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"It's Killing Us!" Narratives of Black Adults About Microaggression Experiences and Related Health Stress

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Abstract

Perceived racism contributes to persistent health stress leading to health disparities. African American/Black persons (BPs) believe subtle, rather than overt, interpersonal racism is increasing. Sue and colleagues describe interpersonal racism as racial microaggressions: "routine" marginalizing indignities by White persons (WPs) toward BPs that contribute to health stress. In this narrative, exploratory study, Black adults (n = 10) were asked about specific racial microaggressions; they all experienced multiple types. Categorical and narrative analysis captured interpretations, strategies, and health stress attributions. Six iconic narratives contextualized health stress responses. Diverse mental and physical symptoms were attributed to racial microaggressions. Few strategies in response had positive outcomes. Future research includes development of coping strategies for BPs in these interactions, exploration of WPs awareness of their behaviors, and preventing racial microaggressions in health encounters that exacerbate health disparities.

Keywords

narrative analysis, health disparities, Black / African American, health stress, racial microaggressions

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How do Black adults experience, interpret, and respond to daily slights and exclusions, by White persons (WPs), called microaggressions? What health consequences do Black persons (BPs) attribute to microaggressions? What if microaggressions occur in cross-race health care interactions? This article reports on an exploratory qualitative study on racial microaggression experiences. The narrative study involved semistructured interviews with 10 African American/Black adults, and categorical as well as narrative analysis.

Is Racism Still a Problem?

Some believe that civil rights progress culminated when President Obama, an African American, was elected and that now society is post-racial (Hesse, 2010; Roediger, 2008; Wise, 2010). Overt and institutionalized forms of racism, such as hate speech and crimes, false arrests, disproportionate incarceration, beatings, and homicide continue (Krivo, Peterson, & Kuhl, 2009). White supremacist groups are resurgent. Yet such overt racism is generally *perceived* as less common. Structural and systematic racism persist, and it is hard to make organizational cultural changes in large institutional systems (Roediger, 2008). Most recent opposition from the Black community has concerned police brutality and resultant homicides of young and especially relatively big Black males. At the hands of police, Michael Brown was killed in Ferguson, Missouri, and Eric Garner in New York; grand jury dismissals of such cases spurred resistance consisting of nonviolent action nationwide. Most recently, Baltimore was the site of resistance and new organization for change, wherein charges were brought by the state's attorney against six officers, for the homicide of yet another Black man. An analysis of these incidents is beyond the scope of this article. These public events and figures are scrutinized by people of color (POC), who identify with those killed and their families. Suffice it to say, racism is still a problem in the United States.

Economic and environmental disparities are widespread for POC. Urban-dwelling BPs pay more for utilities as compared with (White) suburban dwellers. De facto segregation occurs through "redlining," and BPs disproportionately face home foreclosure. Unemployment is highest among Black Americans, and thus fewer have employment-based health insurance (Krivo et al., 2009; West, 2001; Wise, 2008, 2010).

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De facto segregated areas have fewer outlets for low-priced produce and other healthy foods, and these residential areas are often more environmentally hazardous than are "White areas." Race has enormous consequences resulting in social and economic inequalities (West, 2001). Despite numerous calls for research and reform, structural racism and racial health disparities continue. This is a vital concern for BP and health care providers (Hall & Fields, 2012, 2013).

Racial Health Disparities

What do we know about racial health disparities? Race is a social construction, not a scientific reality (Brewer, 2006; Fullwiley, 2008; Goodman, 2000; Gravlee, 2009). Clinicians sometimes profile exclusively by assumed group genetic differences and miss individuals' needs (Hunt, Truesdell, & Kreiner, 2013). Few racial health disparities are genetically based. Racial health disparities vary with lifestyles, diet, and economics but also occur with lack of access, undertreatment, no or incorrect referrals, and missed diagnoses. Some barriers occur because of biases on the part of White care providers. BPs mistrust of U.S. health care is justified by an atrocious history of "treatment" and experimentation spanning centuries by medical "scientists" in the United States (Washington, 2008). Some health disparities are likely connected to interpersonally experienced racial microaggressions. Therefore, interpersonal subtle racism is likely contributing to racial health disparities, but how this occurs has not been explored.

Racial Microaggressions

Subtle interpersonal racism refers to daily racial hassles and slights engendered by WPs and directed at POC, here specifically BPs. These experiences likely contribute to stress, increasing allostatic load for targeted persons (Geronimus, Hicken, Keene, & Bound, 2006; Wise, 2008). These ubiquitous slights, including patronizing behaviors, stereotyping, ignoring persons, and other insults, are called *racial microaggressions* (Sue et al., 2007). Microaggressions comprise interpersonal, biased behaviors that can be described and tested for (Nadal, 2011). The objective is not only to eliminate them but also to help targeted people strategize to avoid associated stress (Hall & Fields, 2012, 2013).

Microaggressions occur between members of a culturally dominant group toward oppressed others, based on gender, ethnicity, color/race, sexual orientation, and so on (Sue, 2010). Concisely defined,

> Racial microaggressions are brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward POC. Perpetrators of microaggressions are often unaware that they engage in such communications when they interact with racial/ethnic minorities. (Sue et al., 2007, p. 271)

Sue (2010) continues,

> Microaggressions have the lifelong insidious effect of silencing, invalidating and humiliating the identity and/or voices of those who are oppressed. Although their lethality is less obvious, they nevertheless grind down and wear out the victims. (p. 66)

They include *microassaults* (name-calling, shunning, purposeful discrimination), *microinsults* (implications of negativity, diminishing the other, rudeness), and *microinvalidations* (minimizing or ignoring target person's feelings and statements, denying racism or oppression, denying White privilege, and so forth; Sue, 2010; Sue et al., 2007). Microaggressions are detectable instances of subtle, interpersonal racism. Structural racism and interpersonal racism interconnect in the form of microaggressive cross-race social interactions, wherein ideologies emerge in everyday social interactions. The statement by a White employer to a Black applicant, for example, that the job has been filled, when it has not, is one interpersonal comment toward one BP. Yet as this occurs thousands of times, it results in higher unemployment for BPs, a structural reality.

Sue identifies the following major categories of racial microaggressions: ascriptions of intelligence ("You are so articulate."), second-class citizen (passed over or ignored), pathologizing cultural values/language (designation as "abnormal," or implying White as the standard of comparison), assumptions of criminality (WPs clutching belongings, clerks or guards surveilling individuals in a store), belief that POC are foreign or alien, colorblindness (WPs denying they "see" color/race), the myth of meritocracy (Whites minimizing White privilege and the role of race in attaining success), and denial of individual racism (White denial of societal racism and/or one's role in maintaining it; Sue, 2010).

Perceived Racism and Health

A meta-analysis revealed that perceived racism is associated with psychological problems and moderates depression (Pieterse, Todd, Neville, & Carter, 2012). Perceived racism is related to HIV-risk sexual behaviors, especially exacerbated with substance use (Stock et al., 2013). Relatively few studies have confirmed the role of perceived racism on cardiovascular health (Brondolo, Rieppi, Kelly, & Gerin, 2003), though there is increasing evidence that the stress of racism as a social determinant of health fosters cardiovascular disease (CVD) over time (Jackson, McGibbon, & Waldron, 2013). Structural factors such as employment, education, and judicial treatment not only increase BPs' risk of myocardial infarction but also *decrease* WPs' risk (Lukachko, Hatzenbuehler, & Keyes, 2014). Perceived racism regarding one's neighborhood negatively affects physical activity levels in African American adults (Edwards & Cunningham, 2013), which has cardiovascular implications.

