak by publishing their manuscripts on open access journals, so African American women in the community actually have access to the research that is both for and about them.

As the Sistah’s Speak continues to grow, I will showcase the work of Black women in the community (i.e. Spotlights) nominated by other women. I will also design a community connections page, which provides state by state information about organizations supporting Black women’s wellness. Sistah’s Speak is in full agreement with the literature asserting that now is the time for focused engagement on African American women to achieve healthy equity and promote wellness within the community (Holt, Johnson, & Zabler, 2018; Spates, 2012; Speights et al., 2017).

In sum, to ensure that information about serving Black women is coming from Black women, researchers and scholars must make an intentional effort to involve and
inform African American women about research related to their health and well-being. Utilizing community-based recruitment strategies, culturally sensitive research methods, and providing a bridge of access between the academy and community are ways that researchers can amplify Black women’s voices and obtain a more comprehensive view of their experiences.

**Limitations and Recommendations**

This study has a few important limitations to note. First, though the initial sample size met the criteria from a priori power analyses for a medium effect size, only 88 of the 135 participants completed the entire web-based survey (i.e. demographics, psychological well-being, health service utilization, and RBTSSS). Given the size of the regression model relative to the sample size, the decision was made to reduce the complexity of the model to include only the relevant factors of the RBTSSS (Carter et al., 2013) and the psychological well-being variable. With a larger sample size, all seven subscales of the Race-Based Traumatic Stress Symptom Scale (Carter et al., 2013) along with important demographic characteristics such as age, socioeconomic status, and nationality could be included. That has the potential to provide a more nuanced understanding of the relationship between African American women’s experiences of race-based traumatic stress, health service utilization, and psychological well-being.

Related to sample size, the amount of missing data is a limitation to this study. Scholars note that missing data is a common problem within quantitative research and could be related to a variety of factors like negligence, confusion, preserving privacy, or questionnaire length (Hugick & Best, 2008; de Leeuw & Hox, 2008; Raykov, 2011; Wang & Wang, 2009). In the current study I estimated a minimum of 45 minutes to
complete the web-based survey, which may have contributed to “greater respondent burden,” thus increasing the amount of missing data (Hugick & Best, 2008, p.660). Even if data are missing completely at random (MCAR) as was the case in the current study, incomplete data sets can pose additional problems during analysis with regard to making meaning of participant responses. Since data in the current study were MCAR, I utilized statistical techniques (i.e. expectation-maximization [EM]) to account for incomplete data and the results of regression analyses were significant. While theoretically these techniques allowed the current study to provide support for continued research on African American women’s experiences of racial stress, these statistical techniques essentially impose meaning where no answer was provided, and the results should be interpreted with caution. Future researchers using survey methods to examine African American women’s experiences of racial stress should consider using shorter measures like the newly released Trauma Symptoms of Discrimination Scale (TSDS) developed by Williams, Printz, and DeLapp (2018). The TSDS is a 21-item self-report measure that focuses on the anxiety-related trauma symptoms that result from discriminatory experiences and so far, the measure demonstrates “good reliability and convergent validity” with African Americans (Williams, Printz, and DeLapp, 2018, p. 738).

Additionally, the current study was a cross-sectional exploration of African American women’s experiences that relied on participants to recall their reactions and responses primarily to events that already passed. Cross-sectional research is often preferred to reduce concerns with regard to time and resources however, longitudinal studies provide opportunities to see how participants’ experiences shift in subtle, more nuanced ways. Regardless of participant age at the time of participation, many reported
their first encounter with racism occurred during childhood along with numerous occurrences since that time. In the current study, the age range was restricted (i.e. 25 to 65 years old) to include only women that were at an age where health issues might emerge or where participants were consistently seeking care however, it may be interesting to follow African American women from the first encounter into middle- and later-adulthood. The development of longitudinal studies of racial stress among Black women might help future researchers gain more insight about at what point stress-related diseases linked to discrimination begin to emerge. In addition, longitudinal studies of African American women’s experiences of racial stress may provide information about if any factors related to phase of life buffer or exacerbate the impact of racially stressful experiences on this population’s health and well-being.

Attention to individual differences in geographic location and socialization may also be a limitation to this study. Experiences of racism vary based on context and racial tension is often a defining characteristic in U.S. regions that are more politically conservative or less racially diverse, like the South, where almost half of the participants in the current study reside. There may be differences in initial exposure, frequency of experiences, and racial socialization for participants that grew up in more politically liberal or racially diverse regions. Future research should focus on examining how differences in geographic location and socialization relate to African American women’s experiences, reactions, and responses to racial stress.

Significance

Belgrave and Abrams’ 2016 article was the foundation for this dissertation study, leading to an exploration of how racial stress, specifically traumatic instances of racial
stress, impact African American women’s well-being. The results of this study specifically support the efforts of researchers and clinicians who are challenging helping professionals from all disciplines to expand our understanding of trauma to include racism (Bryant-Davis & Ocampo, 2005; Carter, 2006; Carter, Muchow, & Pieterse, 2018; Carter & Saint-Barket, 2015; Carter et al., 2013; Williams, Printz, DeLapp, 2018). These contributions to the field are extremely valuable. I also understand the approach of challenging the field to include racism by using their language and criteria, as is the case with racism and posttraumatic stress disorder (PTSD). At the same time, the women in the current study were clear that there is nothing “post” about the experience of racial stress. They are in it every single day of their lives. Is it possible then to expand our understanding and conceptualize the process of experiencing racial stress on a daily basis as traumatic?

The findings from the current study provide an opportunity for scholars and helping professionals across disciplines (i.e. mental health, medical, neuroscience) to partner with one another and explore how African American women’s brains are directing, processing, and taking in stressful stimuli. Not every experience of racial stress is traumatic and at the same time, Black women report experiencing racial stress every day. Many are surviving, but not without a cost. The accumulation of these experiences must be contributing to diminished health among Black women and once the stress-related disease emerges it is often too late. A study by Copeland et al., (2017) found high rates of co-morbid major depressive disorder and cardiovascular disease among African American women, even after accounting for socioeconomic status. The leading cause of death for African Americans is heart disease and the CDC (2017) also notes that
"younger African Americans are living or dying with many conditions typically found in White Americans at older ages” (p.1), highlighting the impact of allostatic load on African Americans health (National Center for Health Statistics, 2017). Helping professionals are missing opportunities to ask questions about racism and stress before it turns into illness and African American women’s health is disproportionately impacted (Allen et al., 2019).

Similarly, why does psychological distress have to be at a clinical level, or in the case of the DSM causing distress to point of severe impairment, in order for a Black woman’s experience to be true and valid? That is an example of what it means to be subject to a healthcare system that has a history of systematic oppression. The way the current criteria are outlined, many African American women may never be able to have their experience of racial stress validated and acknowledged because they are too resilient. Our diagnostic criteria and the way we conceptualize a client’s need for support present an issue of extremes. Black women’s resilience does not negate their humanity, nor their capacity to experience pain and exhaustion. African American women’s resilience also does not negate their need for support. The current conceptualization of distress does not leave room for Black women who, as a client said to me once, “still have shit to do.” The women in the current study were explicit about their exhaustion and the responsibilities that they cannot afford to let fall by the wayside. When severe impairment is not the presenting concern, helping professionals must collaborate with African American women to support what appears to be an increased need for balance.
Conclusions

Black women in the current study shared their tears, fears, and frustrations about racial stress, some of which was identified as traumatic. Without a doubt the resulting narrative reinforced African American women’s resilience but above all else, it echoes a question Black women have been asking for centuries, “Who will listen to and honor my pain?” Across a variety of health issues, the literature demonstrates higher mortality risk for Black women (Charlot et al., 2017; McCarthy, Yang & Armstrong, 2015; Shippee, Rinaldo, & Ferraro, 2011; Smilowitz, Maduro, Lobach, Chen, & Reynolds, 2016). Although scholars (Albert et al., 2010) show no direct link between racism, discrimination, and mortality among this population, African American women are being impacted by these experiences. As helping professionals, we must expand our understanding and risk assessment to account for the pervasive racial stress that is leading to the emergence of stress related diseases. As African American women we must be intentional about engaging one another in conversations about experiences of stress and support one another by building communities of accountability. Sistercircles where we share our pain, provide supportive feedback, and encourage one another to visit a healthcare professional, even if we need to go to the doctor together. The time is now, and we must respond to African American women with a sense of urgency.
References


Black Women’s Health Imperative (BWHI) (n.d.) Retrieved from https://www.bwhi.org/who-we-are-2/


Appendix A: Definition of Terms

For the purposes of this study the following terms are defined.

**Stress.** This term refers to “the circumstance in which transactions lead a person to perceive a discrepancy between the physical or psychological demands of a situation and the resources of his or her biological, psychological, and social systems” (Sarafino, 2008, p.63).

**Trauma.** This term refers to physically or emotionally painful events that are experienced as sudden, uncontrollable, and extremely negative, to which the individual’s primary response includes reexperiencing, arousal, and avoidance (Carter, 2007; Carlson & Dalenberg, 2000).

**Historical trauma.** This term refers to “cumulative emotional and psychological wounding, across generations, including the lifespan, which emanates from massive group trauma (Brave Heart, Chase, Elkins, & Altschul, 2011, p.283).

**Racism.** This term refers to a complex and dynamic phenomenon involving relationships between individuals, institutions, and the dominant culture (Carter, 2007).

**Race-related stress.** This term refers to “race related transactions between individuals or groups and their environment that emerge from the dynamics of racism, and that are perceived to tax or exceed existing individual and collective resources or threaten well-being” (Harrell, 2000, p.44).

**Race-based traumatic stress.** The term refers to “emotional or physical pain or the threat of emotional or physical pain that results from racism in the forms of racial harassment (hostility), racial discrimination (avoidance), or discriminatory harassment (aversive hostility) (Carter, 2007, p.88).
**Psychological well being.** This term refers to positive functioning characterized the following six dimensions: self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth (Ryff, 1989)

**African American/Black American women.** These terms refer to women “of African ancestral origins who self identifies or is identified by others as African American” (Agyemang, Bhopal, & Bruijnzeels, 2005, p.1016). These terms include African Americans with “distant ancestry” or “descendants of persons brought to the Americas as slaves between the 17th and 19th century” as well as individuals with “recent ancestry” or “others who came from Africa or the Caribbean in the 20th and 21st centuries” (p.1016). These terms will be utilized interchangeably throughout the discussion of the literature however, this dissertation focuses on African American women with “distant ancestry” (Agyemang, Bhopal, & Bruijnzeels, 2005, p.1016).
Appendix B: Recruitment Email

Recruitment Email to African American Women’s Organization

To Whom It May Concern:

My name is Amina Simmons; I am currently a fourth-year counseling psychology doctoral student at the University of Miami. You are being contacted because of your organization’s focus on serving African American women and girls. I have developed a dissertation study that is attempting to explore African American women’s experiences of race-based traumatic stress, health service utilization behaviors, and psychological well-being.

