

**Gendered Racism, Coping, and Traumatic Stress Among
Black Women: The Moderating Role of Womanist Attitudes
and the Strong Black Woman Schema**

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ABSTRACT

The purpose of this study was to investigate the relations between gendered racial microaggressions (GRMS), coping strategies, womanist attitudes, the Strong Black Woman (SBW) schema, and traumatic stress symptoms among Black women. This study utilized an intersectionality framework to test coping strategies (detachment, internalization, drug/alcohol use, education/advocacy, and resistance) as mediators and aspects of Black women's identity as moderators (womanist attitudes and SBW schema) in the link between GRMS and traumatic stress symptoms. Participants were 185 Black women from across the United States who completed an online survey. Results from a mediation analysis indicated that detachment coping and drug/alcohol use significantly mediated the relations between GRMS and traumatic stress, such that experiencing a greater frequency of gendered racial microaggressions was associated with greater use of detachment coping and drug/alcohol use, which in turn, was associated with greater traumatic stress. Results from two separate moderated mediation analyses were not significant, though the SBW schema was associated with greater disengagement coping (internalization and detachment) and womanist attitudes were associated with greater engagement coping (education/advocacy and resistance). SBW schema also moderated the relations between GRMS and detachment coping. The results of this study can contribute to our understanding of how Black women cope with gendered racism as well as internalized beliefs that may be beneficial or harmful.

Keywords: gendered racism, coping, microaggressions, Strong Black Woman, trauma

TABLE OF CONTENTS

CHAPTER ONE: INTRODUCTION.....	1
Gendered Racism.....	2
Oppression and Traumatic Stress.....	4
Coping with Discrimination as a Mediator.....	8
Aspects of Black Women’s Identity as Moderators	10
Current Study	16
CHAPTER TWO: METHOD.....	20
Participants.....	20
Procedure	21
Measures	22
Data Analysis Plan.....	26
CHAPTER THREE: RESULTS.....	28
Data Screening and Preliminary Analyses.....	28
Mediation Analysis	32
Moderated Mediation Analyses	34
CHAPTER FOUR: DISCUSSION.....	39
Limitations and Directions for Future Research.....	44
Implications for Practice and Advocacy	47
Conclusion	48
REFERENCES	50
APPENDICES	71
APPENDIX A: LITERATURE REVIEW	72
APPENDIX B: CONSENT FORM	102
APPENDIX C: DEBRIEFING RESOURCE LIST	106
APPENDIX D: RECRUITMENT MATERIALS	111
VITA.....	112

LIST OF TABLES

Table 1.....	29
Table 2.....	31
Table 3.....	36
Table 4.....	38

LIST OF FIGURES

Figure 1.....	19
Figure 2.....	33

CHAPTER ONE: INTRODUCTION

Within the large body of literature that explores the negative influence of perceived racism on the mental and physical health of African Americans (e.g., (Paradies, 2006; Pascoe & Smart Richman, 2009; Pieterse et al., 2012, 2013; Utsey, Ponterotto, et al., 2000), there is still a lack of attention to the influence of gendered racism (i.e., the simultaneous experience of the interlocking systems of racism and sexism) on Black women's health. Moreover, the link between discrimination and traumatic stress is an understudied, but growing area (Bryant-Davis & Ocampo, 2005b, 2005a; Comas-Díaz & Jacobsen, 2001; Dale & Safren, 2019; Moody & Lewis, 2019; Torres & Taknint, 2015; L. B. Watson et al., 2016). This study seeks to fill a gap across this body of literature by exploring Black African American women's experiences of gendered racism and traumatic stress.

It is particularly important to explore the link between gendered racism and traumatic stress given recent sociopolitical events. This study was conducted during the COVID-19 pandemic, which coincided with increased public discourse and racial reckoning around racism and extrajudicial police killings. Although there is empirical support for an association between discrimination and increased traumatic stress, these events underscore the importance of further investigation. Harrell's (2000) multidimensional model of racism and racism-related stress describes racism as taxing or exceeding resources to cope and threatening to an individual's collective wellbeing. Harrell's (2000) model includes six forms of racism-related stress that influence mental health, four of which are particularly relevant to this study: 1) vicarious racism experiences (i.e., witnessing racism happening to others, or hearing about racism happening to loved ones), 2) daily racism microstressors (i.e., racial microaggressions), 3) chronic-contextual stress (i.e., unequal distributions of resources that affect living conditions and quality of life,

which have worsened due to the COVID-19 pandemic), and 4) collective experiences (awareness of how racism impacts one's own racial group). Thus, witnessing instances of racist violence via social media and the news coupled with the ways existing systemic inequalities have been impacted by the pandemic (e.g., housing, employment, and healthcare equity) have undoubtedly impacted Black women's wellbeing. This study seeks to fill a gap in the literature by exploring the impact of gendered racism on traumatic stress among Black women.

The purpose of this study is to investigate the link between gendered racial microaggressions (i.e., subtle gendered racial slights and everyday gendered racism) and traumatic stress symptoms among Black women by testing the biopsychosocial model of gendered racism proposed by Lewis and colleagues (2017). This model conceptualizes coping as a mediator of the relations between gendered racism and physical and mental health outcomes, with aspects of gendered racial identity as a moderator of the gendered racism-health link. Using this model as a conceptual framework, this study explores two specific aspects of gendered racial identity—the Strong Black Woman schema and womanist attitudes. This study extends the model by Lewis and colleagues (2017) by exploring a potential exacerbating moderator (i.e., the Strong Black Woman schema) in addition to a potential buffer (i.e., womanist attitudes).

Gendered Racism

Gendered racism describes the simultaneous experience of interlocking systems of racist and sexist oppression (Essed, 1991). Black feminist scholars have long highlighted the ways in which Black women's experiences of oppression are simultaneously similar to and different from Black men and white women's experiences (Beal, 1970; Collins, 1991; Hull et al., 1993; St. Jean & Feagin, 1998; Truth, 1851; Walker, 1983); notably, much of the literature on gendered racial oppression has focused on the unique ways that Black women are affected by issues such as

enslavement, reproductive justice, sexual violence, and patriarchy. Synthesizing this legacy, Crenshaw (1989) is credited with introducing the concept of *intersectionality* into popular discourse by examining the ways in which racial and gender discrimination laws did not afford Black women the same protections as men of color and white women. Intersectionality is a theoretical framework for understanding Black women's unique experience of gendered racism; it argues that Black women's oppression is greater than the sum of its parts (e.g., racism and sexism separately; Bowleg & Bauer, 2016; Crenshaw, 1989; Lewis & Grzanka, 2016). From an intersectional standpoint, Black women's experiences can only be understood when all components are taken into account simultaneously. Thus, this study implements an intersectional framework through the use of measures designed to capture gendered racism (e.g., Gendered Racial Microaggressions Scale; Lewis & Neville, 2015), and intersectional aspects of identity (e.g., Giscombé Superwoman Schema Questionnaire; Woods-Giscombe et al., 2019) and the Women of Color subscale of the Feminist Perspectives Scale (Henley et al., 1998)).

There is both qualitative and quantitative empirical support for the influence of gendered racism in the lives of African American women, particularly as it relates to negative mental health consequences. Qualitative studies have provided critical support for intersectionality theory, finding that often Black women are unable to parse experiences of discrimination into “just racism” or “just sexism” (Andersen & Collins, 2004; Jones & Shorter-Gooden, 2003; King, 2005). Building upon these studies, quantitative research supports a significant association between gendered racism and a range of negative mental health outcomes for Black women (e.g., (Moradi & Subich, 2003; Szymanski & Lewis, 2016; Szymanski & Stewart, 2010; Thomas et al., 2008). There is a growing body of literature on gendered racial microaggressions (i.e., subtle gendered racism) and African American women's mental health. Negative comments about

Black women's natural, African curly textured hair are an example of gendered racial microaggressions; these comments are underscored by implications about gender (i.e., standards of femininity) as well as race (superiority of certain hair textures over others). Gendered racial microaggressions have been found to be positively associated with greater psychological distress (Lewis & Neville, 2015; Williams & Lewis, 2019), greater negative mental and physical health outcomes (Lewis et al., 2017), greater anxiety symptoms (Wright & Lewis, 2020), and greater traumatic stress symptoms (Dale & Safren, 2019; Moody & Lewis, 2019) among Black women. Lewis and colleagues (2017) have extended the biopsychosocial model of perceived racism (Clark et al., 1999) to gendered racism to investigate the link between gendered racism and mental health outcomes. This study seeks to add to this growing body of literature by testing Lewis et al.'s (2017) biopsychosocial model of gendered racism. Specifically, this study explores the relations between gendered racial microaggressions and a traditionally understudied mental health outcome—traumatic stress.

Oppression and Traumatic Stress

Lazarus and Folkman's (1984) transactional conceptualization of *stress* and coping has influenced much of the literature on discrimination and its effects on mental health and wellbeing. Within this model, *trauma* is a more severe form of stress, in which an individual's typical coping resources are exceeded or insufficient for the magnitude of the stressor. Within racism literature, many scholars have offered alternative theoretical models of trauma that incorporate the influence of oppression on marginalized communities' and individuals' wellbeing (Awad et al., 2019; Bryant-Davis & Ocampo, 2005b, 2005a; Carlson, 1997; Carter, 2007; Comas-Díaz & Jacobsen, 2001; Gone et al., 2019; Kira, 2001; Nagata et al., 2019; Scurfield & Mackey, 2001; Skewes & Blume, 2019). Some have conceptualized racism as a

traumatic stressor in and of itself, and some have conceptualized racism as a stressor that can produce traumatic stress symptoms (especially after chronic exposure) (Alessi et al., 2013; Carter, 2007; Ford, 2008; Holmes et al., 2016; Khaylis et al., 2007). There is a growing body of empirical support for the link between the experience of multiple oppressions and greater traumatic stress symptoms for individuals belonging to multiple marginalized communities (e.g., (Berg, 2006; L. B. Watson et al., 2016). *Insidious trauma* describes the cumulative effects of discriminatory events that, in isolation, may not be enough to trigger a traumatic stress response on their own (L. S. Brown, 2013; Root, 1992, 2001); the concept of insidious trauma is especially relevant to the study of microaggressions. A microaggression experience is not likely to be stressful enough to produce traumatic stress symptoms on its own; however, empirical evidence suggests that the cumulative effects (both recent and lifetime) of microaggressions are significantly associated with traumatic stress symptoms (T. Abdullah et al., 2021; Moody & Lewis, 2019; Nadal et al., 2019; Torres & Taknint, 2015).

This study extends Carlson's (1997) model of racism and trauma to gendered racial microaggressions for Black women. Within this model, a person of color's subjective appraisal of an event as stressful or traumatic is the primary component. Carlson (1997) recognizes that threatened or actual emotional pain from racist events is sufficient enough for an individual to conceptualize the experience as traumatic. This is particularly important for understanding microaggressions, which are often dismissed or minimized by others, including the targeted person (Sue et al., 2007). Additionally, this model stresses the importance of racism's sudden and unpredictable nature—it is impossible to predict the exact moment that one will experience a racist event, which can contribute to its traumatic nature. Lastly, Carlson (1997) recognizes how the unpredictability of racism is compounded by its uncontrollability, in that the tension derived

from the ever-present expectation of future racist events can exacerbate distress. This is supported by Himmelstein and colleagues' (2015) community study of Black American adults, which found that using vigilance coping (i.e., taking actions to reduce the likelihood that one will experience discrimination) explained the significant association between racism and negative psychological outcomes (e.g., stress and depression). Gendered racial microaggressions can be perceived as emotionally painful (and thus, traumatic), unpredictable, and uncontrollable. Due to their more subtle nature, dismissal or minimization of instances of gendered racial microaggressions can compound distress.

Few studies have explored the relations between microaggressions and traumatic stress. These studies have focused on race or gender and do not account for the gendered racial microaggressions of women of color. Torres and Taknint (2015) found a significant, positive association between ethnic microaggressions and traumatic stress symptoms, which was then positively related to greater depression symptoms for Latinx individuals. Nadal and colleagues (2019) found that a greater frequency of racial microaggressions was associated with greater traumatic stress symptoms among people of color, with school and workplace microaggressions most strongly associated with traumatic stress. Within a sample of Black American adults (75.6% women), Abdullah and colleagues (2021) found that invisibility-themed racial microaggressions were significantly associated with endorsement of PTSD symptoms, with distress (stress appraisal) having a stronger association than frequency of microaggressions. In a study of predominantly white cisgender women, Cherry and Wilcox (2021) found that self-compassion partially mediated the positive association between sexist microaggressions and trauma symptomatology.

To date, only two studies have explored traumatic stress as it relates to the gendered racial nature of microaggressions among Black women. Moody and Lewis (2019) found that a greater frequency of gendered racial microaggressions was significantly related to greater traumatic stress symptoms for Black women, and that this association was exacerbated by higher levels of internalized gendered racial oppression (i.e., hearing negative comments about Black women from caregivers). Dale and Safren (2019) found that frequency and stress appraisal of gendered racial microaggressions uniquely contributed to total PTSD symptoms and posttraumatic cognitions, over and above HIV-related discrimination and racial discrimination among Black women living with HIV. This study seeks to add to this small, but growing body of literature by using an intersectionality framework to further explore the influence of gendered racial microaggressions on traumatic stress symptoms among Black women.

In addition to the link between racism and traumatic stress, there is empirical evidence that shows differential PTSD rates between people of color and white individuals for similar traumatic experiences, even when controlling for possibly confounding factors such as poverty and substance abuse (Frueh et al., 1998, 2002; Kulka et al., 1990; Ruef et al., 2000). Although white individuals are more likely to be exposed to traumatic events, the impact of these events tends to be greater for people of color (Norris, 1992). Additionally, a recent longitudinal study found significant differences in reported PTSD symptoms between Black, Latinx, and white individuals, with racial discrimination predicting PTSD for the Black and Latinx participants (Sibrava et al., 2019). These studies provide further evidence of the need to explore the influence of discrimination on traumatic stress symptoms, particularly for Black women, who experiences intersectional oppression. Additionally, it is important to explore the mediating role of different coping strategies in the link between gendered racism and traumatic stress.

Coping with Discrimination as a Mediator

The literature on coping with discrimination is similarly grounded in Lazarus and Folkman's (1984) transactional model of stress. In the primary appraisal stage, an individual assesses their environment and makes meaning of certain stimuli (e.g., stimuli are interpreted as positive (benign-positive), not significant (irrelevant), or threatening/harmful (stressful). The secondary appraisal process involves an assessment of one's ability to cope with stimuli perceived to be stressful. Individuals are constantly appraising various stimuli on an unconscious basis in their day-to-day lives. However, the chronic nature of both overt and covert discrimination makes them unique environmental stimuli that can be particularly stressful for marginalized individuals and groups (Miller & Kaiser, 2001).

Within the literature on coping more broadly, coping strategies have typically been categorized as: 1) active, problem-focused, or engagement coping (i.e., addressing the problem directly), 2) passive, avoidant, or disengagement coping, and 3) emotion-focused coping (Carver et al., 1989; Folkman et al., 1986; Folkman & Lazarus, 1988; Lazarus & Folkman, 1984). Across these three broad categories, scholars have identified a wide range of clusters, including distancing, positive reappraisal, seeking social support, and using drugs or food to cope, which are typically conceptualized as being effective in reducing stress (engagement) or exacerbating (disengagement). The large body of coping literature illustrates the vast range of coping strategies people employ when faced with stressful life events. However, discrimination is a unique stressor that deserves further attention. Clark and colleagues' (1999) biopsychosocial model of perceived racism was the first model to build upon Lazarus and Folkman's (1984) general model of stress and coping to focus on racism as a unique stressor. Lewis and

colleagues' (2017) model further extends this work by focusing on gendered racism as a unique, multidimensional stressor for Black women.

Scholars have developed and adapted several measures designed to capture the ways in which people of color may respond to and cope with discrimination (Carter et al., 2013; Forsyth & Carter, 2012; Utsey, Adams, et al., 2000; Wei et al., 2010). Empirical evidence indicates that African Americans may tend to use different coping strategies for racism-related stressors than for general life stressors (T. L. Brown et al., 2011; Greer, 2007; Hoggard et al., 2012). Moreover, Black women cope with gendered racism in a variety of ways, including direct challenging (i.e., standing up for oneself), denial, avoidance, and eating (Harrington et al., 2010; Lewis et al., 2013; Shorter-Gooden, 2004; Utsey, Adams, et al., 2000; Ward et al., 2009; Ward & Heidrich, 2009). Empirical evidence supports a partial mediating effect of cognitive-emotional coping (Thomas et al., 2008), negative religious coping (Szymanski & Obiri, 2011), detachment and internalization (i.e., self-blame) (Szymanski & Lewis, 2016), and disengagement coping (Lewis et al., 2017; Williams & Lewis, 2019) in the relations between gendered racism and psychological distress for African American women. This study uses the Coping with Discrimination Scale (CDS; Wei et al., 2010), which asks participants to reflect on how they cope with discrimination specifically; additionally, the subscales of the CDS reflect common disengagement coping strategies explored by other measures within the general coping literature (e.g., Detachment, Drug/Alcohol Use, Internalization) as well as some engagement strategies unique to coping with discrimination (Education/Advocacy, Resistance). In this study, I hypothesize that, similar to previous findings in the literature, education/advocacy and resistance will function as engagement coping strategies, and detachment, drug/alcohol use, and internalization will function as disengagement coping strategies.

Though there is empirical support for the exacerbating influence of certain coping mechanisms, there is less empirical support for coping strategies that effectively buffer or reduce the deleterious effects of discrimination on well-being. In a qualitative exploration of writing as a way to cope with microaggressions, Kilgore and colleagues (2020) found that participants reported experiencing greater negative emotions when writing about gendered racial microaggression experiences, but that writing itself elicited positive emotions. This highlights the complexity of coping with insidious trauma for Black women. This study seeks to contribute to the literature by exploring how Black women cope with gendered racial microaggressions, particularly whether more adaptive coping methods (e.g., Education/Advocacy and Resistance; Wei et al., 2010) are effective against discrimination. Building on this, I explored two aspects of Black women's identity that may positively or negatively influence how they cope with discrimination. Specifically, I extend Lewis and colleagues' (2017) model, which conceptualized gendered racial identity centrality as a moderator, by exploring two specific aspects of Black women's gendered racial identity—the "Strong Black Woman" schema and womanist attitudes.