Increasingly, literature documents health disparities as most pronounced and severe for African Americans (Dailey,

2008; Hall & Fields, 2012; Hardy, 2007; Tashiro, 2005; Underwood et al., 2004, 2005; Utsey, Ponteretto, Reynolds, & Cancelli, 2000; Williams & Williams-Morris, 2000); BPs have the lowest life expectancy (men are lowest) compared with all other POC, and highest rates of infant mortality (Clark, 2006; Gravlee, 2009; Hardy, 2007; Smedley, Stith, & Nelson, 2002). Infant mortality worsens in the 20s to 30s in Black women because they have already sustained significant stress. This is called "weathering" (Geronimus et al., 2006). A systematic review (Dolezsar, McGrath, Herzig, & Miller, 2014) demonstrated that perceived racism was associated especially with nighttime ambulatory hypertension in Black men. Disparities in mental and physical health risks range from cancer to CVD and diabetes, to depression and traumatic stress. Further exploration of *behavioral coping, perceived racism*, and *health effects* is needed. (Mwendwa et al., 2011). This study partly addresses these concerns from the standpoint of African American/Black adults' narratives of racial microaggressions.

Study Background

Our study reports microaggression experiences and their consequences, as expressed in narrative interviews with 10 Black American adults in the southeastern United States. We concurred that interpersonal racism might partially contribute to health disparities by increasing allostatic load (Geronimus et al., 2006; Hall & Fields, 2012; Wise, 2008). In the chronic and exhaustion phases of stress, there is a tipping point as disease emerges. Other sociopolitical/economic factors further limit access, acceptability, and quality of care: discrimination, inability to afford medications, family obligations, and so on. In addition, microaggressions likely occur between White providers and Black patients, as has been seen in cross-racial counseling relationships (Constantine, 2007; Sue, Rivera, Capodilupo, Lin, & Torino, 2010). BPs often distrust providers and hold suspicions of second-class treatment, compounding the suffering of illness with lack of confidence in care.

Thus, in this study, we elicited narratives of racial microaggressions and inquired as to immediate interpretations, coping strategies, results of these strategies, and health effects participants attributed to microaggressions. The dual concerns were the daily stresses of subtle interpersonal racism and the possibility that microaggressions may interfere with quality of care and overall health.

Method

Theoretical Framework

The study is grounded in critical race theory (CRT; Delgado & Stephancic, 2001), which defines racial oppression more complexly than is framed by an Enlightenment "rights" perspective. CRT emphasizes that focusing on "rights" does not necessarily engender community empowerment, activism, and critical analysis of history, economics, consciousness, and diversity. In CRT, scholarly activism and community organizing expose and transform oppressive racialization and power dynamics (West, 2001). CRT also emphasizes everyday bias experiences, and thus, personal narratives are central. Counternarratives are those that undermine dominant ideologies, giving voice to oppressive experiences, including slavery. Current personal narratives from Black men and women in the United States are instructive of interpersonal racism and should be critically heard.

Terminology

Many BPs have no preference between the terms *African American* and *Black*; we use the term *Black* because (a) in the southeastern states, this is the most obvious context of racism; (b) the history of slavery and Jim Crow affects BP in a distinct way from refugees and immigrant/immigrant-descended POC; (c) there are many BPs who are descended from a diaspora, and despite different cultural/geographical roots, they similarly face Black–White discrimination. Racialization of skin color gradations within subgroups of POC sets up another shifting hierarchy. Yet it is context, how the dominant White group, that defines whether one is considered "Black or White," *perceives* the individual and what privileges and rights that person can assume (Painter, 2010).

Frequently, marginalized persons experience *intersectionality* of multiple stigmatizing characteristics, including race, gender (lesbian, gay, bisexual, transgender, queer and intersex) status, class, and illness (Collins, von Unger, & Armbrister, 2008; Van Herk, Smith, & Andrew, 2011). We found some gender differences, but a complete exploration of intersecting oppressions was beyond the study scope.

Purpose and Specific Aims

The purpose of this narrative study was to explore the experiences of racial microaggressions in a group of urban-dwelling Black men and women in the southeastern United States. We especially focused on recalled microaggression experiences, strategic responses, and attributed health effects.

The specific aims of the study were to

1. Describe individuals' experiences of a variety of racial microaggressions, including perceptions, interpretations, and strategies used, and consequences of strategies taken.
2. Assess for stress-related symptoms and illnesses attributed to experiences of microaggressions.
3. Identify microaggressions experienced in health care-seeking and health encounters.
4. Pilot several instruments related to symptoms and perceived stress for acceptability and applicability in future studies of subtle racism.

This article reports on Aims 1 through 3. The long-range goal of the study is the reduction of racial health disparities through isolating the role of subtle interpersonal racism in producing stress-related symptoms. Stressful interactions contribute directly as well as indirectly, for example, through preventing BPs from seeking or continuing treatment with White providers and White-dominated health systems.

Based on CRT, the subjective is vital in revealing the context of marginalization. Narrative is a usual form of communication, an expressive manner of providing social, political, and geographic context in daily life, and in disruptions of it (E. M. Bruner, 1986; J. S. Bruner, 2001; Polkinghorne, 1988). Narratives show temporality of events and contain narrative truths that may not conform to "what really happened" (Nairn, 2004; Paley & Eva, 2005; Reissman, 2008; Sandelowski, 1991; Seibold, Richards, & Simon, 1994; Wilkinson & Hough, 1996). In this exploratory study, perceptions took precedence over historical (indeterminable) "facts."

We emphasized key perceptions and considered contingencies, opportunities, and barriers faced in interactive situations (Reissman, 2008). We noted the manner of telling as well as the story content. This process revealed motivations of the teller and of the interviewer's openness to hear about physical and mental stress, White privilege, and resistance, and was accompanied by descriptions of a variety of emotional and behavioral responses to recalling microaggressive circumstances.

Syntactic and semantic narrative analyses were done, but we focused on the semantic (Daiute & Lightfoot, 2004; Emden, 1998; Lieblich, Tuval-Mashiach, & Zilber, 1998). The study was cross-sectional and retrospective, involving the recalled microaggression experiences of Black adults, performed by WPs toward BPs, in diverse situations. We used the taxonomy of racial microaggressions established by Sue and colleagues (Sue, 2010; Sue, Capodilupo, & Holder, 2008; Sue et al., 2007) as a starting point for interviewing, and categories were further particularized based on in vivo-defined microaggressions. For example, in the broad categories of seeing the individual as abnormal, or as foreign, we noted exoticism (Said, 1979) as a particular instance of this category.

Interviews

Five of the interviews were conducted by a Black woman and five by a White woman; both are nurse researchers and self- and socially identified as to their race. The researchers have extensive psychiatric and/or geropsychiatric experience and are skilled at eliciting narratives in the phrasing of questions and the language of temporality: "When did the situation start to unravel?" "Have you ever had a WP comment on your intelligence? What happened? How did it finally turn out?" and so forth. We probed especially for interpretations of microaggressions and outcomes to the incidents narrated. We explored the following: overidentification and overfamiliarity, exoticism, assumptions of criminality, surprise at achievement and intelligence, denial of racism, stereotyping, colorblindness, social invisibility, and expectations of conformity to White standards, inferiorization, and infantilizing.