In order to meet study inclusion criteria, participants must have access to the internet (e.g. computer, smartphone, etc.), as the first phase of the study will be conducted via online survey. After being informed of study procedures, risks, benefits, compensation, and the voluntary nature of the study, those who provide informed consent will be directed to the online survey platform. The web-survey is expected to take 45-60 minutes to complete. The web-survey will include measures that assess: a) experiences and symptoms of race-based traumatic stress, b) psychological well-being, and c) health service utilization behaviors.

If you wish to learn more about the study, and/or are willing to allow recruitment either via your agency, website, or listserv please contact Amina Simmons, M.A. at a.simmons4@miami.edu.

Thank you in advance for your cooperation and willingness to help.

Respectfully,

Amina Simmons, M.A.
Doctoral Candidate
Appendix C: Recruitment Flyer

African American Women Speak

This is a call for self-identified African American women to participate in survey exploring their experiences of racial stress.

Your participation is needed in order to fill the gaps in research and interventions as it relates to African American women’s experiences of racial stress and impacts on psychological well-being.

Please click the web-link below to access the survey

umiami_AAWSpeak

Study Team Contact: a.simmons4@miami.edu

University of Miami

School of Education & Human Development

Photo Credit: https://everydayfeminism.com/2015/02/light-skinned-privilege/
Appendix D: Survey Informed Consent

Study #: 20180145 Effective Date: 3/13/2018 Expiration Date: 9/12/2018

CONSENT TO PARTICIPATE IN A RESEARCH STUDY African American women’s experiences of Race-Based Traumatic Stress (RBTS).

The following information describes the research study in which you are being asked to take part. Please read the information carefully. At the end, you will be asked to agree to take part.

PURPOSE OF STUDY:

You are being asked to be in a research study. The purpose of this study is to look at African American women’s experiences of racial stress and explore how racial stress affects mental health and use of health services.

PROCEDURES:

If you agree to be in the study, we would like you to take a survey that is about 45 minutes long. You will be asked about your background and experiences of racial stress, mental health, and visiting doctors, hospitals, or clinics.

RISKS AND/OR DISCOMFORTS: You may become upset from sharing race-based experiences. You may skip any questions you do not wish to answer.

If, after taking the survey, you feel anxious or upset and would like to talk with a counselor, you may contact the following:

National Alliance on Mental Health (NAMI) Helpline. The NAMI HelpLine can be reached Monday through Friday, 10 am–6 pm, ET., and the number is 1-800-950-NAMI (6264).

Crisis Text Line – Text NAMI to 741-741. The text line connects you with a trained crisis counselor to receive free support and is open 24 hours/day, 7 days/week.

National Suicide Prevention Lifeline. The National Suicide Prevention Lifeline is toll-free, can be reached 24 hours/day, 7 days/week, and the number is 800-273-TALK (8255). Your call will be answered by a trained crisis worker who will listen empathetically and without judgment. The crisis worker will work to make feel safe and help identify options and information about mental health services in your area. Your call is confidential and free.

BENEFITS: No direct benefit can be promised to you from being in this study. The
study will provide a chance to reflect and look at your experiences of racial stress and your reactions.

CONFIDENTIALITY: All answers to survey questions will be stored in the survey program and saved on a secure computer. Only the research team will have access to your survey answers. No survey answers used for analysis or publication will include your name or other information that could link your answers to you. Your name or other information that could link your answers to you will not be reported or shared with others.

RIGHT TO DECLINE OR WITHDRAW: Your participation in this study is voluntary. You are free to say no to taking the survey or stop answering the survey questions at any time.

CONSENT TO PARTICIPATE IN A RESEARCH STUDY African American women’s experiences of Race-Based Traumatic Stress (RBTS).

CONTACT INFORMATION: Amina Y. Simmons, under the supervision of Dr. Guerda Nicolas, will gladly answer any questions you may have about this project. If you have questions about the study please contact her at a.simmons4@miami.edu or Dr. Nicolas at nguerda@miami.edu. If you have questions about your rights as a research subject you may contact Human Subjects Research Office at the University of Miami, at (305) 243-3195.

PARTICIPANT AGREEMENT:

I have read the information in this consent form and agree to take part in this study. I have had the chance to ask any questions I have about this study, and they have been answered for me. I am entitled to a copy of this form after it has been read and signed.

__________________________  __________________
E-signature of Participant  Date
Appendix E: Interview Informed Consent

Dear Prospective Participant:

Your participation is being solicited for a research project on African American women’s experiences of race-based traumatic stress. The purpose of the research is to better understand African American women’s experiences of racial stress and trauma.

If you consent to participate in the study, we would like to conduct a single interview with you that would proceed for about 60 - 90 minutes. The interview will be tape-recorded, and you will be asked questions about your experiences of racial discrimination stress, trauma, and impacts on your physiological and psychological well-being. If you decide to participate, you will receive a $10 e-gift card for your participation.

The results of this study will increase researchers' understanding of African American women’s experiences of racial stress as well as the impact of these experiences on their well-being and contributes to research that seeks to promote health equity for African American women. The information obtained will also have important implications for healthcare professionals (i.e. physicians, counselors, etc) who work with African American women.

If, after participating in the interview, you feel anxious or upset and feel that you would like to talk with a professional counselor, please review the following options to speak with a crisis counselor and/or determine mental health resources in your community:

- **National Alliance on Mental Health (NAMI) Helpline.** The NAMI HelpLine can be reached Monday through Friday, 10 am–6 pm, ET., and the number is 1-800-950-NAMI (6264).

- **Crisis Text Line – Text NAMI to 741-741.** The text line connects you with a trained crisis counselor to receive free support and is open 24 hours/day, 7 days/week.

- **National Suicide Prevention Lifeline.** The National Suicide Prevention Lifeline is toll-free, can be reached 24 hours/day, 7 days/week, and the number is 800-273-TALK (8255). Your call will be answered by a trained crisis worker who will listen empathetically and without judgment. The crisis worker will work to ensure that you feel safe and help identify options and information about mental health services in your area. Your call is confidential and free.

The information you provide in the interview will remain confidential and anonymous. That is, no one other than the researchers will have access to the information you provide. The audio files and transcripts will be stored in a de-identified and stored on a secure (i.e. password protected), external hard drive with access granted to the primary investigator and members of the research team only. In any written materials based on the study, no real names will be used.
If you have questions about the research project, please contact Amina Y. Simmons, Department of Educational and Psychological Studies, University of Miami, at a.simmons4@miami.edu. Or Dr. Guerda Nicolas, Educational and Psychological Studies, University of Miami, at nguerda@miami.edu.

Your participation in the research is completely voluntary, and your decision to participate or not in no way affects your relationship with the University of Miami. Furthermore, if you decide to discontinue participation, you may do so at any time, without penalty, and you will still receive the $10 e-gift card compensation.

By signing this form, you affirm that you have read and understood the requirements for participating in the study.

I, ___________________________, have read and understood the terms for participation in the study on African American women’s experiences of race-based traumatic stress.

_________  ____________  
Print Name    Date

_________  ____________  
Signature    Date
Appendix F: Demographics Measure

Please indicate your age in years (e.g. 25 or 52):_____

What country were YOU born in?
1. ( ) U.S.
2. ( ) Outside of the U.S., Where? ______________________
   How old were you when you first came to the U.S.? ___________
   How many years have you lived in the U.S.? _________

What country was your MOTHER born in?
1. ( ) U.S.
2. ( ) Outside of the U.S., Where? ______________________
   Did your mother come to the U.S.?  1 ( ) Yes  2 ( ) No
   If YES, how old was your mother when she first came to the U.S.? __________

What country was your FATHER born in?
1. ( ) U.S.
2. ( ) Outside of the U.S., Where? ______________________
   Did your father come to the U.S.?  1 ( ) Yes  2 ( ) No
   If YES, how old was your father when he first came to the U.S.? __________

Please select the highest level of education you have completed or the highest degree you have received:
- Less than high school degree
- High school graduate (high school diploma or equivalent including GED)
- Some college but no degree
- Associate degree in college (2-year)
- Bachelor's degree in college (4-year)
- Master's degree
- Doctoral degree
- Professional degree (JD, MD)
- Other, please specify: ______

Please indicate the answer that includes your entire household income in 2017 before taxes:
- Less than $10,000
- $10,000 to $19,999
- $20,000 to $29,999
- $30,000 to $39,999
- $40,000 to $49,999
- $50,000 to $59,999
- $60,000 to $69,999
- $70,000 to $79,999
- $80,000 to $89,999
- $90,000 to $99,999
$100,000 to $149,999
$150,000 or more
Prefer not to say

What is your ZIP code?: ____________

Which of the following best describes your sexual orientation?
Heterosexual/Straight
Lesbian
Bisexual
Queer
Questioning
Other
Prefer not to say

Which of the following best describes your current relationship status? Please check all that apply.
Married
Widowed
Divorced
Separated
In a Relationship/Partnered
Dating
Single
Prefer not to say

How many people are living or staying at this address?: ________

INCLUDE:
- Everyone who is living or staying here for more than 2 months.
- Yourself if you are living here for more than 2 months.
- Anyone else staying here who does not have another place to stay, even if they are here for 2 months or less.

DO NOT INCLUDE:
- Anyone who is living somewhere else for more than 2 months, such as a college student living away or someone in the Armed Forces on deployment.