Aspects of Black Women's Identity as Moderators

"Strong Black Woman" Schema

Within U.S. culture, there are several enduring stereotypes of Black women such as Mammy, Jezebel, Sapphire, and Superwoman that extend beyond abstract representations and include physical manifestations of gendered racial tropes (A. S. Abdullah, 1998; Bell, 1992; C. M. West, 1995). These caricatures of Black women range from being: (1) subservient to others, unattractive by white beauty standards (overweight, dark-skinned, and with Afrocentric facial features), strong, and selfless to her own detriment (Mammy), (2) overly aggressive and emasculating, hostile and obnoxious, and filled with rage (Sapphire), (3) hypersexual with

animalistic sexual desires, sexually immoral (i.e., “loose”), and sexually aggressive (Jezebel), to being (4) strong enough to handle multiple problems or tasks at once, not needing of help or support (emotional or material) from others, and unaffected by hardships in life (Superwoman) (A. S. Abdullah, 1998; Bell, 1992; Greene, 1994; McNair, 1992; Mitchell & Herring, 1998; Shorter-Gooden & Jackson, 2000; C. M. West, 1995). These stereotypes have endured over time, though their presence in modern society is in many ways more covert.

Certain stereotypes of Black women appear positive but can have negative influences on mental health and wellbeing. For example, the “Superwoman” or “Strong Black Woman” (SBW) stereotype is often appraised by Black women as a positive characteristic, though findings from qualitative studies illustrate that Black women are also aware of drawbacks to this characterization (e.g., stress and other negative psychological outcomes as well as relationship strain; Abrams et al., 2014; Jones & Shorter-Gooden, 2003; N. N. Watson & Hunter, 2016; L. M. West et al., 2016; Williams & Lewis, 2021; Woods-Giscombé, 2010). Thomas and colleagues (2004) found that internalizing SBW beliefs were associated with negative self-esteem over and above racial identity attitudes related to self-esteem. Witherspoon and colleagues (2006) found that internalizing the SBW schema was positively related to paranoia, hostility, depressive symptoms, and interpersonal insensitivity. Other studies have found a positive association between the SBW schema and outcomes such as psychological distress, emotional dysregulation, and binge eating (Harrington et al., 2010; N. N. Watson & Hunter, 2016; Woods-Giscombé, 2010).

Woods-Giscombé and colleagues (2019) developed the Giscombé Superwoman Schema Questionnaire (SWS) and found that greater internalization was related to greater perceived stress, depressive symptoms, and eating as a stress coping mechanism, as well as related to poor

sleep quality and physical inactivity. Allen and colleagues (2019) used the SWS to offer an integrative stress-coping model to conceptualize the relations between racial discrimination, allostatic load (cumulative biological stress), and the Superwoman schema. They found that intense motivation to succeed and a sense of obligation to help others exacerbated the association between racial discrimination and allostatic load, while a sense of obligation to project an image of strength and an obligation to suppress emotions weakened the association. In other words, internalizing certain aspects of the SBW schema may have differing impacts on wellbeing, though previous studies have found that greater overall internalization of the SBW is more strongly associated with negative mental health outcomes.

These findings illustrate that internalizing the SBW schema can have varied impacts on Black women's wellbeing. This study seeks to contribute to the current understanding of the role of the SBW schema in the lives of Black women by exploring the ways in which it influences coping behaviors, which in turn influences mental health outcomes. Based on previous research, greater overall internalization of the SBW schema is expected to be related to greater use of disengagement coping strategies. Based on previous studies that have found a significant association between disengagement coping strategies and negative mental health outcomes, I hypothesize that greater internalization of the SBW schema will be related to greater disengagement coping, which will in turn exacerbate the relations between gendered racial microaggressions and traumatic stress. Although the SBW schema is one important aspect of Black women's identity, another important factor to consider is womanist attitudes, which has been conceptualized to play a role in how Black women contextualize their gendered racial experiences and respond to discrimination.

Womanist Attitudes

Womanism is an aspect of identity that reflects a connection between an understanding of the unique oppression of women of color, especially African American women, along race, gender, and class lines and an understanding of oneself as a Black woman or woman of color (Bart, 1991; Donovan, 1985; Jaggar & Rothenberg, 1993; Walby, 1990; Walker, 1983).

Womanist attitudes are an aspect of womanist identity that reflects an individual's personal understanding (i.e., critical consciousness) of the interlocking nature of systems of oppression and how they affect women of color differently than white women. Scholars have developed and adapted measures designed to capture feminist and womanist attitudes (e.g., Henley et al., 1998; Ossana, 1986; Ossana et al., 1992). Womanist identity attitudes have been explored as a possible protective factor in the link between discrimination and negative mental health outcomes.

Empirical evidence from quantitative studies supports a buffering effect of womanist attitudes for women of color for a range of outcomes, such as job-related burnout (Velez et al., 2018) to psychological distress (Chadwick & DeBlaere, 2019; DeBlaere & Bertsch, 2013). Additionally, Poindexter-Cameron and Robinson (1997) found that racial identity, womanist identity attitudes, and self-esteem were positively correlated with one another; there is empirical support for the protective role of strong, positive ethnic and gender identity in the relations between discrimination and psychological wellbeing (e.g., Lee & Ahn, 2013).

Womanist attitudes is operationalized in this study using the Women of Color (WOC) subscale of the Feminist Perspectives Scale (Henley et al., 1998), which has been utilized in studies exploring womanist attitudes with diverse samples of women of color. The items capture participants' beliefs and understanding about the interlocking nature of racism and sexism. This is different than how feminist or womanist identity are traditionally conceptualized, which

extends these beliefs to beliefs about the self (e.g., Moradi and Subich, 2002). In other words, this scale captures an aspect of womanist identity often described as “womanist identity *attitudes*” or (critical) “*consciousness*”. Thus, it is important to consider both womanist identity attitudes and critical consciousness more broadly.

Critical consciousness describes an individual’s awareness and conceptualization of their lived experiences within the context of systemic oppression and their engagement in direct action (i.e., activism) (Diemer et al., 2006). Prilleltensky (2003) describes critical consciousness as an intervention that can help individuals resist the trauma of oppression and mitigate its effects. In this study, critical consciousness is represented in the WOC subscale (attitudes and beliefs about intersectional oppression) as well as the CDS, particularly Resistance and Education/Advocacy (i.e., direct action and resistance). Mosley and colleagues’ (2021) Critical Consciousness of Anti-Black Racism (CCABR) model offers an important framework for considering the buffering role of womanist attitudes within the context of critical consciousness. Using interviews with 12 Black Lives Matter activists and critical-ideological and Black feminist-womanist lenses, they identified three distinct processes: witnessing (or experiencing) anti-Black racism, processing anti-Black racism, and critical action against anti-Black racism (Mosley et al., 2021). These processes are simultaneous and bidirectional, in that experiences of racism may initiate processing and then critical action, but that critical action can also inform how one processes and conceptualizes systemic oppression as well as how one witnesses or experiences anti-Black racism. Extending this model to the current study, womanist attitudes are an aspect of identity that influences how Black women experience and process gendered racism; this processing includes gaining a greater intersectional context of one’s experiences (Mosley et al., 2021) as well as critical action (e.g., how they cope or respond to these experiences). These ongoing,

simultaneous critical consciousness processes help to connect individuals to others with similar experiences, gain a greater sense of agency and awareness, and engage in action to resist internalizing negative beliefs about the self. The current study focuses on how Black women process and respond to experiences of gendered racism.

L. B. Watson and colleagues' (2018) qualitative study of coping behaviors among a sample of predominantly white feminist- and womanist-identified women found that these women coped using a range of behaviors such as advocacy, social support, self-care, disengagement, and religion and spirituality. They also found that womanist and feminist identity was described by participants as being protective in many ways amidst experiencing discrimination. This, along with Kilgore and colleagues' (2020) qualitative investigation of writing about discrimination as a coping strategy for Black women, further suggests that being able to conceptualize one's own experiences within a larger framework of systemic oppression may be related to increased use of engagement coping strategies, which in turn may be related to lesser negative mental health outcomes. In other words, an intersectionality framework for understanding oppression can mitigate the negative influence of marginalization on mental health.

However, these studies also illustrate the persistent deleterious impacts of experiencing and processing instances of discrimination. L. B. Watson and colleagues (2018) found that in some instances, this greater awareness of systems of oppression had a negative impact on psychological wellbeing. Moreover, Kilgore and colleagues (2020) found that although Black women reported experiencing positive emotions from the act of writing, they were more likely to experience negative emotions while writing about these experiences. This highlights the complex ways discrimination impacts wellbeing. These findings can be understood within the context of

racial socialization literature, which explores how African American parents teach their children about race and racism (Bowman & Howard, 1985; Hughes et al., 2006; McHale et al., 2006). Studies have shown that while parents discuss racism with their children in efforts to prepare them for future discriminatory experiences and protect them from negative psychological impacts, it can have the opposite effect (Fischer & Shaw, 1999; Harris-Britt et al., 2007; Reynolds & Gonzales-Backen, 2017); in other words, in some instances this awareness can exacerbate the psychological impacts of discrimination, and in other instances it can serve as a buffer and thus lessen these negative impacts.

The influence of discrimination on womanist attitudes among Black women remains an understudied area in quantitative research. Based on previous research, greater womanist attitudes are expected to be related to greater use of engagement coping strategies. This study seeks to fill this gap in the literature by exploring the moderating (buffering) role of womanist attitudes in the link between gendered racial microaggressions and traumatic stress symptoms for Black women, through the use of engagement coping strategies. Generally, quantitative studies have found that womanist attitudes serve as a buffer between discrimination and negative mental health outcomes. Qualitative research has demonstrated greater complexity in the role of womanist attitudes, such that at times it can be perceived as exacerbating or protective. Based on previous studies that have found womanist attitudes to serve as a moderator, I hypothesize that greater womanist attitudes will be related to greater engagement coping, which will in turn buffer the relations between gendered racial microaggressions and traumatic stress.

Current Study

The purpose of this study is to examine the relations between experiences of gendered racial microaggressions (GRMS), coping strategies, and traumatic stress symptoms among a

diverse sample of Black women. Womanist attitudes and the SBW schema are important aspects of identity for Black women. These aspects of identity play a complex role in Black women's lives, serving as both protective and exacerbating factors. However, there is a stronger association between womanist attitudes and engagement coping strategies and a stronger association between the SBW schema and disengagement coping strategies. Thus, this study hypothesizes that womanist attitudes and the SBW schema moderate the link between GRMS and traumatic stress symptoms via greater use of particular types of coping strategies (engagement vs. disengagement). The hypotheses for the current study are as follows:

- (1) Coping strategies will partially mediate the relations between GRMS and traumatic stress, such that greater GRMS will be positively associated with greater Internalization, Detachment, and Drug/Alcohol Use (disengagement) coping strategies, which will be related to greater traumatic stress symptoms. Additionally, greater GRMS will be positively associated with greater Education/Advocacy and Resistance (engagement) coping strategies, which will be related to fewer traumatic stress symptoms.
- (2) (a) The SBW schema will moderate the direct relations between GRMS and coping strategies. High SBW internalization will be associated with disengagement coping and low internalization will be associated with engagement coping. In addition, SBW schema will moderate the direct relations between GRMS and traumatic stress. Specifically, high SBW internalization will be related to greater traumatic stress.
(b) The SBW schema will moderate the indirect association between GRMS and traumatic stress through coping, such that greater GRMS and high SBW internalization will be associated with greater disengagement coping, which will, in

turn, be related to greater traumatic stress symptoms, and greater GRMS and low SBW internalization will be associated with greater engagement coping, which will, in turn, be related to fewer traumatic stress symptoms (see Figure 1).

- (3) (a) Womanist attitudes will moderate the direct relations between GRMS and coping strategies. Greater endorsement of womanist attitudes will be associated with engagement coping, and low endorsement of womanist attitudes will be associated with disengagement coping. In addition, womanist attitudes will moderate the direct relations between GRMS and traumatic stress. Specifically, greater endorsement of womanist attitudes will be associated with fewer traumatic stress symptoms.
- (b) Womanist attitudes will moderate the indirect association between GRMS and traumatic stress through coping, such that greater GRMS and high endorsement of womanist attitudes will be associated with greater engagement coping, which will, in turn, be related to fewer traumatic stress symptoms, greater GRMS and low endorsement of womanist attitudes will be associated with greater disengagement coping, which will, in turn, be related to greater traumatic stress symptoms (see Figure 1).

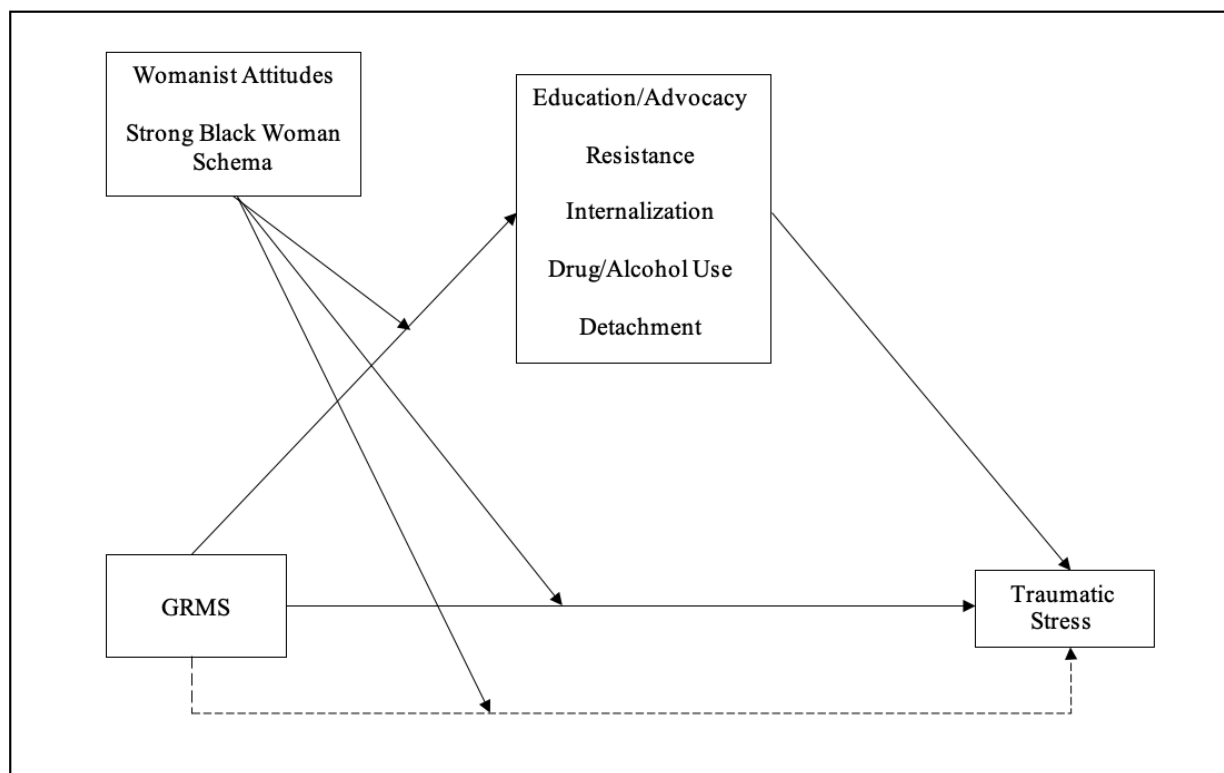


Figure 1. Conceptual moderated mediation model predicting traumatic stress symptoms.
Note: Dashed line indicates conditional indirect effect.

CHAPTER TWO: METHOD

Participants

Individuals who self-identified as Black or African American women over the age of 18 years old and living in the United States were eligible to participate in this study. The geographic target range for participants was broadened due to limitations of local, in-person data collection associated with the COVID-19 pandemic. Those who completed the survey and did not meet the inclusion criteria were excluded from data analysis. There were no other exclusion criteria based on any other demographic variables. Participants represented Black women who ranged in age from 19 to 71 years, with a mean age of 37.5 years ($SD = 13.3$). The majority of participants identified as Black/African American (91.9%, $n = 170$), 7.6% identified as biracial or multiracial Black women ($n = 14$), and 0.5% identified as Latina/Hispanic Black women ($n = 1$). Heterosexual participants represented 78.4% of the sample ($n = 145$), while lesbian, bisexual, queer, questioning, asexual, pansexual, and other identities represented 21.6% of the sample ($n = 40$). The majority of the sample (72.9%, $n = 135$) completed or were pursuing a graduate or professional degree, 16.2% completed a bachelor's degree ($n = 30$), 1.6% completed an associate's or other two-year degree ($n = 3$), and 9.1% completed some college, business or trade school, or a high school diploma or equivalent ($n = 17$). In terms of class, the majority of the sample identified as middle class (64.3%, $n = 119$), 16.2% upper middle class ($n = 30$), 16.2% working class ($n = 30$), 2.2% poor ($n = 4$), 0.5% wealthy ($n = 1$), and 0.5% of participants did not complete the class item ($n = 1$). In terms of income, a majority of participants reported a combined family income of less than \$100,000 (58.9%, $n = 109$), which included 9.7% between \$0-\$24,999 ($n = 18$), 15.1% between \$25,000-\$49,000 ($n = 28$), 16.8% between \$50,000-\$74,999 ($n = 31$), and 17.3% between \$75,000-\$99,999 ($n = 32$). Of the participants who

reported an income greater than \$100,000 ($n = 76$), 14.6% reported an income between \$100,000-\$124,999 ($n = 27$), 8.1% between \$125,000-\$149,999 ($n = 15$), 3.8% between \$150,000-\$174,999 ($n = 7$), 2.7% between \$175,000-\$199,999 ($n = 5$), and 11.9% greater than \$200,000 ($n = 22$).