Ethical Considerations

The institutional review board of the University of Tennessee approved the study. Before each interview, the study and consent document were explained to the potential participant, questions were answered, written informed consent was obtained, and participants were informed they could skip any questions and discontinue the study with no penalties or loss of any services. The sound and text data files were de-identified using identification numbers, and pseudonyms were assigned to text files. Research materials were kept in a locked file in a university office, and on password-protected drives and servers. Those having access to data (transcriptionist and graduate students) signed a confidentiality pledge. Data will be destroyed when all analyses are completed, within 3 years.

The study involved discussion of a sensitive topic, yet microaggressions are everyday occurrences for BPs, as the data confirmed. In case of distress during interviews, help was available in that interviewers were psychiatric nurses who could intervene and make necessary referrals. No untoward events occurred during interviews. A few participants became tearful; laughter was more frequent, which in some cases might indicate anxiety. No intervention beyond a brief pause was necessary.

Procedure

Men and women above 18 years of age, identifying as African American or Black, who could read and write in English were included. Exclusion criteria included acute mental/physical distress and cognitive impairment. Cognitive impairment was assessed using a simple clock-drawing test. Participants were initially recruited through researchers' contacts, flyers, and referral (snowball) sampling from initial participants. Semi-structured but reasonably open-ended interviews, lasting from 60 to 120 minutes, were conducted at university office or in participants' homes. A US$50 gift card was given to thank participants for their time. The card was given directly after consent and not used as an incentive to complete the interview. Because this study was limited to Black adults, age and gender were purposefully diversified, but experiences of children, other POC, LGBTQI persons, and so forth should not be considered commensurate with these findings.

Demographic Data

We collected the following demographic data: age, self-identified race/ethnicity, employment status, education, and level and adequacy of income. We also administered several scales

by pencil and paper, including perceived stress, quality of life, and rating of physical and mental health, to pilot these instruments. Here, we are specifically reporting on the narrative analysis. We administered the scales after the interview so as not to bias the choices of stories participants might tell in the interviews.

Data Management and Analysis

The analysis procedure was as follows: (a) an initial read-through identified the genre and form of the participant's whole account and was compared as needed for clarification, with the sound files and/or field notes, which also provided accuracy and context; (b) narratives were blocked out or "chunked" into meaningful utterances of a few words to a few paragraphs that revealed specific stories; (c) narratives of microaggression incidents were examined for plotlines of what occurred and how the participant responded. We identified health symptoms or problems attributed to the experience of the microaggression at hand, or generally attributed to microaggressions occurring over years; (d) summary narrative accounts of individual participants were written, and the basic stories of 6 of the 10 were identified as iconic, representing diverse life contexts, and responses to microaggressions; and (e) quotations were selected illustrating reported incidents, strategies used, and health effects. The researchers reached consensus on the most illustrative and rich stories and representative quotes.

Rigor and Validity

Multiple readers, iterative readings, and discussion of processes involved in identifying and naming findings helped to increase reflexivity and reinforce consensus. In addition, a dual approach was effectively used: a descriptive categorical analysis of small utterances and composite derivation of integrated, iconic narratives showing life contexts of individuals' microaggression experiences. Thus, major criteria for rigor included rapport, credibility, verisimilitude, coherence of accounts, and reflexivity in analysis, all of which were sufficiently met. An audit trail revealed decision points and rationales for analysis and achieving consensus.

Results

The findings are organized as follows: (a) participant profile; (b) microaggressions experienced; (c) strategies used to stop microaggressions, avoid them, and/or attenuate their effects; and (d) health-related experiences associated with microaggressions, including health care interactions; and (e) six iconic, summarized accounts.

Participant Profile

The brief demographic information is summarized in Table 1.

Table 1. Participant Profile.

Gender	
Male	4
Female	6
Age	
26–62 years	*M* = 45
Partner status	
Married/partner	7
Divorced/separated	1
Single	2
Education	
High school	1
Some college	6
Master's	3
Children	*M* = 2.2
Employment	
Full-time	6
Part-time	2
Unemployed	2
Income adequate	
Yes	3
No	4
Health status	
Excellent	1
Very good	5
Good	2
Fair	2

Although these participants were well educated, underemployment and unemployment were evident. Seven rated their income as inadequate to meet their needs. Paradoxically, most self-rated their quality of life and health as good to excellent, despite that accounts indicated many stress symptoms.

Microaggressions Experienced

Although usually open-ended interviews are used in narrative research, we began with specific questions posing scenarios and examples of microaggressions. We elicited narratives of incidents, and these were reported in story form. However, we use only brief quotes rather than whole stories in illustrating these categories. Later, we report more narratively contextualized interactions in the six iconic accounts. See Table 2 detailing microaggressions experienced.

The reported microaggressions shared some commonalities. Most incidents happened at work, but also on the street, in WPs homes, and in stores or businesses. Each participant reported multiple types of microaggressions, though individuals did not experience all of the examples in the taxonomy. Gender differences included that assumptions of criminality were worse for men. Especially, younger men reported that they were frequently stopped by the police (though this was not asked about as an exemplar microaggression and is in many cases a more severe aggression).

Table 2. Microaggressions Experienced.

Microaggression	Description	Quotes
Assumptions of criminality	Avoiding BP based on fear, seeing Whites clutching belongings, etc. Followed in a store, being unable to hail a taxi, etc.	The minute they think you will steal something, they ride on your trail. I'm watching over my shoulder. Uncomfortable. They watch you but don't speak. Makes me angry.
Surprise at intelligence/ achievement	Statements indicating intelligence is unexpected when encountered in a BP	Man, they are calling all these Blacks intelligent because they are educated. Do they think we are all illiterate?
Overfamiliarity	Assuming closeness or similarity of feeling with minorities	They say "Oh I love that song." Or "Do you cook this?" Don't entertain me like that. Nah . . . I mean, I don't know you.
Stereotyping	Assuming sameness of members of a group	They assume that all Blacks think alike, when everyone has their own opinion. Makes you feel small. They want to lump you all together.
Underestimating inferiorization	Statements indicating assumption of White superiority and Black defectiveness	There's not a genuine . . . positive expectation in any sense. Because their grandfather was in a high military position, they think they should still be in charge. We come out the womb having to prove ourselves.
Infantilizing	Considering BP immature, individually or as a group	All African Americans are thought of as children . . . You were a slave and you must know your place. It's either overt or very subtle. Just have to do what you are told . . . but I can't model that to my kids!
Conformity/ abnormality	Implications that white appearance is best, that White = normality	If I wear a head wrap they gawk, stare a hole in the back of your head. Why do Black men have to wear their hair short? Some WPs have theirs dyed purple. Look as white as possible . . . I don't want to be too African, too Black.
Exoticism	Excessive curiosity, objectifying BP as foreign or strange	Staring at me as if I am on display. I understand it is different from what you are used to, but its offensive. You act like you are scared to touch. They think Black men are sexual animals.
Loss of job, forced out	Job lost or not gotten, assumed to be racially motivated. Exceeds "micro" aggression.	When I lost my job, was terminated, I wanted to be sure it would not happen to someone else. I can't afford to be sick. I'm stressed . . . I worry.
Name-calling	Using demeaning language, hate speech	They yell, "nigger" and I want to throw a brick at them, but I don't. She (White woman) was recalling what someone else did, and she said *he* said, "look at those niggers dance!" I didn't need the whole detail that he had called them "niggers." Did she really say that?!
Denial of racism in society	Refuting structural and/or subtle racism. Statements about society as "post-racial," that racism is now resolved.	Very little understanding . . . It is them (WPs) assuming and declaring what is in their own minds. It's "why are you guys still talking about that?" I was angry . . . little understanding of the dynamics of the Black community and what has happened historically.
Denial of personal racism	Refusing to acknowledge prejudices and White privilege.	When they say "I wasn't there, or I did not do those things (slavery, Jim Crow) . . . Well I guarantee someone behind you, he did!" She always said "I'm not prejudiced."
Held back	Promoting less qualified WP. Not giving BP a chance to succeed. Selectively biased hiring, renting, and so on.	White people think they should still be in control . . . hold Blacks back. It is because of your color . . . you try to get ahead in the company, struggling to even get your foot in the door. That brings stress. They don't call you back.
Colorblindness	Stating, "we are all the same," or "I don't see color."	I would like to pick their brains . . . what do they mean? Never expected it from that person! You *see* the differences, you *see* color! It is what it is.
Ignoring/invisibility	Avoidance, not seeing or hearing what BP is saying. Looking past or "through" the BP.	I had thought of ways to make my work easier. No one listens. They think I'm crazy. At work, they make you feel small. I'm here! Frustrating.