Have you ever served on active duty in the US Armed Forces?
Yes
No

If yes, Are you now serving in the U.S. Armed Forces?
Yes
No
If no, **When did you serve in the U.S. Armed Forces?**
- September 2001 or later
- August 1990 to August 2001
- May 1975 to July 1990
- Vietnam Era (August 1964-April 1975)
- February 1955 to July 1964
- Korean War (July 1950 to January 1955)
- January 1974 to June 1950
- World War II (December 1941 to December 1946)
- November 1941 or earlier

**Which statement best describes your current employment status?**
- Working (paid employee)
- Working (self-employed)
- Not working (temporary layoff from a job)
- Not working (looking for work)
- Not working (retired)
- Not working (disabled)
- Not working (other), please specify: 
- Prefer not to answer

**Did you vote in the last U.S. Presidential election?**
- Yes
- No
Appendix G: Adult Access to Health Care & Utilization Selected Items

**General Use:**
Is there a place that you USUALLY go to when you are sick or need advice about your health?

1 (yes)
2 (no)
3 (there is MORE THAN ONE place)
7 (refused)
9 (don’t know)

**If 2, 7, or 9 then → go to Question #2**

**If 1 or 3 then → a, b**

a. **What kind of place is it - a clinic, doctor's office, emergency room, or some other place?**

1 (clinic or health center)
2 (doctor’s office or HMO)
3 (hospital emergency room)
4 (hospital outpatient department)
5 (some other place)
6 (doesn’t go to one place most often)
7 (refused)
9 (don’t know).

b. **What kind of place do you go to most often?**

1 (clinic or health center)
2 (doctor’s office or HMO)
3 (hospital emergency room)
4 (hospital outpatient department)
5 (some other place)
6 (doesn’t go to one place most often)
7 (refused)
9 (don’t know).

**If 1-5 then → c.**

c. Is that {fill from 1b: What kind of place do you go most often} the same place you USUALLY go when you need routine or preventive care, such as a physical examination or checkup?

1 (yes)
2 (no)
7 (refused)
9 (don’t know)
What kind of place do you USUALLY go to when you need routine or preventive care, such as a physical examination or checkup?
0 (Doesn't get preventive care anywhere)
1 (clinic or health center)
2 (doctor’s office or HMO)
3 (hospital emergency room)
4 (hospital outpatient department)
5 (some other place)
6 (doesn’t go to one place most often)
7 (refused)
9 (don’t know).

About how long has it been since you last saw or talked to a doctor or other health care professional about your own health? Include doctors seen while a patient in a hospital.

Never
1 (6 months or less)
2 (More than 6 mos, but not more than 1 yr ago)
3 (More than 1 yr, but not more than 2 yrs ago)
4 (More than 2 yrs, but not more than 5 yrs ago)
5 (More than 5 years ago)
7 (Refused)
9 (Don't know)

** If 3 - 9 then → SKIP to next measure
**If 1 or 2 then → continue to next question (complete rest of measure)

At any time in the PAST 12 MONTHS did you CHANGE the place(s) to which you USUALLY go for health care?
1 (yes)
2 (no)
7 (refused)
9 (don’t know)

** If 2, 7, or 9 then → GO TO DELAYED SERVICE USE 1
**If 1 then → a.

a. Was this change for a reason related to health insurance?
1 (yes)
2 (no)
7 (refused)
9 (don’t know)
Delayed Service Use Section 1 (5 items; Logistics Focused):

There are many reasons people delay getting medical care. Have you delayed getting care for any of the following reasons in the PAST 12 MONTHS?

**Answer Choices:** 1 (yes), 2 (no), 7 (refused), or 9 (don’t know)

...You couldn't get through on the telephone.
...You couldn't get an appointment soon enough.
...Once you get there, you have to wait too long to see the doctor.
...The (clinic/doctor's) office wasn't open when you could get there.
...You didn't have transportation.

Delayed Service Use Section 2 (6 items; Broad Range of Care):

DURING THE PAST 12 MONTHS, was there any time when you needed any of the following, but didn't get it because you couldn't afford it?

**Answer Choices:** 1 (yes), 2 (no), 7 (refused), or 9 (don’t know)

...Prescription medicines.
...Mental health care or counseling.
...Dental care (including check ups).
...Eyeglasses.
...To see a specialist.
...Follow-up care.

Prescription Medication Adherence (1 required, 6 conditional items):

DURING THE PAST 12 MONTHS, were you prescribed medication by a doctor or other health professional?

1 (yes)
2 (no)
7 (refused)
9 (don’t know)

**If 1 then → a-f

Prompt: DURING THE PAST 12 MONTHS, were any of the following true for you?

**Answer Choices:** 1 (yes), 2 (no), 7 (refused), or 9 (don’t know)

a. ...You skipped medication doses to save money.
b. ...You took less medicine to save money.
c. ...You delayed filling a prescription to save money.
d. ...You asked your doctor for a lower cost medication to save money.
e. ...You bought prescription drugs from another country to save money.
f. ...You used alternative therapies to save money.
Specific Provider Use Section (9 items; Broad Range of Care):

Prompt: DURING THE PAST 12 MONTHS, have you seen or talked to any of the following healthcare providers about your own health?
Answer Choices: 1 (yes), 2 (no), 7 (refused), or 9 (don’t know)

...any type of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists.
...A mental health professional such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker.
...An optometrist, ophthalmologist (AHF-thal-MOL-oh-jist), or eye doctor (someone who prescribes eyeglasses).
...A foot doctor.
...A chiropractor.
...A physical therapist, speech therapist, respiratory therapist, audiologist, or occupational therapist.
...A nurse practitioner, physician assistant, or midwife.
...A doctor who specializes in women's health (an obstetrician/gynecologist).
...A medical doctor who specializes in a particular medical disease or problem (other than obstetrician/gynecologist, psychiatrist, or ophthalmologist).
...A general doctor who treats a variety of illnesses (a doctor in general practice, family medicine, or internal medicine)?

Specific Location for Service Section (9 items; Broad Range of Care):

Prompt: DURING THE PAST 12 MONTHS, have you received care at any of the following health service locations for your own health?
Answer Choices: 1 (yes), 2 (no), 7 (refused), or 9 (don’t know)

...a HOSPITAL EMERGENCY ROOM about your own health (This includes emergency room visits that resulted in a hospital admission.)?

...receive care AT HOME from a nurse or other health care professional?

...seen a doctor or other health care professional at the following: (Do not include times you were hospitalized overnight, visits to hospital emergency rooms, home visits, dental visits, or telephone calls)
  a. ...at a DOCTOR’S OFFICE
  b. ...at a CLINIC
  c. ...at SOME OTHER PLACE

DURING THE PAST 12 MONTHS, have you had SURGERY or other surgical procedures either as an inpatient or outpatient? *Read if necessary: This includes both major surgery and minor procedures such as setting bones or removing growths.
  1 (yes)
Vaccines Section (9 items; Non-required vaccinations):

**DURING THE PAST 12 MONTHS, have you had a flu vaccination?** A flu vaccination is usually given in the fall and protects against influenza for the flu season.

1 (yes)
2 (no)
7 (refused)
9 (don’t know)

**Have you EVER had a pneumonia shot?** This shot is usually given only once or twice in a person’s lifetime and is different from the flu shot. It is also called the pneumococcal vaccine.

1 (yes)
2 (no)
7 (refused)
9 (don’t know)

**Have you EVER received the hepatitis B vaccine?** *Read if necessary: This is given in three separate doses and has been available since 1991. It is recommended for newborn infants, adolescents, and people such as health care workers, who may be exposed to the hepatitis B virus.

1 (yes)
2 (no)
7 (refused)
9 (don’t know)

**Have you ever received the hepatitis A vaccine?** The hepatitis A vaccine is given as a two dose series routinely to some children starting at 1 year of age, and to some adults and people who travel outside the United States. Although it can be given as a combination vaccine with hepatitis B, it is different from the hepatitis B shot, and has only been available since 1995.

1 (yes)
2 (no)
7 (refused)
9 (don’t know)

**Have you ever had a blood test for hepatitis C?**

1 (yes)
2 (no)
7 (refused)
9 (don’t know)
Have you ever had the Zoster (ZOSS-ter) or Shingles vaccine, also called Zostavax®? Shingles is an outbreak of a rash or blisters on the skin that may be associated with severe pain. The pain is generally on one side of the body or face. Shingles is caused by the chicken pox virus. A vaccine for shingles has been available since May 2006.

1 (yes)
2 (no)
7 (refused)
9 (don’t know)

Have you received a tetanus shot in the past 10 years?
1 (yes)
2 (no)
7 (refused)
9 (don’t know)

Have you ever received an HPV shot or vaccine? *HPV stands for human papillomavirus (pap-uh-LOW-muh-vi-rus). The vaccines are sometimes called CERVARIX (trademark) or GARDASIL (trademark).

1 (yes)
2 (no)
7 (refused)
9 (don’t know)

Specific Tests and Health Checks Section (8 items; Broad Range Care/Common Health):

Prompt: DURING THE PAST 12 MONTHS
Answer Choices: 1 (yes), 2 (no), 7 (refused), or 9 (don’t know)

..have you had your blood pressure checked by a doctor, nurse, or other health professional?
..have you had your blood cholesterol checked by a doctor, nurse, or other health professional?
..have you had a fasting test for high blood sugar or diabetes?
..have you had a Pap smear or Pap test? *A Pap smear or Pap test is a routine test for women in which the doctor examines the cervix, takes a cell sample from the cervix with a small stick or brush, and sends it to the lab.
..have you had a Mammogram? *A mammogram is an x-ray of each breast to look for breast cancer.
..have you had any test done for colon cancer? *Colon cancer tests include blood stool tests, colonoscopy and sigmoidoscopy. A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. A sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems.
..has a doctor or other health professional talked to you about your diet?
…has a doctor or other health professional talked to you about your smoking?
Appendix H: Mental Health Continuum Short Form

Adult MHC-SF (ages 18 or older)

Prompt: Please answer the following questions about how you have been feeling during the past month. Place a mark in the answer choice that best represents how often you have experienced or felt the following:

Answer Choices:

1. happy
2. interested in life
3. satisfied with life
4. that you had something important to contribute to society
5. that you belonged to a community (like a social group, or your neighborhood)
6. that our society is a good place, or is becoming a better place, for all people***
7. that people are basically good
8. that the way our society works makes sense to you
9. that you liked most parts of your personality
10. good at managing the responsibilities of your daily life
11. that you had warm and trusting relationships with others
12. that you had experiences that challenged you to grow and become a better person
13. confident to think or express your own ideas and opinions
14. that your life has a sense of direction or meaning to it

**Note:** The original wording for item 6 was “that our society is becoming a better place for people like you.” This item does not work in all cultural contexts. However, when validating the MHC-SF, test both versions of item 6 to see which one works best in your context.
Appendix I: Race-Based Traumatic Stress Symptoms Scale (RBTSSS)

**Reaction Survey**
In the lines below, please list and briefly describe up to three of the most memorable events of racism you have experienced in your life, the setting where the event(s) occurred (e.g., school, work, store), the location of where the event(s) occurred (e.g., city, state, or country), and d) when in your life the event took place (e.g., childhood, adolescence, adulthood, later adulthood).