Procedure

Due to the COVID-19 pandemic, this study was conducted online using a Qualtrics survey rather than in-person using a paper-and-pencil survey method. Participant recruitment involved online strategies targeted to increase diversity within the sample (e.g., economic, age, and educational diversity). For example, the study information was posted in social media forums geared toward Black women, such as Facebook groups, and the research team personally contacted individuals who met the eligibility criteria and/or had access to potential participants due to their status (e.g., the moderator of a closed Black women-focused social media group) via email. Participants were also recruited through community organizations and participants were encouraged to pass information along to their social networks.

The online survey experienced multiple spam and bot attacks throughout data collection, and additional procedures were added to address this. Spam and bot attacks have increasingly presented a challenge for researchers, driven by a variety of factors; notably, researchers have explored the influence of economic hardship on the sudden increase in spam and bot attacks since February 2018 (del Castillo, 2020; Kennedy et al., 2018). Periodically throughout data collection, the research team sorted through these responses using systematic criteria to determine which responses were legitimate (i.e., the participants were Black women taking the survey) and which were illegitimate (i.e., a bot response or individual maliciously taking the survey). Using Qualtrics bot detection features, a significant portion of bot responses were

automatically flagged as suspicious. Other criteria used to eliminate responses included: 1) traditionally male names (e.g., Patrick Stewart), 2) nonsensical email addresses or email addresses that fit a consistent pattern with other known bot responses (e.g., jdksfh9347@gmail.com), 3) responses coming in from sources we did not use for recruitment (e.g., Facebook paid ads), 4) multiple survey responses from the same IP address, 5) less than 20 minutes to complete the survey, 6) numerous responses within the same small timeframe (e.g., 10 responses in 1 minute), and 7) nonsensical open-ended responses or responses that contained racial slurs. An additional column in Qualtrics Data View was added, titled “Valid?” Legitimate responses were flagged with a “Y” or “Yes”. Both graduate student members of the research team reviewed the data independently and flagged questionable responses. All questionable responses were then reviewed by both graduate student researchers together and resolved as either legitimate or spam. To reduce the chances of future attacks, participants were asked to share the recruitment information through more private channels, such as via email, text message, or private message on a social network platform.

After reading the informed consent and agreeing to participate in the survey, participants answered a variety of questions that took on average 30-45 minutes to complete. After participants completed the survey, they were provided with a debriefing form and sent a \$10 electronic gift card if they chose to share their contact information.

Measures

Demographics

Participants completed a demographic survey form at the end of the survey which included questions about their race, ethnicity, socioeconomic status, sexual orientation, age, and religious beliefs. Given that data was collected during the COVID-19 pandemic, participants

were also asked to describe any stressors related to the COVID-19 pandemic or sociopolitical issues (e.g., racism, police brutality, healthcare).

Gendered Racial Microaggressions

Subtle gendered racism was measured using the Gendered Racial Microaggressions Scale for Black Women (GRMS; Lewis & Neville, 2015), which is a 26-item measure that assesses Black women's experiences of four different subtypes of gendered racial microaggressions: Assumptions of Beauty and Sexual Objectification, Silenced and Marginalized, Strong Black Woman Stereotype, and Angry Black Woman Stereotype. A sample item includes: "I have received negative comments about my hair when I wear it in a natural hairstyle." Participants rate the frequency of their experiences on a 0 (never) to 5 (once a week or more) scale and a total mean score is computed by adding all items and then dividing by the number of items to achieve a mean frequency score. Participants are also asked to rate how stressful these experiences were on a 0 (this has never happened to me) to 5 (extremely stressful) scale. Responses to the GRMS have demonstrated internal consistency for frequency ($\alpha = .92$) and stress appraisal ($\alpha = .93$) with community-based samples of Black women (Lewis & Neville, 2015). For the current study, only frequency scores were used in the analysis. Internal consistency for the current study was similar to previous studies ($\alpha = .93$).

Coping Strategies

Coping strategies was measured using the Coping with Discrimination Scale (CDS; Wei et al., 2010), which is a 25-item measure capturing various coping strategies used to cope with discrimination. On a 6-point Likert scale ranging from 1 (never like me) to 6 (always like me), participants indicate how much each of the different strategies describes how they generally cope with discrimination. A sample item includes: "I wonder if I did something to provoke this

incident.” The CDS was developed using diverse samples of people of color, and convergent validity with depression outcomes as well as with active coping (Education/Advocacy), self-blame (Internalization), substance use (Drug/Alcohol Use), and behavioral disengagement (Detachment) has been demonstrated. Alpha estimates ranged from $\alpha = .77$ to $.82$ across three samples of diverse groups of people of color during scale development. In a previous study of Black women, alpha levels for the subscales have ranged from $\alpha = .71$ to $.87$ (Carr et al., 2013; Szymanski & Lewis, 2016). Alpha levels for the current study were $.85$ (Education/Advocacy), $.85$ (Drug/Alcohol Use), $.88$ (Internalization), $.74$ (Resistance), and $.73$ (Detachment).

Womanist Attitudes

Womanist attitudes was assessed using the 10-item Women of Color (WOC) subscale of the Feminist Perspectives Scale (FPS; Henley et al., 1998). Participants rate their level of agreement with the items using a 7-point Likert scale ranging from 1 (strongly agree) to 7 (strongly disagree). A sample item includes: “In education and legislation to stop rape, ethnicity and race must be treated sensitively to ensure that Women of Color are protected equally.” Item scores are averaged to obtain a total subscale score. This subscale has been used separately for previous studies focused on assessing womanist attitudes for women of color. Reliability has been demonstrated with diverse samples of women of color, including samples with Black women representing significant portions (40-59%) of participants ($\alpha = .75$ to $.92$) (Chadwick & DeBlaere, 2019; Henley et al., 1998; Velez et al., 2018). The Cronbach’s α for the current study was $.78$.

“Strong Black Woman” Schema

The Strong Black Woman (SBW) schema was measured using the Giscombé Superwoman Schema Questionnaire (SWS; Woods-Giscombé et al., 2019), which is a 35-item

scale with five subscales that capture different aspects of the SBW schema: Obligation to Present an Image of Strength, Obligation to Suppress Emotions, Resistance to Being Vulnerable, Intense Motivation to Succeed, and Obligation to Help Others. Participants are asked to rate whether each statement applies to them (e.g., “I keep problems to myself to prevent burdening others”). If a statement does not apply, participants choose “This is NOT TRUE for me” and move to the next question. If a statement does apply, participants rate how true it is on a scale of 1 (rarely) to 3 (all the time); a rating of not true is equivalent to a 0. If a statement applies, participants then rate how much each statement bothers them on a scale of 0 (not at all) to 2 (very much). A total score can be obtained by creating a sum of all “TRUE” response choices ($\alpha = .95$) and using interpretation categories of 0-35 for “low SWS,” 36-70 for “moderate SWS,” and 71-105 for “high SWS.” The total score was used in the current study, and the Cronbach’s α was .92.

Traumatic Stress Symptoms

Traumatic stress symptoms were assessed using the PTSD Symptom Checklist for *DSM-5* (PCL-5; Weathers et al., 2013), which is a 20-item measure whose items correspond to the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* symptom criteria. Items are rated on a 5-point Likert scale, ranging from 0 (not at all) to 4 (extremely), and measure four clusters of symptomatology: intrusion symptoms (cluster B), persistent avoidance (cluster C), negative alterations in cognitions and mood (cluster D), and increased arousal (cluster E). For the purpose of this study, instructions were adapted to ask participants to respond to a specific experience of gendered racism. Participants were asked, “In the space below, please describe a memorable incident of discrimination you have experienced in your life **because you are a Black woman**,” which is similar to a portion of Criterion A of the PCL-5, which asks individuals to describe their worst traumatic event. Then, participants were asked “Below is a list of

problems that people sometimes have in response to a very stressful experience. Keeping **the event you just thought about** in mind, please read each problem carefully and then select the response that indicates how much you have been bothered by that problem in the past month.” The bolded portion represents our changes to the general directions, which state “Keeping your worst event in mind...” Because the current study uses a nonclinical sample, the total symptom severity score, which ranges from 0 to 80, was used for analysis. Strong internal consistency was demonstrated with samples of trauma-exposed college students and with samples of Black women and other women of color ($\alpha = .94$ to $.95$) (Moody & Lewis, 2019; L. B. Watson et al., 2016; Weathers et al., 2013). Internal consistency for the current study was $.95$.

Data Analysis Plan

Primary Analyses

Hypothesis 1 was tested using Model 4 of Hayes’ (2017) PROCESS macro Version 3.3 in SPSS Version 25 (IBM Corp., 2017). Model 4 allows up to 10 mediators in parallel. Within the mediational analysis, Model 4 also tests whether 1) GRMS is directly related to traumatic stress. Hypotheses 2 and 3 were tested using Model 8 of Hayes’ (2017) PROCESS macro to examine whether the coping-mediated association between GRMS and traumatic stress is moderated by the SBW schema and womanist attitudes. Model 8 tests a moderated mediation model with one variable moderating the IV-mediator path (GRMS-coping) and the IV-DV path (GRMS-traumatic stress), and up to 10 mediators in parallel. The PROCESS macro includes the MODMED command, which directs SPSS to estimate the coefficients for the specific moderated mediation model specified by the user (Preacher et al., 2007). PROCESS uses a bootstrapping method with bias-corrected and accelerated samples to adjust standard errors and derive more conservative estimates of the model (Hayes, 2013). In this study, 5,000 bias-corrected samples

will be used. Additionally, PROCESS was instructed to mean-center the predictor variables involved in construction of interactions to avoid multicollinearity (Field, 2013).

CHAPTER THREE: RESULTS

Data Screening and Preliminary Analyses

I initially obtained a total of 190 completed online survey responses. Of these 190, five were excluded for completing less than 50% of the variables of interest, leaving a final sample size of 185 participants. All variables of interest were examined for accuracy of data entry, missing values, and normality of distribution. With the final study sample of 185, data was assessed for missingness using Little's Missing Completely at Random (MCAR; Little, 1988) test and imputed as necessary using the Expectation Maximization (EM). EM uses a maximum likelihood technique for estimating missing values (Little & Rubin, 2002) and is an appropriate imputation method to use when data are missing completely at random. According to Fritz and MacKinnon's (2007) bias-corrected bootstrap resampling procedure, a minimum sample size of 116 was needed to detect a medium effect size with a power of .80 for a mediation analysis. According to Preacher and colleagues' (2007) bias-corrected bootstrap resampling procedure, a minimum sample size of 200 is necessary to detect a medium effect with a power of .80 for a moderated mediation analysis. Means, standard deviations, and Pearson product-moment bivariate correlations between all study variables were calculated before hypothesis testing occurred.

Means and standard deviations for all study variables, as well as Cronbach's alpha for scales are listed in Table 1. Data were missing completely at random for the GRMS, $\chi^2(79) = 80.41, p = 0.44$; the SWS, $\chi^2(736) = 797.12, p = 0.06$; the PCL, $\chi^2(19) = 2.74, p = 1.00$; and four subscales of coping (Education/Advocacy, $\chi^2(3) = 4.91, p = 0.18$; Internalization, $\chi^2(3) = 1.15, p = 0.76$; Detachment, $\chi^2(4) = 2.62, p = 0.62$; and Resistance, $\chi^2(3) = 5.96, p = 0.11$) according to a series of Little's Missing Completely at Random (MCAR) tests (Little, 1988). Missing values

Table 1Means, Standard Deviations, and Cronbach's α for Study Variables

Variables	<i>M</i>	<i>SD</i>	Cronbach's α
Gendered Racial Microaggressions	2.06	0.83	.92
Womanist Attitudes	6.18	0.67	.78
SBW Schema	70.15	17.87	.92
Education/Advocacy	18.75	5.67	.85
Drug/Alcohol Use	10.24	6.47	.85
Internalization	12.30	5.81	.88
Resistance	14.99	4.67	.74
Detachment	12.11	4.62	.73
Traumatic Stress	24.75	18.64	.95

Note. Education/Advocacy, Drug/Alcohol Use, Internalization, Resistance, and Detachment are subscales of the Coping with Discrimination scale (CDS). SBW = Strong Black Woman.

ranged from (.11% to .69%) for the above variables. The Women of Color (WOC) subscale of the Feminist Perspectives Scale and the Drug/Alcohol Use subscale of the CDS had no missing values. Additionally, data met assumptions of univariate normality (skewness < 3, kurtosis < 10; Weston & Gore, 2006). Due to an error, the first five participants who completed the survey did not have a “Never” (Likert value of 0) option for the GRMS items 11-20. The mean GRMS for this sample ($M = 2.06$, $SD = 0.83$) is similar to other published studies using the GRMS (e.g., Lewis & Neville, 2015; Moody & Lewis, 2019; Williams & Lewis, 2019); thus, this error did not appear to have a significant impact on the data.

The Pearson product-moment correlations indicated significant correlations between GRMS, WOC, all five CDS subscales, SWS, and PCL (see Table 2). GRMS was positively associated with SWS ($r = .46$, $p < .001$), PCL ($r = .53$, $p < .001$), Education/Advocacy ($r = .37$, $p < .001$), Drug/Alcohol Use ($r = .30$, $p < .001$), Internalization ($r = .31$, $p < .001$), Resistance ($r = .26$, $p < .001$), Detachment ($r = .29$, $p < .001$), and WOC ($r = .29$, $p < .001$).

Although there were no a priori hypotheses involving demographic variables, preliminary analyses explored the relationship between age, sexual orientation, and class on reported traumatic stress. Age was negatively correlated with PCL ($r = -.32$, $p < .001$), such that younger women reported greater traumatic stress symptoms than older women. An analysis of variance (ANOVA) test indicated that no difference existed between class groups for traumatic stress ($F(4, 179) = 2.47$, $p = 0.05$). An ANOVA test indicated a significant difference between sexual orientation groups for traumatic stress ($F(7, 177) = 2.33$, $p = 0.03$), such that sexual minority individuals reported greater traumatic stress.

Table 2
Intercorrelations Between Study Variables

Variable	1	2	3	4	5	6	7	8	9
1. GRMS	--								
2. Womanist Att.	.29***	--							
3. SBW Schema	.46***	.09	--						
4. Edu./Advocacy	.37***	.42***	.17*	--					
5. Drug/Alcohol Use	.30***	.12	.22**	.08	--				
6. Internalization	.31***	.02	.33***	.16*	.19**	--			
7. Resistance	.26***	.29***	.09	.46***	.34***	.05**	--		
8. Detachment	.29***	.02	.48***	-.13	.22**	.39***	-.17*	--	
9. Traumatic Stress	.53***	.13	.38***	.24**	.37***	.37***	.19*	.31***	-

Note. SBW = Strong Black Woman; Womanist Att. = Womanist Attitudes; Edu./Advocacy = Education/Advocacy Education/Advocacy, Drug/Alcohol Use, Internalization, Resistance, and Detachment are subscales of the Coping with Discrimination scale (CDS).

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

Mediation Analysis

To test Hypothesis 1, I conducted a mediation analysis using Model 4 of the PROCESS Macro (Hayes, 2013) with 5,000 bias-corrected bootstrap samples. Within this model, all five coping subscales were entered as simultaneous mediators of the relations between GRMS and traumatic stress symptoms, and age and sexual orientation (dichotomized as 0 = heterosexual, 1 = sexual minority individuals) were entered as covariates. GRMS had an indirect effect on traumatic stress symptoms through Drug/Alcohol Use ($B = 1.14$, $SE = .54$, 95% CI [0.23, 2.33]); greater frequency of GRMS was associated with greater use of drug and alcohol use coping, which in turn was associated with greater traumatic stress (see Figure 2). GRMS also had an indirect effect on traumatic stress symptoms through Internalization ($B = 1.22$, $SE = .65$, 95% CI [0.21, 2.68]); greater frequency of GRMS was associated with greater use of internalization coping, which in turn was associated with greater traumatic stress. Education/Advocacy ($B = 0.64$, $SE = .64$, 95% CI [-0.65, 1.93]), Resistance ($B = 0.01$, $SE = .45$, 95% CI [-0.96, 0.89]), and Detachment ($B = 0.49$, $SE = .45$, 95% CI [-0.18, 1.56]), did not significantly mediate the relations between GRMS and traumatic stress symptoms. Therefore, results of the mediation analysis partially supported Hypothesis 1 that Drug/Alcohol Use and Internalization would significantly mediate the relations between GRMS and traumatic stress, such that greater use of disengagement coping explains the relationship between greater GRMS and greater traumatic stress symptoms. Age was significantly associated with fewer traumatic stress symptoms ($B = -0.19$, $SE = .09$, 95% CI [-0.38, -0.01]), such that older women reported fewer traumatic stress symptoms. Sexual orientation was significantly associated with Drug/Alcohol Use ($B = 4.00$, $SE = 1.19$, 95% CI [1.64, 6.35]), and Detachment ($B = 2.46$, $SE = .86$, 95% CI [0.79, 4.15]), such that sexual minority individuals reported greater use of both types of coping. However, age ($B =$

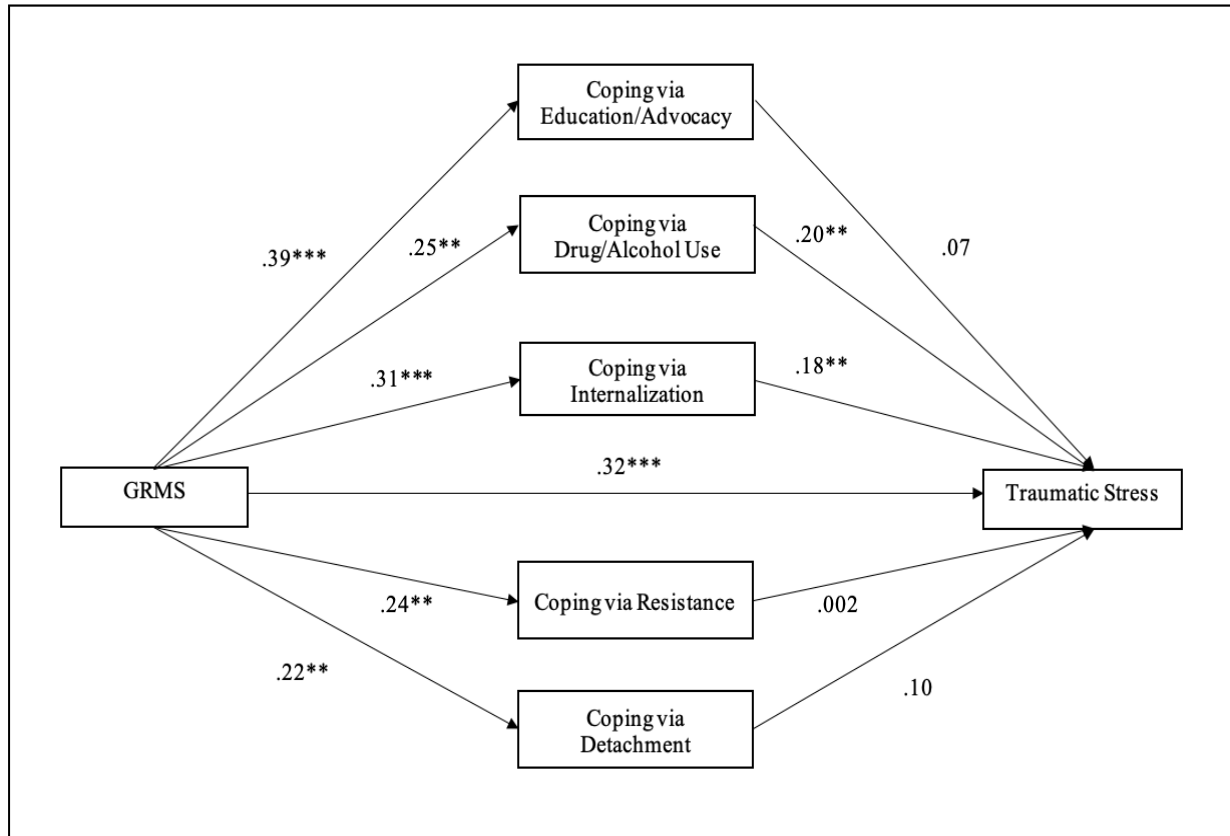


Figure 2. Results of the mediation analyses highlighting direct and indirect relations of predictor variables with traumatic stress.

