

COPING AT THE INTERSECTION: A TRANSFORMATIVE MIXED METHODS STUDY
OF GENDERED RACISM AS A ROOT CAUSE OF MENTAL HEALTH CHALLENGES IN
BLACK COLLEGE WOMEN

by

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ABSTRACT

Background. Racism negatively impacts the mental health of people of color. Racial identity has been suggested as a buffer against racism. But women of color are at increased risk for mental health challenges due to gendered racism; it is based on intersectionality theory. The purpose of this study was to understand the impact of and coping strategies used to deal with gendered racism on the mental health of Black college women.

Methods. The mixed methods design included a nonrandom sample of 213 Black college women. Mental health was operationalized as depression (PHQ-9) and psychological distress (K-6). Correlation and regression analyses tested the impact of gendered racism on mental health; examined the role of racial identity; and, explored coping strategies. Through intensity sampling, the qualitative phase included individual interviews (n=12) and a focus group (n=6). Narrative inquiry was used to construct composite counter-narratives, using thematic narrative analysis.

Findings. Quantitative results suggested that 84% of the sample require mental health treatment. Gendered racism negatively correlated with mental health; the most significant correlation was between depression and the frequency of gendered racism, $r(95) = .405, p \leq .01$. Racial identity was not related to mental health and therefore could not be tested as a mediating factor. The qualitative phase revealed narratives of gendered racism across multiple levels. The institutional level helped to create the normative experience of gendered racism through lack of effective policy; it also impacted the individual and interpersonal levels. Belief in the SBW and acceptance of limitations to full humanity were the result of internalized gendered racism. The

interpersonal level included narratives of sexual assault, being mistaken as ‘the help,’ and assumptions about communication style and educational level. The mixed methods results suggested that effective coping depends on increased education and the deconstruction of gendered racism followed by the use of humor and social support.

Discussion. College mental health interventions should include an emphasis on gendered racism. Narratives revealed how Black college women accept and resist the normative experience of gendered racism. The mixed methods design provided a more nuanced understanding of how Black women cope with gendered racism.

DEDICATION

This dissertation is dedicated to my daughters, Kourtney & Khloe, with love and hope for tomorrow.

LIST OF ABBREVIATIONS AND SYMBOLS

ABW	Angry Black Woman ideology
ACHA-NCHA	American College Health Association-National College Health Assessment
APHA	American Public Health Association
Brief COPE	Brief Coping Orientations to Problems Experienced: coping measure
CDC	Centers for Disease Control and Prevention
CRT	Critical race theory
GRMS	Gendered racial microaggressions scale: gendered racism measure
K6	Kessler-6: psychological distress measure
<i>n</i>	Sample size
MIBI	Multi-dimensional Inventory of Black Identity: racial identity measure
<i>p</i>	Probability
QUAL	Qualitative phase of mixed methods research
QUAN	Quantitative phase of mixed methods research
<i>r</i>	Pearson product-moment correlation
PHCRP	Public Health Critical Race Praxis
PHQ-9	Patient Health Questionnaire-9: depression measure
PWI	Predominantly white institution
SEM	Social ecological model
SBW	StrongBlackWoman ideology

SD Standard deviation

< Less than

= Equal to

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CHAPTER 1. INTRODUCTION

Background

The Centers for Disease Control and Prevention (CDC) defines mental health as a state of well-being in which individuals realize their abilities, cope with normal stressors, work productively, and make contribution to their community and recognizes it as an important component to overall health (CDC, 2013). Mental illness is defined collectively as diagnosable mental disorders that are characterized by alterations in thinking, mood, and or behavior associated with distress and or impaired functioning (CDC, 2013). Healthy People 2020 states that mental disorders are the leading cause of disability, accounting for nearly 19% of all years of life lost to disability and premature mortality (US Burden of Disease, 2013).

Depression is the most common type of mental illness, affecting approximately 26% of the U. S. adult population (CDC, 2013). Data from the American College Health Association National College Health Assessment (ACHA - NCHA) show that nearly 14% of college students have been diagnosed or treated for depression within the last 12 months (ACHA-NCHA, 2016). However, most people with a mental illness do not have contact with mental health care providers and tend to go undiagnosed (Kessler et al., 2010; Wang et al., 2005). Due to the challenges of measuring mental illness in general populations, nonspecific psychological distress is often studied as an indicator of mental illness (Kessler et al., 2010; Lincoln, Taylor, Watkins & Chatters, 2011; Szymanski & Lewis, 2015; Thomas, Witherspoon & Speight, 2008; Watson & Hunter, 2015). Both depression and non-specific psychological distress are considered indicators

of mental illness (CDC, 2013; Cochran, Sullivan, & Mays, 2003; Lincoln et al., 2011). Further, social science investigations of general populations often use depression or depressive symptoms as a measure of psychological distress (Dyrbye, Thomas, & Shanafelt, 2006; Lincoln et al., 2011).

Depression is the world's most pervasive psychiatric disorder; it affects the mind, emotions, behaviors, and physical health of those who suffer from it (World Health Organization, WHO, 2008). Characterized by persistent sadness and sometimes irritability, depression can be costly and debilitating to sufferers. It can adversely affect common chronic conditions such as arthritis, asthma, cardiovascular disease, cancer, diabetes, and obesity. It is also related to increased work absenteeism, short-term disability, and decreased productivity (CDC, 2010). In the U. S., 1 in 10 women report some level of depression with the highest rates concentrated in the southeast (CDC, 2010). Depression is twice as likely to occur in women as in men (CDC, 2013; Nolen-Hoeksema, 2001). Similarly, college women report having been treated or diagnosed with depression more than men, 15.6% vs. 8.7%, respectively (ACHA-NCHA, 2016). Nearly 13% of Blacks are diagnosed with depression (CDC, 2010); but, there are no specific rates for Black women because population health research collect data using unitary categories such as race or gender (Bauer, 2014; Carrington, 2006). In addition, primary care physicians are less likely to diagnose depression in African Americans in comparison to their white counterparts (Nicolaidis et al., 2010).

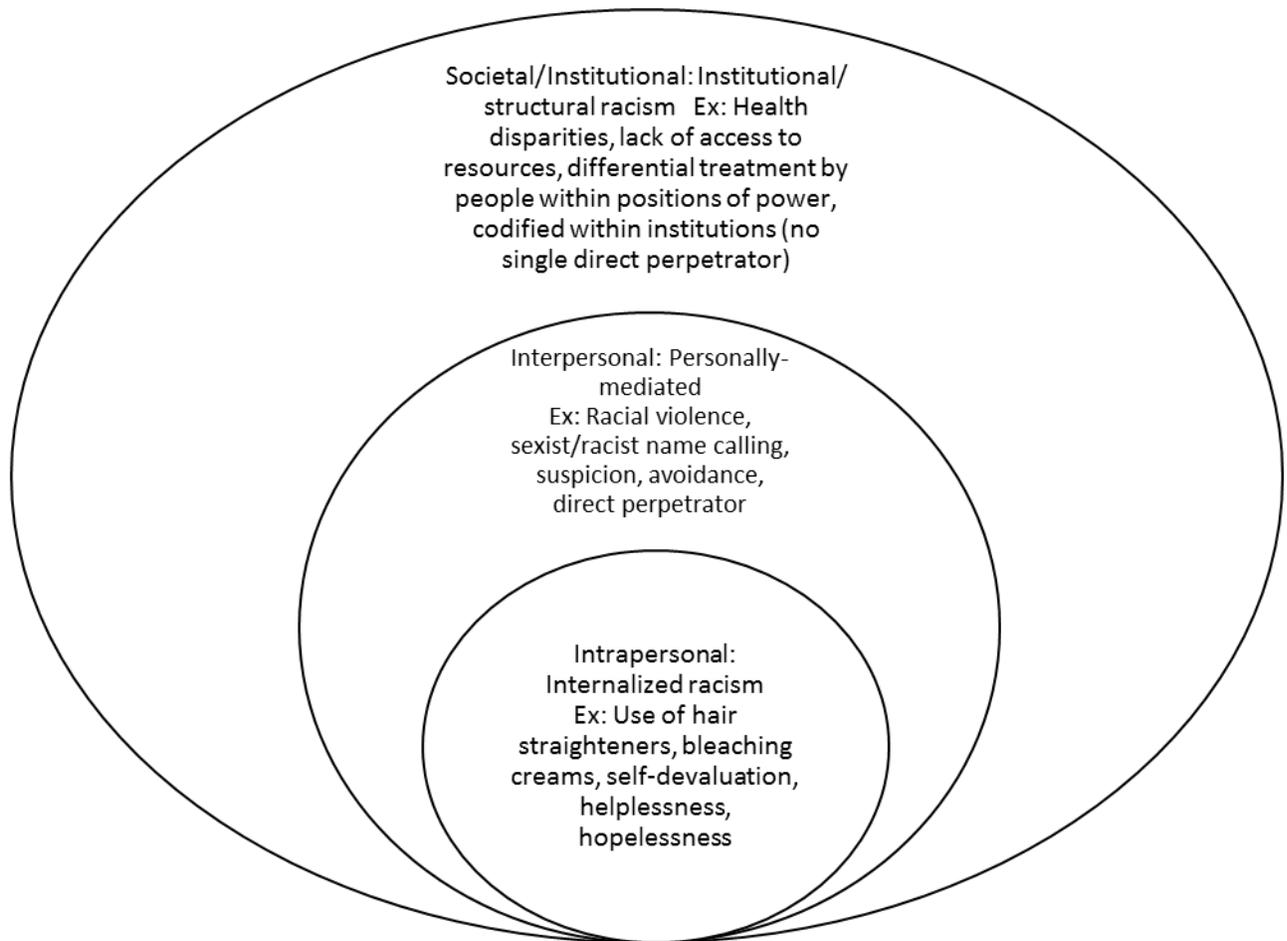
Psychological distress is a reactive disorder affected by external stress (George, Hughes, & Blazer, 1986). It is characterized by a range of symptoms including lack of enthusiasm, sleep problems, feeling blue, hopeless or emotional (Decker, 1997). The CDC reports that in a national study, approximately 40% of the sample had serious psychological distress (2013). Of those

reporting psychological distress, women outnumbered men (CDC, 2013). Nearly 13% of Blacks are diagnosed with depression (CDC, 2010). Like depression, psychological distress is also higher in women than in men (CDC, 2013; Health, US, 2011). College women report experiencing above average or tremendous levels of stress more so than men (ACHA-NCHA, 2016). A report from the Office of Minority Health (OMH) states that African Americans are 20% more likely to report having serious psychological distress as their white counterparts (DHHS, OMH, 2016). Among African Americans, mental health status is also affected by income, with those below the poverty level three times more likely to report psychological distress (Health, US, 2011). Similar to depression, psychological distress is also higher in women than in men (Health, US, 2011). To fully appreciate depression, un- or diagnosed in Black women, racism must be examined.

Colleges and universities have been suggested as appropriate settings since racism is particularly prevalent at predominantly white institutions (PWI) and contributes to lower classroom performance, self-doubt, and mental health challenges (Harwood, Huntt, Mendenhall, & Lewis, 2012; Nadal, 2011). As a goal of Healthy People 2010, James (2008) stated that eliminating health disparities would not be achieved without first “undoing racism.” Healthy People 2020 calls attention to racism as a social and structural determinant of health and suggests research focused on its various forms may help to explain racial health disparities (Braveman, Egerter, & Williams, 2011; Gee & Ford, 2011). As a social determinant of health, racism can be understood as a phenomenon that results in avoidable and unfair inequalities in power, resources and opportunities across racial or ethnic groups. (Berman & Paradies, 2010). Racism can occur at three levels: internalized, interpersonal, and systemic (Berman & Paradies, 2010).

The social ecological model proposes that multiple and broad levels of influence impact an individual's health; thus, interventions designed to create individual-level change should consider the multiple levels of influence (McLeroy, Bibeau, Steckler, & Glanz, 1988). Further, leading health researchers advise that attending to broader environmental factors as well as the individual provides the best opportunity for effective behavior change (Minkler, 1999; Syme, 1987). Internalized racism, at the intrapersonal level, includes the acceptance of racist attitudes, beliefs or ideologies into one's worldview. It may manifest as the use of hair straighteners, bleaching creams, and skin tone stratification within communities of color (Jones, 2000). Interpersonal racism involves interactions between individuals, including name calling, threats and personal violence and is more commonly known as racial discrimination. Jones (2000) described it as personally-mediated racism to indicate a clear and direct perpetrator; it is what most people think of when they hear the term "racism." It includes intentional and unintentional acts of commission as well as omission (Jones, 2000). Systemic racism refers to the production, control and access to power, material and symbolic resources within a society (Berman & Paradies, 2010). Similarly, institutional racism is defined as differential access to goods, services, and opportunities based on race. It manifests materially as differential quality in education, housing, and medical facilities. Additionally, it manifests as differential access to information, such as one's own history (Jones, 2000). It can be understood across the organizational, community, and policy levels. In this paper, systemic racism will be referred to as institutional racism to align with the language used in public health research (Jones, 2000) and will be included on the societal/institutional level of influence. Figure 1 shows Jones' levels of racism expressed across the social ecological model through internalized beliefs, behaviors, and deeply embedded social systems and structures.