Event #1:
__________________________________________________________________
__________________________________________________________________
______________________________________________________________

Setting
__________________________________________________________________

Location (city/state):
__________________________________________________________________

Period of Life:
__________________________________________________________________

Event #2:
__________________________________________________________________
__________________________________________________________________
______________________________________________________________

Setting
__________________________________________________________________

Location (city/state):
__________________________________________________________________

Period of Life:
__________________________________________________________________

Event #3:
__________________________________________________________________
Setting

Location (city/state):

Period of Life:
OF THE EVENTS DESCRIBED ABOVE, PLEASE CIRCLE THE ONE MOST MEMORABLE EXPERIENCE AND USE IT TO ANSWER THE REMAINING QUESTIONS.

How often has this type of event occurred? (Circle One)
   a. Only ONE time
   b. A FEW (3-4) times
   c. Several (5-6) times
   d. ALL the time

Please check the box next to each period in your life when you experienced the event.

    (3-12 yrs) (13-18 yrs) (19-60 yrs) (61+
    yrs)
   a. Only ONE time: in ☐ childhood, ☐ adolescence, ☐ adulthood, ☐ later adulthood.
   b. A FEW (3-4) times: in ☐ childhood, ☐ adolescence, ☐ adulthood, ☐ later adulthood.
   c. Several (5-6) times: in ☐ childhood, ☐ adolescence, ☐ adulthood, ☐ later adulthood.
   d. ALL the time: in ☐ childhood, ☐ adolescence, ☐ adulthood, ☐ later adulthood.

Did you find that this event was out of your control? ☐ Yes ☐ No

Did you find that this event was unexpected? ☐ Yes ☐ No

Did you find that this event was a negative experience? ☐ Yes ☐ No
Using the ONE experience you described and circled above, respond to the following reactions. Read each reaction carefully and circle the number that best describes your reactions or feeling *Right After the Event (within one month)* and then, the best description of your reactions or feelings *More Recently* when you think about, speak about, or are reminded of the event. In the third column, please circle whether or not (Y/N) *Others (i.e., friends, family, or coworkers) Noticed a Change in your behavior or personality following the event.*

1. As a consequence of the memorable encounter I had with racism, I felt that I had nothing to look forward to.

   **Right After Event (Circle one)**

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   Did others notice a change in you? (Circle one)

   Yes
   No

2. As a consequence of the memorable encounter I had with racism, I felt that life was meaningless.

   **Right After Event (Circle one)**

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   Did others notice a change in you? (Circle one)

   Yes
   No

3. As a consequence of the memorable encounter I had with racism, I experience tiredness and lack of energy.

   **Right After Event (Circle one)**

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   Did others notice a change in you? (Circle one)

   Yes
   No
4. As a consequence of the memorable encounter I had with racism, I experience tearfulness.

Right After Event (Circle one)

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Did others notice a change in you? (Circle one)

Yes

No

5. As a consequence of the memorable encounter I had with racism, I experience feelings of hopelessness.

Right After Event (Circle one)

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Did others notice a change in you? (Circle one)

Yes

No

6. As a consequence of the memorable encounter I had with racism, I found it difficult to work up the initiative to do things.

Right After Event (Circle one)

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Did others notice a change in you? (Circle one)

Yes

No

7. As a consequence of the memorable encounter I had with racism, I couldn't seem to experience any positive feelings at all.

Right After Event (Circle one)

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More Recently (Circle one)
8. As a consequence of the memorable encounter I had with racism, I feel I can seldom do anything right.

Right After Event (Circle one)

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Did others notice a change in you? (Circle one)

Yes

No

9. As a consequence of the memorable encounter I had with racism, I found myself getting upset rather easily.

Right After Event (Circle one)

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Did others notice a change in you? (Circle one)

Yes

No

10. As a consequence of the memorable encounter I had with racism, I found it hard to calm down after something upset me.

Right After Event (Circle one)

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Did others notice a change in you? (Circle one)

Yes

No

11. As a consequence of the memorable encounter I had with racism, I found myself getting agitated.

Right After Event (Circle one)
12. As a consequence of the memorable encounter I had with racism, I become easily pissed-off (as if you can't control your temper during an otherwise normal conversation).

Right After Event (Circle one)

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Did others notice a change in you? (Circle one)

Yes  No

13. As a consequence of the memorable encounter I had with racism, I become easily upset or defensive (for example, when receiving feedback from a peer about a paper you wrote).

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Did others notice a change in you? (Circle one)

Yes  No

14. As a consequence of the memorable encounter I had with racism, I was in a state of nervous tension.

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Did others notice a change in you? (Circle one)  
Yes  
No  

15. As a consequence of the memorable encounter I had with racism, I tended to over-react to situations.  
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Did others notice a change in you? (Circle one)  
Yes  
No  

16. As a consequence of the memorable encounter I had with racism, I found it difficult to relax.  
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Did others notice a change in you? (Circle one)  
Yes  
No  

17. As a consequence of the memorable encounter I had with racism, I felt that I was rather touchy.  
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Did others notice a change in you? (Circle one)  
Yes  
No  

18. As a consequence of the memorable encounter I had with racism, I was worried about situations in which I might panic and make a fool of myself.  
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More Recently (Circle one)
19. As a consequence of the memorable encounter I had with racism, I feel nervous (for example, when others approach you).

Right After Event (Circle one)

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Did others notice a change in you? (Circle one)

Yes
No

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Did others notice a change in you? (Circle one)

Yes
No

20. As a consequence of the memorable encounter I had with racism, I experience more headaches and stomach aches since the event.

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Did others notice a change in you? (Circle one)

Yes
No

21. As a consequence of the memorable encounter I had with racism, I experience physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminds me of the event.

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Did others notice a change in you? (Circle one)

Yes
No

22. As a consequence of the memorable encounter I had with racism, I experienced trembling (e.g., in the hands).
23. As a consequence of the memorable encounter I had with racism, I experience poor appetite.

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Did others notice a change in you? (Circle one) Yes No

24. As a consequence of the memorable encounter I had with racism, I was aware of dryness of my mouth.

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Did others notice a change in you? (Circle one) Yes No

25. As a consequence of the memorable encounter I had with racism, I was aware of the action of my heart in the absence of physical exertion (e.g., racing heart).

Right After Event (Circle one)

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26. As a consequence of the memorable encounter I had with racism, I try not to think about, talk about, or have feelings about the event.

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27. As a consequence of the memorable encounter I had with racism, I find myself spending a lot of time at home and away from family or friends.

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28. As a consequence of the memorable encounter I had with racism, I often find myself denying that the event occurred.

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29. As a consequence of the memorable encounter I had with racism, I just can't believe the event really happened to me.

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30. As a consequence of the memorable encounter I had with racism, I feel like I am immune to pain.

31. As a consequence of the memorable encounter I had with racism, when I describe the event, I feel nothing, as if I'm not "really there."

32. As a consequence of the memorable encounter I had with racism, I tend to stay away from people/places who remind me of the event.
33. As a consequence of the memorable encounter I had with racism, I experience trouble falling or staying asleep.

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More Recently (Circle one)

| Does not describe my reactions | Had this reaction infrequently | Had this reaction sometimes | Had this reaction frequently | This reaction would not go away |
| 0                              | 1                               | 2                               | 3                               | 4                               |

Did others notice a change in you? (Circle one)  
Yes  No

34. As a consequence of the memorable encounter I had with racism, I have used alcohol or other drugs to help me sleep or to make me forget the event.

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More Recently (Circle one)

| Does not describe my reactions | Had this reaction infrequently | Had this reaction sometimes | Had this reaction frequently | This reaction would not go away |
| 0                              | 1                               | 2                               | 3                               | 4                               |

Did others notice a change in you? (Circle one)  
Yes  No

35. As a consequence of the memorable encounter I had with racism, I feel easily intimidated (as if someone is going to hurt you as they walk passed you in the street).

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More Recently (Circle one)

| Does not describe my reactions | Had this reaction infrequently | Had this reaction sometimes | Had this reaction frequently | This reaction would not go away |
| 0                              | 1                               | 2                               | 3                               | 4                               |

Did others notice a change in you? (Circle one)  
Yes  No

36. As a consequence of the memorable encounter I had with racism, I feel paranoid (for example, when people look at you when you walk into a room).

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| Does not describe my reactions | Had this reaction infrequently | Had this reaction sometimes | Had this reaction frequently | This reaction would not go away |
| 0                              | 1                               | 2                               | 3                               | 4                               |

Did others notice a change in you? (Circle one)  
Yes  No
37. As a consequence of the memorable encounter I had with racism, I feel hyperactive all the time (for example, feel like you can’t relax).

Right After Event (Circle one)

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<thead>
<tr>
<th>Did not describe my reactions</th>
<th>Had this reaction infrequently</th>
<th>Had this reaction sometimes</th>
<th>Had this reaction frequently</th>
<th>This reaction would not go away</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Did others notice a change in you? (Circle one)

Yes No

38. As a consequence of the memorable encounter I had with racism, I feel worried a lot (for example, walking down the street).

Right After Event (Circle one)

<table>
<thead>
<tr>
<th>Did not describe my reactions</th>
<th>Had this reaction infrequently</th>
<th>Had this reaction sometimes</th>
<th>Had this reaction frequently</th>
<th>This reaction would not go away</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Did others notice a change in you? (Circle one)

Yes No

39. As a consequence of the memorable encounter I had with racism, I become easily frightened (for example, when you hear subtle noises).

Right After Event (Circle one)

<table>
<thead>
<tr>
<th>Did not describe my reactions</th>
<th>Had this reaction infrequently</th>
<th>Had this reaction sometimes</th>
<th>Had this reaction frequently</th>
<th>This reaction would not go away</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Did others notice a change in you? (Circle one)

Yes No
40. As a consequence of the memorable encounter I had with racism, I feel as though my heart is beating hard and fast, as if it might pop out of my chest.

**Right After Event (Circle one)**

<table>
<thead>
<tr>
<th>Does not describe my reactions</th>
<th>Had this reaction infrequently</th>
<th>Had this reaction sometimes</th>
<th>Had this reaction frequently</th>
<th>This reaction would not go away</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**More Recently (Circle one)**

<table>
<thead>
<tr>
<th>Does not describe my reactions</th>
<th>Had this reaction infrequently</th>
<th>Had this reaction sometimes</th>
<th>Had this reaction frequently</th>
<th>This reaction would not go away</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Did others notice a change in you? (Circle one)  
Yes  No

41. As a consequence of the memorable encounter I had with racism, I feel distressed and frustrated about things that used to not bother me.