** $p < .01$, *** $p < .001$.

-0.17, $SE = .10$, 95% CI [-0.37, 0.03]) and sexual orientation ($B = 2.12$, $SE = 3.11$, 95% CI [-4.02, 8.26]) were not significant in the total effect model. Thus, these variables were not included in the moderated mediation analyses.

Moderated Mediation Analyses

To test Hypothesis 2, a moderated mediation analysis was conducted using Model 8 of PROCESS with 5,000 bias-corrected bootstrap samples. Within this model, all five coping subscales were entered as simultaneous mediators to explore whether they mediated the indirect association between GRMS and traumatic stress, with the SBW schema as a moderator. Results of the moderated mediation analysis partially supported Hypothesis 2. As hypothesized, the SBW schema significantly moderated the direct association between GRMS and one type of disengagement coping, ($B = 0.60$, $SE = 0.20$, 95% CI [0.02, 0.10]). The SBW schema significantly moderated the direct relation between GRMS and Detachment at +1 SD above the mean ($B = 1.53$, $SE = .51$, 95% CI [0.51, 2.54]), but not at the mean ($B = 0.40$, $SE = .40$, 95% CI [-0.38, 1.18]), or -1 SD below the mean ($B = -0.72$, $SE = .57$, 95% CI [-1.85, 0.40]). This indicates that the combination of greater GRMS and greater internalization of the SBW schema was associated with greater use of Detachment coping. The SBW schema did not moderate the relations between GRMS and engagement coping (Resistance $B = -0.05$, $SE = -.02$, 95% CI [-0.09, 0.001]; Education/Advocacy $B = -0.04$, $SE = .03$, 95% CI [-0.09, 0.02]) or the other disengagement coping strategies (Internalization $B = 0.03$, $SE = .03$, 95% CI [-0.02, 0.09]; Drug/Alcohol Use $B = -0.05$, $SE = -.02$, 95% CI [-0.09, 0.001]). The SBW schema also did not moderate the relations between GRMS and traumatic stress ($B = 0.05$, $SE = .08$, 95% CI [-0.11, 0.21]). In addition, I hypothesized that the SBW schema would be significantly related to disengagement coping strategies. As hypothesized, the SBW schema was significantly related to

Internalization ($B = 1.53$, $SE = .53$, 95% CI [0.48, 2.59]) and Detachment ($B = 0.12$, $SE = .02$, 95% CI [0.08, 0.16]), such that greater internalization of the SBW schema was associated with greater use of internalization and detachment coping strategies. Contrary to Hypothesis 2, the SBW schema was not significantly related to drug/alcohol use ($B = 0.05$, $SE = .03$, 95% CI [-0.01, 0.10]). The SBW schema did not moderate the indirect association of GRMS on traumatic stress through Education/Advocacy (index of moderated mediation, $B = -0.01$, $SE = .01$, 95% CI [-0.04, 0.01]), Drug/Alcohol Use (index of moderated mediation, $B = 0.03$, $SE = .02$, 95% CI [-0.01, 0.07]), Internalization (index of moderated mediation, $B = 0.02$, $SE = .02$, 95% CI [-0.02, 0.07]), Resistance (index of moderated mediation, $B = 0.002$, $SE = .02$, 95% CI [-0.04, 0.03]), or Detachment (index of moderated mediation, $B = 0.02$, $SE = .02$, 95% CI [-0.02, 0.07]) (see Table 3).

To test Hypothesis 3, a moderated mediation analysis was conducted using Model 8 of PROCESS with 5,000 bias-corrected bootstrap samples. Within this model, all five coping subscales were entered as simultaneous mediators to explore whether they mediated the indirect association between GRMS and traumatic stress, with womanist attitudes as a moderator. Results of the moderated mediation analysis partially supported Hypothesis 3. Contrary to Hypothesis 3, womanist attitudes did not moderate the direct association between GRMS and engagement coping (Education/Advocacy $B = 0.71$, $SE = .66$, 95% CI [-0.60, 2.02]); Resistance $B = -0.31$, $SE = .59$, 95% CI [-1.48, 0.86]) or disengagement coping (Drug/Alcohol Use $B = 1.01$, $SE = .83$, 95% CI [-0.62, 2.65]; Internalization $B = 0.20$, $SE = .74$, 95% CI [-1.27, 1.66]; Detachment $B = -0.55$, $SE = .59$, 95% CI [-1.72, 0.62]). Womanist attitudes also did not moderate the relations between GRMS and traumatic stress ($B = -2.03$, $SE = 2.04$, 95% CI [-6.05, 1.99]). However, I also hypothesized that womanist attitudes would be significantly related to engagement coping

Table 3

Moderated Mediation Analysis for Gendered Racial Microaggressions, Strong Black Woman Schema, Coping, and Traumatic Stress Symptoms

Predictor	Outcome	B	SE	t	95% CI
Education/Advocacy					
GRMS		2.61	0.43	4.95	[1.57, 3.65]***
SBW		-0.01	0.02	-0.28	[-0.06, 0.04]
GRMS x SBW		-0.04	0.03	-1.33	[-0.09, 0.02]
Drug/Alcohol Use					
GRMS		1.81	0.61	2.96	[0.60, 3.02]**
SBW		0.05	0.03	1.65	[-0.01, 0.10]
GRMS x SBW		0.05	0.03	1.67	[-0.01, 0.11]
Internalization					
GRMS		1.38	0.54	2.56	[0.32, 2.45]*
SBW		0.08	0.03	3.13	[0.03, 0.13]**
GRMS x SBW		0.03	0.03	1.12	[-0.02, 0.09]
Resistance					
GRMS		1.59	0.45	3.55	[0.71, 2.48]***
SBW		-0.02	0.02	-0.69	[-0.06, 0.03]
GRMS x SBW		-0.05	0.02	-1.90	[-0.09, 0.001]
Detachment					
GRMS		0.40	0.40	1.01	[-0.38, 1.18]
SBW		0.12	0.02	6.50	[0.08, 0.16]***
GRMS x SBW		0.06	0.02	2.04	[0.02, 0.10]**
Traumatic Stress					
GRMS		7.44	1.66	4.49	[4.17, 10.71]***
SBW		0.09	0.08	1.18	[-0.06, 0.25]
GRMS x SBW		0.05	0.08	0.62	[-0.11, 0.21]
Education/Advocacy		0.21	0.24	0.89	[0.26, 0.68]
Drugs/Alcohol Use		0.54	0.20	2.78	[0.16, 0.93]**
Internalization		0.52	0.21	2.44	[0.10, 0.95]*
Resistance		0.05	0.29	0.17	[-0.53, 0.63]
Detachment		0.30	0.31	0.98	[-0.31, 0.92]

Note. GRMS = Gendered racial microaggressions; SBW = Strong Black Woman.

* $p < .01$, ** $p < .01$, *** $p < .001$

strategies. As hypothesized, womanist attitudes were significantly related to Resistance ($B = 1.53$, $SE = .53$, 95% CI [0.48, 2.59]) and Education/Advocacy ($B = 3.04$, $SE = .60$, 95% CI [1.86, 4.23]), such that greater endorsement of womanist attitudes was associated with greater use of resistance and education/advocacy coping strategies. Womanist attitudes did not moderate the indirect association of GRMS on traumatic stress through Education/Advocacy (index of moderated mediation, $B = 0.21$, $SE = .30$, 95% CI [-0.22, 0.96]), Drug/Alcohol Use (index of moderated mediation, $B = 0.60$, $SE = .66$, 95% CI [-0.52, 2.13]), Internalization (index of moderated mediation, $B = 0.11$, $SE = .51$, 95% CI [-0.92, 1.18]), Resistance (index of moderated mediation, $B = -0.01$, $SE = .20$, 95% CI [-0.41, 0.43]), or Detachment (index of moderated mediation, $B = -0.24$, $SE = .43$, 95% CI [-1.24, 0.53]) (see Table 4).

Table 4

Moderated Mediation Analysis for Gendered Racial Microaggressions, Womanist Attitudes, Coping, and Traumatic Stress Symptoms

Predictor	Outcome	B	SE	t	95% CI
Education/Advocacy					
GRMS		1.82	0.46	3.96	[0.91, 2.72]***
Womanist Attitudes		3.04	0.60	5.07	[1.86, 4.23]***
GRMS x WA		0.71	0.66	1.07	[-0.60, 2.02]
Drug/Alcohol Use					
GRMS		2.18	0.57	3.91	[1.05, 3.32]***
Womanist Attitudes		0.65	0.75	0.87	[-0.83, 2.23]
GRMS x WA		1.01	0.83	1.23	[-0.62, 2.65]
Internalization					
GRMS		2.34	0.51	4.55	[1.32, 3.35]***
Womanist Attitudes		-0.64	0.67	-0.95	[-1.96, 0.69]
GRMS x WA		0.20	0.74	0.27	[-1.27, 1.66]
Resistance					
GRMS		1.05	0.41	2.56	[0.24, 1.86]*
Womanist Attitudes		1.53	0.53	2.86	[-0.48, 2.59]**
GRMS x WA		-0.31	0.59	-0.53	[-1.48, 0.86]
Detachment					
GRMS		1.76	0.41	4.30	[-0.95, 2.57]***
Womanist Attitudes		-0.67	0.54	-1.25	[-1.73, 0.39]
GRMS x WA		-0.55	0.59	-0.35	[-1.72, 0.62]
Traumatic Stress					
GRMS		8.19	1.61	5.10	[5.02, 11.36]***
Womanist Attitudes		-1.84	1.95	-0.94	[-5.69, 2.02]
GRMS x WA		-2.03	2.04	-1.00	[-6.05, 1.99]
Education/Advocacy		0.31	0.25	1.23	[-0.21, 0.98]
Drugs/Alcohol Use		0.59	0.20	3.04	[0.21, 0.98]**
Internalization		0.53	0.22	2.48	[0.11, 0.96]*
Resistance		0.02	0.29	0.08	[-0.56, 0.60]
Detachment		0.44	0.29	1.53	[-0.13, 1.00]

Note. GRMS = Gendered racial microaggressions; WA = Womanist attitudes.

* p < .01, ** p < .01, *** p < .001

CHAPTER FOUR: DISCUSSION

Utilizing the intersectionality framework proposed by Lewis and colleagues (2017), I investigated the role of coping strategies as mediators of the relations between gendered racial microaggressions and traumatic stress symptoms among Black women. Building upon their model, I explored two specific aspects of gendered racial identity as moderators, womanist attitudes and SBW schema, that may buffer or exacerbate the mediated link between discrimination and negative mental health outcomes.

The first research hypothesis, exploring whether coping strategies mediated the relations between gendered racial microaggressions and traumatic stress, was partially supported. A greater frequency of gendered racial microaggressions were associated with greater use of disengagement coping strategies (Internalization and Drug/Alcohol Use), which in turn were associated with greater traumatic stress symptoms. Contrary to expectation, Detachment was not a significant mediator of the GRMS-traumatic stress link. Disengagement coping strategies were conceptualized as behavioral and cognitive strategies individuals may use to cope with discriminatory experiences, such as self-blame, substance use, and not reaching out to others for emotional support. This significant partial mediation indicates that greater frequency of gendered racial microaggressions has a direct effect on traumatic stress, even when accounting for use of disengagement coping strategies. Additionally, GRMS was significantly associated with each of the five coping strategies, though only Drug/Alcohol Use and Internalization were significantly associated with traumatic stress (see Figure 2). This is similar to findings of previous studies that found significant mediation of disengagement coping strategies within the link between discrimination and negative mental health outcomes for Black women (e.g., Williams & Lewis, 2019; Szymanski & Obiri, 2011). However, Shorter-Gooden (2004) highlights the ways that

disengagement coping may be adaptive in the context of living under oppression. For example, Lewis et al. (2013) reframed disengagement coping as *self-protective coping* to emphasize that Black women who coped with gendered racial microaggressions made intentional and strategic decisions about trying to disengage from these daily life stressors. Thus, the immediate and long-term effects of disengagement coping are worthy of further exploration.

The finding that Drug/Alcohol Use and Internalization were the only significant mediating coping strategies of the link between gendered racial microaggressions and traumatic stress is worthy of further exploration. Previous research with African American samples indicates a relationship between substance use coping and discrimination (e.g., Curtis-Boles & Jenkins-Monroe, 2000; Gibbons et al., 2010; Landrine, Klonoff, Corral et al., 2006). Problematic drinking can be conceptualized as a negative mental health outcome of discrimination (e.g., Martin et al., 2003), and has a range of negative impacts on quality-of-life such as maintaining stable housing and employment. Thus, although not assessed in this sample, Black women may experience other collateral outcomes associated with using substances to cope with discrimination, such as impacts on interpersonal relationships. Moreover, the significant finding of Internalization is supported by previous research that found an association between internalized oppression and negative mental health outcomes for individuals belonging to marginalized groups (e.g., Carr et al., 2014; Graham et al., 2016; Moody & Lewis, 2019; Moradi et al., 2010; Szymanski et al., 2009).

The non-significant finding of Detachment is worthy of further consideration, given that Detachment was a significant mediator in previous research with Black women using the CDS (i.e., Szymanski & Lewis, 2016). The non-significant result could be attributed to the low usage of Detachment coping within the sample. Detachment coping was the least-common coping

strategy used by participants (see Table 1); in other words, participants utilized the other four coping strategies at a greater frequency than Detachment. Thus, it may not be used often enough to have a significant impact. Nonetheless, these findings extend the literature by providing further support for the role of disengagement coping strategies on negative mental health outcomes for Black women. Future research should explore specific disengagement coping strategies to further clarify their influence on psychological well-being.

The second part of Hypothesis 1 was not supported; engagement coping strategies were not significant mediators of the link between gendered racial microaggressions and traumatic stress. Mixed findings exist in the literature as to whether more adaptive factors have an impact on mental health outcomes, with some studies demonstrating that engagement coping strategies such as problem-focused coping and spirituality are adaptive for Black women (e.g., Bacchues, 2008; David & McClure, 2009; Shorter-Gooden, 2004; Thomas et al., 2008; L. M. West et al., 2010) and other studies showing no significant role of more culturally specific engagement coping strategies (e.g., Szymanski & Obiri, 2011; Thomas et al., 2008). The coping measure used in this study was developed using samples of people of color more broadly; thus, it does not capture unique, specific ways Black women cope with discrimination (such as spirituality or other culturally specific ways of coping). Szymanski and Lewis (2016) similarly found no significant mediating effect of engagement coping strategies utilizing this measure. It is possible that discrimination is such a significant stressor that more adaptive ways of coping are not consistently sufficient enough to counteract the negative effects of discrimination. Moreover, though there are scales that evaluate African-centered coping strategies, there is no scale that specifically focuses on Black women's gendered racial coping styles.

The second hypothesis, exploring whether the Strong Black Woman (SBW) schema would moderate (exacerbate) the direct relations between gendered racial microaggressions and coping, gendered racial microaggressions and traumatic stress, and the indirect association between gendered racial microaggressions and traumatic stress through coping, was partially supported. The SBW schema did not moderate the indirect association between gendered racial microaggressions and traumatic stress through education/advocacy, drug/alcohol use, internalization, resistance, and detachment coping, nor did it moderate the direct association between gendered racial microaggressions and traumatic stress. However, a greater frequency of gendered racial microaggressions was related to greater use of all coping strategies except detachment and was also related to greater traumatic stress. Additionally, greater drug/alcohol use and greater internalization coping were significantly associated with greater traumatic stress. I also hypothesized that greater SBW internalization would be related to disengagement coping and found that greater internalization of the SBW schema was associated with greater use of internalization and detachment coping (see Table 3).