Figure 1 Socio-ecological model of Racism and Gendered Racism



Perceived racism is the extent to which individuals are aware of racism as a social element (Ford et al., 2009). It reflects an individual's assessment of everyday occurrences of racist practices, commonly referred to as micro-aggressions (Sue, 2010). Micro-aggressions are often invisible forms of prejudice and discrimination that operate on an unconscious level for the perpetrator but negatively impact people of color (Lewis, Mendenhall, Harwood, & Hunt, 2013; Sue, 2010). While racial discrimination seems to be a prevalent experience for people of color

(Kessler, Mickelson, & Williams, 1999; Landrine & Klonoff, 1996), there are individual differences in how people appraise an incident as discriminatory (Sellers & Shelton, 2003).

Psychology research suggest that the more Blacks identify with their racial groups, the more vigilant and sensitive they are to perceiving discrimination (Crocker & Major, 1989; Sellers & Shelton, 2000). Racial identity is described as the significance and meaning that Blacks attribute to their membership within the Black racial group within their self-concepts (Sellers, Rowley, Chavous, Shelton, & Smith, 1997). The individual's ascriptions and perceptions about their racial groups likely serve as personal guides for making individual decisions, depending upon the importance and meaning of racial identity (Harvey & Afful, 2011). When racial identity is scored as less important by black college students, it is associated with increased stress and depression, even when there is a positive correlation with perceiving racial discrimination (Sanchez & Awad, 2016).

Racial identity plays an important role in perceiving racial discrimination as well as in providing protection from the negative mental health consequences of exposure to racial discrimination (Sellers, Copeland-Linder, Martin, & Lewis, 2006; Sellers & Shelton, 2003). A recent meta-analysis (Smith & Silva, 2011) and a review of the literature (Rivas-Drake, et al., 2014) contend that for Black adolescents, a stronger racial identity is related to positive psychosocial factors, academic achievement, and health outcomes. In addition, empirical research suggest that racial identity may buffer the deleterious consequences of racial discrimination (Galliher, Jones, & Dahl, 2011; Rivas-Drake, Hughes, & Way, 2008; Sellers et al., 2006). With ample quantitative support for racial identity in perceiving of racism and protecting mental health, much less is known about the role of racial identity specifically in Black women who experience gendered racism.

Gendered racism was coined by sociologist, Philomena Essed (1991) and refers to the simultaneous experience of racism and sexism (Lewis, Mendenhall, Harwood, & Hunt, 2013). Gendered racism explains the complexity of oppression specific to Black women based on gendered and classed forms of racism. Gendered racism manifests through constructed ideologies and stereotypes of Black womanhood (Collins, 1990). For example, Black women have been stereotyped as the Strong Black Woman (SBW) (Morgan, 1999). It is presented as one word to show the embedded and inseparableness of the three elements, whereas strength is understood when one speaks of Black women (Morgan, 1999). While it might be considered by some as a positive image, it can also be understood as the super-human capacity to endure inordinate amounts of stress and lead to essentialist notions that all Black women are strong (Morgan, 1999; Woods-Giscombe, 2010). This projected and internalized stereotype is thought to lead to suppressed emotions and negative health effects that are specific to Black women (Collins, 1990; Woods-Giscombe & Black, 2010). Collins explained that the construction of the SBW equipped to endure hardship served as the justification for oppression, in the form of gendered racism (Collins, 2000). Feminists and critical race theorists describe this simultaneous oppression as intersectionality; whereby systems of oppressions based on race, class, gender, sexuality, ethnicity, nation, age (Collins, 1998), and disability (Erevelles & Minear, 2010) intersect and form mutually constructing features of social organization (Collins, 1998).

Few quantitative studies have examined the health impact of gendered racism on Black women. However, those that have report inconsistent findings and often operationalize gendered racism as sexism and racism. Some report that gendered racism increase mental health problems (Szymanski & Lewis, 2015; Thomas, Witherspoon, & Speight, 2008; Watson & Hunter, 2015) while another found no correlation between gendered racism and mental health when other

factors are considered (Carr, Szymanski, Taha, West, & Kaslow, 2014). Yet another found that the impact of gendered racism on mental health is not the same for all Black women (Perry, Pullen, & Oser, 2012). Additionally, qualitative studies have sought to understand how Black women cope with gendered racism. Still, few of them have conceptualized gendered racism as a unitary construct (Robinson-Wood et al., 2015; Shorter-Gooden, 2004; Woods-Giscombé, 2010). These studies have found that there are a variety of coping strategies used to address gendered racism dependent on the context. Only one study specifically examined coping strategies that specifically focus on gendered racism (Lewis et al., 2013). It too found that Black women use a variety of coping strategies depending on the context; some strategies include resistance coping, collective coping and self-protecting strategies. All of these studies call for further exploration of the impact of and the coping strategies used to address gendered racism.

Statement of Problem

Given the inconsistent quantitative findings (Szymanski & Lewis, 2015; Watson & Hunter, 2015; Perry, Pullen, & Oser, 2012; Carr et al., 2014; Thomas, Witherspoon, & Speight, 2008), and the limited qualitative findings on the health impact of gendered racism, and effective coping strategies (Lewis et al., 2013; Woods-Giscombé, 2010; Shorter-Gooden, 2004), a mixed methods study was appropriate (Creswell & Plano Clark, 2011). A mixed methods study was selected for multiple reasons. Primarily, neither the quantitative or qualitative phase alone provides the complete story of gendered racism; while the quantitative phase examined the relationship between gendered racism on mental health, the qualitative phase explained and enhanced the quantitative results, and empowered the participants through interviews and focus groups (Mertens, 2009; Pini, 2002). A mixed methods approach is needed when the focus on the research is on qualitatively exploring a phenomenon but requires initial quantitative results to

identify and purposefully select participants (Creswell & Plano Clark, 2011). Additionally, mixed methods are used to advance a theoretical perspective in order to bring about change and to provide a lens through which the entire study is viewed (Creswell & Plano Clark, 2011); a critical theory is often used to bring about change.

Theoretical Framework

Critical race theory (CRT) differs from behavior change and epidemiological theories typical in health research (Ford & Airhihenbuwa, 2010). Born out of the union between critical legal studies and radical feminism in the mid-1970s, CRT intellectually originated with the works of Derrick Bell (Delgado, 1995) and Patricia Williams (Ladson-Billings, 1998). It is a transdisciplinary methodological approach to addressing racial stratification through activism and scholarship (Delgado & Stefancic, 2001). Critical race research seek to actively study and transform the relationship among race, racism and power (Delgado & Stefancic, 2001). CRT posits that racial stratification, or white supremacy, is ordinary and is engrained in the foundation of our nation (Delgado & Stefancic, 2001). CRT includes five key tenets, with three emphasized in this study: ordinariness, intersectionality and counter-narratives (Crenshaw, 1991; Delgado & Stefancic, 2001). Ordinariness suggests that racism is a normal, ordinary experience engrained in American society (Delgado, 1995). Intersectionality, also developed as its own theory, refers to the experiences of women whereby multiple systems of oppression, based on gender, race, class, sexuality, ethnicity, nation, ability, and age, are interconnected and cannot be understood separately (Crenshaw, 1991). Counter-narratives are defined as telling the stories of those whose experiences are not often told, those on the margins, to challenge myths of meritocracy and a post-racial society (Solorzano & Yosso, 2002). CRT has been adapted to several academic fields including public health (Ford & Airhihenbuwa, 2010).

Purpose and Research Questions

The purpose of this study was to understand the impact of gendered racism on the mental health of Black college women at the University of Alabama. It also explored the coping strategies they use when dealing with gendered racism. The quantitative phase portrayed the impact of gendered racism on mental health and tested the role of racial identity as a protective factor against gendered racism. It was also used to select participants for interviews. The qualitative phase enhanced the understanding of gendered racism and provided the opportunity for Black women to resist gendered racism. The qualitative phase also explored the coping strategies used to address multiple forms of gendered racism in individual interviews and a focus group. The following research questions were included in this mixed methods study:

Quantitative

1. What is the relationship between gendered racism and mental health (operationalized as psychological distress and depression) in Black college women?
2. Does racial identity predict gendered racism in Black college women?
3. Does racial identity (indirectly, partially or fully) mediate the effect of gendered racism on mental health in Black women in college?

Null Hypotheses:

1. Gendered racism is not significantly related to mental health.
2. Racial identity is not significantly related to gendered racism.
3. Racial identity does not mediate the effect of gendered racism on mental health.

Qualitative

4. What stories do Black college women tell about gendered racism to describe its mental health impact and meaning?

5. What coping strategies do Black college women use when they perceive of gendered racism?

Mixed Method

6. How do the perspectives of Black college women who perceive of gendered racism enhance the understanding of gendered racism on health outcomes (mental health) and behaviors (coping strategies)?

Research Design

The transformative explanatory sequential design was used for this study. A transformative design can be paired with any design type as long as the theoretical lens used in the study has a pervasive influence throughout the research process (Mertens, 2003). The purpose of the transformative design is to conduct research that is change oriented and that seeks to advance social justice by identifying power imbalances and empowering individuals (Greene, 2007; Mertens, 2003; 2009). Researchers use the methods best suited for advancing the transformative goal. In this study, the transformative design works well with critical race theory as the goal of critical theory is to disrupt normative experiences that are based on hegemonic ideology (Kincheloe & McLaren, 2002). The explanatory sequential design was selected in order to understand the impact of gendered racism on mental health and empower the participants impacted by it.

The explanatory sequential design begins with the collection and analysis of the quantitative data and is then followed by the collection and analysis of the qualitative data (Creswell & Plano Clark, 2011). The quantitative data was used to test the hypotheses that gendered racism increases mental health problems, operationalized as psychological distress (K6) and depression (PHQ-9), and that racial identity (MIBI) mediates the effect of gendered

racism (GRMS) on mental health. The quantitative phase served two purposes. First, it showed the relationships between gendered racism, mental health, and racial identity. Secondly, it identified participants for the qualitative phase. The explanatory sequential participant-selection variant, Morgan (1998) described, is used when the research is focused on qualitatively exploring a phenomenon but requires initial quantitative results in order to identify and purposefully select the best participants to address the research questions. In order to answer the qualitative research questions, only participants who perceive of gendered racism were eligible for interviews. Interpreting the qualitative data revealed how women who are marginalized by gendered racism persist and thrive by utilizing various coping strategies.

The purpose of mixing methods in transformative designs is for value-based and ideological reasons more than for reasons related to methods and procedures (Greene, 2007; Mertens, 2009). The mixed methods approach provided a comprehensive view of gendered racism by quantitatively showing its impact on mental health and by following up with participants to understand their coping strategies. The descriptive statistics were used to describe participants in the interviews. For example, a participant with high psychological distress may have different coping strategies than a participant with low psychological distress. Thus, participants described the coping strategies that they believe work best. Lastly, a focus group was conducted as an empowering mechanism; participants discussed gendered racism and their coping strategies (Pini, 2002).

Potential Challenges to the Design

Four challenges were anticipated for using the transformative explanatory sequential design, including time, incentives, novelty of design, and trust. First, significant time was required for implementing two distinct phases; quantitative data was collected and initially

analyzed before the qualitative data was collected. As reciprocity is key to participatory research, the participants had the opportunity share and reflect on their experience during the interview. The focus group allowed participants the opportunity to support and validate each other. Both the interview and the focus group have been discussed elsewhere as empowering for participants. Second, in regards to incentives, interview participants received \$10 cash for their engagement. During the focus group, participants were served dinner. Funding was secured through the graduate school's Research and Travel Committee as well as the Department of Health Science. A third challenge was the novelty of the design in health education and health promotion research. To date, I have not identified any research that used transformative mixed methods in health education where structural oppression is the primary focus. I depended on health equity research from public health as well as research from various other disciplines. Lastly, and most importantly, I had to develop trust with the participants to conduct the research in a culturally sensitive way. Trustworthiness (Maxwell, 2013) is key to collecting qualitative research and requires sufficient time and effort to build. I used critical self-awareness strategies including memoing to identify power imbalances to meet the participants where they were. Although not necessary in this study, I offered multiple interview sessions so that the participants and I could reach a level of comfort.