Note. BP = Black person; WP = White person.

Laughter was associated with several microaggression examples, especially that of being mistaken for a service worker, reportedly because it was "embarrassing to the WP." However, there was also some anxious laughter associated with telling of painful incidents. In general, most reported being unsurprised that microaggressions occur, but, at the time of the incidents, most also reported having felt humiliated, demeaned, diminished, stunned, helpless, angry, disappointed, betrayed, and so on. Paradoxically, participants recalled feeling "invisible," yet often in non-verbal interactions with WPs, they were "stared at," as if hyper-visible.

Most participants mentioned President Obama and the disrespectful way that many WPs consider and talk about him. Many participants commented that, currently, racism was more "behind your back" and thus less detectable. Participants stated they *preferred overt racism* to covert racism, noting that it was clearer, not producing time-consuming doubts and the need to decipher ambiguous motives of White perpetrators.

Strategies in Response to Microaggressions

We constructed a comprehensive list of the identified strategies with terse exemplar quotes. The exemplars serve to define and also show diversity of responses. See the summary of strategies in Table 3.

Clearly, participants tried a variety of strategies, although few strategies yielded positive results or reduced stress. An apt analogy was "dropping back two steps" when microaggressions occurred and struggling to get back to the original place, costing time and extra effort. It seemed to be uphill to begin with, and the effects of microaggressions kept one from moving forward, for variable amounts of time. Confrontation was empowering, but it often increased animosity and could endanger employment. Processing the incident with others took up time. Worse, if it became the focus of peer and family conversation, this exacerbated the intrusiveness of microaggressions into everyday life. Avoidance fostered social isolation. Intensive preparation and "overachieving" reportedly led to exhaustion. Insomnia often accompanied ruminating over incidents. Giving a pass and moving on were the most frequent strategies. Yet saying nothing, moving on, and walking away could foster internalization of negative feelings. And, obviously, all of these strategies required effort that, comparatively, WPs do not have to expend.

Physical and Mental Effects Linked to Microaggressions

Following is a comprehensive list of the adverse emotional and health effects attributed by the participants to microaggression experiences. As is obvious, these were diverse and many are medically serious and foster other increased risks. We did not explore these effects in detail, but the total number we saw was unexpectedly diverse. See Table 4.

Iconic Narratives

Recognizing the importance of holism and the diversity of life contexts, interpretations of microaggressions, and health-related consequences, we selected summary constructions of six individual, iconic narratives. These "cameos" also included some of others' similar quotes and life circumstances, where appropriate. Thus, they are composites, and identifiers and details were changed to additionally protect confidentiality. These narratives contextualize the categorical data already presented.

Carmen. Carmen, in her late 30s, worked in a public school. Her supervisor was a White woman who often mentioned having "biracial children," as a means to establish that she could not be biased. There was habitual conflict with this White woman, who repeatedly slighted the African American children, but favored Latinos and White children, in distributing school supplies. Carmen eventually confronted her, cautioning, "Everyone sees what you are doing!" In response to microaggressions, especially targeting others, she made direct verbal replies. The White woman once commented on Carmen's color using the negative "woodshed" imagery. Carmen directly replied, underscoring that sexual exploitation of Black women by White men "comes from slavery." Carmen was haunted by the stressful micro- and macroaggressions in the workplace that then pressurized the home/family environment. "It brings it home, . . . yelling and screaming at my husband and kids." Carmen perceived WPs as aware of their offensive comments indicating, "BPs are beneath them."

Carmen discussed the events and history surrounding WP's treatment of the president. She believed that President Obama's election stirred Black–White conflict, but she did not imply that things were fine before then. "I don't think those (disrespectful) things would be said if he [president] was White." She saw BPs stuck at the bottom of a hierarchy, below other minorities. She expressed anger and rage, and has chronic insomnia, anxiety, and "stress." She reported social avoidance, that she wants to "get out of the room" anytime the above-mentioned White woman is there. The microaggressions led to days of sleepless rumination and anger. Concerning denial of racism and Whites who say they are "colorblind," she said,

> [I think] what did that person mean by that? Do you mean that we're all equal? And if that's the case then, is that in your own mind again? Or is that according to society, because according to society, we are not equal by any means. Give me an example of how we're equal. . . . Interviewer (I): "Is there anything that you can imagine they would say that would convince you of that?" Participant (P): (silence) No.

Table 3. Strategies in Response to Microaggressions.

Strategy	Exemplars
Give them a pass	They were raised that way. He was an older man. Could be they are having a bad day.
Explain offensiveness	Try to explain what they did. Give them a history lesson. I say that's not the case and tell them things I went through growing up.
Say something, confront	What do you mean by that? Why did you say that? That's offensive. Why can't we get any help in this store? (Instead of being followed.)
Laugh	It happens all the time. Her face turned red (chuckle). I mean, you got to laugh about it sometimes. Mess with 'em. I grabbed my (White) girlfriend and gave her a big kiss in front of them (laugh).
Vigilance/hypervigilance	I was taught to watch for these things. You look out for it. Its everyday, not surprising. Just so on guard all the time . . . it's stressful.
Observe behavior beyond words	Don't tell me you "like BP," Show me! I'm gonna watch what you do, not what you say.
Ignore it	Let it roll off. Don't spend any time on it . . . they are stupid.
Take the high road	Don't stoop to their level. Forgive and move on.
Move on	Get past it, just move on. That's just another one (racist sounding person). Just went on about my business.
Talk to others	I tell someone who understands. Talk to my family, but hate to bring it home.
Internal dialogue	I go over it in my mind wondering should I have said something? Stays in my thoughts; I can't sleep. I call them all kinds of things in my head.
Intensive planning	Have to be twice as good. I have to prepare weeks before I set foot in that room (to give presentation).
Caution, politeness	Constantly having to walk on eggshells . . . no one walks on eggshells for BP. You stay in your place, like slave days.
Religion/spirituality	Talk to my pastor . . . gives me food for thought.
Respect	I try to treat them the way I would like to be treated. I will listen to them, but not for long.
Avoidance	I try to stay away, or just walk away. Just leave me alone and let me do my job. Don't talk to me."
Sort the general from the personal	If it is directed at me personally? I will definitely have a response.
Make yourself known to WP	I'm gonna get you to talk to me, because I feel, number one, you don't know me, and the only way for you to know me is to talk to me.
Know your culture	If you know your history and heritage, you see it is the psychological effects of slavery, on both sides.