The SBW schema moderated the direct association between gendered racial microaggressions and one aspect of disengagement coping, such that individuals who reported a greater frequency of gendered racial microaggressions and greater SBW internalization used greater detachment coping strategies than those who reported less SBW internalization. These findings are contextualized by previous studies that have found a significant association between greater internalization of the SBW schema (represented by a belief that Black women should be strong enough to handle their own and others' challenges, not needing emotional or material support from others, and being unaffected by life's hardships) and greater use of less adaptive ways of coping and negative mental health outcomes (Harrington et al., 2010; N. N. Watson &

Hunter, 2016; Woods-Giscombé, 2010). Thus, these findings support the association between a personal cognitive aversion to help-seeking and a behavioral avoidance of strategies that involve others' support. In other words, this finding suggests that Black women who internalize the SBW schema to a greater degree are less likely to turn to others for emotional support and may be more likely to disengage from addressing the issue due to feeling stuck or without support. Moreover, the finding that greater drug/alcohol use and internalization coping were related to greater traumatic stress suggests that greater internalization of the SBW schema has negative implications for Black women's well-being, despite some positive subjective appraisals of the schema.

The third hypothesis, exploring whether greater womanist attitudes would moderate (buffer) the direct relations between gendered racial microaggressions and coping, the relations between gendered racial microaggressions and traumatic stress as well as the indirect association between gendered racial microaggressions and traumatic stress through engagement coping, was partially supported. Womanist attitudes did not moderate the indirect association between gendered racial microaggressions and traumatic stress through education/advocacy, drug/alcohol use, internalization, resistance, and detachment coping, nor did it moderate the relations between gendered racial microaggressions and traumatic stress. However, a greater frequency of gendered racial microaggressions was significantly associated with all five coping strategies and was also related to greater traumatic stress. I also hypothesized that greater womanist attitudes would be related to engagement coping and found that greater womanist attitudes were associated with greater use of resistance and education/advocacy coping (see Table 4). These findings align with previous studies that womanist identity and attitudes buffer the relations between discrimination and negative mental health outcomes (e.g., Chadwick & DeBlaere, 2019; DeBlaere & Bertsch,

2013; Velez et al., 2018) as is related to greater self-esteem and positive racial identity (e.g., Poindexter-Cameron & Robinson, 1997). These findings indicate that Black women who conceptualize experiences of systemic discrimination within a larger intersectional context are more likely to utilize coping strategies that allow them to externalize discrimination (e.g., education/advocacy) and stand up for themselves (i.e., resistance).

Limitations and Directions for Future Research

The results of this study should be interpreted in the context of several key aspects that are worthy of further exploration. Due to the cross-sectional nature of data collection, causal relationships cannot be inferred from the results. Additionally, the minimum sample to detect significance for the moderated mediation analyses was not met, although sufficient power was achieved for the mediation analysis. Thus, it is possible that the results from testing Hypotheses 2 and 3 were not significant due to lack of power.

Though there were no hypotheses regarding the role of demographic variables, results highlight interesting trends between age and sexual orientation and coping and traumatic stress. Specifically, older women reported fewer traumatic stress symptoms, although this effect was not significant in the total effect model for the mediation analysis. This finding is in line with the posttraumatic stress literature, in which reported traumatic stress symptoms tend to decline with older age (Creamer & Parslow, 2008; Norris, 1992). Additionally, sexual minority women reported greater Drug/Alcohol Use and Detachment coping, although this effect was also not significant in the total effect model. Moreover, although sexual orientation was not significantly related to traumatic stress in the mediation analysis, a univariate analysis highlighted that sexual minority women reported a higher mean level of traumatic stress than heterosexual women. These findings are similar to previous studies that highlight the deleterious effects of racism,

sexism, and heterosexism on negative mental health outcomes for sexual minority women of color (e.g., DeBlaere & Bertsch, 2013; Moody & Lewis, 2019; Sigurvinsdottir & Ullman, 2016; Szymanski & Meyer, 2008; Velez, Moradi, & DeBlaere, 2015). Future research should explore Black women's experiences with gendered racism and negative mental health outcomes across various demographic variables, particularly age and sexual orientation. A particularly understudied area is older Black women's experiences with gendered racism, how they cope with those experiences, and the immediate and long-term impacts of discrimination on their mental health.

Additionally, middle class women and women with higher levels of education were overrepresented in this sample, which limits generalizability to Black women of other education levels and social classes that were not as represented in this study. The use of snowball sampling and the necessity of a reliable internet connection likely contributed to this imbalance within the sample. This study was originally designed as a pencil-and-paper study with a local community sample of Black women. Arrangements were made with local community organizations and cultural focal areas (e.g., hair salons) to recruit on site. Due to the COVID-19 pandemic, these recruitment strategies were not feasible, and the study was moved entirely online. Thus, had the study been conducted as originally planned, the sample would be more likely to be more representative of all education levels and social classes.

The bot and spam attacks that occurred intermittently throughout data collection contributed another limitation. To the best of our ability, the research team sorted through thousands of fake spam responses to determine which responses were legitimate; however, it is possible that due to human error, we either inadvertently marked a few responses as legitimate

when they were not and/or we incorrectly marked some responses as spam when they were legitimate.

The CDS was chosen for this study because it is a measure of coping that specifically asks participants to describe how they cope with discriminatory events, and it is briefer than other targeted coping measures such as the Racism-Related Coping Scale (Forsyth & Carter, 2012). In effort to accurately capture the variable of interest (coping *with* discrimination), it was important to consider participant fatigue and the potential for a decline in response rate; thus, Forsyth and Carter's (2012) 59-item scale was not chosen. However, the CDS was developed using samples of people of color broadly, and thus is not specifically focused on coping with gendered racism and it does not measure cultural factors that are particularly relevant for Black women's coping, such as spirituality or internal strength. The results of this study reflect mixed results in the literature as to the role of engagement and disengagement coping strategies, using a variety of coping measures, as mediators of the relations between discrimination and mental health. Currently, there are measures that assess coping without regard for cultural variables (e.g., COPE Inventory; Carver et al., 1989), or focus only on one aspect of culture (i.e., race, such as the Africultural Coping Systems Inventory (Utsey, Adams, et al., 2000). Future research should consider ways to capture how Black women cope with gendered racism to aid in quantitative research on Black women's gendered racial experiences (i.e., scale development).

Lastly, though the PCL-5 is the most commonly used trauma measure within discrimination research, the questions reflect *DSM-5* (American Psychiatric Association, 2013) criteria of posttraumatic stress disorder and are not culturally attuned to the ways people of color and other marginalized group members are impacted by discrimination. The PCL-5 was chosen given its strong internal consistency across studies involving diverse samples and its ease of

interpretation and administration for participants. This scale was modified to better reflect experiences of gendered racism; rather than the standard Criterion A questions, participants were given an open-ended prompt to describe a particularly memorable example of gendered racism. This modification allowed us to prompt participants to think of this experience and other similar experiences while responding to the traumatic stress questions. Moreover, our modification mirrored other scales that assess for discrimination-related coping and traumatic stress experiences (Carter et al., 2013; Forsyth & Carter, 2012). Adapting Carter and colleagues' (2013) Race-Based Traumatic Stress Symptom Scale was ultimately not considered due to considerations of participant fatigue, though this scale was similarly developed using a sample of people of color and white individuals. Future research should consider developing a quantitative measure of the psychological impacts (namely, traumatic stress) of gendered racism for Black women, with attention toward sufficiently capturing these experiences in a more concise manner to prevent response rate decline and participant fatigue.

Implications for Practice and Advocacy

These findings have important implications for clinical practice and larger advocacy work. Psychologists should be cognizant of the myriad, sometimes conflicting beliefs and attitudes Black women may hold regarding coping with gendered racism and other forms of stress. For example, within a therapeutic context, it would be beneficial to utilize culturally appropriate interventions to facilitate clients' exploration of how they cope and highlight underlying beliefs that influence coping (e.g., internalizing the Strong Black Woman schema). It is important to be mindful of the complexity of gendered racial identity and allow Black women to hold space for aspects that can be perceived as both beneficial and harmful, but nonetheless important to their identity. In a group therapy context, consciousness-raising interventions can

allow Black women and other women of color to connect through shared experiences and move toward externalizing rather than internalizing distress. This reframing may help Black women move away from disengagement and toward engagement coping strategies.

Though addressing intersectional oppression in a clinical setting is important, therapy can replicate oppressive dynamics and cause harm (e.g., Greene, 1996; Mazzula & Nadal, 2015; McNair, 1992; Owen et al., 2014). Individual and group therapy interventions may help raise individual awareness and offer new ways of coping; however, therapeutic interventions take an individualistic approach to broader, systemic problems. Additionally, while consciousness-raising can occur in therapy, it is considered to be a lifelong process that occurs within and between marginalized communities in largely non-therapeutic contexts (L. S. Brown, 2018; Charmaz, 2017; Diemer et al., 2006; Prilleltensky, 2003; Mosley, 2021). Psychologists must recognize and accept the limits of the therapeutic space in addressing these issues and utilize advocacy on local and national levels as an additional tool to improve client wellbeing. For example, psychologists could contribute to improving workplace discrimination policies to be more inclusive of microaggressions and the impact of cumulative experiences. Psychologists could also join a community coalition or advisory board and assist with periodic needs assessments designed to identify pertinent issues and advocate for solutions based on lived experiences of community members.

Conclusion

These findings further illustrate a link between gendered racial microaggressions and traumatic stress and expands upon the literature by suggesting a complex role of the Strong Black Woman schema and womanist attitudes for Black women. Additionally, our findings indicate that certain aspects of coping may be more salient for Black women in the context of the

SBW schema and womanist attitudes, such that Black women may utilize coping strategies based on their internalization of the need to be self-sufficient as well as their ability to situate gendered racism in a broader, systemic context. This study highlights the need for researchers to continue to explore both exacerbating and buffering factors in the link between discrimination and negative mental health outcomes for Black women. Moreover, it is equally important to explore positive mental health outcomes for Black women, such as measures of flourishing and posttraumatic growth. Future research should also explore the interactional nature between womanist attitudes and the SBW schema for Black women, as they are both salient aspects of identity that can have a range of impacts on wellbeing.

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APPENDICES

APPENDIX A: LITERATURE REVIEW

This chapter is a review of extant literature regarding racism, sexism, gendered racism, coping with discrimination, womanist attitudes, the “Strong Black Woman” schema, and traumatic stress symptoms. First, important theoretical conceptualizations of the deleterious effects of racism in the lives of African Americans will be presented, followed by a review of empirical evidence that supports these theoretical models. Subtle forms of racism (i.e., racial microaggressions) are highlighted due to their significance in the current study. Next, theoretical foundations within sexism research are explored, followed by a review of empirical evidence on the negative effects of sexism in the lives of women. Limitations within both racism and sexism literature are highlighted, namely the lack of intersectional analysis that does not fully capture Black women’s experiences with discrimination. Intersectionality theory is offered as an important framework for exploring Black women’s gendered racial experiences. Specifically, the current study applies an intersectional framework to the biopsychosocial model of perceived racism (Clark, Anderson, Clark, & Williams, 1999) and Harrell’s (2000) multidimensional conceptualization of racism-based stress.

Next, this chapter explores traumatic stress symptoms as a psychological distress outcome that is a largely overlooked, but growing area of study within the literature on the discrimination-mental health link. Alternative models of trauma are briefly presented, including Carlson’s (1997) model which serves as a conceptual framework for the current study. Then, the literature on coping is reviewed as it relates to the ways in which African Americans, with particular attention to African American women, cope with discrimination. Lastly, womanist attitudes and the “Strong Black Woman” schema are explored as two possible moderating variables that are especially relevant for Black women and may influence how they cope with

discrimination. Taken together, extant theoretical and empirical research from these bodies of literature provide a strong rationale for investigating the moderating roles of womanist attitudes and the “Strong Black Woman” schema within the mediational pathway between gendered racial microaggressions, coping, and traumatic stress symptoms.

Racism and Racism-Related Stress

Within the large body of literature on racism and racism-related stress, scholars have explored how racism functions in society and how it influences the mental and physical wellbeing of people of color. *Racism* can be defined as “the transformation of race prejudice and/or ethnocentrism through the exercise of power against a racial group defined as inferior, by individuals and institutions with the intentional or unintentional support of the entire culture” (J. M. Jones, 1972, p. 112). Jones’ (1997) pivotal tripartite model of racism describes discrete, yet interlinked levels of racism in society: individual (personal beliefs of racial superiority of one’s own group over others), institutional (systemic mechanisms of maintaining inequality, such as through infringing on rights, mobility, and access), and cultural (individual and institutional ethnocentrism). This model provides a strong foundation for understanding the multidimensional nature of racism and how to explore it through empirical research.

Much of the literature on racism focuses on individual-level expressions of discrimination (both overt and covert). There has historically been greater attention to overt racist acts and beliefs than the covert nature of racism; however, recent psychological research on the relations between racism and mental health has further explored subtle forms of racism. Pierce, Carew, Pierce-Gonzalez, and Willis (1978) described *racial microaggressions* as “subtle, stunning, often automatic, and nonverbal exchanges, which are “put downs” towards people of color” (p. 66). Building upon this foundation, Sue and colleagues (2007) extended the theory by

describing racial microaggressions as “brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color” (p. 271) which take one of three forms: microassaults (e.g., being called a racial slur), microinsults (e.g., comments that convey racially prejudiced beliefs of criminality, citizenship, cultural values and aesthetics, and intelligence), and microinvalidations (minimizing or denying the experiences of people of color). A unique aspect of racial microaggressions is that, because they can be unintentional, they are often minimized even by targets of these racial slights and insults. Thus, this trivialization of instances of racial microaggressions may compound the negative psychological effects.

There are three significant theoretical models that have provided strong foundations for exploring the effects of racism on mental health: Clark and colleagues’ (1999) biopsychosocial model of racism, Harrell’s (2000) multidimensional conceptualization of racism-based stress, and Meyer’s (2003) minority stress framework. All three of these models feature similar constructions of the relations between discrimination and overall wellbeing; however, they each approach the issue from a different perspective. Although this study is an empirical investigation using Clark and colleagues’ (1999) and Harrell’s (2000) models as a theoretical foundation, all three models are important to consider.

Clark and colleagues (1999) proposed that “the perception of an environmental stimulus as racist results in exaggerated psychological and physiological stress responses” (p. 806) that interact with factors such as coping responses, psychological and behavioral factors, and demographic characteristics. As such, there are factors that may buffer (e.g., reduce) the negative effects of racism on mental health, and there are others that may exacerbate (e.g., worsen) the effects. Extending pivotal research on stress and health (see Lazarus & Folkman, 1984; Slavin,

Rainer, McCreary, & Gowda, 1991), Clark and colleagues (1999) conceptualized racism as a repeated stressor that initiates chronic activation of stress responses that negatively impact mental and physical wellbeing over time.

Harrell's (2000) conceptualization also uses a stress and coping framework while focusing greater attention on the ways in which different forms of racism affect mental health. *Racism-related stress* is defined within this model as "the racism-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" (p. 44). Harrell described six forms: racism-related life events (specific, time-limited instances of racism such as receiving verbal abuse), vicarious racism experiences (witnessing a racist incident or a racist incident happening to your loved ones), daily racism microstressors (i.e., microaggressions), chronic-contextual stress (inequity in resources that affect quality of life, such as living conditions), collective experiences (understanding the larger impact of racism on your racial group), and transgenerational transmissions (an understanding of racism and society passed through the process of racial socialization). Within this framework, any combination of these experiences affects individuals and groups on a daily basis. Factors such as coping skills, socioeconomic status, and the concurrent experience of multiple forms of discrimination (e.g., racism and sexism, heterosexism, etc.) (Harrell, 2000). Stress occurs when an individual or community's available resources (e.g., protective mechanisms) are outweighed by the strength and frequency of a stressor (e.g., racism in a variety of forms).

Meyer (2003) developed a framework to understand how heterosexism affects LGB (lesbian, gay, and bisexual) people; however, the framework has implications for a wide range of minority groups. Within this model, antagonistic elements in the social environment (e.g.,

heterosexism) negatively affect mental health. The minority stress framework describes a pathway in which the accumulation of both general (“life”) stress and discrimination stress interacts with identity strength and salience, coping resources, social support, and negative outcome expectancy to impact mental health (Meyer, 2003). These three models have provided a solid theoretical foundation to empirically examine the relations between perceived racism and mental health.

Racism and Mental Health

Empirical studies have investigated these theoretical models, and greater perceived racism has been significantly associated with a range of negative mental health, physical health, and quality of life outcomes (e.g., Graham, West, Martinez, & Roemer, 2016; Graham, West, & Roemer, 2013; Munford, 1994; Pieterse, Carter, & Ray, 2013; Utsey, Ponterotto, et al., 2000). Additionally, several key meta-analyses have found a consistent significant relation between experiencing racism and negative mental and physical health outcomes. Williams, Neighbors, and Jackson (2003) identified 53 community-based studies that explored the relations between perceived racism and physical and mental health outcomes. Their analysis is especially important given the lack of community studies due to a variety of factors (e.g., time and cost). This study uses a community sample to address this gap in the literature. Greater perceived discrimination was positively associated with greater negative mental health outcomes (e.g., lower self-esteem, major depression, anxiety disorder, overall psychological distress), negative physical health outcomes (e.g., increased blood pressure, lower self-rated health), and greater engagement in unhealthy behavior (e.g., smoking, alcohol) (D. R. Williams, Neighbors, & Jackson, 2003). In an analysis of 138 studies, Paradies (2006) found a significant, positive relation between greater perceived racism and greater negative mental health outcomes (e.g.,

psychological/psychiatric/emotional distress, stress, depressive symptoms, somatization), negative physical health outcomes (e.g., increased blood pressure, infant low birth weight), lower quality of life indicators (e.g., lower self-esteem, lower overall mental health), and greater engagement in unhealthy behavior (e.g., cigarette smoking, alcohol (mis)use, and substance (mis)use).