Significance of Study

To my knowledge, this study is the first of its kind in the field of health education and health promotion. The literature review provided an interdisciplinary and contextual understanding of Black women's health. Traditionally, health education research focuses on the status and outcomes without providing historical or socio-cultural context. This has led to the study of Black women, in comparison to non-Black counterparts, using a deficit framework with

little emphasis on their strengths (Calderon, 2016; Dutta, 2016; Johnston-Goodstar, 2013; Tuck, 2009). Thus, this study sought to benefit Black women through the use of counter-narratives; and, to transform health education and health promotion's understanding of Black women's health from a deficit-lens to one of empowerment by calling attention to the system of gendered racism and how Black women persist and thrive.

Terms and Definitions

African Americans – used interchangeably by the federal government with “Black” to represent race and or ethnicity (United States Census Bureau, 2011). The term African American was popularized by the Rev. Jesse Jackson in the 1980s; however, not everyone prefers it over Black, or Black American (Philogene, 1999). Since little may be known about the actual ancestral roots of Black Americans, some resist this terminology for multiple reasons although it is often used in public health research. Black represents race within a racialized society, to indicate those who are not white and thus who are not racially privileged (Okpalaoka & Dillard, 2012). Black is capitalized because it represents people of the African diaspora as opposed to a color as an adjective (Philogene, 1999). In this study, of gendered racism, Black is used to represent race, not ethnicity.

Counter-narratives – the use of an individual's story involving various forms of oppression to create individual or composite accounts within social, historical, and political situations. A key construct in critical race theory; used to challenge ideas of meritocracy and post-racial societies (Solorzano & Yosso, 2002).

Composite counter-narratives – multiple narratives from various experiences of people of color presented compositely to bring attention to the experience of racism as opposed to a single individual. Composite counter-narratives may provide social,

historical and or political context of racism, sexism and other forms of oppression; used specifically in critical race theory (Bell, 1987; DeCuir & Dixson, 2004; Solorzano & Yosso, 2002)

Deficit-based research – research that emphasizes need or lack in order to attain funding to address an important health problem. Considered dangerous because it tends to singularly define communities based on problems as opposed to strengths (Tuck, 2009).

Black college women – sample of study that includes undergraduate and graduate level students who identify as Black or African American and as a woman; who take at least one class on campus. Includes women who identify as cisgender, transgender and gender nonconforming.

Gendered racism – oppression based on race and gender where the intertwined experiences form a hybrid form of oppression that people of color experience (Essed, 1991). In this study, gendered racism conceptualizes intersectionality and will be quantitatively measured with the newly developed Gendered Racial Microaggressions Scale (Lewis, 2015).

Intersectionality - refers to the overlapping or intersecting social identities (gender, race, class, sexuality, ethnicity, nation, ability, and age) and related systems of oppression that make up experiences for marginalized groups that cannot be understood separately. For example Black women may experience racism differently than Black men and sexism differently than White women. As another example, an older White male with a physical disability may be at the intersection of ageism and ableism. Intersectionality refers to a construct in Critical Race Theory and is its own theory (Crenshaw, 1991).

Mental disorders – generally understood as a way of representing a variety of clinically undiagnosed mental illnesses; refers to the presentation of symptoms, such as psychological

distress, or a deviation from a psychological norm. Mental disorders tend to lack a consistent operational definition across disciplines (Stein et al., 2010).

Mental Health – a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Mental Illness – refers collectively to all diagnosable mental disorders. They are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning (CDC, 2013)

Narratives – generally used to mean “stories” where events are sequential, organized, connected and evaluated as meaningful for a particular audience; commonly used in qualitative research. They provide the opportunity for meaningful reflection on past experiences; used to construct identities and encourage action (Riessman, 2008).

Narrative Inquiry – a way of understanding and inquiring into human lives while honoring lived experiences. It focuses on ordinary human experience and is based on a meaningful collaboration between the researcher and participants (Clandinin, 2013).

Participant-selection variant - a sampling design specific to explanatory sequential mixed methods where the research is focused on qualitatively exploring a phenomenon but requires initial quantitative results in order to identify and purposefully select the best participants to address the research questions (Morgan, 1998).

Racial identity – the importance and meaning that Blacks attribute to their membership within their racial group within their self-concepts (Sellers et al., 1997).

Serious Psychological distress - mental health problems severe enough to cause moderate-to-serious impairment in social, occupational, or school functioning and to require

treatment (Weissman, Pratt, Miller, & Parker, 2015); an outcome of stress when stressors (demands or challenges) are met with inadequate resources; key indicator of undiagnosed mental illness (Dohrenwend & Dohrenwend, 1974).

Nonspecific psychological distress – Operationalized as an outcome variable indicating mental health challenges; measured with the Kessler 6 (K6) indicates undiagnosed psychological distress in general populations.

StrongBlackWoman (SBW) – an ideological misrepresentation of Black women that suggest that extraordinary strength is innate. Originally created to justify historical oppression. Characterized by multiple roles and responsibilities with little to no care of self. Tends to lead to negative health practices and outcomes for Black women (Woods-Giscombe, & Black, 2010; Collins, 1990).

Structural determinant of health – implicit cause of public health problems built within contextual or environmental factors that influence individual risk behaviors. Include inequalities based on class, gender, race or ethnicity that influence health (Thomas et al., 2011).

Subjectivity statement – a summary of the researcher in relation to what and whom is studied; a way of recognizing the researcher as an instrument in collecting, analyzing, and interpreting qualitative data as opposed to the standard of objectivity in post-positivist research (Brinkmann, 2013).

Transformative design – change-oriented research done to advance the needs of underrepresented or marginalized communities that focuses on social justice. It involves the researcher's ideological perspective and valuing participants. In mixed methods research, methods are chosen that are best suited for advancing a specific goal. Often paired with a critical theory (Mertens, 2009).

Weathering - early health deterioration experienced African Americans as a consequence of the cumulative exposures to racialized stressors (Geronimus, 1992).

Limitations

The University of Alabama has unique modern and historical characteristics associated with racism and gendered racism, thus the results of this study should be applied elsewhere with great caution. Findings from both the quantitative and qualitative phases should be understood within this context. Further, the personal experiences and perceptions are unique to each individual participant. Both phases of the study were conducted over the course of a single semester which limited the ability to fully capture the complete experience of gendered racism.

The quantitative phase included several limitations. This study was cross-sectional in nature thus causation could not be inferred. A nonrandom convenience sample was used although the sample included 8% of the total population and far exceeded the sample size requirement based on the power analysis. Data collection occurred at a single, predominantly White university in the southeast so it is possible that the quantitative findings are not generalizable to institutions beyond the southeast as well as to historically Black colleges and universities. Participants may have misinterpreted items on the various instruments used. Although two measures of mental illness were used, anxiety, bipolar disorder, and schizophrenia were not measured. Finally, the gendered racism scale used in this study predominantly captures personally-mediated, or interpersonal, racism and does not address internalized racism. The scale only captures a minute aspect of institutional racism based Eurocentric beauty standards as microaggressions. Therefore the quantitative phase did not fully capture the totality of gendered racism.

Limitations of the qualitative phase included time constraints which limits the potential for thick description since typically multiple interview sessions are required. Although all of the qualitative data was gathered in a relatively short time span, two months, participants were allowed to talk at length within their respective interview sessions. Additionally the focus group was not restricted by time and the group met for over three hours. My role as researcher and representative of the institution did not seem to inhibit participants' voice during the interview and focus group. Finally, given the perceived freedom of expression, the researcher may have been viewed as an "insider," which made the participants more likely to share sensitive information.

Delimitations

This study did not directly address and quantitatively control for all known stressors (general stressors including academic performance, accidents and interpersonal conflict) though those most commonly associated with women (age, financial strain, marital and maternal status) was assessed. I chose to specifically focus on the experiences of Black women in college, though all men and women of color experience varying forms of gendered racism.

Assumptions

The self-reported data in both phases of this study were assumed to be accurate perceptions of participants' experiences. I made the assumption that as a Black woman and an investigator, with privileges based on class, sexual orientation, ability and religion, my use of reflexive memoing would limit potential negative influence I may have on the study.

Quantitative assumptions included those that human experience can be explained and predicted; while a qualitative assumption included the desire to understand and challenge normative

hegemonic experience. A fundamental assumption of narrative inquiry is that stories are an essential way of understanding human experience.

I made the assumption that students who decide not to participate in or complete either phase of the study did not have an impact on the findings. I made the assumption that a mixed methods approach yields a more comprehensive view of the impact of and coping strategies used to address gendered racism. Based on the theoretical and paradigmatic framework of the study, I made the assumption that gendered racism is normative in the lives of Black college women. Finally, I made the assumption that data collected from students at one institution generates important findings in this area of research.

CHAPTER 2. LITERATURE REVIEW

Health disparity is defined as a particular type of health difference that is closely linked to social, economic, and/or environmental disadvantage. Healthy People 2020 expanded the 2010 goal of eliminating health disparities to achieving health equity, eliminating disparities, and improving the health of all people. At the foundation, the broader goal of attaining health equity recognizes the importance of focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities (Office of Minority Health, 2010). Healthy People 2020 calls attention to the powerful and complex relationship between health outcomes, individual behavior, and the social determinants of health. Increasingly, racism has been receiving attention as a determinant of racial health disparities in an attempt to understand negative health outcomes (Braveman, Egerter, & Williams, 2011; Mays, Cochran, & Barnes, 2007).

As a social determinant of health, racism can be understood as a phenomena that results in avoidable and unfair inequalities in power, resources, and opportunities across racial or ethnic groups (Berman & Paradies, 2010). Racism can be expressed across the socio-ecological model through beliefs, emotions, behaviors/practices, and deeply embedded social systems and structures. Further, racism can occur at three levels: internalized, interpersonal, and systemic (Berman & Paradies, 2010), whereas internalized racism includes the acceptance of racist attitudes, beliefs or ideologies into one's worldview (Pyke, 2010). Interpersonal racism involve interactions between individuals, including name calling, threats and personal violence

and is more commonly known as racial discrimination. Jones (2000) described it as personally-mediated racism to indicate a clear and direct perpetrator; it is what most people think of when they hear the term “racism”. Systemic racism refers to the production, control and access to power, material and symbolic resources within a society (Berman & Paradies, 2010; Paradies, 2006a). In this study, systemic racism is referred to as institutional racism to align with the language used in public health research (Jones, 2000). Racism, as a social determinant of health, has led to inequitable access to social, educational, and material resources that have both direct and indirect effects on health status. Direct effects include access to healthy diets and medical care; indirect effects include the influence of stress, psychosocial resources, and positive and negative emotions (Adler & Snibbe 2003; Adler & Rehkopf, 2008; Gallo & Matthews, 2003). All forms of racism can have individual as well as population level health consequences (Brondolo, Gallo, & Myers, 2009).

Critical Race Theory & Public Health Critical Race Praxis

Racism has been defined as “the state-sanctioned and/or extralegal production and exploitation of group differentiated vulnerability to premature death” (Gilmore, 2007). This definition is central in critical race theory (CRT) which has been suggested as an important theoretical framework for addressing health disparities (Thomas et al., 2011). Gilmore’s definition of racism suggests that health equity cannot be achieved within the presence of structural racism (Ford & Airhihenbuwa, 2010). Critical race theory provides the foundation for the health equity action research trajectory (HEART) as a platform for fourth-generation research. The ultimate goal of fourth generation research is to take action to eliminate health disparities; this research is in direct response to the aim of Healthy People 2020 at achieving health equity (Thomas et al., 2011). Thus in order to work toward achieving health equity,

critical race theory and its use in public health research through the Public Health Critical Race Praxis (PHCRP) must be understood.

Originating from critical legal studies (Crenshaw, Gotanda, Peller, & Thomas, 1995), CRT has been adapted to education (Ladson-Billings, 1998) and more recently to public health (Ford & Airhihenbuwa, 2010). It provides guidance for understanding the impact of racism on health outcomes as well as the research process (Ford & Airhihenbuwa, 2010). Critical race theory differs from behavior change and epidemiological theories typically used in health research; it is an iterative methodology that helps researchers attain to equity during the research process and works to address systemic oppression (Ford & Airhihenbuwa, 2010). CRT centers on race and how racism is intensely entrenched within the structure of American society (Parker & Lynn, 2002). CRT posits that white supremacy is ordinary and is engrained in the foundation of our nation; thus racism is ordinary as opposed to an aberrational experience. (Delgado & Stefancic, 2001; Ladson-Billings, 1998). In addition, CRT is built on several key tenets including: race as a social construct, intersectionality (Crenshaw, 1991) and the use of narratives (Delgado, 1995).

Ordinariness is an understanding of racism as a common and normative experience for people of color (Delgado & Stefancic, 2001). The PHCRP suggests that constant, chronic exposure to seemingly minor insults may have enduring impacts on one's health (Ford & Airhihenbuwa, 2010). Intersectionality refers to the experiences of women whereby multiple systems of oppressions, based on gender, race, class, sexuality, ethnicity, nation, ability, and age, are interconnected and cannot be understood separately (Crenshaw, 1991). Additionally, intersectionality theory has been developed as its own theory and will be discussed later in this chapter. Narratives, also called counter-stories, counter narratives, or voice, are defined as a

method of telling the stories of those whose experiences are not often told, those on the margins (Solorzano & Yosso, 2002).