Note. BP = Black person.

This example demonstrates the level of confusion and doubts raised by denials of racism. Trying to figure out the meanings in microaggressive statements by WPs is baffling and arduous. This account raises many mental and social health concerns, and the micro-/macroaggressions occurring in the workplace are the most inescapable and high risk. This situation with an individual White woman in a position of authority was a subtext to the whole interview. Note that making a verbal response to a microaggression was not evidenced here as a relief or as stress reducing. Carmen did not give "passes" on microaggressions, though she often ignored them until it would become impossible for her not to say something.

Nathan. Nathan, in his mid-20s, lived with his White woman partner of 5 years. When asked about several microaggressions, macro-level incidents emerge. He described frequently being stopped by the police and recounted that his Black men

Table 4. Physical and Mental Health Effects Attributed to Racial Microaggressions.

Attributed Effect	Description/Explanation
Insomnia	For days to months
Social isolation	Being avoided by WP, needing to avoid WP
Hypertension	Diagnosed, or "feeling BP go up . . ."
Weight loss	"Lost 39 lbs" after discriminatory events
Neck and shoulder pain	Immediately or chronic
Depression	Sad, listless, unable to work
Perceptual shock	Disbelief, suddenness of stressful interaction
Social ambiguity	Uncertainty of meanings and motives of others
GI problems	Reflux disease, upper and lower GI conditions
Helplessness, hopelessness	Feeling vulnerable; pessimism
Over-planning	"Mental space" and time in avoiding criticism
Stress regarding appearance	Hair, clothing, not looking "too Black"
Psychological effects of slavery	Self deprecation; lack of cultural pride
Burden of self care	"The stress of not getting stressed."
Downward life/health trajectory	Cascading negative events leading to illness
Feeling judged	"Need to be twice as good."
Anger	Upset, annoyed, furious, aggravated
Tension	Physical tightness, anxiousness
Sense of betrayal	Broken or diminished relationship with WP
Hypervigilance	Social guardedness, scrutiny, watchfulness
Traumatic stress	"I have PTSD." Intrusive recall of prior traumatic race-related events
Preoccupation	Ruminating on incidents, days to months
Stigma in health encounters	"He acts like he won't touch me."
Lesser quality of care	Physician leaves care solely to assistant

Note. WP = White person; BP = Black person; GI = gastrointestinal; PTSD = posttraumatic stress disorder.

friends experience this "all the time. It's the norm." When stopped over a "seat belt" when he was wearing one, he reported feeling "fear, helpless, adrenaline, heart pumping." Assumptions of criminality predominated, though there was no evidence that Nathan had committed crimes. Often stopped in stores, he considered this laughable, as is being mistaken for a service worker, because he believes the WP doing this "haven't been trained," (as children). Thus, he would give a pass in this situation.

When asked about stereotyping, he implicated his girlfriend first, stating that frequent arguments over money would degenerate into his girlfriend calling him a "thug" or stating he had "thug-like behavior." Nathan would become "upset," but he would give her passes, presumably to keep his intimate relationship. He saw BPs as still "oppressed" but saw improvement in that "more people have jobs now." His responses to microaggressions varied, but descriptions of bodily feelings were vivid, especially regarding pronounced anger and fear. "I feel TENSION!"

This account points to the elevated risks faced by young Black men and boys, especially as targets of police profiling or in potentially being attacked over WP's fears that they might become "violent." Nathan's physiological and psychological responses were pronounced, characterizing a traumatic experience, although in summing up, he did not see his health as affected at this point. A life risk that is high for Black men is incarceration, often for nonviolent crimes, or through judicial bias. A pertinent future health concern for Nathan is hypertension, which results from, or is exacerbated by, frequent adrenaline-increased states.

Tuni. Tuni, in her early 30s, graduated from an Ivy League university and quickly turned to this as a constant source of demeaning microaggressions and her subsequent angry reactions. WPs, shocked at knowing where Tuni was educated, often asked, "How did you *get in*?" Although not confrontive, she tended to let the person know that she did not miss the slight. When this would happen, she would cut off the conversation, as well as the relationship, wanting nothing further to do with the person who commented with surprise about her education. She would think, "I don't have to explain anything to you. There is nothing I want to say to you." She had a managerial position but concentrated her career story on the daily set of contingencies, hassles, and pressures to "not look too Black." She talked at length about the persistent pressures associated with keeping her hair straight. She reported repeatedly being exoticized in the question by WPs if they can "touch her hair." She felt "like an animal in a petting zoo." Though these were repetitive events, she felt surprised and acutely puzzled each time they

would happen, asking, "Why!?" Other participants underscored the problems with hair:

> African American women . . . go through the stress, the dollars, the mental gymnastics that it takes you to think all the time on keeping my hair straight. That alone is crazy. That will stress you out and you don't even know how crazy you'll be after years and years.

> That was so ingrained in our mindsets that that's the only way that we'll get a job. That's the only way to be accepted . . . if you wore your hair in an Afro or . . . other than straight then that would not be acceptable either. I see WP all the time with nose piercings or blue hair but when BP do it it's considered "ghetto."

Another woman who said that the time, the money, the effort it takes to look "closer, closer to White" was incredible and fed into negative self-concept: "So we look into the mirror and say, yeah, we're ugly. And then you live with that." A man expressed,

> You know that's the de facto standard . . . It's not it's not written, it's not in the law, it's not in the law book, . . . we're just faced with that. You say "man ya'll got to cut ya'll beards' . . . We started saying, 'so why are these things important? What's too Black!?"

Tuni had friends of different races/cultures, traveled to countries where Black–White hierarchy is minimal, and saw the possibilities of people getting along human to human. She then said, however, "I absolutely do believe in the word racism." She reported that daily stress of the pressures to conform to White standards gave her constant pain in her upper back and shoulders, which lasts for days to weeks. She stated that strategies in response to microaggressions also include trying to explain to WP, but this was usually done when the individual is known, a coworker, or a friend. Her efforts usually came to naught as the WP would become defensive and deny racism. Another Black woman explained that she tried to help a White friend understand that BPs often have long waits and get ignored by clerks, just as the White woman had experienced (and had become furious). This Black woman stated that this created "enormous tension!" and concluded that trying to teach WP did not work very well.

Roxanne. Roxanne, in her late 30s, recounted victimization in a series of employment-associated microaggressions that created a macroaggressive environment, as White coworkers acted together against her interests. Initially, White women asked, "How did you *get* this position?" Besides making microaggressive comments, one woman also seemed to be jockeying for Roxanne's job: "How did you get your experience?" The White coworkers' overfamiliarity in discussing what music Roxanne likes, and telling her "I love greens," also seemed disingenuous to her, and she called it "overkill" and "deceptive."

A prevailing perception in this geographic area was that there is a Black glass ceiling, which stops the BP from advancement and places them at risk, especially if they supervise a number of WPs. Likewise, other participants also said they feel "held back," and that "they only let a few in, and then the door closes."