Pascoe and Smart Richman (2009) found a significant relation between greater perceived discrimination and greater negative mental health outcomes (e.g., various mental illness symptomatology, greater overall psychological distress) and greater heightened stress responses. Greater perceived discrimination was also significantly related to greater negative physical health outcomes (e.g., blood pressure) (Pascoe & Smart Richman, 2009). Most recently, in a meta-analysis of 66 studies Pieterse, Todd, Neville, and Carter (2012) found a significant relation between greater perceived racism and negative mental health outcomes such that psychological outcomes (e.g., depression, anxiety, and posttraumatic stress) were more strongly associated with greater perceived racism than were quality of life indicators for Black American adults.

Racial microaggressions as racism-related stress. Much of the racism literature focuses on explicit forms of racism such as those captured by the Schedule of Racist Events (SRE; Landrine & Klonoff, 1996), the Perceived Racism Scale (PRS; McNeilly et al., 1996), and the Index of Race-Related Stress (IRRS; Utsey & Ponterotto, 1996). Recently, there has been increasing attention to the ways in which even subtle forms of racism (i.e., racial microaggressions) can negatively affect mental health. Measures such as the Racial and Ethnic Microaggressions Scale (REMS; Nadal, 2011) and the Racial Microaggressions Scale (RAMS; Torres-Harding, Andrade Jr., & Romero Diaz, 2012) were developed to capture the microaggression experiences of people of color. Several empirical studies have explored the

impact of racial microaggressions for clients of color within the therapeutic relationship; greater perceived racial microaggressions have been associated with negative perceptions of the working alliance, lower satisfaction ratings, and lower perceived general and multicultural competency of the therapist (Constantine, 2007; Mazzula & Nadal, 2015; Owen et al., 2011; Owen, Tao, Imel, Wampold, & Rodolfa, 2014). In everyday life, greater perceived racial microaggressions have been associated with a range of negative mental health outcomes (e.g., depressive symptoms, negative affect, anxiety, anger) for people of color (Blume, Lovato, Thyken, & Denny, 2012; Huynh, 2012; Nadal, Wong, Griffin, Davidoff, & Sriken, 2014; Torres, Driscoll, & Burrow, 2010).

Taken together, these studies highlight the need for continued study of the relations between greater perceived racism (both explicit and subtle forms) and mental and physical health outcomes, with attention toward variables that may buffer these relations. However, absent from these studies is specific attention to gender and the ways in which experiencing multiple forms of oppression may impact these outcomes. The next section will address sexism and explore the literature on the relations between perceived sexism and mental health outcomes.

Sexism and Sexism-Related Stress

There is a large body of literature that explores the relations between perceived sexism and negative mental health outcomes for women. Within the literature, sexism has been conceptualized as having multiple components: hostility toward women and endorsement of traditional gender norms that can be overt (e.g., hostile affect), covert (unequal, harmful treatment of women in a hidden manner), or subtle (i.e., gender microaggressions) (Benokraitis & Feagin, 1999; Swim & Campbell, 2008; Swim & Cohen, 1997; Swim, Mallett, & Stangor, 2004). In accordance with the changing social environment in the United States, blatant sexism

(also termed *overt sexism*, *traditional sexism*, *old-fashioned sexism*, and *hostile sexism*) began to fall out of public favor. This gave rise to *benevolent sexism* which describes a form of sexism that appears benign or even positive by the recipients (women), but is still discriminatory (Glick & Fiske, 1996). There are other terms for the ways sexism appears in contemporary society, such as *modern sexism* (e.g., denying the existence of contemporary sexism, being unsupportive of policies), and *neosexism* (a cognitive dissonance in which one believes in an equal society while holding underlying hostile sexist beliefs) (Glick & Fiske, 1996; Swim, Aikin, Hall, & Hunter, 1995; Tougas, Brown, Beaton, & Joly, 1995). Although earlier measures of sexism were designed to capture the nature of sexist beliefs held by both women and men. However, exploring the ways in which these sexist beliefs negative influence women's mental health is also important. While much of the sexism literature focuses on describing the changing nature of sexist beliefs, there is also considerable empirical study of the relations between perceived sexism and negative mental health for women.

Sexism and Mental Health

The Schedule of Sexist Events (SSE; Klonoff & Landrine, 1995) was designed to capture women's experiences of everyday sexism. The SSE encompasses four categories of sexist experiences: sexist degradation and its consequences, sexist discrimination in distant relationships, sexism in close relationships, and sexist discrimination in the workplace (Klonoff & Landrine, 1995). This pivotal scale is used in much of the empirical research on the effects of sexism on mental health. However, there are other scales that capture more specific forms of sexism (e.g., sexual harassment, sexual objectification, etc.) that have greatly contributed to our understanding of the link between sexism and mental health as well. Greater perceived sexism has been associated with greater negative mental health outcomes such as premenstrual,

depressive, obsessive-compulsive, and somatic symptoms (Landrine et al., 1995), body shame and self-surveillance (Calogero & Jost, 2011), and overall psychological distress (Landry & Mercurio, 2009; Moradi & Funderburk, 2006; Moradi & Subich, 2004). Moradi and Funderburk (2006) argued that measures of psychological wellbeing and measures of psychological distress should be parsed out; the findings from their study build upon earlier research that demonstrate consistent, significant relations between perceived discrimination and distress (e.g., depressive symptoms) versus the relations between perceived discrimination and wellbeing (e.g., self-esteem) (e.g., Cassidy, O'Connor, Howe, & Warden, 2004; Fischer & Shaw, 1999; Utsey et al., 2000).

Empirical studies have explored the relations between sexism, racism, and psychological distress for African American women. Greater perceived racism and perceived sexism have been associated with greater negative mental health outcomes such as overall psychological distress (Moradi & Subich, 2003; Szymanski & Stewart, 2010). Both Moradi and Subich (2003) and Szymanski and Stewart (2010) found that sexism contributed more to psychological distress for African American women than did racism. The results from these studies suggest that African American women have unique experiences with multiple forms of oppression and that these experiences warrant further empirical exploration.

Gender microaggressions as sexism-related stress. There is currently no measure designed specifically to capture gender microaggressions experiences. However, there is both theoretical and empirical support for the existence of gender microaggressions and their effects on mental health. Although there is a lack of attention specifically toward the relations between gender microaggressions and mental health outcomes, there is empirical support for an association between greater perceived gender microaggressions and overall poorer psychological

wellbeing (Nadal, 2010; Nadal & Haynes, 2012). In a qualitative investigation, Capodilupo and colleagues (2010) identified several categories of gender microaggressions: assumption of traditional gender roles, assumption of inferiority, sexual objectification, sexist language, second-class citizen, and environmental microaggressions. These categories had been previously identified within the literature (e.g., Sue & Capodilupo, 2008) and represent similar themes found in early conceptualizations of sexism (e.g., Glick & Fiske, 1996; Swim, Hyers, Cohen, & Ferguson, 2001; Tougas et al., 1995); however, they also found evidence of an additional “leaving gender at the door” category similar to “color blind” racial ideology. The nature of gender microaggressions and the relations between gender microaggressions and mental health warrant further theoretical and empirical investigation.

Within sexism literature, there is a lack of attention toward race and the experiences of multiple oppression for women of color. Many of the studies include samples that are nearly all-white or unequal in racial diversity (e.g., (Berg, 2006; Klonoff & Landrine, 1995). However, contemporary empirical studies support a unique experience of women of color that differs from that of white women due to the intersection of racism and sexism (e.g., Moradi & Subich, 2003; Szymanski & Gupta, 2009; Szymanski & Stewart, 2010; Watson, DeBlaere, Langrehr, Zelaya, & Flores, 2016). Because of this intersection, it is important that racism and sexism are explored together for African American women. The next section will explore the theory of *intersectionality* and how it is applied to empirical research of African American women’s experiences.

Intersectionality and Gendered Racism

Research on African American women’s experiences has taken a number of approaches to exploring the dynamics of both race and gender. Crenshaw (1989) introduced the term

intersectionality to the discourse by framing African American women's experiences as greater than the sum of racism and sexism. Intersectionality theory argues that Black women experience a unique form of oppression as *Black women*, and that Black women's experiences cannot be wholly understood without an intersectional lens. While Crenshaw (1989) introduced the term *intersectionality* into popular discourse, the concept is not new among Black feminist scholars. Sojourner Truth's (1851) speech at a Women's Rights Conference critiqued contemporary notions of womanhood and women's rights advocacy that excluded issues specific to Black women—namely, slavery and emancipation. By calling attention to both patriarchy and racism, her declarations were critical to bringing Black women's issues to the forefront.

Black feminist scholars have built upon this earlier work, calling for a reexamination of the conceptualization of oppression to include interlocking systems of oppression and how they interact with each other (e.g., Beale, 1970; Collins, 1991). Beale (1970) declared that Black women experience a sort of “double jeopardy,” in which they experience the accumulative effects of simultaneous racist and sexist oppression; Beale (1970) highlighted the ways in which Black women are uniquely impacted by economic exploitation, reproductive injustice, racial insensitivity of the women's movement, and patriarchy within the Black community. Hull, Bell-Scott, and Smith's (1982) seminal anthology of Black women's studies further contributed to the scholarship on gendered racism and intersectionality. Taken together, these works signify that Black women experience a unique form of oppression that is both similar to and different from white women and Black men.

Scholars across disciplines have taken varied approaches to exploring Black women's gendered racial experiences. The three main approaches are additive (i.e., double jeopardy), interactional, and intersectional. The additive and interactional approaches are similar to each

other in that they both view racism and sexism as discrete, mutually exclusive phenomena that interact with each other in some way. Within an additive approach, racism and sexism are viewed as having a cumulative effect for Black women; thus, Black women deal with a sort of “double jeopardy” as they experience racism and sexism simultaneously (Beal, 1970; St. Jean & Feagin, 1998). This approach also assumes that each of these discrete entities would have an equal impact on Black women. Within an interactional approach, racism and sexism are viewed as having a multiplicative effect, producing unique combinations of oppression experiences for Black women (St. Jean & Feagin, 1998).

An intersectional approach is unique from an additive and interactional approach because it views racism and sexism as producing a unique construct that is separate from racism and sexism altogether (Bowleg, 2008; Bowleg & Bauer, 2016; Lewis & Grzanka, 2016; Shields, 2008; Thomas et al., 2008). Intersectionality focuses on overlapping systems of oppression that are constant and have cumulative effects regardless of how salient a particular identity is for an individual or marginalized community (Andersen & Collins, 2004). In other words, though a Black woman may subjectively appraise one aspect of her identity (e.g., race) as being more salient in a given context, other systems of oppression are still acting in overlapping ways. In this way, intersectionality theory balances honoring individual subjective experience with an understanding of the complex nature of multiple systems of oppression.

Scholars within psychology have begun to incorporate intersectionality theory into their research on multiply marginalized individuals and communities. Else-Quest and Hyde (2016) highlight the challenges in implementing an intersectional approach in quantitative psychology when there are a variety of ways researchers interpret intersectionality based on their existing epistemology (e.g., standpoint, positivism, and social constructionism). Some of these

epistemologies lend themselves to incorporating an intersectional framework, while others are less flexible. Cole (2009) offered guidelines for researchers when developing and conducting research studies in the field of psychology. Psychologists should always be mindful of three things: who is included and excluded from the sample based on eligibility criteria, the role of systems of oppression for the population of study, and an understanding of the similarities between systems of oppression (Cole, 2009). Both of these commentaries push psychologists to think critically about their research in the context of systems of oppression in larger society. There are ways that psychologists can work to understand and combat these systems by active engagement and self-assessment. There are also ways that psychologists can recreate these dynamics of oppression on a smaller scale due to a lack of critical examination and reflection.

Terms such as *gendered racism* (Essed, 1991) and *ethgender discrimination* (Jeffries & Ransford, 1980) have been used to describe this unique form of oppression for Black women. Gendered racism describes the simultaneous experience of the interlocking systems of racist and sexist oppression (Essed, 1991). Additionally, Black feminist scholars have paid particular attention to the ways in which Black women are uniquely affected by sexual violence; *racialized sexual harassment* is a form of gendered racism that describes the interlocking systems of racial harassment and sexual harassment, in that "...for many African American women, the issue of sexual harassment seems inextricably intertwined with racism" (Mecca & Rubin, 1999, p. 817). Empirical evidence supports a differential experience for African American women, wherein their experiences of sexual harassment are objectively and subjectively dissimilar from those of white women (Buchanan & Ormerod, 2002). Hull, Bell-Scott, and Smith (2000) described the national mobilization of Black feminists during the confirmation hearings of Supreme Court Justice Clarence Thomas amidst sexual harassment claims by Anita Hill, further highlighting the

significance of using intersectionality theory to understand Black women's experiences. Qualitative empirical studies indicate that Black women may have difficulty in naming an experience as only racist or only sexist (e.g., C. Jones & Shorter-Gooden, 2003; King, 2005), suggesting that Black women experience a unique form of oppression that cannot be parceled into discrete, mutually exclusive categories. King (2005) found that Black women participants often labeled experiences as both racist and sexist, and attributed the racism aspect, but not necessarily the sexism aspect, as being more directly related to their subjective appraisal of distress. Results from these studies provide support for earlier Black feminist theoretical work and underscore the idea that Black women experience a form of oppression because they are *Black women*, not because they are Black and a woman.

Gendered Racism and Health

There is empirical evidence from quantitative research to support a significant association between gendered racism and negative mental health outcomes for Black women. Greater experiences of both explicit and subtle forms of gendered racism (i.e., gendered racial microaggressions) are related to greater depression, psychological distress, anxiety, and posttraumatic stress symptoms (Carr, Szymanski, Taha, West, & Kaslow, 2014; Lewis et al., 2017; Moradi & Subich, 2003; Szymanski & Stewart, 2010; Thomas et al., 2008; L. B. Watson et al., 2016). Additionally, Buchanan and Ormerod (2002) found that racial and sexual harassment significantly contributed to psychological distress for Black women, with cross-racial sexual harassment being appraised as more stressful. Cross-racial sexual harassment has been linked to greater traumatic stress symptoms for Black women (Woods, Buchanan, & Settles, 2009).

However, the lack of intersectional measures is a limitation in quantitative research on Black women's experiences of gendered racism and its effects on mental health and wellbeing. Researchers have taken a variety of approaches in addressing this limitation at both the measurement level and the data analysis level. At the measurement level, researchers have used methods such as: modifying language in existing scales (e.g., changing "woman" or "Black" to "Black woman"; Thomas et al., 2008), using multiple scales in which some are intersectional and some are not (e.g., Carr et al., 2014), and using modified versions of existing measures that have been empirically validated on multiethnic samples (e.g., Stevens-Watkins, Perry, Pullen, Jewell, & Oser, 2014). At the data analysis level, researchers have used an interactional approach (e.g., concomitant analyses) to explore multiple aspects of oppression simultaneously for Black women (e.g., Moradi & Subich, 2003; Szymanski & Stewart, 2010). Given these alternative approaches, there are still limitations to how results of these studies can be interpreted. For example, Moradi and Subich (2003) and Szymanski and Stewart (2010) found that sexism predicted psychological distress for Black women, whereas racism did not. This is contrary to qualitative research that has found racism or gendered racism to be identified as more salient to distress (e.g., C. Jones & Shorter-Gooden, 2003; King, 2003, 2005).

Despite the strong body of empirical evidence of the link between discrimination and mental health, the problem of a lack of intersectional measures adds limitations on how researchers can interpret results of these studies. Moreover, much of the research on discrimination and mental health, there is a lack of attention to traumatic stress as a mental health outcome. The next section will explore the literature on oppression and traumatic stress, examining both theoretical and empirical work in this area.

Oppression and Traumatic Stress

The following section explores the application of trauma and traumatic stress theory to systems of oppression, highlighting the different perspectives among scholars on how to approach this topic empirically and theoretically. Much of the literature on discrimination and its effects on mental health and wellbeing are rooted in Lazarus and Folkman's (1984) transactional conceptualization of *stress* and coping as an assessment of environmental stimuli that are cognitively appraised in two phases: primary appraisal and secondary appraisal. Primary appraisal describes the meaning individuals assign to a situation and its impact on them (e.g., a positive effect (benign-positive), not significant (irrelevant), or threatening/harmful (stressful)) (Lazarus & Folkman, 1984). After primary appraisal, secondary appraisal describes a stage in which an individual assesses what can be done about a stressful situation; in other words, what resources they have to cope with it (Lazarus & Folkman, 1984). Stress theory argues that individuals are constantly evaluating the environment and responding to stimuli even on an unconscious basis; many of these stimuli are benign or represent a "normal" level of stress. However, trauma is a more severe form of stress that has been conceptualized as both posttraumatic stress disorder (PTSD) and *traumatic stress*. This study seeks to explore the relations between subtle gendered racism and traumatic stress for Black women.

Many theoretical scholars have posited a direct relation between experiencing racism and traumatic stress (Bryant-Davis & Ocampo, 2005b, 2005a; Comas-Díaz & Jacobsen, 2001, p.; Scurfield & Mackey, 2001). Within racism literature, there is a growing body of theoretical and empirical research that explores racism as either a form of trauma in itself, or as a stressor that can produce trauma symptoms (typically after repeated experiences) (Alessi et al., 2013; Carter, 2007; Ford, 2008; Khaylis et al., 2007). Some have argued for the inclusion of discrimination as

a qualifying traumatic event in Criterion A of the PTSD Symptom Checklist and other diagnostic scales used for clinical diagnosis of PTSD (e.g., Holmes et al., 2016) while others have criticized the “medicalization” of oppression, arguing that it divorces oppression from social context and places a focus on individuals (e.g., Gilfus, 1999). There is a similar trend within feminist psychology and literature on sexism, in which there are a few major lines of thought: that diagnoses that are more frequently given to women simply represent compensatory reactions to traumas and should be viewed as such; that the clinical definition of trauma places focus on a supposed dysfunction in the individual, which ignores environmental and systemic factors and de-politicizes them; and that a PTSD diagnosis can benefit women and other marginalized groups because it can serve as a sort of indictment of the cruelty of systemic oppression (Berg, 2002). Regardless of the theoretical conceptualization, there is empirical evidence to support a significant association between experiencing discrimination and traumatic stress symptoms.