Ford importantly notes CRT tenets in public health research, offering that while health studies involve racialized exposures and or outcomes, most do not adhere to CRT's core tenets. Thus, Public Health Critical Race Praxis provides directions to help move beyond documenting health inequities toward understanding and challenging systemic power hierarchies (Ford & Airhihenbuwa, 2010). The PHCRP offers health equity researchers the guidance to carry out research with fidelity to CRT by providing the following key tenets presented in Appendix J.

Racism, Class & Health

The idea that racism harms health is certainly not new, as abolitionists in the mid-1800s posited that the poor health of Blacks relative to Whites was not due to innate inferiority, but to white privilege, slavery and legal discrimination. However despite its long history, the study of racism as a determinant of population health remains immature (Krieger, 2003). Traditional public health studies tend to focus on racial differences in disease. They test whether health outcomes are similar among different racial or ethnic groups at the same socioeconomic level (Krieger, et al., 1993). Hypotheses tend to focus on two themes: Do social gradients exist for the disease? And, if so, are the adverse outcomes the same across class in the different racial/ethnic groups? Oftentimes through this type of methodology, researchers phase out race and focus on class as the main determinant. When, in fact, racism and class are not an “either/or” debate, but a “both/and” conclusion. Sociological and historical research posits that race and class are intertwined. Since the mid-15th century international slave trade, people have lived in a world of racialized class and class-contingent race relations (Krieger, 2008). Logically, inequalities are shaped by their integration. In the traditional study of health, race and class, studies have shown

that adjusting for socioeconomic factors often reduces, and at times eliminates, racial disparities, but in many cases differences in well-being still persist (Krieger, et al., 1993).

Despite the focus on socioeconomic status and health behaviors, racial disparities persist in life expectancy, and among the leading causes of death such as heart disease, hypertension, and diabetes (CDC, 2011). Krieger (2008) proposes a way to understand how racism directly impacts health through stress. Racism becomes “embodied” over the life-course, adversely affecting the health of oppressed populations through five pathways:

1. Economic and social deprivation; 2. Toxic substances and hazardous conditions; 3. Socially inflicted trauma (mental, physical, and sexual, directly experienced or witnessed, from verbal threats to violent acts); 4. Targeted marketing of commodities that can harm health, e.g. junk food and psychoactive substances (alcohol, tobacco, and other licit and illicit drugs); and 5. Inadequate or degrading medical care. (p. S22)

Krieger’s (2012) model emphasizes the dual impact of racism on health by harming the subordinate group and benefitting the dominant one. “Racism may be conceptualized as a tool employed by those in power to maintain privilege and control over resources (for example, wealth, knowledge, prime land and housing) that ultimately benefit health” (Link, & Phelan, 2014; Lukachko, Hatzenbuehler, & Keyes, 2014).

Stress & Racism

Ample research provide evidence for the impact of racism on health both directly and indirectly (Krieger, 2000). The Life-course perspective explains how racism affects health directly through negative physical and psychological consequences. The Life-course perspective offers that early and long-term exposure to stress, like racism, provide wear and tear on the body’s allostatic system (Lu & Halfon, 2003). Or, indirectly through institutional racism that

leads to the identification of ethnic minority groups, their reification as biologically and culturally different, and the consequent exclusion, and social and economic disadvantage (Miles, 1989). Further, racism is understood as a fundamental cause of racial health disparities through its interaction with socio-economic conditions, societal and institutional structures, racial prejudice and discrimination, and stress, all of which harm health (Carty et al., 2011). How one perceives of racism also impacts health but is less understood (Mays, Cochran, & Barnes, 2007).

Perceived racism is the extent to which individuals are aware of racism as a social element (Ford et al., 2009). It reflects an individuals' assessment of everyday occurrences of racists' practices, commonly referred to as micro-aggressions (Sue, 2010). Micro-aggressions are often invisible forms of prejudice and discrimination that operate on an unconscious level for the perpetrator but negatively impact people of color (Sue, 2010). Racial discrimination is a pervasive phenomenon (Sellers & Shelton, 2003). While racial discrimination seems to be a prevalent experience for people of color (Kessler, Mickelson, & Williams, 1999; Landrine & Klonoff, 1996), there are individual differences in how people appraise an incident as discriminatory (Sellers & Shelton, 2003).

Racial Identity Development Theory

Racial identity and racial identity development theory are defined by Helms (1990) as:
a sense of group or collective identity based on one's perception that he or she shares a common racial heritage with a particular racial group... racial identity development theory concerns the psychological implications of racial-group membership, that is belief systems that evolve in reaction to perceived differential racial-group membership. (p. 3)

In societies where racial-group is emphasized, racial identity will develop in some form for everyone, but in different ways depending on the dominant/subordinate group membership (Helms, 1990). William Cross's (1978, 1991) model of Black identity, known as the Nigrescence model of racial identity, provides a more detailed examination of racial identity specific to African Americans.

Racial identity is defined as an understanding of the racial self-concept in a race-based society (Cross, 1991). According to Cross, there are five stages in the development of Black racial identity: Preencounter, Encounter, Immersion/Emersion, Internalization, and Internalization-Commitment. Though presented in stages, the development process is more spiral than linear. The first stage consists of an internalized acceptance of white supremacy that may be outside of the individual's conscious awareness. During this stage, individuals seek to assimilate and actively or passively distance her/himself from other Blacks. There is a de-emphasis on one's racial-group membership because it is believed that race is not a relevant factor. The second, the encounter stage, is usually precipitated by an even or series of events that forces the individual to acknowledge race. The encounter forces the individual to acknowledge their membership of a group targeted by racism. Individuals in the third stage, Immersion/Emersion, actively seek out opportunities to explore their own history and culture. It is characterized by the simultaneous desire to immerse one's self in visible symbols of racial identity, glorifying Black people, while actively avoiding symbols of Whiteness, denigrating White people. Eventually, anger towards Whites dissipates and a newly defined sense of self emerges. The emergence marks the beginning of the fourth stage, internalization, characterized by more openness and less defensiveness. With a secure sense of self, internalized racial identity allows individuals to establish meaningful relationships with Whites and build coalitions with other oppressed groups.

Cross suggests that the fifth stage is similar to the fourth but that individuals here have found ways to translate their personal sense of Blackness into action and is sustained across time. Internalization-Commitment is characterized by a positive racial identity that both proactively perceives and transcends race (Cross, 1991).

Racial identity has also been conceptualized within the Multidimensional Model of Racial Identity (MMRI) (Sellers et al., 1997) and offers significant differences from the Nigrescence theory (Cross, 1991). Notably, the MMRI does not assume that race is the defining characteristic for all Blacks, or that there is an optimal Black identity (Sellers et al., 1998). Instead, it focuses on the significance and qualitative meaning that Blacks attribute to their racial group within their self-concepts (Sellers et al., 1997). This understanding of racial identity comprises two elements: the importance of race in the individual's perception of self and the meaning the individual ascribes to being a member of this racial group (Phinney, 1990). The individual's ascriptions and perceptions about their racial groups likely serve as personal guides for making individual decisions, depending upon the strength of racial identity (Harvey & Afful, 2011).

The MMRI delineates four dimensions of racial identity in African Americans that are both independent and interrelated suggesting that certain dimensions are more relevant to certain phenomena than other dimensions (Sellers et al., 1998). The dimensions are salience, centrality, ideology and regard. Salience refers to the extent to which one's race is a relevant part of one's self-concept within a particular situation and recognizes that salience may vary depending on the context (Sellers et al., 1998). Salience is understood as a process variable contingent on the situation and personal factors, such as centrality. Centrality refers to the extent to which a person defines her or himself with regard to race; it measures race as a core part of an individual's self-

concept. Inherent in centrality is a ranking of hierarchical identities with respect to the individual's main definition of self. Thus, centrality is concerned with the importance of race in the self-concept (Sellers et al., 1998). Racial ideology is concerned with the meaning that individuals ascribe to being Black; it includes the general attributes, characteristics, and values associated with Black people. It represents the personal philosophy about the ways in which African Americans interact in society (Sellers et al., 1998). Sellers suggest that there are at least four ideologies that capture African Americans' view on the importance of racialized group membership (Sellers et al., 1998). A *nationalist ideology* stresses the uniqueness of being of African descent; an *oppressed minority ideology* stresses the similarities of being African American with other oppressed groups; an *assimilationist ideology* stresses the similarities between African Americans and American mainstream society; and a *humanist ideology* stresses the commonalities of all humans (Sellers et al., 1998). While centrality and ideology have to do with how an individual views herself, regard accounts for social interaction and is comprised of two elements, private and public regard. Private regard, the fourth dimension, examines the extent to which an individual has positive feelings toward African Americans in general and public regard is the extent to which an individual feels that other groups have positive feelings toward African Americans (Sellers et al., 1998).

While racial discrimination seems to be a prevalent experience for people of color (Kessler, Mickelson, & Williams, 1999; Landrine & Klonoff, 1996), there are individual differences in how people appraise an incident as discriminatory (Sellers & Shelton, 2003). Racial identity has been linked to different emotional states, personal beliefs, and how individuals process racial information (Carter, Pieterse, & Smith, 2008). Racial group identification or racial centrality has been well-documented with findings suggesting the more an

individual identifies with their racial group, the more vigilant and sensitive they are to perceiving discrimination, with or without the presence of evidence (Crocker & Major, 1989; Sellers & Shelton, 2000).

Racial Identity as a Protective Factor

Much attention has been focused on racial identity and its role in perceiving racial discrimination. One study suggests that racial identity plays a significant role in perceiving racial discrimination and depression (Sanchez & Awad, 2016). This study found that certain categories of racial identity (or low racial identity) in Black college students is associated with increased stress and depression (Sanchez & Awad, 2016). An earlier study with 267 African American college students specifically identified racial centrality as being positively associated with how much discrimination an individual report that they have experienced (Sellers & Shelton, 2006). At the same time, racial centrality seems to provide protection from the negative mental health consequences of perceived discrimination. Thus individuals with high racial centrality perceive of racial discrimination more often but are protected by the negative consequences of exposure (Sellers & Shelton, 2006). For young African-American adults, racial identity overall was a protective factor in buffering the negative impact of discrimination on psychological distress (Sellers et al., 2003).

Black racial identity is well documented in the field of psychology particularly in adolescents and young adults. A recent meta-analysis (Smith & Silva, 2011) and a review of the literature (Rivas-Drake, et al., 2014) contend that for Black adolescents, a stronger racial identity is related to positive psychosocial factors, academic achievement, and health outcomes, even when these findings are not consistent across other racial minority groups. In addition, empirical research suggest that racial identity may buffer the deleterious consequences of racial discrimination

(Galliher, Jones, & Dahl, 2011; Rivas-Drake, Hughes, & Way, 2008; Sellers et al., 2006). One study conceptualized conformity as a devaluing of one's Blackness and found that it was positively related to feelings of anger, depression, confusion, fatigue, and tension among Black Americans (Carter & Reynolds, 2011). This study also found that a positive commitment to other Blacks, operationalized as Internalization, was related to less intense emotional reactions (Carter & Reynolds, 2011). Further, another study found that racial identity predicted more of the variance in mental health than race-related stress in Black American adults (Franklin-Jackson & Carter, 2007).

While much of the research is cross-sectional in nature, findings from longitudinal designs show incremental changes that provide a more nuanced perspective. One study using a longitudinal design found that racial identity was strongly correlated with self-esteem for African American male youth (Mandara, Gaylord-Harden, Richards, & Ragsdale, 2009). Further, that study also found an increase in racial identity over seventh and eighth grade students (age 12 – 14 years of age) was associated with a decrease in the prevalence of depressive symptoms, for that age group, even with self-esteem controlled (Mandara et al., 2009). A correlational study supports that while there is an indirect link between racial identity and depressive symptoms through perceived stress, the significance and meaning that African American adolescents attribute to racial identity may be critical to their psychological well-being (Caldwell et al., 2002).

Racial socialization and racial pride are accepted as antecedents of racial identity. Racial socialization often precedes pride; socialization is conceptualized as a common family setting process where parents of color orient their children to implicit and explicit attitudes and beliefs about race, and how to cope with racial discrimination (Boykin & Toms, 1985). In a sample of

African American college students, findings suggest that parental messages emphasizing the importance of religion, Black history, and the benefits of kinship for coping with racism reduced the impact of racism on psychological stress (Bynum et al., 2007). One theme that is often born out of racial socialization is racial pride (Bowman & Howard, 1985). Recently, Neblett and colleagues (2013) reported that individuals who received more frequent messages of racial pride were more likely to report positive feelings about African Americans and those feelings were associated with less depressive symptomatology. In a correlational study of over 300 African-American adolescents, positive attitudes about African Americans were associated with decreased depressive symptomatology (Sellers et al., 2006). Thus racial identity, racial socialization and racial pride have been linked to positive psychological health.