**Right After Event (Circle one)**

<table>
<thead>
<tr>
<th>Does not describe my reactions</th>
<th>Had this reaction infrequently</th>
<th>Had this reaction sometimes</th>
<th>Had this reaction frequently</th>
<th>This reaction would not go away</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**More Recently (Circle one)**

<table>
<thead>
<tr>
<th>Does not describe my reactions</th>
<th>Had this reaction infrequently</th>
<th>Had this reaction sometimes</th>
<th>Had this reaction frequently</th>
<th>This reaction would not go away</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Did others notice a change in you? (Circle one)  
Yes  No

42. As a consequence of the memorable encounter I had with racism, I feel emotionally upset when I am reminded of the event.

**Right After Event (Circle one)**

<table>
<thead>
<tr>
<th>Does not describe my reactions</th>
<th>Had this reaction infrequently</th>
<th>Had this reaction sometimes</th>
<th>Had this reaction frequently</th>
<th>This reaction would not go away</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**More Recently (Circle one)**

<table>
<thead>
<tr>
<th>Does not describe my reactions</th>
<th>Had this reaction infrequently</th>
<th>Had this reaction sometimes</th>
<th>Had this reaction frequently</th>
<th>This reaction would not go away</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Did others notice a change in you? (Circle one)  
Yes  No

43. As a consequence of the memorable encounter I had with racism, I find myself thinking about what happened even when I don't want to.

**Right After Event (Circle one)**

<table>
<thead>
<tr>
<th>Does not describe my reactions</th>
<th>Had this reaction infrequently</th>
<th>Had this reaction sometimes</th>
<th>Had this reaction frequently</th>
<th>This reaction would not go away</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**More Recently (Circle one)**
44. As a consequence of the memorable encounter I had with racism, I experience mental images of the event.

Did others notice a change in you? (Circle one)

<table>
<thead>
<tr>
<th>Right After Event (Circle one)</th>
<th>Does not describe my reactions</th>
<th>Had this reaction infrequently</th>
<th>Had this reaction sometimes</th>
<th>Had this reaction frequently</th>
<th>This reaction would not go away</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

Did others notice a change in you? (Circle one)

<table>
<thead>
<tr>
<th>More Recently (Circle one)</th>
<th>Does not describe my reactions</th>
<th>Had this reaction infrequently</th>
<th>Had this reaction sometimes</th>
<th>Had this reaction frequently</th>
<th>This reaction would not go away</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

Did others notice a change in you? (Circle one)

<table>
<thead>
<tr>
<th>45. As a consequence of the memorable encounter I had with racism, there are times when I feel and think as if the event is happening again.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right After Event (Circle one)</td>
</tr>
<tr>
<td>Does not describe my reactions</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

Did others notice a change in you? (Circle one)

<table>
<thead>
<tr>
<th>More Recently (Circle one)</th>
<th>Does not describe my reactions</th>
<th>Had this reaction infrequently</th>
<th>Had this reaction sometimes</th>
<th>Had this reaction frequently</th>
<th>This reaction would not go away</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

Did others notice a change in you? (Circle one)

<table>
<thead>
<tr>
<th>46. As a consequence of the memorable encounter I had with racism, I can't seem to get the event out of my mind even when I try.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right After Event (Circle one)</td>
</tr>
<tr>
<td>Does not describe my reactions</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

Did others notice a change in you? (Circle one)

<table>
<thead>
<tr>
<th>More Recently (Circle one)</th>
<th>Does not describe my reactions</th>
<th>Had this reaction infrequently</th>
<th>Had this reaction sometimes</th>
<th>Had this reaction frequently</th>
<th>This reaction would not go away</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

Did others notice a change in you? (Circle one)

<table>
<thead>
<tr>
<th>47. As a consequence of my most memorable encounter with racism, I feel a lack of initiative or a lessened desire to succeed since the event.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right After Event (Circle one)</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
48. As a consequence of my most memorable encounter with racism, I feel a sense of responsibility for the event.

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Right After Event</th>
<th>More Recently</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Circle one)</td>
<td>(Circle one)</td>
</tr>
<tr>
<td></td>
<td>Does not describe my reactions</td>
<td>Does not describe my reactions</td>
</tr>
<tr>
<td></td>
<td>Had this reaction infrequently</td>
<td>Had this reaction infrequently</td>
</tr>
<tr>
<td></td>
<td>Had this reaction sometimes</td>
<td>Had this reaction sometimes</td>
</tr>
<tr>
<td></td>
<td>Had this reaction frequently</td>
<td>Had this reaction frequently</td>
</tr>
<tr>
<td></td>
<td>This reaction would not go away</td>
<td>This reaction would not go away</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
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<tr>
<td></td>
<td>1</td>
<td>1</td>
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<td>2</td>
<td>2</td>
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<td></td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Did others notice a change in you? (Circle one) Yes No

49. As a consequence of my most memorable encounter with racism, at times, I think I am no good at all.

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Right After Event</th>
<th>More Recently</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Circle one)</td>
<td>(Circle one)</td>
</tr>
<tr>
<td></td>
<td>Does not describe my reactions</td>
<td>Does not describe my reactions</td>
</tr>
<tr>
<td></td>
<td>Had this reaction infrequently</td>
<td>Had this reaction infrequently</td>
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<tr>
<td></td>
<td>Had this reaction sometimes</td>
<td>Had this reaction sometimes</td>
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<td></td>
<td>Had this reaction frequently</td>
<td>Had this reaction frequently</td>
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<td></td>
<td>This reaction would not go away</td>
<td>This reaction would not go away</td>
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<td>1</td>
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<td>2</td>
<td>2</td>
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<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Did others notice a change in you? (Circle one) Yes No

50. As a consequence of my most memorable encounter with racism, I certainly feel useless at times.

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Right After Event</th>
<th>More Recently</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Circle one)</td>
<td>(Circle one)</td>
</tr>
<tr>
<td></td>
<td>Does not describe my reactions</td>
<td>Does not describe my reactions</td>
</tr>
<tr>
<td></td>
<td>Had this reaction infrequently</td>
<td>Had this reaction infrequently</td>
</tr>
<tr>
<td></td>
<td>Had this reaction sometimes</td>
<td>Had this reaction sometimes</td>
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<tr>
<td></td>
<td>Had this reaction frequently</td>
<td>Had this reaction frequently</td>
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<td></td>
<td>This reaction would not go away</td>
<td>This reaction would not go away</td>
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<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Did others notice a change in you? (Circle one) Yes No
51. As a consequence of my most memorable encounter with racism, I wish I could have more respect for myself.
Right After Event (Circle one)

<table>
<thead>
<tr>
<th></th>
<th>Does not describe my reactions</th>
<th>Had this reaction infrequently</th>
<th>Had this reaction sometimes</th>
<th>Had this reaction frequently</th>
<th>This reaction would not go away</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

More Recently (Circle one)

<table>
<thead>
<tr>
<th></th>
<th>Does not describe my reactions</th>
<th>Had this reaction infrequently</th>
<th>Had this reaction sometimes</th>
<th>Had this reaction frequently</th>
<th>This reaction would not go away</th>
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<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Did others notice a change in you? (Circle one)

Yes
No

52. As a consequence of my most memorable encounter with racism, I am inclined to feel that I am a failure.
Right After Event (Circle one)

<table>
<thead>
<tr>
<th></th>
<th>Does not describe my reactions</th>
<th>Had this reaction infrequently</th>
<th>Had this reaction sometimes</th>
<th>Had this reaction frequently</th>
<th>This reaction would not go away</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

More Recently (Circle one)

<table>
<thead>
<tr>
<th></th>
<th>Does not describe my reactions</th>
<th>Had this reaction infrequently</th>
<th>Had this reaction sometimes</th>
<th>Had this reaction frequently</th>
<th>This reaction would not go away</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Did others notice a change in you? (Circle one)

Yes
No
Appendix J: Steps for G-Power Analysis

For Small Effect, $r = 0.1$
1. Test Family: Exact
2. Statistical Test: Correlation Bivariate Normal Model
3. Type of Power Analysis: A priori
4. Input Parameters
   a. Two tailed test (because we are not specifying a direct, just seeing a relationship exists)
   b. Correlation $p$ for the Alternative Hypothesis ($p_{H_1}$) → Click Determine
      i. $r^2 = (0.1)^2 = .01$ (input this in the Coeff of Determination box)
      ii. Press calculate and transfer
   c. Alpha level = .05 (because that's usually what it is)
   d. Power = .95 (because we want to be 95% confident that are results are not due to error)
   e. Correlation $p$ for the Null Hypothesis ($p_{H_0}$) = 0 (because the null is there is no relationship between the variables among a population of BAW
5. Click Calculate
6. Estimated Sample Size: **1294**

For Medium Effect, $r = 0.3$
7. Test Family: Exact
8. Statistical Test: Correlation Bivariate Normal Model
9. Type of Power Analysis: A priori
10. Input Parameters
    a. Two tailed test (because we are not specifying a direct, just seeing a relationship exists)
    b. Correlation $p$ for the Alternative Hypothesis ($p_{H_1}$) → Click Determine
       i. $r^2 = (0.3)^2 = .09$ (input this in the Coeff of Determination box)
       ii. Press calculate and transfer
    c. Alpha level = .05 (because that’s usually what it is)
    d. Power = .95 (because we want to be 95% confident that are results are not due to error)
    e. Correlation $p$ for the Null Hypothesis ($p_{H_0}$) = 0 (because the null is there is no relationship between the variables among a population of BAW
11. Click Calculate
12. Estimated Sample Size: **139**

For Large Effect, $r = 0.5$
13. Test Family: Exact
14. Statistical Test: Correlation Bivariate Normal Model
15. Type of Power Analysis: A priori
16. Input Parameters
   a. Two tailed test (because we are not specifying a direct, just seeing a relationship exists)
   b. Correlation p for the Alternative Hypothesis (p H₁) → Click Determine
      i. $r^2 = (0.5)^2 = .25$ (input this in the Coeff of Determination box)
      ii. Press calculate and transfer
   c. Alpha level = .05 (because that’s usually what it is)
   d. Power = .95 (because we want to be 95% confident that are results are not due to error)
   e. Correlation p for the Null Hypothesis (p H₀) = 0 (because the null is there is no relationship between the variables among a population of BAW
17. Click Calculate
18. Estimated Sample Size: 47
## Appendix K: Reliability Analyses