While there is greater attention towards the relations between perceived discrimination and mental health outcomes such as depression and anxiety, there is also a growing body of literature that demonstrates a strong association between discrimination and traumatic stress. Sexism, racism, and the experience of multiple oppressions have been significantly related to greater traumatic stress symptoms for individuals from marginalized communities (Berg, 2006; Moody & Lewis, 2019; Torres & Taknint, 2015; L. B. Watson et al., 2016). Moody and Lewis (2019) found an association between gendered racial microaggressions and traumatic stress, such that Black women who reported greater frequency of gendered racial microaggressions also reported greater traumatic stress symptoms; Black women who identified as sexual minorities reported significantly greater traumatic stress symptoms compared to Black heterosexual women. In a study of ethnic microaggressions among Latinx individuals, Torres and Taknint

(2015) found a significant association between greater microaggression experiences and traumatic stress. These two studies provide evidence that even subtle forms of discrimination can accumulate and produce traumatic stress symptoms.

There is also empirical evidence that shows people of color experience PTSD at higher rates compared to white individuals for similar traumatic experiences (e.g., military trauma or robbery), even when controlling for factors such as poverty and substance abuse (e.g., Frueh et al., 1998, 2002; Kulka et al., 1990; Ruef et al., 2000). There is a wide range of estimated lifetime rates of PTSD (5% – 39%; Breslau, 2001); however, an average of 5% – 10% of people develop PTSD after experiencing a clinically qualifying traumatic event (Norris, Friedman, & Watson, 2002; Norris, Friedman, Watson, et al., 2002). However, although white individuals are more likely to be exposed to traumatic events than people of color, the impact of these events (e.g., development and severity of PTSD, and impact on functioning) has been found to be greater for people of color (Norris, 1992). In a prospective, observational longitudinal study of Black, Latinx, and white individuals, Sibrava and colleagues (2019) found significant differences in reported PTSD symptoms between the three groups, with racial discrimination predicting PTSD outcomes for Black and Latinx participants. These studies provide support for further research into the relations between discrimination and traumatic stress for people of color and other marginalized individuals.

The relations between discrimination and traumatic stress can be conceptualized from an *insidious trauma* standpoint, which recognizes the cumulative effects of discriminatory events that, in isolation, may not be enough to trigger a traumatic stress response on their own (L. S. Brown, 2013; Root, 1992, 2001). The concept of insidious trauma is especially relevant to the study of microaggressions and their impact on mental health and wellbeing. Other factors that

have been suggested to influence the differential traumatic stress outcomes for people of color have been factors such as: cultural protective factors (e.g., socialization), context (e.g., a physical assault versus a physical assault that was motivated by racism), and culture-specific responses to stressful and traumatic events (Carter, 2007; Milan, Zona, Acker, & Turcios-Cotto, 2013). Scholars have also posited a methodological critique, such that previous studies have used measures that solely focus on the individual at the expense of recognizing larger systemic factors (e.g. Norris, Friedman, Watson et al., 2002). Additionally, the lack of measures that can capture multiply marginalized individuals' experiences from an intersectional perspective is another factor absent from this body of work.

Alternative Models of Trauma

Several scholars have put forth alternative models of trauma that take a more holistic, systemic approach to understanding traumatic events and how they influence an individual's mental health and wellbeing. Notably, Carlson (1997), Kira (2001), and Carter (2007) developed models that were more flexible in their classification of a traumatic event, allowing the subjective appraisal of the individual to take precedence. These models move beyond the traditional clinical definition of a single traumatic event in which there was actual or threatened serious bodily harm, death, or sexual violence (criteria from the *Diagnostic and Statistical Manual of Mental Disorders*). Kira (2001) conceptualizes these experiences in terms of their impacts over the lifespan, and in areas such as attachment, autonomy or identity, interdependence, achievement or self-actualization, and survival. Additionally, Kira (2001) specifically identifies the intergenerational transmission of historical traumas such as slavery and genocide as traumatic events, thereby subverting the clinical definition of trauma as direct, individual exposure.

Carlson's (1997) model provides a strong framework for understanding the impact of racism-based traumatic stress due to three core components: 1) a prioritization of the subjective appraisal of the event as stressful or traumatic, 2) an understanding that the unpredictability of racist events contributes to their distressing properties, and 3) an understanding that the subjective appraisal of racist events as being uncontrollable also contributes to distress. These components are important because they transfer power to people of color by prioritizing their subjective experiences and viewing their traumatic stress in context of larger systems of oppression, thereby removing the source of dysfunction from the individual to society at large.

Building from this previous research, Carter's (2007) major contribution conceptualizes racism as a *psychological injury* that, cumulatively can produce traumatic stress symptoms. One major critique of the literature is that often, there are symptoms of traumatic stress that are measured as outcomes in research on discrimination and mental health but are not conceptualized together as traumatic stress (e.g., somatization, anxiety, and interpersonal sensitivity; Carlson, 1997; Moreau & Zisook, 2002). This is in part due to the narrow conceptualization of trauma and traumatic stress, such that only a few key symptoms are considered to be "classic" trauma responses. However, Carter (2007) developed a nonpathological framework for viewing responses to psychological injury of racism. Similar to other models, this framework uses the individual's subjective appraisal of an event (either emotional or physical pain) as identification of a traumatic event.

Carter's (2007) model draws from earlier racism and racism-related stress research in that there are different manifestations of racism (racial harassment, racial discrimination, and discriminatory harassment) which represent interpersonal, institutional, and cultural levels manifestations described by earlier scholars (e.g., Harrell, 2000; J. M. Jones, 1972, 1997). Carter

(2007) includes “symptom clusters” that are broader than the four typically used in clinical diagnosis: increased vigilance, activism, spiritual coping, flashbacks and nightmares, depression, withdrawal, and more critical signs such as avoidance, intrusion, and arousal (Carter, 2007). Most importantly, Carter (2007) critiqued the hierarchy often assigned to different types of racist incidents (e.g., physical versus verbal assault, overt versus covert), arguing that the severity of an event is determined by an individual’s appraisal of severity; additionally, Carter (2007) recognized the cumulative impacts of relatively “benign” incidents that accumulate over the lifetime.

Despite the significance and contribution of these theoretical models, there is a disconnect between theoretical conceptualization and application of these principles in empirical research on the relations between discrimination and traumatic stress. While both racism and sexism literature have highlighted the link between oppression and trauma, there is currently very little attention to the intersectional nature of oppression and how that may manifest as traumatic stress. Very few studies (for exceptions, see Moody & Lewis, 2019; Watson et al., 2016) have examined this specifically for Black women and other women of color. This study seeks to fill this gap in the literature by further exploring the relations between gendered racial microaggressions and traumatic stress symptoms. Beyond exploring the microaggressions-trauma link, this study also seeks to explore variables that may serve as protective or exacerbating factors for Black women.

Coping

The literature on coping with discrimination is largely grounded in Lazarus and Folkman’s (1984) secondary appraisal stage, in which an individual utilizes coping resources after they have appraised a given situation. The chronic nature of discrimination makes it a

unique stressor compared to more traditional types of stressful or traumatic events. Moreover, discrimination can be particularly stressful because it targets not only the individual, but a group that the individual belongs to (Miller & Kaiser, 2001). In other words, both a person's individual and collective identity are being threatened, which can cause experiences of racism to be particularly stressful for those who are targeted.

Coping strategies have historically been described as: active or problem-focused coping (i.e., taking efforts to address the problem directly), passive or avoidant coping (i.e., disengaging from the problem, avoiding addressing it, and emotion-focused coping (i.e., taking efforts to manage one's emotional distress); however, it is always important to consider contextual factors of a given situation. Folkman and Lazarus' (1988) revised version of the Ways of Coping Checklist contained eight types of coping strategies: confrontive coping (i.e., directly addressing the problem), distancing, self-controlling, seeking social support, accepting responsibility, escape-avoidance, planful problem-solving, and positive reappraisal. Carver, Scheier, and Weintraub (1989) identified 13 common clusters of coping responses in the development of the COPE Inventory. These clusters include avoidant, problem- and emotion-focused coping strategies such as seeking social support, venting one's emotions, turning to religion and spirituality, drug and alcohol use, denial, disengagement, and positive reappraisal. Many of these clusters identified by Carver and colleagues (1989) can be mapped onto Folkman and Lazarus' (1988) conceptualization of coping strategies.

Within Clark and colleagues' (1999) biopsychosocial model of perceived racism, coping is conceptualized as a partial mediator of the relations between appraisal of a racist event and stress responses. Empirical evidence indicates that African Americans may tend to use different coping strategies for racism-related stress than for general life stress (T. L. Brown et al., 2011;

Hoggard et al., 2012). Quantitative and qualitative studies show that African American women cope with experiences of gendered racism using a unique combination of coping and resistance strategies such as religious coping, social and racial community support, direct challenging (i.e., standing up for oneself), denial, desensitization and escape, harnessing self-esteem and self-worth, and maintaining a positive attitude (Lewis et al., 2013; Shorter-Gooden, 2004; Utsey, Ponterotto, et al., 2000; Ward et al., 2009; Ward & Heidrich, 2009). Empirical evidence supports a partial mediating effect of cognitive-emotional coping (Thomas et al., 2008), negative religious coping (Szymanski & Obiri, 2011), and detachment and internalization (self-blame) (Szymanski & Lewis, 2016) in the relations between gendered racism and psychological distress for African American women. In other words, perceived discrimination is both directly and indirectly (via these coping strategies) related to negative mental health outcomes.

Lazarus and Folkman (1984) argued for the need for specificity in coping research, noting that particular coping responses that an individual may engage in depends on the specifics of the stressor. Empirical evidence of coping among African Americans highlights the importance of greater nuance and specificity in our understanding. Wei and colleagues (2010) identified five domains of racial discrimination coping among a sample of people of color: Education/Advocacy, Resistance, Internalization, Drug and Alcohol Use, and Detachment. Wei and colleagues' (2010) Coping with Discrimination Scale (CDS) has been used with diverse samples of people of color to explore the ways in which they cope with racism (e.g., Carr, Szymanski, Taha, West, & Kaslow, 2014; Szymanski, Dunn, & Ikizler, 2014; Wei, Heppner, Ku, & Liao, 2010). This study will use the CDS scale to explore the mediating role of coping strategies in the relations between gendered racial microaggressions and traumatic stress for African American women. The next few sections highlight two potential variables that might

moderate the mediational pathway between gendered racial microaggressions, coping, and traumatic stress: womanist attitudes and the Strong Black woman schema.

Black Women's Gendered Racial Identity

Womanist Attitudes

Feminist identity attitudes encapsulate an individual's awareness and understanding of gender oppression in society. Within the literature, several main subgroups of feminist thought have been identified: liberal (a belief that cisgender men and women are inherently the same and that social policy is the vehicle for social change), radical (gender oppression is seen as the "first," most widespread and deeply rooted oppression upon which other oppressions were modeled after), socialist (class, race, and gender oppression are viewed as equally contributing and inseparable), cultural (places an emphasis on "masculine" versus "feminine" cultural values that can be held by a person of any gender), and women of color feminism (termed *womanism* by Walker (1983); views oppression from an intersectional framework, noting unique experiences of oppression of women of color along race, gender, and class lines) (Bart, 1991; J. Donovan, 1985; Jaggar & Rothenberg, 1993; Walby, 1990; Walker, 1983). Feminist scholars have explored feminist identity and feminist attitudes as a possible protective factor in the relations between perceived sexism and negative psychological outcomes.

There are many different ways scholars have conceptualized womanist identity and attitudes within empirical research. In conceptualizing feminist attitudes, Henley, Meng, O'Brien, McCarthy, and Sockloskie (1998) developed the Feminist Perspectives Scale (FPS) using samples of men and women. The FPS includes seven subscales: conservative perspective, liberal feminist perspective, radical feminist perspective, socialist feminist perspective, cultural feminist perspective, women of color perspective, and fembehave (a measure of both intentional

and unintentional behavior) subscale (Henley et al., 1998). The Womanist Identity Attitudes Scale (WIAS; Ossana, 1986; Ossana et al., 1992) was developed to operationalize womanist identity as well. However, later research on the validity of the WIAS' factor structure raised questions about the validity of the scale (Moradi, Yoder, & Berendsen, 2004). Nonetheless, these scales have contributed to the literature by attempting to operationalize feminist and womanist identity to be used in quantitative research.

The women of color perspective subscale of the FPS is the most widely used in research exploring womanist identity attitudes as a buffer, and empirical evidence supports a buffering effect for a range of outcomes ranging from mental health to job satisfaction, such that there is a weaker, if not nonexistent relation between multiple oppression experiences and these outcomes (Chadwick & DeBlaere, 2019; DeBlaere & Bertsch, 2013; Velez et al., 2018). These findings indicate that promoting greater contextualization of women of color's experiences with interlocking systems of oppressions can be a way to combat the deleterious effects of gendered racism.

Although there are empirical studies that have explored womanist identity attitudes as a buffer, there is still a dearth of research in this area, especially as it relates to African American women. Additionally, though the FPS is not a measure that was developed solely using samples of African American women or women of color, the items of the FPS represent an understanding of the ways in which other systems of oppression (e.g., racism) interact with sexism for women of color. Therefore, this study will use this subscale to explore womanist identity as a moderator of the coping-mediated association between gendered racial microaggressions and traumatic stress.

The “Strong Black Woman” Schema

There are several predominant caricatures of Black womanhood within American society: *Superwoman* (able to handle multiple problems at once, including others’ issues, with little to no help), *Mammy* (a subservient, matronly woman who takes care of others to her own detriment), *Sapphire* (aggressive, emasculating, hostile, angry), and *Jezebel* (sexually aggressive, promiscuous, and hypersexual) (Abdullah, 1998; Bell, 1992; Greene, 1994; C. Jones & Shorter-Gooden, 2003; McNair, 1992; Mitchell & Herring, 1998; C. M. West, 1995). The Mammy and Superwoman caricatures are especially relevant to Black women and coping, as they describe expectations that Black women are emotionally strong enough to handle issues on their own while still managing other areas of their life. This coincides with African American women’s gendered racial socialization process, which includes being socialized to appear strong, resilient, and self-sufficient, even if that is not a reflection of how one feels internally (Shorter-Gooden & Jackson, 2000). Moreover, Black women are viewed by others as being unaffected by hardships and able to withstand great burden (C. Jones & Shorter-Gooden, 2003).

Qualitative studies have explored Black women’s positive appraisal of the “Superwoman” or “Strong Black Woman,” such that Black women view strength as an important component of their identity (Abrams et al., 2014; C. Jones & Shorter-Gooden, 2003; N. N. Watson & Hunter, 2016; L. M. West et al., 2016). Traits Black women have identified as being important to what it means to be a Black woman include being hardworking, caring, possessing multiple forms of strength, asserting and strong, possessing pride, and embracing religion and spirituality (Abrams et al., 2014; L. M. West et al., 2016). Additionally, Black women have identified beneficial aspects of being a Strong Black Woman, including preservation of self and family, being feminine while rejecting traditional (white) femininity, and a sense of self-efficacy

(Abrams et al., 2014; N. N. Watson & Hunter, 2016; Woods-Giscombé, 2010). However, while these aspects are positive, the Strong Black Woman schema can be detrimental to Black women's mental health and self-concept.

Qualitative studies have also explored Black women's understanding of the negative effects of the Strong Black Woman schema. Black women have identified negative effects such as relationship strain (due to unequal burden), stress, depression, and other negative psychological health outcomes (Abrams et al., 2014; N. N. Watson & Hunter, 2016; L. M. West et al., 2016). Black women in N. N. Watson and Hunter's (2016) study identified three key conflicting aspects of the Strong Black Woman schema: 1) that Black women should be mentally tough, but not utilize coping strategies that can maintain mental wellness (e.g., going to counseling or show emotions to others), 2) that struggle is sometimes necessary in order to become a Strong Black Woman (e.g., personal strength develops from learning to cope with gendered racism), and 3) adhere to gender norms of being caretakers while simultaneously rejecting white hegemonic femininity (e.g., emphasizing being independent and strong). McNair (1992) explored themes unique to Black women's experiences, noting that women who internalize these beliefs of complete self-sufficiency may have difficulty seeking help due to these stereotypes and expectations of others. In L. M. West and colleagues' (2016) study, Black women reported a dual awareness of the expectations of being strong while holding negative views of engaging in certain help-seeking behaviors that could improve their personal strength. These studies highlight the complexities of the Strong Black Woman schema, emphasizing the tension between positive appraisal and self-identification with its negative psychological effects.

Quantitative studies have explored the role of the Strong Black Woman schema in Black women's lives, especially as it relates to stress and coping. Thomas and colleagues' (2004)

Stereotypic Roles for Black Women Scale captures Black women's endorsement of elements of the Mammy, Jezebel, Sapphire, and Superwoman stereotypes; higher scores indicate greater endorsement. Their findings indicated that greater levels of Mammy and Sapphire endorsement were contributors of self-esteem and uniquely contributed to variance over and above racial identity attitudes related to self-esteem (Thomas et al., 2004). Additionally, though they hypothesized that Mammy, Sapphire, and Jezebel endorsement would be negatively correlated to self-esteem and Superwoman endorsement would be positively correlated with self-esteem, they found that all four stereotypes were negatively correlated with self-esteem (Thomas et al., 2004). Within empirical research, self-esteem is sometimes used as a proxy for exploring the impact of internalizing stereotypes about one's identity group as well as the impact of repeated exposure to discrimination. For example, L. B. Watson and colleagues (2016) found that self-esteem was a partial mediator between racist experiences and greater trauma symptoms for women of color. This finding illustrates the complex influence of the Strong Black Woman schema in Black women's lives. Witherspoon, Thomas, and Speight (2006) found that Sapphire and Superwoman internalization were positively related to paranoia, hostility, depressive symptoms, and interpersonal insensitivity; additionally, greater Sapphire endorsement was associated with a significant amount of the variance in psychological distress. Findings from these studies indicate an overall negative influence of the Strong Black Woman schema on Black women's mental health.