Racial identity positively correlated with perceiving racial discrimination and depression among Black college students (Sanchez & Awad, 2016). Importantly, racial identity plays an important role in not only perceiving racial discrimination but in providing protection from the negative mental health consequences of exposure to racial discrimination (Galliher, Jones, & Dahl, 2011; Rivas-Drake, Hughes, & Way, 2008; Sellers et al., 2006; Sellers & Shelton, 2003). Though there is adequate quantitative support for racial identity in perceiving of racism and protecting mental health, racial identity has not been examined within the context of gendered racism which is specific to Black women who experience racism intersected with sexism (Essed, 1991) putting them at increased risk for mental health concerns (Woods-Giscombé, 2010; Carrington, 2006; Worthington, 1992). In a study of 229 African American adults examining the effect of racial identity, emotions and race-related stress across a variety of college and professional settings, significant differences were found between men and women. Women

reported experiencing more institutional and cultural racism-related stress than men (Carter & Reynolds, 2011).

Gendered Racism

Gendered racism was coined by sociologist, Philomena Essed (1991) and refers to the simultaneous experience of racism and sexism (Lewis et al., 2013). Gendered racism explains the complexity of oppression specific to Black women based on gendered and classed forms of racism. Gendered racism includes oppressive experiences such as discrimination, inferiority racialized stereotypes, racialized sexual objectification, and discrimination (Collins, 1991). Examples of gendered racism that African American women may experience include insults (“Black bitch”, “nappy-headed bitch”), rude remarks made about one’s body (“your big Black ass”) and hearing offensive comments (“Black women are rude”) (Buchanan, 2005). Experiences of gendered racism among Black women have been related to higher levels of psychological distress (Thomas, Witherspoon, & Speight, 2008) and poor mental health (Carr et al., 2014).

Gendered racism manifests through constructed ideologies and stereotypes of Black womanhood (Collins, 1990). For example, Black women have been stereotyped as the *Strong Black Woman* (SBW). While it might be considered by some as a positive image, it can also be understood as the super-human capacity to endure inordinate amounts of stress and lead to essentialist notions that all Black women are strong (Woods-Giscombe, 2010). This projected and internalized stereotype is thought to lead to suppressed emotions and negative health effects that are specific to Black women (Woods-Giscombe, & Black, 2010; Collins, 1990). Collins explains that the construction of the SBW equipped to endure hardship served as the justification for oppression, in the form of gendered racism (Collins, 2000). At the intrapersonal level, internalizing gendered racism is also described as endorsing the SBW ideology. One study found

that belief in the SBW significantly increased anxiety (Watson & Hunter, 2015). Other studies report that gendered racism most often occurs at the interpersonal level. These include being sexually harassed, hearing inappropriate jokes related to being a Black woman, and being mistaken for “the help” (Essed, 1991; Jones & Shorter-Gooden, 2003; Thomas, Witherspoon, & Speight, 2008).

Gendered racism grew out of intersectionality theory and taps into oppressive sexual experiences and racism among women of color (Buchanan, 2005). Feminists and critical race theorists use intersectionality to describe the simultaneous experiences of oppression, whereby race, class, gender, sexuality, ethnicity, nation, age (Collins, 1998), and disability (Erevelles & Minear, 2010) intersect and form mutually constructing features of social organization (Collins, 1998). Intersectionality theory provides the lens in which gendered racism is understood and conceptualized, thus before examining the occurrence of depression in Black women, intersectionality requires a more thorough examination.

Intersectionality Theory

Feminist legal scholar, Kimberlé Crenshaw coined the term intersectionality in 1989 to complicate understandings of race and gender. She argued that for women of color multiple marginalizations of race and gender intersect (Crenshaw, 1989), thus the experiences of women of color could not be fully understood through any single lens (exploring race OR gender). Women of color occupy a space where they are and have been silenced and dominated by the antiracist and feminist movements due to the movements’ historic and continued failures addressing those that are affected by both forms of oppression. Intersectionality recognizes the intragroup differences of multiple socially constructed identities (race, gender, class, sexual orientation [Collins, 2000] and disability [Erevelles & Minear, 2010]) and highlight the need to

account for multiple grounds of identity when considering how the social world is constructed. Intersectionality calls attention to how the identity of the group has been centered on the intersectional identities of a few within the group. Crenshaw stated,

Although racism and sexism readily intersect in the lives of real people, they seldom do in feminist and antiracist practices. And so, when the practices expound identity as woman or person of color as an either/or proposition, they relegate the identity of women of color to a location that resists telling (1991, p. 1242).

This notion of “resisted telling” is directly responsible for the silencing and erasure of Black women. In the absence of her own voice, the story that is written for and about her is not one that is genuine. This is critical in the rewriting of the Black woman as egregiously strong. The motivations that lie at the center of the Black woman’s strength is not to lift her up as the standard of excellence in femininity or African American pride, but has ulterior motives that are very familiar to whiteness and patriarchy.

Crenshaw (1991) explained that both movements not only fail women of color by not acknowledging the additional issues of race or patriarchy, but both discourses are inadequate in articulating the experiences of women of color. Black women, for example, experience racism that may not be the same as what Black men experience and sexism that may not be the same as what white women experience. Further, both often denies the existence of the other – white feminists regularly fail to interrogate racist practices just as antiracists fail to interrogate sexist practices (Crenshaw, 1991). These failures result in further subordination of women of color pushing them further to the margins.

As an extreme, yet common, representation of marginalization specific to Black women is the historic occurrence of rape. Black women’s bodies were fair game for rape. Thus, rape

laws only focused on protecting White women's bodies, explicitly from Black men. Interracial rape really on meant White victim, Black perpetrator, because the raping of Black women by white men as slave masters was a normal occurrence (Crenshaw, 1991). There has been no move to protect Black women from rape, except that which Black women have done themselves in telling their stories and building empowerment. Subsequently, sexual objectification and rape often embedded within gendered racism, continue to be strong predictors of depression in women (Carr et al., 2014).

Mental Health & Black women

There has long been inconsistencies in reporting on the mental health of Black women. In 2001, the U.S. Department of Health and Human Services suggested that African Americans were less likely to suffer from major depression (DHHS, 2002). National rates of depression in Black women 18 and over, 13.85%, nearly double that of men at the national average, 7% (National Mental Health Association, 1996). Yet community-based studies reported significantly greater prevalence rates in African Americans than in European Americans (Neighbors et al., 2007) or no racial differences in mental disorders (Watson & Hunter, 2015). Other studies posit that African American women are at increased risk for psychological distress because of racism and sexism (Greer, Laseter, & Asiamah, 2009; Woods-Giscombé & Lobel, 2008). Moreover, one study of 204 Black women with low income found that 22% of the sample reported significant mental health problems. Nearly 20% of the sample reported seriously considering or attempting suicide in their lifetimes (Perry, Pullen, & Oser, 2012). Another study assessed 144 Black women who sought mental health treatment and found that sexual objectification experiences, racists' events and gendered racism significantly contribute to depression (Carr et al., 2014). Yet, when all three forms of oppression were examined concurrently along with

internalizing as a coping strategy only racist events predicted depression (Cart et al., 2014). Sexual objectification included unwanted sexual advances, body evaluation, sexual harassment and sexual assault. Further, another study found a strong correlation between sexism-related stress and racism-related stress, $r(202) = .61, p < .001$, (Stevens-Watkins et al., 2014). More stress was associated with sexism and racism than with employment and finances, lifetime victimization and social network loss.

Yet, there remains a persistent myth that mental disorders are rare for Black women. This myth persists largely for two primary reasons: Black women have been historically underdiagnosed, misdiagnosed, and untreated in mental health investigations (Brooks, 1997; Snowden & Pingitore, 2001) and because of the ideology of the StrongBlackWoman (SBW) (Morgan, 1999). While a critique of the mental health system is needed, the latter is the focus of this study. SBW is presented as one word to show the embedded and inseparableness of the three elements, whereas strength is understood when one speaks of Black women. The SBW ideology permeates every aspect of Black womanness (Collins, 2009). To fully understand this concept, a historical context is necessary.

Historical and Social Context of the SBW

The construction of the SBW is based on the intersecting oppressions between racism and sexism and is deeply rooted during the time of African enslavement. It is during this time when African people endured the robbing of their identity. In addition, Black women's bodies served a particular use of not only being property but also reproducing property, thus normalizing the experience of rape and violence (Spillers, 1987). Here in lies the origination of the SBW; forced to endure institutionalized violence and live through it silently. The inherent strength understood in Black women was born out of the demanded denial of their own emotional, physical, and

material needs in order to attend to the needs of others (Mollow, 2006). Collins explains that the construction of the SBW equipped to endure hardship served as the justification for oppression, in the form of gendered racism (Collins, 2000). Over time and across generations, the construction of the SBW became invisible and the ideology became normative and standard. The ideology of the SBW continues to affect how Black women understand themselves as well as how others understand Black women (Beauboeuf-Lafontant, 2009).

Meri Nana-Ana Danquah (1999) provides a personal narrative of struggling with depression in *Willow Weep for Me*. Within the framework of the silencing paradigm, Danquah attempted to acknowledge her loss of identity, but was constantly reminded of the SBW standard. Similarly, Boyd (1999) a psychotherapist, discussed the diagnosis of depression with a Black woman and was told, “Look at what our mothers and grandmothers went through in their lives and we don’t hear them whining about depression” (p.21). Strength is written in the grammar of *Black woman*. It is understood by those within the Black community as well as those outside of it. Danquah’s obstetrician dismissed her first episode of severe depression as the effect of “hormones” and left her untreated. The fact that a Black woman would actually seek help for something she struggles with was so far beyond what even a medical doctor expected speaks to the ubiquitous nature of the SBW. When Danquah tells a White woman at a dinner party that she is writing a book on Black women and depression, the woman responds, “*Black* women and depression? Isn’t that kinda redundant? When *Black* women start going on Prozac, you know the whole world is falling apart” (p. 19-20). The party goer unabashedly states what so many others accept as truth: Black womanhood is synonymous with tremendous strength (Mollow, 2006).

Futhermore, Danquah observes that, “When a Black woman suffers from a mental disorder, the overwhelming opinion is that she is weak. And weakness in Black women is

intolerable.” (Danquah, 1999, p. 61). Internalizing the notion of the SBW is a perfected performance of constant self-deprivation. I use self-deprivation to mean the fact of being deprived of your authentic identity; the identity one would have absent the institution of gendered racism and social conditioning of SBW. Thus, it should not be implausible that internalizing the SBW would weigh heavily on Black women’s mental health and stand as a barrier to receiving treatment.

A qualitative study using focus groups provides a collective view of depression and care in Black women (Nicolaidis, et al, 2010). Many participants talked about strength as a barrier to recognizing depression themselves, accepting it, or being able to seek care for it. One participant described being told, “‘Somebody’s worsen off than we are.’ So we just got to deal. So that’s where the mask came in. ‘I’m a StrongBlackWoman.’ So I got to be strong and inside you’re breaking down” (p. 1473). The SBW ideology requires the ability to accomplish multiple tasks, overcome adversities, and be a leader in her family and community while managing racism and sexism, all without complaining. Internalizing the stereotypical myth of the SBW is the belief that Black women possess a greater degree of emotional strength than other women. Thus, Black women are more likely to set high expectations and less likely to express psychological distress (Nicolaidis, et al, 2010).

Mental Health Care & Un-diagnosis in Black Women

In addition to how Black women may view themselves, the SBW ideology has implications for how others treat them as well. In general, Black women are significantly less likely to receive guideline-appropriate depression care (Nicolaidis et al., 2010). Furthermore, several studies have shown that primary care physicians are less likely to detect, treat, refer, or actively manage depression in people of color in comparison to whites (Brooks, 1997; Nicolaidis

et al., 2010; Snowden & Pingitore, 2001). Research suggests that Blacks are less likely than whites to seek specialty mental health care, accept recommendations to take antidepressants, or view counseling as an acceptable option (Nicolaidis et al., 2010). Accessibility barriers that are not specific to Black women include cost, lack of transportation, lack of proximity, language difficulties, and child care scheduling problems (Conner et al, 2010).

Distrust of the medical system is born out of institutionalized violence and requires an understanding of historical conditions that helped to create it (Nicolaidis et al., 2010).