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Cronbach’s Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHC-SF (14 items)</td>
<td>$\alpha = .924$</td>
</tr>
<tr>
<td>RBTS (symptom subscales)</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>$\alpha = .905$</td>
</tr>
<tr>
<td>Intrusion</td>
<td>$\alpha = .880$</td>
</tr>
<tr>
<td>Anger</td>
<td>$\alpha = .920$</td>
</tr>
<tr>
<td>Hypervigilance</td>
<td>$\alpha = .880$</td>
</tr>
<tr>
<td>Physical</td>
<td>$\alpha = .879$</td>
</tr>
<tr>
<td>Self Esteem</td>
<td>$\alpha = .857$</td>
</tr>
<tr>
<td>Avoidance</td>
<td>$\alpha = .860$</td>
</tr>
</tbody>
</table>
Appendix L: Interview Procedure and Questions

1. **CONNECT** with Participant via Skype (*Greeting*)/Get Phone Number in Case of Disconnection
2. **SEND** participant link to qualtrics consent form: https://umiami.qualtrics.com/jfe/form/SV_7Qck8EobxGiw08l
3. **ASK**: “Do you have any questions about the consent form or the interview before we begin?”
4. **CONFIRM**: Signature → *Click Data & Analysis on Qualtrics Site*
5. **ASK**: “We’d like you to select fake name, do you have one in mind?”
6. **TURN ON RECORDER(s)**: Confirm correct file format and audio quality.
7. **BEGIN** Interview: See protocol below
8. **ASK**: “Are there any other questions you might have for me before we wrap up?”
9. **TURN OFF RECORDER** (s):
10. **ASK**: Which retailer participant would you like your $10 e-gift card from?
    Confirm email address/phone?
    a. Target, Amazon, Walmart,

    **Interview**: (INSERT FAKE NAME ________________)

Tell me a little bit about yourself...get a sense of demographics

1. **Can you tell me about your experiences of racial stress?**
   **Prompts**:
   - What kinds of things did you experience?
   - What was your mood like? How did you interpret your mood?
   - What was going in your mind then? (thoughts/associations/fantasies)
   - How did that feel in your body? How did you interpret those changes?

2. **What was your first/subsequent reaction?**
   **Prompts**:
   - How did you decide to go about dealing with your racial stress?
   - Where did you seek help?
   - What stopped you from seeking help?
   - If sought help (e.g. mental health counseling, debriefing with a friend), what was that experience like?

3. **How does it feel to share these experiences now?**
   **Prompts**:
   - What is your mood like? How are you interpreting your mood?
   - What is going on in your mind? (thoughts/associations/fantasies)
   - How does your body feel? How are you interpreting those changes?
4. Do you have any questions for me?
Appendix M: Sample Interview Set-Up Email

Good Afternoon {Participant Name Removed},

Thank you so much for completing the doodle poll so promptly! Your interview date and time are: **Wednesday, June 20th, 2018 at 6:00pm MST (8:00pm ET)** via **Skype**.

Can you send me your Skype username please? My username is: [username removed] and I will send you a request to connect the evening of the interview.

**Interview Reminders:**
- We will review the consent form together first; you are welcome to withdraw consent at any time.
- You will be asked to provide me with a "fake name" (Your Choice) to help maintain your confidentiality. I will ask you for your fake name before we begin recording.
- The interview will be audio-recorded. When selecting a location it may be helpful to consider picking a space where: you feel comfortable speak freely about your experiences and is quiet with minimal distractions.
- I may write some brief notes during the interview.

Please let me know if you have any questions before we connect next week. Thank you again for your support and participation.

Looking forward to speaking with you!

A

Amina Y. Simmons, M.A.
Counseling Psychology Doctoral Candidate - UM ’19
Research Assistant – CRECER Lab
a.simmons4@miami.edu
*Pomona College Alum ’12
Mizzou Alum ’14*
Appendix N: IPA Data Analysis Graphic(s)
Figure 1. Average psychological well-being scores. This figure illustrates the range of participants’ average psychological well-being scores.
<table>
<thead>
<tr>
<th>Aim</th>
<th>Measure</th>
<th>Publication</th>
<th>Construct</th>
<th>Scale</th>
<th>Psychometrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Demographic Questionnaire</td>
<td>N/A</td>
<td>Demographic variables</td>
<td>Checkbox and open-ended questions</td>
<td>None</td>
</tr>
<tr>
<td>1,3</td>
<td>Race-Based Traumatic Stress Symptom Scale (RBTSSS)</td>
<td>Carter et al., 2013</td>
<td>Racial stress</td>
<td>54 items, 3 response formats, 1 open-ended question, yes/no response format, and 5-point Likert scale ranging from 0 (<em>does not describe my reaction</em>) to 4 (<em>this reaction would not go away</em>).</td>
<td>Construct validity; Exploratory Factor Analysis: 7 factors, Cronbach’s α = .65 to α = .90 for subscales, α = .96 for RBTSSS Total Composite</td>
</tr>
<tr>
<td>1, 3</td>
<td>Mental Health Continuum Short Form (MHC-SF)</td>
<td>Keyes (2009)</td>
<td>Psychological well being</td>
<td>14 item, 6-point Likert scale ranging from 0 (<em>never</em>) to 5 (<em>every day</em>)</td>
<td>Internal consistency, Test-retest reliability, Discriminant validity</td>
</tr>
<tr>
<td>1,3</td>
<td>Adult Access to Health Care and Utilization** (AAU)</td>
<td>NHIS Manual (2017c); NCHS (2017)</td>
<td>Health service utilization</td>
<td>8 subsections, 46 items, 3 response scales, multiple choice response format</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Interview Questions</td>
<td>N/A</td>
<td>Racial stress</td>
<td>Open-ended questions and prompts</td>
<td>None</td>
</tr>
<tr>
<td>---</td>
<td>---------------------</td>
<td>-----</td>
<td>---------------</td>
<td>----------------------------------</td>
<td>------</td>
</tr>
</tbody>
</table>

**Note:** 46 of the 107 items of the AAU were selected for administration in the current study
Table 2. Background Characteristics of Participants

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>36.8</td>
<td>9.68</td>
<td>25</td>
<td>62</td>
</tr>
<tr>
<td>Household Size</td>
<td>2.16</td>
<td>1.40</td>
<td>0</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant Country of Birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S. Born</td>
<td>126</td>
<td>93.3</td>
</tr>
<tr>
<td>Born outside of U.S.</td>
<td>5</td>
<td>3.7</td>
</tr>
<tr>
<td>Mother's Country of Birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S. Born</td>
<td>118</td>
<td>87.4</td>
</tr>
<tr>
<td>Born outside of U.S.</td>
<td>16</td>
<td>11.9</td>
</tr>
<tr>
<td>Father’s Country of Birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S. Born</td>
<td>113</td>
<td>83.7</td>
</tr>
<tr>
<td>Born outside of U.S.</td>
<td>20</td>
<td>14.8</td>
</tr>
<tr>
<td>Geographic Location (Regional/Census)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S. Region</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Northeast</td>
<td>22</td>
<td>16.3</td>
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<tr>
<td>New England</td>
<td>6</td>
<td>4.4</td>
</tr>
<tr>
<td>Middle Atlantic</td>
<td>16</td>
<td>11.9</td>
</tr>
<tr>
<td>Midwest</td>
<td>14</td>
<td>10.4</td>
</tr>
<tr>
<td>East North Central</td>
<td>11</td>
<td>8.2</td>
</tr>
<tr>
<td>West North Central</td>
<td>3</td>
<td>2.2</td>
</tr>
<tr>
<td>South</td>
<td>66</td>
<td>48.9</td>
</tr>
<tr>
<td>South Atlantic</td>
<td>56</td>
<td>41.9</td>
</tr>
<tr>
<td>East South Central</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Region</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>-------------------------</td>
<td>----</td>
<td>-----</td>
</tr>
<tr>
<td>West South Central</td>
<td>9</td>
<td>6.7</td>
</tr>
<tr>
<td>West</td>
<td>23</td>
<td>17.0</td>
</tr>
<tr>
<td>Mountain</td>
<td>3</td>
<td>2.2</td>
</tr>
<tr>
<td>Pacific</td>
<td>20</td>
<td>14.8</td>
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<tr>
<td>Outside the U.S.</td>
<td>2</td>
<td>1.5</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual/Straight</td>
<td>112</td>
<td>83.0</td>
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<tr>
<td>Lesbian</td>
<td>1</td>
<td>0.7</td>
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<tr>
<td>Bisexual</td>
<td>6</td>
<td>4.4</td>
</tr>
<tr>
<td>Queer</td>
<td>9</td>
<td>6.7</td>
</tr>
<tr>
<td>Questioning</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>Prefer Not to Say</td>
<td>1</td>
<td>0.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship Status</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>31</td>
<td>23.0</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Divorced</td>
<td>12</td>
<td>8.9</td>
</tr>
<tr>
<td>Separated</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>In a Relationship/Partnered</td>
<td>25</td>
<td>18.5</td>
</tr>
<tr>
<td>Dating</td>
<td>12</td>
<td>8.9</td>
</tr>
<tr>
<td>Single</td>
<td>51</td>
<td>37.8</td>
</tr>
<tr>
<td>Prefer Not to Say</td>
<td>1</td>
<td>0.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Voting Behavior</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>123</td>
<td>91.1</td>
</tr>
<tr>
<td>No</td>
<td>9</td>
<td>6.7</td>
</tr>
</tbody>
</table>
**Military Status**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3</td>
<td>130</td>
</tr>
<tr>
<td></td>
<td>2.2</td>
<td>96.3</td>
</tr>
</tbody>
</table>