In addition to the Strong Black Woman schema being related to negative mental health outcomes such as psychological distress and emotional dysregulation, empirical studies have explored the relations between the Strong Black Woman schema, help-seeking behaviors, and coping strategies (Harrington et al., 2010; N. N. Watson & Hunter, 2016; Woods-Giscombé,

2010). For example, Harrington and colleagues (2010) found that the Strong Black Woman schema (operationalized by combining the Mammy and Superwoman subscales) mediated the relations between 1) trauma exposure/distress and emotional inhibition/regulation difficulties and 2) trauma exposure/distress and self-silencing for trauma-exposed Black women. Additionally, they found that the relations between the Strong Black Woman schema and eating for psychological reasons was mediated by emotional inhibition/regulation difficulties (Harrington et al., 2010). These findings illustrate that the Strong Black Woman schema can have a negative influence on Black women's ability to regulation their emotions and engage in help-seeking behaviors.

This study seeks to contribute to the current understanding of the role of the Strong Black Woman schema in the lives of Black women by exploring the ways in which it influences coping behaviors. Empirical evidence illustrates the negative physical and mental health consequences of internalizing the belief that Black women must be able to handle their problems, and the problems of others (e.g., loved ones), on their own. Building on this growing body of literature, I hypothesize that the Strong Black Woman schema will moderate the coping-mediated relation between gendered racial microaggressions and traumatic stress symptoms for Black women.

In sum, existing empirical research provides strong evidence for the link between subtle and covert forms of discrimination and a range of negative mental health outcomes. However, there is still a gap in the literature regarding the experiences of multiple forms of oppression for Black women. It is important to use an intersectional framework when investigating the experiences of individuals from multiply marginalized communities. Thus, the current study uses an intersectionality framework to identify elements relevant to Black women's gendered racial experiences. The current study seeks to fill a gap in the literature by exploring several aspects

that may moderate (womanist attitudes and the Strong Black Woman schema) and mediate (coping) the relations between gendered racial microaggressions and traumatic stress.

APPENDIX B: CONSENT FORM

Consent for Research Participation

Research Study Title: Exploring How Black Women Cope with Life Stress

Researcher(s): Anahvia T. Moody, M.A., LaTrice N. Wright, M.S., and Jioni A. Lewis, Ph.D.,
University of Tennessee, Knoxville

Why am I being asked to be in this research study?

We are asking you to be in this research study because you are a Black or African American woman living in the Southeastern United States. You must be age 18 or older to participate in the study. The information in this consent form is to help you decide if you want to be in this research study. Please take your time reading this form and contact the researcher(s) to ask questions if there is anything you do not understand.

What is this research study about?

The purpose of the research study is to understand Black women's experiences of different types of stress and the ways they cope with that stress.

How long will I be in the research study?

If you agree to be in this study, your participation will last on average 30 – 45 minutes.

What will happen if I say “Yes, I want to be in this research study”?

If you agree to be in this study, we will ask you to complete an online survey. The survey includes questions about different types of stressful experiences you may have had, ways these stressful experiences may have affected you, different things you might do to cope with stress, and general questions about your background. The survey also asks information about the status and nature of your relationship with a spouse/partner. You can skip any questions that you do not want to answer.

What happens if I say “No, I do not want to be in this research study”?

Being in this study is up to you. You can say no now or leave the study later. Either way, your decision won't affect your relationship with the researchers or the University of Tennessee.

What happens if I say “Yes” but change my mind later?

Even if you decide to be in the study now, you can change your mind and stop at any time. If you decide to stop before the study is completed, then please exit out of the browser. Your answers will be destroyed, and they will not be used in our research study. If you complete the

survey and change your mind later, please contact the researcher and your answers will be destroyed.

Are there any possible risks to me?

There is no more than a minimal risk to participate in this study. Some of the survey questions are personal in nature and may make you feel uncomfortable. You can always choose not to respond to some of the survey questions. If you experience any distress or discomfort, you can contact the National Help Line at 1-800-662-HELP (4357) for additional support. You may also contact Cherokee Health Systems at (865) 544- 0406 or your local mental health agency if you live outside of the Knoxville area. The researchers can also provide you with a list of mental health resources at any time.

Are there any benefits to being in this research study?

Your participation may help us to learn more about how Black/African American women cope with different types of stress. We hope the knowledge gained from this study will benefit others in the future. However, there is no direct benefit to your participation in this study.

Who can see or use the information collected for this research study?

We will protect the confidentiality of your information by storing your online consent form and your survey responses in a secure password-protected database. Each participant will be assigned a code number. The code key that links your name to your numerical ID will be kept completely separate from your responses and will be stored in a secure, password-protected electronic database.

If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information or what information came from you. Although it is unlikely, there are times when others may need to see the information we collect about you. These include:

- People at the University of Tennessee, Knoxville who oversee research to make sure it is conducted properly.
- Government agencies (such as the Office for Human Research Protections in the U.S. Department of Health and Human Services), and others responsible for watching over the safety, effectiveness, and conduct of the research.
- If a law or court requires us to share the information, we would have to follow that law or final court ruling.

What will happen to my information after this study is over?

We will keep your information to use for contacting you in the future about other study opportunities. Your name and other information that can directly identify you (or your

partner/spouse) will be kept secure and stored separately from your research data collected as part of the study.

Will I be paid for being in this research study?

After you complete the survey, you will receive a \$10 electronic gift card for your participation.

Who can answer my questions about this research study?

If you have questions or concerns about this study, or have experienced a research-related problem or injury, contact the researchers, Anahvia T. Moody (amooddy10@vols.utk.edu), LaTrice N. Wright (lwright52@vols.utk.edu), or Dr. Jioni A. Lewis (jalewis@utk.edu). For questions or concerns about your rights or to speak with someone other than the research team about the study, please contact:

Institutional Review Board
The University of Tennessee, Knoxville
1534 White Avenue
Blount Hall, Room 408
Knoxville, TN 37996-1529
Phone: 865-974-7697
Email: utkirb@utk.edu

STATEMENT OF CONSENT

I have read this form and the research study has been explained to me. If I have any questions, I have been told who to contact. By selecting “Yes” to the following three questions, I am agreeing to be in this study. I will receive access to an electronic copy of this document for my records.

I understand that to be eligible to participate in this study, I must meet the following criteria.

1. I am at least 18 years of age or older.
 - a. Yes
 - b. No
2. I identify as a Black or African American woman.
 - a. Yes
 - b. No
3. I agree to take this survey.
 - a. Yes
 - b. No

Contact Form (at end of survey)

Thank you very much for considering our study, *Exploring How Black Women Cope with Life Stress*. Please enter the following information if you are willing to be contacted for future study opportunities. By completing this form, your identifiable data will be kept to track responses in future studies. We will protect the confidentiality of your information as noted in the consent form.

Name: _____

Phone number: (____) _____ - _____

Email address: _____

What is the best way to reach you? *Please circle all that apply:* Phone Email

APPENDIX C: DEBRIEFING RESOURCE LIST

Debriefing Resource List

Thank you for your participation in this study. Information collected from this project will help us gain a better understanding of some of the subtle forms of racism and sexism that Black women experience on a day-to-day basis.

Some of the issues raised in this study may be difficult to deal with and may have stirred up some feelings for you. If you would like to talk to someone more about these issues, here are some suggested resources. Below is a list of mental health, wellness, and educational resources for you.

Local Mental Health Resources

- You can contact the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Helpline:
National Helpline
Phone: 1-800-662-HELP (4357)
- Cherokee Health Systems offers a range of mental health services for **Tennessee** residents:
Cherokee Health Systems
Phone: 866-231-4477
Website: <http://cherokeehealth.com>
- If you are a **University of Tennessee student**, you can contact the following resource:
University of Tennessee Student Health Counseling Center
Phone: (865) 974-2251
Website: http://web.utk.edu/~shs/clinics_mental.php
- If you are a **Knoxville resident**, you can contact the following resource:
Knox County Health Department
Phone: (865) 215-5400
Website: http://www.knoxcounty.org/health/adult_primary_care.php
- The UT Psychological Clinic offers sliding scale services for members of the **Knox County/East Tennessee area**:
Phone: (865) 974-2161
Website: <https://psychclinic.utk.edu/>

National Mental Health Resources

- If you are a college student, you can contact your university Counseling Center or Student Health Center and ask to see a counselor.
- If you are a community resident, you can use the following online therapist directories to find a local mental health professional:

- **Psychology Today:** <https://www.psychologytoday.com/us/therapists>
Detailed listings for psychologists, psychiatrists, therapists and counselors are available throughout the United States and Canada.
- **Therapy for Black Girls:** <https://therapyforblackgirls.com>
Listings of Black women psychologists, therapists, and counselors available throughout the United States.
- **National Queer & Trans Therapists of Color Network:**
<https://www.nqtcn.com/directory>
Listings of queer and trans psychologists, therapists, and counselors of color throughout the United States.
- **Therapist Locator:** <http://www.therapistlocator.net/>
This directory will assist you in locating a marriage and family therapist in your area. The listed therapists are Clinical Members of the American Association for Marriage and Family Therapy.

Educational Resources

Here are some educational resources that provide additional information about some of the topics covered in this research project:

- The Mental Health Cost of Being a Strong Black Woman (by Josephine Gurch, 2019):
<https://hogg.utexas.edu/mental-health-cost-of-a-black-woman>
- Black Women: Mental Health Treatment is for Us, Too (by Lydia Blanco, 2019):
<https://www.blackenterprise.com/black-women-mental-health-treatment-is-for-us-too/>
- Why are Black Women Suffering from PTSD? (by Nareissa Smith, 2018):
<https://atlantablackstar.com/2018/04/15/black-women-suffering-ptsd/>
- Mental Health and the Current Times: Racial Trauma (by Charmaine Perry, 2017):
<https://www.counseling.org/news/aca-blogs/aca-member-blogs/aca-member-blogs/2017/12/12/mental-health-and-the-current-times-racial-trauma>
- Women's Mental Health in the African-American Community (by the American Psychological Association): <https://www.apa.org/pi/oema/resources/ethnicity-health/african-american/women-firsts>
- Mental Health Among African American Women (by Erica Martin Richards, M.D., Ph.D.): <https://www.hopkinsmedicine.org/health/wellness-and-prevention/mental-health-among-african-american-women>
- Harris-Perry, M. V. (2011). *Sister Citizen: Shame, Stereotypes, and Black Women in America*. New Haven, CT: Yale University Press.

- Sue, D. W. (2010). *Microaggressions in Everyday Life: Race, Gender, and Sexual Orientation*. John Wiley & Sons, Inc. New Jersey.
- Sue, D. W. (2010). *Microaggressions and Marginality: Manifestation, Dynamics, and Impact*. John Wiley & Sons, Inc. New Jersey.
- Jones, C. & Shorter-Gooden, K. (2003). *Shifting: The double lives of Black women in America*. New York: HarperCollins Publishers, Inc.
- Collins, P. H. (1990). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. Cambridge, MA: Unwin Hyman, Inc.
- hooks, b. (1981). *Ain't I a woman: Black women and feminism*. Cambridge, MA: South End Press.
- Lewis, J. A. Williams, M. G., Moody, A. T., Peppers, E. P., & Gadson, C. A. (2018). Intersectionality theory and microaggressions: Implications for research, teaching, and practice. In C. M. Capodilupo, K. L. Nadal, D. P. Rivera, D. W. Sue, & G. C. Torino (Eds.), *Microaggression Theory: Influence and Implications* (pp. 48-64). Hoboken, NJ: John Wiley & Sons.
- Moody, A. T. & Lewis, J. A. (2019). Gendered racial microaggressions and traumatic stress symptoms among Black women. *Psychology of Women Quarterly*, 43, 201-214. <https://doi.org/10.1177/0361684319828288>
- Williams, M. G., & Lewis, J. A. (2019). Gendered Racial Microaggressions and Depressive Symptoms Among Black Women: A Moderated Mediation Model. *Psychology of Women Quarterly*, 43(3), 368-380. <https://doi.org/10.1177/0361684319832511>
- Lewis, J. A., Williams, M. G., Peppers, E. J., & Gadson, C. A. (2017). Applying intersectionality to explore the relations between gendered racism and health among Black women. *Journal of Counseling Psychology*, 64(5), 475-486. <https://doi.org/10.1037/cou0000231>

Wellness Book List

The Value in the Valley: A Black Woman's Guide Through Life's Dilemmas by Iyanla Vanzant

- Provides descriptions of ten common life experiences that African American women face and advice on how to overcome difficulties associated with these experiences.

Sisters of the Yam: Black Women and Self-Recovery by bell hooks

- Provides information on how African American women can recover from systems of oppression such as racism, sexism, and consumer capitalism.

Rock My Soul: Black People and Self-Esteem by bell hooks

- hooks examines the political and social barriers that keep African Americans from emotional well-being.

Souls of My Sisters by Dawn Marie Daniels and Candace Sandy

- Provides a series of essays describing the emotional trials of Black women and ways in which the women were able to triumph over their pain in order to appreciate the gifts life has to offer.

Souls Revealed: A Souls of My Sisters Book of Revelations and Tools for Healing Your Spirit, Soul and Life by Dawn Daniels and Candace Sandy

- Provides coping strategies for dealing with painful experiences that may cause disruption within your life.

Your Inner Eve: Discovering God's Woman Within by Reverend Dr. Susan Newman

- Provides guidance on how African American women can increase their psychological well-being from a spiritual point of view.

Black Pain: It Just Looks Like We're Not Hurting by Terri Williams

- Describes what depression looks like within the African American community and dispels the myth of stoicism among African American men and women.

Internet Resources

- **Dear Black Women, Let's Talk about Healing | Angela Bowden (TED Talk)**
<https://www.youtube.com/watch?v=deJd1X6YW-I>
- **Blueprint for the Black Joy Era | Jazmine "Da K.O.S." Walker & Amber Phillips (TED Talk)**
<https://www.youtube.com/watch?v=ZzP3AxOmmjY>
- **Liberate Meditation (Podcast)**
<https://liberatemeditation.com/>
- **Black Girls Smile Inc.**
 - This is an organization founded in 2012 whose vision includes building towards “a society that through the normalization and dialogue surrounding mental wellness, all individuals, including young African American females would be provided the education, support and resources necessary to lead a positively mentally healthy life”. <https://blackgirlssmile.org>
- **Black Women's Health Imperative**
 - This is an online community that provides a wealth of online resources, support communities, and informative articles in order to promote physical, spiritual, and emotional health among African American women. <http://www.bwhi.org/>
- **California Black Women's Health Project**
 - Founded in 1994, the California Black Women's Health Project (CABWHP) focuses on empowering Black women to take personal responsibility for our own health and to advocate for changes in policies that adversely affect Black women's health status. <https://www.cabwhp.org>
- **Crunk Feminist Collective**
 - Online blog that discusses issues relevant to Black women from a feminist perspective that intersects issues of race and gender.
<https://crunkfeministcollective.wordpress.com/>
- **National Women's Health Information Center**

- This website provides information on special topics like mental health, pregnancy, breastfeeding, body image, HIV/AIDS, girls' health, heart health, menopause and hormone therapy, quitting smoking, and violence against women.
<http://www.womenshealth.gov/>
- **Journey to Wellness**
 - This is an online health magazine for African Americans that also provides audio links to its nationally syndicated radio show. <http://www.journeytowellness.com/>
- **Websites on Racism Education and Anti-Racist Action**
 - Taking Action Against Racism (TAAR); website providing resources and activities designed to address issues related to racism. Organized by the American Psychological Association's Society of Counseling Psychology.
<https://www.div17.org/TAAR/media/default.htm>
- **National Resource Center for the Healing of Racism**
 - Website providing resources in the form of structured sharing and personal experiences around issues related to racism. <https://nrchr.org>

APPENDIX D: RECRUITMENT MATERIALS

(FIRST E-MAIL RECRUITMENT LETTER)

Hello,

My name is [Name of Research Assistant] and I am a doctoral candidate in the Counseling Psychology Program at the University of Tennessee, working with Dr. Jioni Lewis in the Department of Counseling, Higher Education, and Special Education at the University of Maryland. Our research team is looking for Black women living in the United States who are willing to complete an online survey. We are hoping to learn more about how Black women cope with stress, and we want to hear from you!

You are eligible if you:

- Self-identify as a Black/African American woman
- Are at least 18 years old

How to Participate

If interested, please click on the following link to:

- Receive additional information about the project
- Complete a 30 – 45-minute survey
- Have an opportunity to participate in future research opportunities

[insert active link]

To express our appreciation, each participant will receive an electronic gift card, which will be sent to the e-mail address provided at the time of survey completion. This study has been approved by the University of Tennessee Institutional Review Board (IRB-19-05492-XP). If you have any questions about the study, please contact us at blackwomenshealth2020@gmail.com. You are welcome to personally email this message to any colleagues, friends, family, or acquaintances in the United States that you know will meet the eligibility requirements. **However, due to recent issues with trolls and spammers, we ask that you do NOT publicly post or share this message on social media in order to preserve the integrity of the survey.**

Thank you for your time, and we look forward to including your voice in this project!

Cordially,
[Name of Research Assistant]
Department of Psychology
University of Tennessee

VITA

Anahvia Taiyib Moody was born in Derby, Connecticut and lived most of her life in Stratford, Connecticut with her mother, Sheila Moody, and younger sister, Shyan Moody-Hicks. She spent her early elementary school years in Mobile, Alabama before returning to Connecticut, attending Lordship Elementary School before transferring to Stratford Academy Johnson House as a student in the Advanced Learning Program (ALP) from fourth to six grades. She attended Wooster Middle school for seventh and eighth grade, after which ALP ended and she attended Stratford High School and graduated in 2012. She attended Harvard University for her undergraduate education, graduating in May 2016 with an A.B. in Psychology and a secondary in Global Health and Health Policy. She earned an M.A. in Psychology in May 2018 from the University of Tennessee, Knoxville, where she is currently enrolled in the Counseling Psychology Ph.D. program. She will begin a predoctoral internship at the Michael E. DeBakey Veterans Affairs Medical Center in Houston, TX in July 2021 to satisfy her final degree requirement. She will earn her doctorate in August 2022.