The group of White women in this professional job setting effectively scapegoated and bullied Roxanne, splitting her from her boss, who was a POC and had been protective of Roxanne in the past. After "an investigation," suddenly Roxanne, a very competent employee, was fired "over a clerical error that everyone makes." Her situation changed from microaggressive office politics to a macroaggressive, biased firing. This initiated a cascade of negative events, including loss of any friends from the workplace, social isolation, exhaustion, anger, loss of income, loss of health insurance, depression, anxiety, insomnia, headaches, back problems, neck aches, digestive problems, and weight loss of 35 pounds. She used the terms *frustration* and *aggravation* frequently. "WPs should stand up for you, and they don't." Comparing this geographic area with a city where she previously lived, she said since she moved here, she has begun to see that "there is Black and there is White," emphasizing that now she "sees color," adding that she becomes "judgmental, like the rest of them."

Roxanne also stated that her husband tended to be treated with more assumptions of criminality than she experienced, specifically mentioning how WPs people lock their car doors when he would walk by. These things enraged him, because they reminded him of an early traumatic situation: being expelled from high school due to a fight with a White boy (who was not expelled). After decades, this was still emotionally unresolved. Roxanne stated he was affected by hypertension and gastroesophageal reflux disease (GERD). Roxanne's narrative demonstrated the continuum of and connections between micro- and more overt macroaggressions, and her story of her husband showed the experiential connection between current microaggressions and prior traumatic situations. This is veritably the same as an abused person having "triggering" experiences that reactivate memories of past trauma, in a vicious cycle.

For Roxanne, when a WP claimed to be "colorblind," this was considered problematic, especially frustrating, and incomprehensible. But BPs such as Roxanne *do not consider it good* if they themselves "see color." The premise is that they should not *have to* see color. "It should not come in there."

Raymond. Raymond, in his late 30s, worked in a health field. He noted WPs sometimes begin sentences with "I am not a racist," to which he would respond with hypervigilance, that is, watching for these things and being self-protective.

> I know that is a red flag . . . I will watch you from then on. I'm gonna be paying attention to you and what you do and what you say and how you act anytime I'm around you, for as long as I'm

> around you . . . These are the things that have happened in the past and they continue to happen, just a little differently. Now the more I pay attention the more subtle I see it's gotten.

Raymond is a large man, and said he often sees people clutch their belongings around him. He seemed to take this for granted. He described situations where a BP does not get the job, or the loan, or the apartment, and then never knows if it was racial, regardless of an explanation, if any is given, for hiring a WP instead.

He underscored, "But as long I'm around, I'm gonna make sure that I pay attention to you [WP] and your actions . . . It ends up being a lot of extra thinking you have to do, but it's second nature." Others echoed the idea of vigilance, and stated that they watched for body language and skin tone when WPs deny racism: "You can tell they are lying by their red face."

Raymond firmly believed that racism is not innate but learned early in life from one's parents. When he was 17, he had an indelible experience of microassault. He was chasing a ball on the street, and

> a White toddler yelled "nigger, nigger!" A *baby* stopped me in my tracks (laughing)! Literally I mean . . . I froze, and my first (laugh) thought and my first emotion was anger. I mean without a doubt . . . and then I was like "Oh my God." I walked up to some of the older kids . . . (laugh) and it gets wilder. I said, "Where is this child's parents? I need to have a talk with the dad, the mom, anybody. Whoever's here." And (laugh) and I was angry and (laugh) this is what (laugh) took all the anger away—what was said *next* . . . "Well, his parents aren't here. We're with a church group." (Laughing) . . . I was so stunned by that. That was probably my first real serious kind of racially motive, it bothered me and it hurt my feelings too."

Raymond considered himself in good health and said he has had health insurance for most of his life. He then recounted a story of an aunt who was forced to seek care at the health department, and without adequate assessment and follow-up, was merely prescribed a medication, and got sicker and sicker. When her kidneys failed, the family learned that, in fact, the medication had ruined her kidneys. Raymond said, "It killed her. She died because of that." Raymond's story about being vigilant is contrasted with his earlier-occurring story, when he was surprised by a situation, "stunned." Presumably, he became more vigilant after this incident, to which he referred several times in the interview. This also reinforces that current microaggressions and strategies are linked to early micro- or macroaggressive traumatic events.

Harrison. Harrison was in his mid-50s. He stated, "WPs have to let you know they are in charge," as though little in society had changed. He discussed his boss starting a sentence with "I like BPs . . ." then proceeding to give him the least desirable tasks.

> They will hire somebody in to be our boss and that really makes me upset instead of giving one of us the chance to be the boss. I: "When you say, 'upset,' what does that mean?" P: "Hm, well I try not to be racist ah, but that sometimes it just makes you feel racist . . . Ah, I feel the anger cause they still holding us back instead of promoting us, they'd rather hire somebody out the street to be your boss instead . . . you're working in the plant all these years and then [they] hire somebody out to come in to be your boss, younger than you, that's what really makes me upset."

Harrison recounted a microaggression of denial of racism and colorblindness by a White veteran who thought that there were no color lines in the army, that all were "treated the same." Harrison said he gave him a pass. Harrison often gave a pass based on age, misconception or lack of education, and so on. He also tended to laugh at being followed in a store, and he found it even funnier to be mistaken for a service worker, because this shows White "stupidity." Despite sometimes giving passes, he stated that racism is very real but is now more "undercover." However, he saw the president as having been overtly ill spoken of throughout his term and that this was disrespectful and indicated animus toward all BPs. "Having them say the president would not be a good leader, it is very stressful."

Harrison was exoticized in coworkers' constant remarks about him and his anatomy, and said, "They think Blacks are sexual animals . . . They won't just let me live." Harrison also emphasized how BPs are "held back" in many situations, flowing from slavery patterns wherein BPs were treated as children. The boss, "He be like your daddy!"

Harrison hopelessly described how little chance he had of getting a new job as he approached 60. He implied that he had quit his job over conflicts with this White boss, when he said of employment-related microaggressions, "[Microaggressions] make us so angry that we quit our jobs early." Twenty years prior, he was incarcerated for a nonviolent crime.

> They won't let you go forward. You can't do a crime. You can't go forward. Everywhere I go, and that's over 20 years, I still get held back for the same thing—I try to move on—They won't let you.

Harrison's insurance agent did not respond to recent storm damage to his home, leaving him without a roof in part of his house for 3 months. He noted that WPs with the same problem were getting assistance relatively easily, and their houses were already repaired. This exemplified environmental or situational microaggression.

Harrison vividly described perceiving his blood pressure going up when he experienced microaggressions:

> Stress goes to anger . . . feel like a heat wave or just a little you know, just something you know you just feel. You can feel, you just, he's [boss] a coming and getting on your nerve or something and you get high [blood pressure], it makes your anger something different, came from your body like you know something, you know. Then it comes back down . . . I can't explain but it ah, you know I know feel ah, different.

He continued, saying that when WPs say offensive or demeaning things, he calls them names to himself, but that sometimes "It slips out." He says this gives him some relief but implies that it backfires in the long run. He reassured himself that because he feels his blood pressure goes down, no real harm is occurring, but then dispelled this by saying, "Over time, it has to have an effect on your health. Stress is a killer."

His health was precarious because of lack of income and access, and he was prone to environmental stressors such as exposure and questionable nutrition. He seemed socially isolated but described a good relationship with his pastor that was a great help to him.

> He gives me food for thought to keep me, you know, and I try to look to the Bible a lot . . . I hope my religion is a stress relief . . . I'm one true believer in that.

He was one of the two who stated that religion or spirituality is helpful in dealing with subtle or overt racism, although this was not asked directly.