**Socioeconomic Status**

<table>
<thead>
<tr>
<th>Household Income</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10,000</td>
<td>4</td>
<td>3.0</td>
</tr>
<tr>
<td>$10,000 to $19,999</td>
<td>7</td>
<td>5.2</td>
</tr>
<tr>
<td>$20,000 to $29,999</td>
<td>7</td>
<td>5.2</td>
</tr>
<tr>
<td>$30,000 to $39,999</td>
<td>16</td>
<td>11.9</td>
</tr>
<tr>
<td>$40,000 to $49,999</td>
<td>14</td>
<td>10.4</td>
</tr>
<tr>
<td>$50,000 to $59,999</td>
<td>16</td>
<td>11.9</td>
</tr>
<tr>
<td>$60,000 to $69,999</td>
<td>11</td>
<td>8.1</td>
</tr>
<tr>
<td>$70,000 to $79,999</td>
<td>11</td>
<td>8.1</td>
</tr>
<tr>
<td>$80,000 to $89,999</td>
<td>7</td>
<td>5.2</td>
</tr>
<tr>
<td>$90,000 to $99,999</td>
<td>7</td>
<td>5.2</td>
</tr>
<tr>
<td>$100,000 to $149,999</td>
<td>13</td>
<td>9.6</td>
</tr>
<tr>
<td>$150,000 or more</td>
<td>15</td>
<td>11.1</td>
</tr>
<tr>
<td>Prefer Not to Say</td>
<td>5</td>
<td>3.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paid Employee</td>
<td>118</td>
<td>87.4</td>
</tr>
<tr>
<td>Self-employed</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>Looking for work</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Retired</td>
<td>3</td>
<td>2.2</td>
</tr>
<tr>
<td>Disabled</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Other (not working)</td>
<td>7</td>
<td>5.2</td>
</tr>
<tr>
<td>Highest Level of Education Completed</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Less than high school degree</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school Graduate (Diploma or Equivalent/GED)</td>
<td>1</td>
<td>.7</td>
</tr>
<tr>
<td>Some college (no degree)</td>
<td>5</td>
<td>3.7</td>
</tr>
<tr>
<td>Associates Degree (2-year)</td>
<td>3</td>
<td>2.2</td>
</tr>
<tr>
<td>Bachelor’s Degree (4-year)</td>
<td>21</td>
<td>15.6</td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>78</td>
<td>57.8</td>
</tr>
<tr>
<td>Doctoral Degree</td>
<td>17</td>
<td>12.6</td>
</tr>
<tr>
<td>Professional Degree (JD, MD)</td>
<td>5</td>
<td>3.7</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>2.2</td>
</tr>
</tbody>
</table>
Table 3. *Types of Racial Stress Events*

<table>
<thead>
<tr>
<th>Event Type</th>
<th>Memorable Event 1</th>
<th>Memorable Event 2</th>
<th>Memorable Event 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal Assault</td>
<td>19 (21.1%)</td>
<td>24 (33.8%)</td>
<td>10 (20.8%)</td>
</tr>
<tr>
<td>Denied Access or Service</td>
<td>10 (11.1%)</td>
<td>7 (9.9%)</td>
<td>7 (14.6%)</td>
</tr>
<tr>
<td>Hostile Work Environment</td>
<td>2 (2.2%)</td>
<td>3 (4.2%)</td>
<td>6 (12.5%)</td>
</tr>
<tr>
<td>Violated Racial Rules</td>
<td>-</td>
<td>1 (1.4%)</td>
<td>-</td>
</tr>
<tr>
<td>Profiled</td>
<td>8 (8.9%)</td>
<td>5 (7.0%)</td>
<td>7 (14.6%)</td>
</tr>
<tr>
<td>Treated on Basis of Stereotype</td>
<td>7 (7.8%)</td>
<td>4 (5.6%)</td>
<td>3 (6.3%)</td>
</tr>
<tr>
<td>Physical Assault</td>
<td>3 (3.3%)</td>
<td>2 (2.8%)</td>
<td>-</td>
</tr>
<tr>
<td>Own Group Discrimination</td>
<td>-</td>
<td>1 (1.4%)</td>
<td>-</td>
</tr>
<tr>
<td>Multiple Experiences</td>
<td>28 (31.1%)</td>
<td>17 (23.9%)</td>
<td>12 (25%)</td>
</tr>
<tr>
<td>Other Event</td>
<td>13 (14.4%)</td>
<td>7 (9.9%)</td>
<td>3 (6.3%)</td>
</tr>
</tbody>
</table>

*Note.* Number indicate how frequently participants endorsed experiencing certain types of memorable racial stress events.
Table 4. *Settings of Racial Stress Events*

<table>
<thead>
<tr>
<th>Setting</th>
<th>Memorable Event 1</th>
<th>Memorable Event 2</th>
<th>Memorable Event 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work/Internship</td>
<td>18 (20%)</td>
<td>9 (13.0%)</td>
<td>17 (35.4%)</td>
</tr>
<tr>
<td>In Transit (Car, Traffic, etc)</td>
<td>5 (5.6%)</td>
<td>1 (1.4%)</td>
<td>3 (6.3%)</td>
</tr>
<tr>
<td>School/Library</td>
<td>39 (43.3%)</td>
<td>28 (40.6%)</td>
<td>8 (16.7%)</td>
</tr>
<tr>
<td>Restaurant</td>
<td>3 (3.3%)</td>
<td>3 (4.3%)</td>
<td>2 (4.2%)</td>
</tr>
<tr>
<td>Traveling (Vacation/Airport)</td>
<td>3 (3.3%)</td>
<td>2 (2.9%)</td>
<td>2 (4.2%)</td>
</tr>
<tr>
<td>Store/Mall</td>
<td>8 (8.9%)</td>
<td>10 (14.5%)</td>
<td>8 (16.7%)</td>
</tr>
<tr>
<td>Healthcare Setting</td>
<td>3 (3.3%)</td>
<td>1 (1.4%)</td>
<td>1 (2.1%)</td>
</tr>
<tr>
<td>Private Home</td>
<td>2 (2.2%)</td>
<td>9 (13.0%)</td>
<td>-</td>
</tr>
<tr>
<td>Night Club/Lounge/Bar</td>
<td>2 (2.2%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Community/Neighborhood</td>
<td>3 (3.3%)</td>
<td>2 (2.9%)</td>
<td>2 (4.2%)</td>
</tr>
<tr>
<td>Multiple Places</td>
<td>4 (4.4%)</td>
<td>4 (5.8%)</td>
<td>4 (8.3%)</td>
</tr>
<tr>
<td>Other Place</td>
<td>-</td>
<td>-</td>
<td>1 (2.1%)</td>
</tr>
</tbody>
</table>

*Note.* Number indicate how frequently participants endorsed experiencing a memorable, racially stressful event within a specific setting.
### Table 5. *Period of Life of Racial Stress Events*

<table>
<thead>
<tr>
<th>Period of Life</th>
<th>Memorable Event 1</th>
<th>Memorable Event 2</th>
<th>Memorable Event 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood</td>
<td>25 (27.5%)</td>
<td>13 (17.8%)</td>
<td>1 (2.0%)</td>
</tr>
<tr>
<td>Adolescence</td>
<td>12 (13.2%)</td>
<td>11 (15.1%)</td>
<td>9 (18%)</td>
</tr>
<tr>
<td>Adulthood</td>
<td>54 (59.3%)</td>
<td>48 (65.8%)</td>
<td>39 (78%)</td>
</tr>
<tr>
<td>Later Adulthood</td>
<td>-</td>
<td>1 (1.4%)</td>
<td>1 (2.0%)</td>
</tr>
</tbody>
</table>

*Note.* Number indicate how frequently participants endorsed experiencing a memorable, racially stressful event during that period of life.
Table 6. *Most Memorable Racial Stress Event*

<table>
<thead>
<tr>
<th></th>
<th>Childhood</th>
<th>Adolescence</th>
<th>Adulthood</th>
<th>Later Adulthood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only ONE time</td>
<td>12</td>
<td>8</td>
<td>20</td>
<td>3</td>
</tr>
<tr>
<td>A FEW(3-4) times</td>
<td>20</td>
<td>33</td>
<td>28</td>
<td>2</td>
</tr>
<tr>
<td>Several(5-6) times</td>
<td>6</td>
<td>11</td>
<td>26</td>
<td>1</td>
</tr>
<tr>
<td>ALL the time</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Never</td>
<td>46</td>
<td>33</td>
<td>10</td>
<td>68</td>
</tr>
</tbody>
</table>

*Note.* Number indicate how frequently participants endorsed experiencing their most memorable racially stressful event during a specific period of life.
### Table 7. RBTSSS Subscale Scores and Subscale T-Scores

<table>
<thead>
<tr>
<th>Scale</th>
<th>M</th>
<th>SD</th>
<th>T-Score Minimum</th>
<th>T-Score Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reaction Scales Right After the Event</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>0.67</td>
<td>0.63</td>
<td>39.31</td>
<td>80.70</td>
</tr>
<tr>
<td>Intrusion</td>
<td>1.11</td>
<td>0.68</td>
<td>33.52</td>
<td>85.31</td>
</tr>
<tr>
<td>Anger</td>
<td>1.08</td>
<td>0.72</td>
<td>35.07</td>
<td>81.82</td>
</tr>
<tr>
<td>Hypervigilance</td>
<td>0.63</td>
<td>0.55</td>
<td>38.58</td>
<td>90.62</td>
</tr>
<tr>
<td>Physical</td>
<td>0.68</td>
<td>0.59</td>
<td>38.37</td>
<td>96.06</td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>0.46</td>
<td>0.55</td>
<td>41.65</td>
<td>107.88</td>
</tr>
<tr>
<td>Avoidance A</td>
<td>0.50</td>
<td>0.61</td>
<td>41.78</td>
<td>99.06</td>
</tr>
<tr>
<td><strong>Reactions Scales when Remembering the Event</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>0.48</td>
<td>0.63</td>
<td>42.27</td>
<td>106.18</td>
</tr>
<tr>
<td>Intrusion</td>
<td>0.78</td>
<td>0.62</td>
<td>37.49</td>
<td>102.01</td>
</tr>
<tr>
<td>Anger</td>
<td>0.96</td>
<td>0.80</td>
<td>38.00</td>
<td>87.77</td>
</tr>
<tr>
<td>Hypervigilance</td>
<td>0.51</td>
<td>0.53</td>
<td>40.52</td>
<td>115.55</td>
</tr>
<tr>
<td>Physical</td>
<td>0.50</td>
<td>0.54</td>
<td>40.81</td>
<td>103.01</td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>0.39</td>
<td>0.60</td>
<td>43.53</td>
<td>110.37</td>
</tr>
<tr>
<td>Avoidance</td>
<td>0.39</td>
<td>0.54</td>
<td>42.79</td>
<td>116.87</td>
</tr>
</tbody>
</table>
Table 8. *Participants HSU Behaviors, General Use*