Participants described the health care system as a “White” system. One participant stated, “When my grandma gave birth to my dad, she didn’t have the option of going to the hospital because the hospital was not open to her” (p. 1472) and when her son got sick, her grandmother encouraged her not to go to the doctor. Racial discrimination leaves a lasting impression on its victims (Nicolaidis et al, 2010). Thus, intergenerational messages to avoid the health care systems are still prevalent and helped to create the preference for self-care. One participant explained that her grandmother advised her against “Triaminic” saying, “You don’t need to spend money on [that], I got this right here” (p. 1472). Focus group participants discussed conflicts between the beliefs they learned from elders and current medical opinions (Nicolaidis et al., 2010). Participants often wanted to take care of their depression on their own. Participants also described their own experiences in which racial discrimination was perceived within the health care system. Several participants noted that providers did not spend enough time with them, did not respect their intelligence, and did not provide adequate explanations. Participants also expressed the preference for treatment programs staffed by and targeted toward African Americans. Many refused to participate if counselors were not African American and female. These preferences

and barriers speak to the ubiquitous effect of gendered racism as institutionalized violence on Black women (Nicolaidis et al., 2010).

Depression & Women

Many women in our society live in an untenable position, wedged between sociocultural expectations and their own human growth potential... Yet women thirst to be more than the roles and behaviors ascribed to them, and therein lies the trap of depression.

(Schreibner, 1996, p. 490).

Feminist theorists and researchers argue that depression is more tied to the normative femininity or woman's experience, rather than to the biological makeup of women as commonly asserted in the medical model. While not refuting the biological contribution, feminist psychologists describe depression as a crisis embedded in the everyday inequitable social relations, both interpersonal and structural, that surrounds and defines a woman's social existence (Beauboef-Lafontant, 2008). Beauty regimes, economic, and political disenfranchisement, and the biological demands of reproductive work seek to render women into 'docile bodies' (Foucault, 1977). This crisis embedded in the process of constructing 'docile bodies' is conceptualized as the silencing paradigm. The silencing paradigm conceives of depression as a psychosocial process in which women lose and then "mourn" a self that has become weakened, and silenced. The onset of depressive episodes is understood as a moment when women become aware of the condition in which they face the dilemma of how to create a life worth living given the absence of viable alternatives to identities of wife and mother (Beauboef-Lafontant, 2008). This dilemma of trying to find one's self is commonly associated with depression: feelings of hopelessness and helplessness, depressed mood, social withdrawal, fatigue, and inability to engage in everyday activities (Stoppard, 2000). In the silencing

paradigm, depression is understood as a complex state of insight and crisis, cognitive awareness and compromised physiological functioning. Women in counseling retrospectively describe themselves in two distinct states. The first state is of relative unawareness or a profound fear of the costs of alternatives to normative femininity. In this state, women live within narrowed boundaries of life where meeting the demands of being a ‘good woman’ is the primary goal. The second state involves making connections between cognitive knowledge and what is felt at the “gut level.” In this state there is an acknowledgement that parts of her identity are missing. Following this insight, depressed women have to choose between returning to her former “unaware” state or integrating aspects of her life that fall outside of the narrow confines of being a “good woman”. The self is said to be silenced or lost if she chooses the first option (Beauboef-Lafontant, 2008).

Despite the insight into women’s depression the silencing paradigm provides, much less attention has been given to broaden our understanding of depression in Black women (Carrington, 2006). The CDC suggests risk factors for major depression include not only being a woman, but also being Black (CDC, 2010). Thus, Black women existing at the intersection of race and gender constructs are at an increased risk for depression (Carr et al., 2014; Woods-Giscombé, 2010) and psychological distress (Everett, Hall, & Hamilton-Mason, 2010; Stevens-Watkins et al., 2014; Watson & Hunter, 2015).

Stress & Coping

Stressors are defined as demands made by the internal or external environment that upset homeostasis and require action to restore balance (Lazarus & Cohen, 1977). Stressors are also conceptualized as changes, threats, or environmental demands that challenge the adaptive capacities of people (Pearlin, 1996). Stressors are often distinguished as either acute or chronic,

where acute surface at discrete points in time and chronic maintain a presence over a considerable period (Pearlin, 1996). Stress can impact health directly through physiological effects, such as weathering (Geronimus et al., 2006), and indirectly through maladaptive health behaviors (Lazarus & Cohen, 1977). Additionally, how individuals perceive and cope with stress affect whether and how they seek medical attention, and social support (Glanz, Rimer, & Viswanath, 2008).

The transactional model of stress and coping emphasizes the conscious purposive cognitions and behaviors related to stressors (Lazarus & Folkman, 1984). Stressful experiences are construed as person-environment transactions, whereby the impact of an external stressor is mediated by the individual's appraisal of the stressor and the biological, psychological, social, and cultural resources available. When faced with a stressor, potential threat is evaluated (primary appraisal), and the resources available for dealing with the threat is assessed (secondary appraisal). Coping efforts attempt to manage the stressor and result in outcomes of the process (Lazarus & Folkman, 1984). Coping is defined as "constantly changing cognitive and behavioral efforts to manage specific external and internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 141). For Black women, common stressors include those associated with time commitments in balancing work and family responsibilities, role strain, and financial stress (Everett et al., 2010). Additionally, acute and chronic stressors may include violence, racial discrimination and poor environmental condition such as inadequate housing and education (Brown & Keith, 2003).

Stress, Racism & Health in Black Women

Racism permeates through each level of society from individual, interpersonal (victimization), to structural (institutional) conditions and practices. At the individual level, the

weathering hypothesis is important to consider. The weathering hypothesis posits that Blacks experience early health deterioration as a consequence of the cumulative exposures to racialized stressors (Geronimus, 1992). These stressors are associated with repeated experiences of social and economic adversity and political marginalization inherent in a racialized society that disadvantages people of color (Geronimus, 1992). Physiologically, persistent high-effort coping with acute and chronic stressors have an overwhelming impact on health; thus Black individuals' health is typical of white individuals' who are significantly older (Geronimus, 2006; McEwen, 1998). This concept is known as allostatic load, which is the cumulative wear and tear on the body's system due to repeated adaption to stressors (Geronimus, 2006; McEwen, 1998; McEwen & Seeman, 1999). Allostatic racial differences are less pronounced in early years but quickly widen in young adults. They are especially high in educated Black women (Geronimus, 2006). Moreover, Black women had higher allostatic load than Black men or white women at every age. Differences were especially noticeable in economically privileged Black women which adds support to the idea that multiple strains associated with gendered racism impact the health of Black women (Geronimus, 1992; Geronimus et al., 2006; Mays, Cochran & Barnes, 2007).

At the interpersonal level, racism can manifest as lack of respect, suspicion, devaluation, scapegoating, and dehumanization (Jones, 2000) including acts that are intentional and unintentional. At the macro-level, structural racism manifests through conditions that constrain opportunities, resources, and well-being of socially disadvantaged groups (Link & Phelan, 2001; 2014; Lukachko et al., 2014). Structural racism, operationalized as neighborhood segregation and redlining practices, has been associated with elevated blood pressure (Hargurg et al., 1973), myocardial infarction (Lukachko et al., 2014), and hypertension (Kershaw et al., 2011, Thorpe et al., 2008) all of which are associated with depression (CDC, 2010). In addition, racism is also

highly correlated with psychological distress (Carr et al., 2014; Harrell, 2000; Szymanski & Lewis, 2015).

Psychological Distress & Black Women

According to the aforementioned transactional model, stress is subjectively perceived discrepancy between an individual's resources and environmental demands within the process of appraisal (Lazarus & Folkman, 1984). Psychological distress is an outcome of stress whereby stressors are met with inadequate resources (Dohrenwend & Dohrenwend, 1974). Research suggest that for Black women, stress appraisals are distinctively connected to their history, sociocultural experiences and position in society (Jackson, Hogue, & Phillips, 2005) similar to depression (Nicolaidis, et al, 2010; Mollow, 2006). Psychological distress is an aversive state evidenced by worry, tension, headaches, or weakness (Dohrenwend & Dohrenwend, 1974). Yet, admitting weakness is unacceptable within the SBW ideology (Nicolaidis, et al, 2010).

Still, studies report a strong correlation between racism, sexism, and psychological distress in Black women (King, 2003; Moradi & Subich, 2003; Woods-Giscombé & Lobel, 2008). A seminal study of stress by Woods-Giscombé and Lobel examined a multidimensional approach to conceptualizing stress specific to Black women (2008). It measured race-related stress by assessing cultural, institutional, and individual racism. Gender-related stress included sexual discrimination, harassment, physical and sexual assault, and stress related to reproductive health, raising children, child support and alimony. In addition, expectations of being strong for their families and communities and obtaining services and resources for their families were included to capture the idea of the strain of multiple roles associated in Black women. Generic stress was assessed by examining items seemingly unrelated to race or gender, such as moving, getting married, or having a car accident. On average, the sample experienced low psychological

distress and moderate levels of all three types of stressors. 99% of the sample experienced race-related stress, 95% experienced generic stress, and 92% experienced gender-related stress. All three forms of stress similarly contributed to the samples' associations with distress. Neither form of stress played a more significant role on their level of distress. These findings support the idea that African American women reject the distinction between race and sex since both make up important parts of their identity. And that the experiences of race-related, gender-related and generic stress are inseparable in its impact on psychological. This study provides empirical support for the concept of intersectionality and gendered racism, though it operationalized gendered racism with two constructs distress (Woods-Giscombé & Lobel, 2008).

Coping with Gendered Racism

Theoretically, gendered racism has received much attention since Essed coined the term in the early nineties (Essed, 1991; Szymanski & Lewis, 2015; Woods-Giscombé, 2010). It has also been thoroughly explored through intersectionality, a key concept in critical race theory (Crenshaw, 1991) and through the lens of Black feminist theory (Collins, 2000). Yet, gendered racism, as an operational and unified concept is infantile in its development. Though few in nature, much of the quantitative literature that describes coping with gendered racism have used multiple measures of racism and sexism due to the lack of an appropriate measure (Carr et al., 2014; Perry, Pullen, & Oser, 2012; Stevens-Watkins et al., 2014). Recently, Lewis and Neville developed the Gendered Racial Microaggressions Scale (GRMS) (2015) which allows for the complex and intersectional concept to be quantitatively investigated.

Still, much can be learned from studying the effects of racism and sexism prior to the availability of the GRMS. One study found that experiencing higher levels of gendered racism, operationalized with sexism and racism measures, was predictive of suicidal thoughts in one

study of over 200 Black women with low income (Perry, Pullen, & Oser, 2012). Some studies suggest Black women are more likely to use avoidance as a coping strategy (Utsey, Ponterotto, Reynolds, & Cancelli, 2000). Avoiding or minimizing experiences of gendered racism may help to maintain the appearance of strength (Thomas, Witherspoon, & Speight, 2008). However, results from the mediation analysis suggests that gendered racism related to avoidance coping (trying to forget, detaching or minimizing) increase psychological distress. Researchers explained that perhaps Black women perceive gendered racism incidents as uncontrollable, there is nothing they can do to change it, and so they do not use more active coping strategies (Thomas, Witherspoon, & Speight, 2008).

One quantitative study of Black women examined internalizing as a coping mechanism for depression and gendered racism (Carr et al., 2014). Internalizing means attributing responsibility for oppression from others to oneself (Szymanski & Obiri, 2011). Coping via internalizing is key in understanding psychological distress in Black women. Research suggest that some Black women have feelings of shame because of their oppressive experiences and blame themselves. Thus the impact of external oppressive experiences along with internalizing as a coping mechanism increase depression and psychological distress (Sue & Sue, 2003; Szymanski & Obiri, 2011; Wei et al., 2010). Carr and colleagues (2014) conducted a mediational analysis using bootstrapping and suggest that internalizing oppressive events mediated the link between sexual objectification and depression and between depression and racist events. In other words, coping with sexual objectification and racist events through internalizing mediated their impact on depression. These findings are consistent with research that suggest internalizing is harmful to mental health; it is a maladaptive coping strategy (Szymanski & Obiri, 2011; Watson & Hunter, 2015). But, internalizing did not mediate the effect

of gendered racism on depression. They explained this by suggesting that Black women may be less likely to internalize gendered racism due to its normalized nature. The media is saturated with gendered racism phrases that may make these experiences seem acceptable (Carr et al., 2014). This study further suggested that due to the normalcy of gendered racism, providing a supportive space for Black women to process their experiences might be an effective coping strategy to deal with gendered racism.

Some qualitative studies have focused on Black women's coping strategies for gendered racism and its impact on health. One study of 41 women using focus groups found that all participants acknowledged race and gender as areas of stress (Everett et al., 2010). Several participants described the difficulty of being themselves in professional settings or being understood by coworkers. Others described feeling as if they lived in two worlds; and feelings of loneliness of being Black in a White society (Everett et al., 2010). Participants described a commonly used method of "acting White" in order to be accepted or advance in the workplace. Several health issues were identified in this study including sleep deprivation, mental health concerns, hair loss, eating habits, hypertension, and anxiety attacks (Everett et al., 2010).