Discussion

We found that there were varied and multiple microaggressions experienced by a diverse group of BPs, there are some gender differences, and responses to microaggressions vary from giving a pass to confrontation, with no particular strategy showing great success. This study suggests certain coping strategies, such as vigilance, might attenuate the shock of facing a microaggression, yet others (Liu & Lau, 2013) found that hypervigilance increases depression and pessimistic mistrust. We also found that microaggressions can trigger intrusive memories of traumatic racially related incidents. This supports that for some, microaggressions are experienced as traumatic events, which is of serious concern. Many of the same principles used to care for survivors of abusive trauma might be adapted to explore and intervene on effects of racial microaggressions, referred to as trauma-informed care.

A plethora of physical and mental adversities are attributed to these daily indignities, and overall, participants believe that subtle interpersonal racism has cumulative stress effects. No participant reported that being the target of microaggressions was conducive to well-being. There was agreement that these microaggressive incidents contribute to the stress load already burdening the person, whether that is stigmatizing stereotyping, intersecting minority statuses, or economic/income inequality. However, there may be some means or theories of coping that might be helpful in combining strategies or in attenuating the initial stress microaggressions generate.

This analysis demonstrated the commonness of microaggressions for Black/African American persons. Participants had many diverse reactions to, interpretations of, the strategies used to counter these socio-micro-traumatic incidents. There was nearly unanimous agreement that racism is now subtle and that the United States is clearly not post-racial. Likewise, there was a pattern of concerns when WP make microaggressive remarks about the president, and for many participants, this reflects how WPs view all BPs. There is therefore also a ripple effect to witnessing microaggressions and being aware of them in the media.

When POC recounted their experiences with microaggressions, effects of negative microaggressive messages, attributed health consequences, and clues to behavioral pathways of interpersonal racism were illuminated. Presumably, if WPs understood the stressful effects of these insidiously biased behaviors, the majority would stop doing them. Yet how aware are WPs of their microaggressive behaviors?

The issue of whether WPs are aware when communicating microaggressions was not settled here, and this should be explored further. Some participants did allude to WP denying racism and who appeared to be "lying." But overall there was an unexpected lack of focus on this point. Does this mean that intentionality does not matter? Does it mean that intention cannot be determined in interactions? Intentionality questions are raised by this study, but were not within its scope as the issue was not explored directly. Giving a pass would seem to be based on BPs assuming that WPs are not aware of what they are saying and doing or are unaware of how it is perceived. There were, however, several contradicting responses from participants about this such as references to lying, which evidence perceived intentionality.

Future Research

Directions for future research include (a) in-depth and detailed examination of strategies to facilitate developing interventions that decrease the exposure to and negative effects of microaggressions, (b) studies specifically focused on microaggressions in health care contexts, and (c) exploration and intervention development for raising WP's consciousness of their own microaggressions, and moreover, those they *do not challenge when they witness them done by other WPs*. This is especially crucial in the health and other service professions.

A goal of future research stemming from findings on strategies would be the development of interventions to increase POC knowledge of strategies that do and do not prove helpful. The hurdle here is that the experiences and interpretations of specific types of microaggressions vary within life contexts. Yet researchers could utilize focus groups to explore strategies in detail and capture some consensus from BPs about helpfulness of specific strategies matched to types of racial microaggressions.

Theory Development

Theory development will likely follow a research-theory path. As we can measure more and more types of microaggressions and determine which are the most stressful, comprehensive theories can be developed about microaggressions generally, and micro theories can be developed regarding

subgroups, such as those who are immigrants, sexual minorities, living with challenges to abilities, and women. Also, this should be integrated with CRT to capture power dynamics of microaggressions and with intersectionality theories to capture the complexities of experiencing multiple forms of microaggressions.

The situation is longstanding but has urgent clinical implications. One participant sums the situation up, along with its dire consequences:

> It's a killer, it is killing us . . . It becomes stressful and we all know stress can have many different effects. Stressful because you constantly thinking about what's taken place, whether it is that day, that week, you're thinking about it, and it affects you personally. It affects how you perceive things in the world. It still falls back on the person. Whether that is becoming angry at society about how it has been laid out or [how racism is] communicated to BPs. It's not healthy at all. It's not healthy at all. It's not healthy.

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References

Brewer, R. M. (2006). Thinking critically about race and genetics. *Journal of Law, Medicine & Ethics*, *34*, 513–519, 480.

Brondolo, E., Rieppi, R., Kelly, K. P., & Gerin, W. (2003). Perceived racism and blood pressure: A review of the literature and conceptual and methodological critique. *Annals of Behavioral Medicine*, *25*, 55–65.

Bruner, E. M. (1986). *Ethnography as narrative*. In V. W. Turner & E. M. Burner (Eds.), *The anthropology of experience* (pp. 139–155). Urbana, IL: University of Illinois Press.

Bruner, J. S. (2001). *Self-making and world-making*. In J. Brockmeier & D. Carbaugh (Eds.), *Narrative identity: Studies in autobiography, self and culture* (pp. 25–36). Philadelphia: John Benjamins.

Clark, R. (2006). Perceived racism and vascular reactivity in black college women: Moderating effects of seeking social support. *Health Psychology*, *25*, 20–25. doi:10.1037/0278-6133.25.1.20

Collins, P. Y., von Unger, H., & Armbrister, A. (2008). Church ladies, good girls, and locas: Stigma and the intersection of gender, ethnicity, mental illness, and sexuality in relation to HIV risk. *Social Science & Medicine*, *67*, 389–397.

Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology*, *54*, 1–16. doi:10.1037/0022-0167.54.1.1

Dailey, D. E. (2008). Conceptualizing perceived racism and its effect on the health of African-Americans: Implications for practice and research. *Journal of National Black Nurses' Association*, *19*(1), 73–80.

Daiute, C., & Lightfoot, C. (2004). Theory and craft in narrative inquiry. In C. Daiute & C. Lightfoot (Eds.), *Narrative analysis: Studying the development of individuals in society* (pp. vii–xviii). Thousand Oaks, CA: SAGE.

Delgado, R., & Stephancic, J. (2001). *Critical race theory: An introduction*. New York: New York University Press.

Dolezsar, C. M., McGrath, J. J., Herzig, A. J., & Miller, S. B. (2014). Perceived racial discrimination and hypertension: A comprehensive systematic review. *Health Psychology*, *33*, 20–34. doi:10.1037/a0033718

Edwards, M., & Cunningham, G. (2013). Examining the associations of perceived community racism with self-reported physical activity levels and health among older racial minority adults. *Journal of Physical Activity & Health*, *10*, 932–939.

Emden, C. (1998). Theoretical perspectives on narrative inquiry. *Collegian*, *5*(2), 30–35.

Fullwiley, D. (2008). The biologistical construction of race: "Admixture" technology and the new genetic medicine. *Social Studies of Science*, *38*, 695–735.

Geronimus, A., Hicken, M., Keene, D., & Bound, J. (2006). Weathering and age patterns of allostatic load scores among Blacks and Whites in the United States. *American Journal of Public Health*, *96*, 826–833. doi:10.21056/AJPH. 2004.060749

Goodman, A. H. (2000). Why genes don't count (for racial differences in health). *American Journal of Public Health*, *90*, 1699–1702.