<table>
<thead>
<tr>
<th>Question</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a place you usually go when sick or need advice about your health?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>74</td>
<td>64.9</td>
</tr>
<tr>
<td>There’s MORE THAN ONE place</td>
<td>20</td>
<td>17.5</td>
</tr>
<tr>
<td>Type of service place</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic/Health Center</td>
<td>16</td>
<td>17.2</td>
</tr>
<tr>
<td>Doctor’s Office/HMO</td>
<td>73</td>
<td>78.5</td>
</tr>
<tr>
<td>Hospital ER</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Hospital Outpatient Dept.</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Some other place</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Doesn’t go one place most often</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Service locations most often visited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic/Health Center</td>
<td>21</td>
<td>18.4</td>
</tr>
<tr>
<td>Doctor’s Office/HMO</td>
<td>74</td>
<td>64.9</td>
</tr>
<tr>
<td>Hospital ER</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Hospital Outpatient Dept.</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Some other place</td>
<td>6</td>
<td>5.3</td>
</tr>
<tr>
<td>Doesn’t go one place most often</td>
<td>8</td>
<td>7.0</td>
</tr>
<tr>
<td>Prefer Not to Say</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Is that the same place you go for routine/preventative care?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>101</td>
<td>88.6</td>
</tr>
<tr>
<td>No</td>
<td>13</td>
<td>11.4</td>
</tr>
<tr>
<td>Service location for routine/preventative care?</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>---</td>
<td>-----</td>
</tr>
<tr>
<td>Clinic/Health Center</td>
<td>4</td>
<td>28.6</td>
</tr>
<tr>
<td>Doctor’s Office/HMO</td>
<td>5</td>
<td>35.7</td>
</tr>
<tr>
<td>Doesn’t get preventative care anywhere</td>
<td>5</td>
<td>35.7</td>
</tr>
<tr>
<td>Did you change your usual place in the last 12 months?</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Yes</td>
<td>40</td>
<td>34.8</td>
</tr>
<tr>
<td>Was the change related to health insurance?</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Yes</td>
<td>19</td>
<td>47.5</td>
</tr>
<tr>
<td>No</td>
<td>20</td>
<td>52.5</td>
</tr>
<tr>
<td>Last visit to doctor or healthcare professional (including hospital visits)...</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>&lt; 6 months</td>
<td>78</td>
<td>67.8</td>
</tr>
<tr>
<td>6 months &gt; n &lt; 1 year</td>
<td>25</td>
<td>21.7</td>
</tr>
<tr>
<td>1 year &gt; n &lt; 2 years</td>
<td>9</td>
<td>7.8</td>
</tr>
<tr>
<td>2 years &gt; n &lt; 5 years</td>
<td>3</td>
<td>2.6</td>
</tr>
</tbody>
</table>
Table 9. *Participants HSU Behaviors, Delayed Service Use*

<table>
<thead>
<tr>
<th>Logistics</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delayed getting care for any of the following reasons...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>...couldn’t get through on the telephone</td>
<td>10</td>
<td>8.9</td>
</tr>
<tr>
<td>...couldn’t get an appointment soon enough</td>
<td>36</td>
<td>32.1</td>
</tr>
<tr>
<td>...long wait to see doctor**</td>
<td>9</td>
<td>8.0</td>
</tr>
<tr>
<td>...office wasn’t open</td>
<td>15</td>
<td>13.4</td>
</tr>
<tr>
<td>...didn’t have transportation</td>
<td>5</td>
<td>4.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Range of Care</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delayed getting the following because couldn’t afford it...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>...prescription medicines</td>
<td>25</td>
<td>22.3</td>
</tr>
<tr>
<td>...mental health care or counseling</td>
<td>29</td>
<td>25.9</td>
</tr>
<tr>
<td>...dental care (including check-ups)</td>
<td>34</td>
<td>30.4</td>
</tr>
<tr>
<td>...eyeglasses</td>
<td>22</td>
<td>19.6</td>
</tr>
<tr>
<td>...seeing a specialist</td>
<td>27</td>
<td>24.1</td>
</tr>
<tr>
<td>...follow-up care</td>
<td>18</td>
<td>16.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription Medication Adherence</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribed medication by doctor or other health professional?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>70</td>
<td>62.5</td>
</tr>
<tr>
<td>To save money, were any of the following true...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>...skipped medication doses</td>
<td>10</td>
<td>14.3</td>
</tr>
<tr>
<td>...took less medicine</td>
<td>6</td>
<td>8.6</td>
</tr>
<tr>
<td>...delayed filling prescription</td>
<td>17</td>
<td>24.3</td>
</tr>
<tr>
<td>...asked doctor for lower cost medication</td>
<td>17</td>
<td>24.3</td>
</tr>
<tr>
<td>...bought prescription drugs from another country</td>
<td>2</td>
<td>2.9</td>
</tr>
</tbody>
</table>
...used alternative therapies
<table>
<thead>
<tr>
<th>Providers (seen or talked to any of the following healthcare providers…)</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>...dentist, dental hygienists, orthodontist, oral surgeon, and all other dental specialists</td>
<td>69</td>
<td>62.2</td>
</tr>
<tr>
<td>...mental health professional (i.e. psychiatrists, psychologists, psychiatric nurse, or LCSW)</td>
<td>32</td>
<td>28.8</td>
</tr>
<tr>
<td>...optometrist, ophthalmologist, or eye doctor</td>
<td>57</td>
<td>51.4</td>
</tr>
<tr>
<td>...foot doctor</td>
<td>4</td>
<td>3.6</td>
</tr>
<tr>
<td>...chiropractor</td>
<td>6</td>
<td>5.4</td>
</tr>
<tr>
<td>...physical therapist, speech therapist, respiratory therapist, audiologist, or occupational therapist</td>
<td>12</td>
<td>10.8</td>
</tr>
<tr>
<td>...nurse practitioner, physician assistant, or midwife</td>
<td>56</td>
<td>50.5</td>
</tr>
<tr>
<td>...women’s health doctor (i.e. obstetrician, gynecologist)</td>
<td>67</td>
<td>60.4</td>
</tr>
<tr>
<td>...specialty medicine doctor (excluding OBGYN, psychiatry, or ophthalmology)</td>
<td>36</td>
<td>32.4</td>
</tr>
<tr>
<td>...general practitioner (e.g. family medicine, internal medicine, etc).</td>
<td>69</td>
<td>62.2</td>
</tr>
<tr>
<td>Location (received care at any of the following locations…)</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>...hospital ER</td>
<td>23</td>
<td>20.9</td>
</tr>
<tr>
<td>...at home</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>...at a doctor’s office</td>
<td>89</td>
<td>80.9</td>
</tr>
<tr>
<td>...at a clinic</td>
<td>45</td>
<td>41.3</td>
</tr>
<tr>
<td>...at some other place</td>
<td>12</td>
<td>10.9</td>
</tr>
</tbody>
</table>
### Table 11. Participants HSU Behaviors, Special Tests and Health Checks

<table>
<thead>
<tr>
<th>Non-required Vaccines</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>flu vaccination</strong></td>
<td>40</td>
<td>36.4</td>
</tr>
<tr>
<td><strong>pneumonia shot</strong></td>
<td>25</td>
<td>22.7</td>
</tr>
<tr>
<td><strong>hepatitis B vaccine</strong></td>
<td>69</td>
<td>62.7</td>
</tr>
<tr>
<td><strong>hepatitis A vaccine</strong></td>
<td>52</td>
<td>47.3</td>
</tr>
<tr>
<td><strong>shingles vaccine</strong></td>
<td>9</td>
<td>8.2</td>
</tr>
<tr>
<td><strong>HPV vaccine</strong></td>
<td>29</td>
<td>26.4</td>
</tr>
<tr>
<td><strong>tetanus shot</strong></td>
<td>79</td>
<td>71.8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Checks/Screenings</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>surgical procedure (inpatient or outpatient</strong></td>
<td>15</td>
<td>13.8</td>
</tr>
<tr>
<td><strong>blood test for hepatitis C</strong></td>
<td>39</td>
<td>35.5</td>
</tr>
<tr>
<td><strong>blood pressure check</strong></td>
<td>99</td>
<td>90.8</td>
</tr>
<tr>
<td><strong>blood cholesterol check</strong></td>
<td>72</td>
<td>66.1</td>
</tr>
<tr>
<td><strong>fasting test for diabetes</strong></td>
<td>55</td>
<td>50.5</td>
</tr>
<tr>
<td><strong>Pap smear</strong></td>
<td>75</td>
<td>68.8</td>
</tr>
<tr>
<td><strong>Mammogram</strong></td>
<td>33</td>
<td>30.3</td>
</tr>
<tr>
<td><strong>colon cancer screening</strong></td>
<td>13</td>
<td>11.9</td>
</tr>
<tr>
<td><strong>conversation about diet</strong></td>
<td>52</td>
<td>47.7</td>
</tr>
<tr>
<td><strong>conversation about smoking habits</strong></td>
<td>11</td>
<td>10.1</td>
</tr>
</tbody>
</table>
Table 12. *Regression Model with Total MHC Score as Predictor Variable*

<table>
<thead>
<tr>
<th></th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$\beta$</td>
<td>Std. Error</td>
</tr>
<tr>
<td>Constant</td>
<td>4.936</td>
<td>.512</td>
</tr>
<tr>
<td>TScore_DEPa</td>
<td>-.018</td>
<td>.013</td>
</tr>
<tr>
<td>TScore_INTa</td>
<td>.022</td>
<td>.012</td>
</tr>
<tr>
<td>TScore_ANGa</td>
<td>-.025</td>
<td>.013</td>
</tr>
<tr>
<td>TScore_PHYa</td>
<td>.020</td>
<td>.016</td>
</tr>
<tr>
<td>TScore_SEFa</td>
<td>-.012</td>
<td>.011</td>
</tr>
<tr>
<td>TScore_AVDa</td>
<td>-.003</td>
<td>.009</td>
</tr>
</tbody>
</table>

*Note.* $R^2 = 11.5\%$; $F(6, 109) = 2.36, p<.05$
<table>
<thead>
<tr>
<th>Category</th>
<th>Theme</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience of Racial Stress</td>
<td>Racial stress is constant.</td>
<td>• Racial stress is inherent to the Black experience</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• There are a range of experiences (indirect and direct)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Racial feels heavy, is burdensome</td>
</tr>
<tr>
<td>Reaction to Racial Stress</td>
<td>The impact of racial stress is not a choice.</td>
<td>• There are a range of reactions (physical, emotional, and cognitive)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Reactions change with time</td>
</tr>
<tr>
<td></td>
<td>Response to racial stress is strategic.</td>
<td>• Active decision</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Avoidance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Protective/Preventative</td>
</tr>
<tr>
<td>Coping with Racial Stress</td>
<td>Support through sisterhood</td>
<td>• Shared experiences</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Normalizing support seeking</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Building knowledge of and trust in support strategies</td>
</tr>
</tbody>
</table>