A qualitative investigation using inductive analysis of open ended questions of 196 Black women portrayed a variety of internal and external coping mechanisms to deal with racism and sexism (Shorter-Gooden, 2004). They seem to function as buffers against oppression. The internal resources are described as belief systems that help shape how the person feels about themselves and how they define their relationship to the larger world. They provide less specific information on strategies used but more on the emotional and philosophical context from which they respond. Three internal resources were identified as: resting on faith, standing on shoulders and valuing oneself (Shorter-Gooden, 2004). Many participants described their relationship with

God and relied on prayer and their spiritual beliefs as a coping strategy. Standing on shoulders represent an awareness of their heritage and a desire to build shoulders for the future children to stand on. It seems to represent a sense of continuity and connection across time. Valuing oneself involved a commitment to engaging in behaviors that develop or nurture herself and manifests by using education, spiritual growth, and giving to others. It also included loving and respecting oneself. An external resource included leaning on shoulders and included the use of social support as a way of coping (Shorter-Gooden, 2004).

More specific coping strategies to deal with racism and sexism included role flexing and standing up and fighting back. Role flexing is altering one's speech, behavior, dress, or presentation to fit in better with the dominant group (Shorter-Gooden, 2004; Wilson & Miller, 2002). Role flexing also includes having to prove themselves by disproving stereotypes, or *proving them wrong* (Shorter-Gooden, 2004). In direct opposition to role flexing, standing up and fighting back was a way to resist dominant pressures. Some women described directly challenged stereotypes by refusing to fit it and by directly confronting bias and stereotypes (Shorter-Gooden, 2004). Though a wealth of knowledge can be gained from this study of racism and sexism, it failed to operationalize gendered racism as a single construct. Thus, these strategies may or may not be similar to women dealing with gendered racism (Shorter-Gooden, 2004).

One study examined coping strategies that specifically focused on gendered racism as a single construct operationalized as micro-aggressions. It used focus groups with 17 undergraduate and graduate (professional) level African American women (Lewis et al., 2013). Findings suggest a variety of coping strategies depending on the context; some active coping strategies include resistance coping, collective coping and self-protecting strategies. Resistance

coping included using one's voice as power and resisting Eurocentric beauty standards. Using one's voice as power refers to actively speaking up and directly addressing microaggression. One participant stated:

Since I've been in graduate school when folks come at me the wrong way, I try to express myself to them because I recognize that I should not have to manage my feelings and somebody else's. It's not fair to me... what that [speaking up] has done though is it's definitely typecast me as the angry Black woman because I am gonna say something. You're not gonna disrespect me, you're not going to make me feel like less than, and I think that has changed the way in which people perceive me. (p. 61)

Being perceived as angry is another gendered racial microaggression (Lewis et al., 2013).

Resisting Eurocentric beauty standards included wearing natural hair and not conforming to thin beauty standards. Collective coping included the use of social support networks. Social networks provided validation and normalization of their experiences from other Black women (Lewis et al., 2013). Self-protective strategies included becoming a Black Superwoman and desensitizing and escaping. Becoming a Black Superwoman refers to endorsing the StrongBlackWoman; it consists of taking on multiple roles and responsibilities to exemplify strength and resilience (Lewis et al., 2013). It has been previously described. Becoming desensitized and escaping refers to the ways avoidance strategies are used. Yet, it also refers to a way of understanding gendered racism but deciding to not allow it to incite anger. Thus this way of considering avoidance coping may not be as maladaptive as previously described (Szymanski & Obiri, 2011; Watson & Hunter, 2015). Additionally, the idea of picking and choosing one's battles was described as a secondary appraisal process (Lewis et al., 2013). This process included making a cognitive decision about the most appropriate way to deal with gendered racial micro-aggression based on

the situation. It was especially present when Black women perceived they had little power to change a situation.

Each of these studies call for future research to explore ways to uncover various forms of gendered racism to develop a more nuanced understanding of coping strategies (Everett et al., 2010; Lewis et al., 2013; Shorter-Gooden, 2004). Though several of the studies used focus groups to understand gendered racism, research suggest that group dynamics may inhibit divergent opinions and perspectives (Lewis et al., 2013; Woods-Giscombé, 2010), thus both individual interviews and a focus group will be conducted in the present study. The individual narrative interview will provide an in-depth, understanding of individual experience (Brinkmann, 2013, p. 21) while the focus group will validate the individual perspective through the shared experiences and be used as an empowering mechanism (Everett, Hall, & Hamilton-Mason, 2010; Harwood, Hunt, Mendenhall, & Lewis, 2012; Pini, 2002).

Purpose and Research Questions

The purpose of this study was to understand the impact of gendered racism on the mental health of Black college women at the University of Alabama. It also explored the coping strategies they use when dealing with gendered racism. The quantitative phase portrayed the impact of gendered racism on mental health and tested the role of racial identity as a protective factor against gendered racism. It was also used to select participants for interviews. The qualitative phase enhanced the understanding of gendered racism and provided the opportunity for Black women to resist gendered racism. The qualitative phase also explored the coping strategies used to address multiple forms of gendered racism in individual interviews and a focus group. The following research questions were included in this mixed methods study:

Quantitative

1. What is the relationship between gendered racism and mental health (operationalized as psychological distress and depression) in Black college women?
2. Does racial identity predict gendered racism in Black college women?
3. Does racial identity (indirectly, partially or fully) mediate the effect of gendered racism on mental health in Black women in college?

Null Hypotheses:

1. Gendered racism is not significantly related to mental health.
2. Racial identity is not significantly related to gendered racism.
3. Racial identity does not mediate the effect of gendered racism on mental health.

Qualitative

4. What stories do Black college women tell about gendered racism to describe its mental health impact and meaning?
5. What coping strategies do Black college women use when they perceive of gendered racism?

Mixed Method

6. How do the perspectives of Black college women who perceive of gendered racism enhance the understanding of gendered racism on health outcomes (mental health) and behaviors (coping strategies)?

Philosophical Framework

Participatory worldviews, philosophically, are concerned with issues of power and inequities with a focus on changing the social world for the better (Creswell & Plano Clark, 2011). The four basic characteristics of the participatory worldview include a focus on political, issue-oriented empowerment, collaboration and change-orientation. Thus the participatory

worldview is guided by the need to improve our society by directly addressing issues affecting those who are marginalized (Creswell & Plano Clark, 2011). Though grounded in qualitative approaches, the participatory worldview is growing within mixed methods and was used to guide this study. The participatory worldview informed the current study in multiple ways. The political implication of this study included an investigation of gendered racism. To begin, the participatory worldview contains an explicit political agenda to address empowerment, inequality, oppression in order to change the lives of the participants (Creswell, 2008). Reciprocity is central to the participatory worldview in that participants reap benefits by participating in research (Creswell, 2008). By examining these issues, I hoped to reveal strategies of dealing with gendered racism that positively impact health. Some strategies were discussed in a focus group after the individual interviews and were thought to validate the participants' coping efforts by providing an opportunity to share and co-construct interpretation. Focus groups play an important role in comprehending complex interpersonal phenomena such as racism due to its subtle and ambiguous nature (Lewis, 2013; Krueger, 1994). Thus, the focus group was an avenue for empowerment, interpretive collaboration, and action (Pini, 2002).

Paradigmatic Framework

As a mixed methods design, this study borrows from the transformative approach as well as critical theory. The transformative approach operationalizes the ethics of social justice by informing research supervisors of the personal belief system held by the researcher then collecting data consistent with that belief (Mertens, 2010). I acknowledged the goal of the study, to empower those who have been marginalized by gendered racism, then collected data that shows how participants who perceive of gendered racism negotiate the effects of it. The transformative approach diverges from the constructivist worldview by recognizing one reality

of which there are multiple opinions. The transformative ontological assumption of multiple opinions of realities allow researchers to delve deeper into understanding factors that lead us to accept one version of reality over another (Mertens, 2010). Thus by centering the research questions on the participants who perceive gendered racism, this research privileged their lived experiences in this context in order to challenge notions of post-racial societies that sustain oppressive systems. Theoretically the advocacy lens within mixed methodologies guided the study; it favors underrepresented groups and acknowledges the need for change (Creswell & Plano Clark, 2011). The present study focused on ordinariness, intersectionality, and narratives, key tenets of CRT. Ordinariness was operationalized by qualitatively focusing on participants who perceived of gendered racism. Intersectionality was operationalized as gendered racism, recognizing that for Black women sexism and racism cannot be severed. Counter-narratives were collected in individual interviews with twelve participants.

Transformative design prioritizes social justice in order to challenge oppression and create social change. A key aspect of the transformative paradigm is linking action to the research process that empowers participants (Mertens, 2009). Due to ongoing racial and gendered inequities, acknowledging and understanding oppression may play a key role in redressing them (Mertens, 2009). The ontological assumption of the transformative paradigm recognizes the influence of privilege and that multiple realities are shaped by socially constructed systems of power such as race and ethnicity, gender, disability, political and other values (Mertens, 2009). The epistemological assumption recognizes the importance of the interactive relationship between researcher and participants in order to address issues of power and privilege explicitly. This relationship is based on trust and is critical to the research process (Mertens, 2009). Methodologically, the inclusion of qualitative methods are essential within the

transformative design due to the historical tradition of research excluding the voices of those who have been marginalized on the basis of gender, race or ethnicity, disability or other characteristic (Mertens, 2007); however, mixed methods are also used (Mertens, 2009).

The inclusion of voice is key within a critical theory framework; it is also an essential aspect of qualitative research. Critical theory is a set of basic perspectives, methods, and pedagogy that pursues the identification, analyzation, and transformation of structural and cultural aspects of society that marginalize people of color (Solorzano, 1997). Critical theory is centrally located within qualitative research (Kincheloe & McLaren, 2002). Though the qualitative piece is only one part of this research design, critical theory is especially useful to understand power and hegemony. Critical theorists are concerned with the empowerment of marginalized groups in rethinking their role in society. Oppressive power has the ability to produce inequalities and present as normative; yet, critical research goes beyond the most subtle, ambiguous and situationally specific form of domination to refuse that people are easily manipulated, passive victims. Epistemologically, critical theory draws from constructivism, recognizing multiple views of the world, yet is more nuanced in that hegemonic ideology constructs people's view of even themselves in the world. Thus the goal of critical theory is to persistently disrupt normative experiences based on hegemonic ideology (Kincheloe & McLaren, 2002).

Hence, transformative research aligns with the goal of critical theory. This mixed methods study addressed the impact and meaning of gendered racism on the mental health of Black college women. A transformative design was used in which CRT provided an overarching framework for the study. CRT was used to highlight the impact of gendered racism on mental health without further marginalizing the participants in the study by only focusing on the health

outcome absent the contextual causal factors. CRT within the transformative design also resists deficit-based theoretical frameworks by valuing the lived experiences of the participants by including their personal stories as data (Delgado, 1989; Ladson-Billings, 1998).

This study sought to identify and understand the role gendered racism has on mental health in order to empower those marginalized by it. The quantitative phase identified the impact of gendered racism on mental health and explored if racial identity buffers the impact. The qualitative phase focused on participants who perceive of gendered racism in order to understand how they negotiate the effects of it. Thus by centering the qualitative research questions on the participants who perceive gendered racism, this research privileged their lived experiences in order to challenge notions of post-racial societies that sustain oppressive systems. Theoretically the advocacy lens, specific to mixed methodologies, guided the study; it favors underrepresented groups and acknowledges the need for change (Creswell & Plano Clark, 2011).

CHAPTER 3. METHODOLOGY

Mixed Methods Design Issues

Strong mixed method designs address decisions related to interaction, priority, timing, integration or mixing, and a visual representation of the design (Creswell & Plano Clark, 2011; Ivankova, Creswell, & Stick, 2006). Interaction refers to the degree to which the phases are kept independent or interact with each other. Interactive studies mix before the final interpretation and will occur after the quantitative phase and before the qualitative phase, at the intermediary (Creswell & Plano Clark, 2011). This study used an interactive approach because there is direct interaction between the phases.

Priority refers to the relative importance or weighting of the quantitative and qualitative approaches (Creswell & Plano Clark, 2011). Priority is indicated by all capital letters in the visual representation of the research design (Creswell & Plano Clark, 2011). The qualitative phase (QUAL) is prioritized in this study, although it follows the quantitative phase (quan) (Ivankova, Creswell, & Stick, 2006). This decision was influenced by the purpose of the study to understand the impact of gendered racism on the mental health of Black women in college and identify coping strategies associated with it. The quantitative phase used a cross-sectional design that assessed the impact of gendered racism on mental health, then tested if racial identity serves as a protective factor against gendered racism on mental health.