Gravlee, C. C. (2009). How race becomes biology: Embodiment of social inequality. *American Journal of Physical Anthropology*, *139*, 47–57. doi:10.1002/ajpa.20983

Hall, J. M., & Fields, B. (2012). Race and microaggression in nursing knowledge development. *Advances in Nursing Science*, *35*, 25–38. doi:10.1097/ANS.0b013e3182433b

Hall, J. M., & Fields, B. (2013). Continuing the conversation in nursing on race and racism. *Nursing Outlook*, *61*, 164–173. doi:10.1016/j.outlook.2012.11.006

Hardy, L. K. (2007). Exploring the concept of race and its implications for health disparities research. *Journal of Theory Construction & Testing*, *11*(2), 46–49.

Hesse, B. (2010). Self-fulfilling prophecy: The postracial horizon. *South Atlantic Quarterly*, *110*, 155–178.

Hunt, L. M., Truesdell, N. D., & Kreiner, M. J. (2013). Genes, race, and culture in clinical care: Racial profiling in the management of chronic illness. *Medical Anthropology Quarterly*, *27*, 253–271. doi:10.1111/maq.12026

Jackson, J., McGibbon, E., & Waldron, I. (2013). Racism and cardiovascular disease: Implications for nursing. *Canadian Journal of Cardiovascular Nursing*, *23*(4), 12–18.

Krivo, L. J., Peterson, R. D., & Kuhl, D. C. (2009). Segregation, racial structure, and neighborhood violent crime. *American Journal of Sociology*, *114*, 1765–1802.

Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (1998). *Narrative research: Reading, analysis and interpretation* (Vol. 47). Thousand Oaks, CA: SAGE.

Liu, L. L., & Lau, A. S. (2013). Teaching about race/ethnicity and racism matters: An examination of how perceived ethnic racial socialization processes are associated with depression symptoms. *Cultural Diversity & Ethnic Minority Psychology*, *19*, 383–394. doi:10.1037/a0033447

Lukachko, A., Hatzenbuehler, M. L., & Keyes, K. M. (2014). Structural racism and myocardial infarction in the United States. *Social Science & Medicine*, *103*, 42–50. doi:10.1016/j.socscimed.2013.07.021

Mwendwa, D. T., Sims, R. C., Madhere, S., Thomas, J., Keen, L. D., 3rd, Callender, C. O., & Campbell, A. L., Jr. (2011). The influence of coping with perceived racism and stress on lipid levels in African Americans. *Journal of the National Medical Association*, *103*, 594–601.

Nadal, K. L. (2011). The Racial and Ethnic Microaggressions Scale: Construction, reliability and validity. *Journal of Counseling Psychology*, *58*, 470–480. doi:10.1037/a0025193

Nairn, S. (2004). Emergency care and narrative knowledge. *Journal of Advanced Nursing*, *48*, 59–67. doi:10.1111/j.1365-2648.2004.03169.x

Painter, N. I. (2010). *The history of white people* (1st ed.). New York: W.W. Norton.

Paley, J., & Eva, G. (2005). Narrative vigilance: The analysis of stories in health care. *Nursing Philosophy: An International Journal for Healthcare Professionals*, *6*, 83–97. doi:10.1111/j.1466-769X.2005.00195.x

Pieterse, A. L., Todd, N. R., Neville, H. A., & Carter, R. T. (2012). Perceived racism and mental health among Black American adults: A meta-analytic review. *Journal of Counseling Psychology*, *59*, 1–9. doi:10.1037/a0026208

Polkinghorne, D. E. (1988). *Narrative knowing and human sciences*. Albany: State University of New York Press.

Reissman, C. K. (2008). *Narrative methods for the human sciences*. Thousand Oaks, CA: SAGE.

Roediger, D. R. (2008). *How race survived U.S. history: From settlement and slavery to the Obama phenomenon*. New York: Verso.

Said, E. (1979). *Orientalism*. New York: Vintage Books.

Sandelowski, M. (1991). Telling stories: Narrative approaches in qualitative research. *Image: Journal of Nursing Scholarship*, *23*, 161–166.

Seibold, C., Richards, L., & Simon, D. (1994). Feminist method and qualitative research about midlife. *Journal of Advanced Nursing*, *19*, 394–402.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.). (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academy Press.

Stock, M. L., Gibbons, F. X., Gerrard, M., Houlihan, A. E., Weng, C. Y., Lorenz, F. O., & Simons, R. L. (2013). Racial identification, racial composition, and substance use vulnerability among African American adolescents and young adults. *Health Psychology*, *32*, 237–247. doi:10.1037/a0030149

Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender and sexual orientation*. Hoboken, NJ: John Wiley.

Sue, D. W., Capodilupo, C. M., & Holder, A. M. (2008). Racial microaggressions in the life experience of Black Americans. *Professional Psychology: Research and Practice*, *39*, 329–336.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *The American Psychologist*, *62*, 271–286. doi:10.1037/0003-066X.62.4.271

Sue, D. W., Rivera, D. P., Capodilupo, C. M., Lin, A. I., & Torino, G. C. (2010). Racial dialogues and white trainee fears: Implications for education and training. *Cultural Diversity & Ethnic Minority Psychology*, *16*, 206–214. doi:1.1037/a0016112

Tashiro, C. J. (2005). Health disparities in the context of mixed race: Challenging the idea of race. *Advances in Nursing Science*, *28*, 203–211.

Underwood, S. M., Buseh, A. G., Canales, M. K., Powe, B., Dockery, B., Kather, T., & Kent, N. (2004). Nursing contributions to the elimination of health disparities among African Americans: Review and critique of a decade of research. *Journal of National Black Nurses' Association*, *15*(1), 48–62.

Underwood, S. M., Buseh, A. G., Canales, M. K., Powe, B., Dockery, B., Kather, T., & Kent, N. (2005). Nursing contributions to the elimination of health disparities among African-Americans: Review and critique of a decade of research—Part III. *Journal of National Black Nurses' Association*, *16*(2), 35–59.

Utsey, S. O., Ponteretto, J., Reynolds, A. L., & Cancelli, A. A. (2000). Racial discrimination, coping, life satisfaction and self esteem among African Americans. *Journal of Counseling & Development*, *78*, 72–78.

Van Herk, K. A., Smith, D., & Andrew, C. (2011). Examining our privileges and oppressions: Incorporating an intersectionality paradigm into nursing. *Nursing Inquiry*, *18*, 29–39.

Washington, H. A. (2008). *Medical apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present*. New York: Anchor Books.

West, C. (2001). *Race matters* (2nd ed.). New York: Vintage Books.

Wilkinson, S., & Hough, G. (1996). Lie as narrative truth in abused adopted adolescents. *Psychoanalytic Study of the Child*, *51*, 580–596.

Williams, D. R., & Williams-Morris, R. (2000). Racism and mental health: The African American experience. *Ethnicity & Health*, *5*, 243–268. doi:10.1080/713667453

Wise, T. (2008). *White like me: Reflections on race from a privileged son* (Revised and updated ed.). Berkeley, CA: Soft Skull Press.

Wise, T. (2010). *Colorblind: The rise of post-racial politics and the retreat from racial equity*. San Francisco: City Lights Books.

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Becky Fields, PhD, RN is a nurse scientist with clinical and academic experience in community health, psychiatric care and geropsychiatry. Fields earned baccalaureate, masters and PhD degrees from the University of Tennessee. She has studied minority health on topics such as Bla~kwomen's breast cancer screening, hypertension, community health interventions, and cognitive and dementia conditions. She is a longtime advocate for eliminating racial health disparities, especially among Black Americans. Fields served as Associate Dean at South College in Knoxville, Tennessee and currently teaches at Roane State Community College and Kings College, also in Tennessee.