Timing, also referred to as implementation, indicates whether the data collection and analyses come in sequence or are concurrent (Creswell & Plano Clark, 2011). Typically in this design, priority is given to the initial quantitative phase where the researcher interprets how the qualitative data helps to explain or enhance the initial quantitative phase (Creswell & Plano Clark, 2011). But in this study, priority was given to the second qualitative phase utilizing the participant-selection variant of the explanatory sequential design where the quantitative data was collected and initially analyzed prior to the collection and analysis of the qualitative data (Creswell & Plano Clark, 2011). The initial analysis included descriptive statistics which informed the selection of participants for phase two; the qualitative phase was not contingent on the correlation and regression analyses.

Integration refers to the stage or stages where the mixing of methods occur (Creswell & Plano Clark, 2011). Mixing at the beginning, at the design level, influences the research questions (Ivankova, Creswell, & Stick, 2006) and aligns with a theoretical framework, which is typical for transformative designs (Creswell & Plano Clark, 2011). There were multiple points of integration in this study. CRT guided the overall research design thus mixing occurred at the beginning, influencing the research questions. Mixing also occurred at the intermediate and during the final interpretation phases. Intermediate mixing occurs when results of the first phase inform or guide data collection in the second phase (Creswell, 2003). In this study, only participants who have a higher perception of gendered racism were eligible to participate in the qualitative phase. Thus, the descriptive analysis during the quantitative phase indicated eligible participants for interviewing. Eligibility depended on the midpoint and quartiles of the gendered racial microaggression scale (GRMS) such that phase two participants scored within the top

25%, well above the mean. Mixing also occurred during interpretation since inferences were drawn from the combination of quantitative and qualitative findings.

Finally, mixed methods researchers advise for the inclusion of a graphical representation of multi-stage procedures. A graphical representation helps researchers visualize the sequence of the data collection, priority, and mixing points of the design. Support for including a visual representation is standard in mixed methodology (Creswell & Plano Clark, 2011; Ivankova, Creswell, & Stick, 2006; Tashakkori & Teddlie, 1998). The graphical representation for the current study is in appendix A.

Sampling Design

The sequential explanatory mixed methods sampling is commonly used in social and behavioral sciences (Teddlie & Yu, 2009). Traditionally, QUAN-QUAL studies employ a follow-up explanation variant where a qualitative phase, using a subsample of the initial quantitative phase, explains the quantitative results (Creswell & Plano Clark, 2011). However, this study used the participant-selection variant of explanatory sampling which involves an initial quantitative phase that results allow for the selection of the qualitative participants (Creswell & Plano Clark, 2011). This type of sampling is used when greater priority is placed on the qualitative phase and requires a purposeful selection of participants.

Purpose and Research Questions

The purpose of this study was to understand the impact of gendered racism on the mental health of Black college women at the University of Alabama. It also explored the coping strategies they use when dealing with gendered racism. The quantitative phase portrayed the impact of gendered racism on mental health and tested the role of racial identity as a protective factor against gendered racism. It was also used to select participants for interviews. The

qualitative phase enhanced the understanding of gendered racism and provided the opportunity for Black women to resist gendered racism. The qualitative phase also explored the coping strategies used to address multiple forms of gendered racism in individual interviews and a focus group. The following research questions were included in this mixed methods study:

Quantitative

1. What is the relationship between gendered racism and mental health (operationalized as psychological distress and depression) in Black college women?
2. Does racial identity predict gendered racism in Black college women?
3. Does racial identity (indirectly, partially or fully) mediate the effect of gendered racism on mental health in Black women in college?

Null Hypotheses:

1. Gendered racism is not significantly related to mental health.
2. Racial identity is not significantly related to gendered racism.
3. Racial identity does not mediate the effect of gendered racism on mental health.

Qualitative

4. What stories do Black college women tell about gendered racism to describe its mental health impact and meaning?
5. What coping strategies do Black college women use when they perceive of gendered racism?

Mixed Method

6. How do the perspectives of Black college women who perceive of gendered racism enhance the understanding of gendered racism on health outcomes (mental health) and behaviors (coping strategies)?

Methods

A transformative sequential explanatory mixed methods design was used in this study. The first phase included a nonrandom convenience sampling and snowball sampling. This phase was cross-sectional in nature. Due to the complex meanings the term *racism* implies, the study was advertised using *race and gender related-stress*. Once the survey was completed, a debriefing message was displayed to describe gendered racism as the focus of the study. Participants then were able to indicate if they wanted their responses to be included in the study. The mixed methods design required participant-selection variant sampling. The qualitative phase used intensity sampling and consisted of individual interviews and a focus group.

Phase One: Quantitative

Participants were undergraduate and graduate Black female students at a large public, predominantly white institution (PWI) in the southeast. Black women make up about 8% (n = 2,703) with total enrollment near 32,000 students. Selection criteria was based on identifying as a Black female. Gender expression was included; thus both cisgender and transgender females attending the University of Alabama were eligible to participate. However, no special effort was made to recruit transgender individuals and consequently very few were included in the sample. Participants were recruited from a range of academic courses (including but not limited to African American studies, women's studies, public health, and social work courses) and student organizations that focused on Black women. Participants self-identified as Black/African American and as a woman, were at least 18 years of age, and currently enrolled full-time at the site of the study. Based on an a priori power analysis, using G*Power 3.1 for regression analyses (Faul, Erdfelder, Buchner, & Lang, 2009) 103 participants were required for 80% power, with a medium effect size of .15 and .05 criterion of statistical significance. Nonrandom

convenience and snowball sampling methods were used. Two-hundred and thirteen Black college women participated in the study. The sample in this study included nearly 8% of Black college women attending the university. The average age of the participants was 21.67 years (SD = 4.93), ranging from 18 – 49. About 81% (n = 132) were undergraduates.

Recruitment. Convenience sampling involves individuals who willingly agree to participate in a research study who are easily accessible to the researcher and snowball sampling includes current participants inviting others who are eligible to participate (Teddlie & Tashakkori, 2009). Participants were recruited from various academic classes in a range of departments and through student organizations through nonrandom convenience sampling. Student organizations were located online through the institution’s database by searching terms such as “African American”, “Black”, and “women”. Classes were identified by reviewing data from the institution’s research and assessment office that quantified the enrollment of Black women based on college, followed by an online search within colleges and departments using similar terms as described. Instructors and representatives of student organizations were contacted via email regarding the study.

Classroom recruitment occurred in two ways. The researcher visited the class and read the recruitment script and students indicated they were interested by providing their email address to the instructor. Or, the researcher emailed the recruitment script, including the link to participate, to the instructor who described the study to their class and collected the email addresses of those who were interested. In some cases, the instructor emailed the entire class, specifically in the African American studies classes, the link to participate after having read the recruitment script. For the student organizations, the researcher either attended their meeting or forwarded the recruitment script and the link to participate to the student organization representative. Snowball

sampling occurred with participants, either from classes or student organization meetings, forwarding the email link to other potential participants.

Data Collection. Instructors emailed the link to participate to students who indicated they were interested. For student organizations, the researcher attended a regularly scheduled organization meeting and introduced herself and the study using an IRB approved script. During the meeting, the researcher distributed iPads, provided by the College of Human Environmental Sciences. Data, from both class and student organization recruitment, were self-reported through Qualtrics (2015), a web-based survey software program. Printed copies of the surveys were provided during the student meetings as back up. Consent forms were included as the first page of the web-based survey and included general information about the study, such as gender and race related stress. Participants had to select ‘yes’ in order to provide consent. Participants were allowed to stop taking the survey at any time. Those who completed the survey were provided a more thorough description of gendered racism including examples and had the opportunity to participate in a raffle. If participants correctly answered a question on their understanding of gendered racism, they were entered into a drawing to receive one of eight \$25 Amazon gift cards. Participants in the raffle included their email addresses.

Instrumentation

Background. Demographic data included information on race, gender, age, year in school, economic position of household, and home residence information. This information was used to describe the participants. The demographic sheet is included as Appendix B.

Gendered racism. The Gendered Racial Microaggressions Scale (GRMS) was developed by Lewis and Neville (2015). It is included as Appendix C. Gendered racial microaggressions are subtle and everyday verbal, behavioral, and environmental expressions of oppression based on

the intersection of race and gender (Lewis & Neville, 2015). The 26-item scale assesses frequency and stress appraisal of slights, insults and invalidations based on stereotypes, assumptions and marginalization. Two distinct studies were conducted in the development of the scale. In the initial study, an exploratory factor analysis using a sample of 259 Black women resulted in a multidimensional scale with four subscales: Assumptions of Beauty and Sexual Objectification, Silenced and Marginalized, Strong Black Woman Stereotype, and the Angry Black Woman Stereotype. In the second study, confirmatory factor analysis using an independent sample of 210 Black women suggested that the 4-factor model was a good fit of the data for both the frequency and stress appraisal scales (Lewis & Neville, 2015). Construct validity was supported by the Racial and Ethnic Microaggressions Scale (Nadal, 2011) and the Schedule of Sexist Events (Klonoff & Landrine, 1995). The Racial and Ethnic Microaggressions Scale (REMS) assesses microaggressions based singly on race and ethnicity and has a reliability estimate of .92 in a study with Black participants (Nadal, 2011). The Schedule of Sexist Events (SSE) examines everyday experiences of sexism and has reliability estimates of .88 to .94 (Klonoff & Landrine, 1995). Reliability coefficient estimates with the GRMS ranged from acceptable to moderate on frequency and stress appraisal for both the SSE and the REMS from .29 to .64 across subscales of frequency and stress appraisal (Lewis & Neville, 2015). The GRMS explicitly addresses gendered racism as experienced by Black women; it is based on an intersectional framework acknowledging that for Black women, racism and sexism cannot be fully understood separately (Jones, 2016). The overall Cronbach alpha is .93 and reliability alphas range from .75 to .88 on each of the subscales (Jones, 2016). Sample items include: “Someone accused me of being angry when I was speaking in a calm manner,” “I have felt unheard in a work, school or other professional setting,” and “Someone has assumed that I

should have a certain body type because I am a Black woman.” Participants indicated how often these experiences occurred over their lifetime (frequency) and how stressful they were (stress appraisal). Stressful was defined as feelings of upset, bothered, offended or annoyed. Frequency ranged from “Never” to “Once a week or more” on a 6-point Likert scale. Appraisal ranged from “This has never happened to me” to “Extremely stressful” on a 6-point Likert scale. The GRMS was significantly related to psychological distress, such that greater perceived gendered racial microaggressions were related to greater levels of reported psychological distress (Lewis & Neville, 2015). Based on the mean score, those who fell within the top 25% were eligible for phase two participation.

Racial identity. Racial identity was assessed using the centrality subscale of the Multi-Inventory of Black Identity (MIBI) (Sellers et al., 1998). This 8-item subscale provides Likert scale responses to show the importance of racial identity. It is established in the literature with acceptable validity and a Cronbach alpha .77 (Sellers et al., 1998) and with extensive use among college students (Cronbach’s alpha = .88) (Hardeman et al., 2016; Jones, 2014; Seaton, Upton, Gilber & Volpe, 2014; Chavous, Rivas-Drake, Smalls, Griffin, & Cogburn, 2008). Sample items include: “In general, being Black, is an important part of my self-image”, “Being Black is an important reflection of who I am,” and “I have a strong attachment to other Black people.” The instrument allowed the researcher to frame interview questions specific to the participants’ responses. For example, participants who scored higher on the MIBI, interview question were, “You indicated racial identity is very important to you, what does racial identity mean to you? How does racial identity influence your ability to perceive gendered racism?” The centrality subscale of the MIBI is included as Appendix D.

Mental Health. The mental illness module of the Behavioral Risk Factor Surveillance System (BRFSS) includes psychological distress and depression. The Kessler 6 (K6) (Kessler, 2002) measures non-specific psychological distress within the past 30 days. Higher scores indicate worse psychological functioning. The K6 screens for severe psychological distress with a score of 13 or higher (Kessler et al., 2002, 2003). However, those who score within the range of 5 to 12 are considered moderately, yet still clinically significant, distressed (Prochaska et al., 2012). The expanded cut-point guidelines are based on receiver operating characteristic (ROC) curve analysis and results suggest a balance between sensitivity (0.76) and specificity (0.75) with an overall classification accuracy of 0.74 and little variance based on race/ethnic group. Further, the area under the curve (AUC) analysis value of 0.82 was comparable to that reported for the K6 cutpoint of ≥ 13 when predicting serious mental illness (AUC=0.865) (Kessler et al., 2003). A cutpoint of greater than or equal to 5 was used in this study. The K6 is a six-item scale used to identify persons with mental health problems severe enough to cause moderate to serious impairment in social and occupational functioning and to require treatment. Each item is measured on a 5-point Likert-type scale ranging from 0 (none of the time) to 4 (all of the time). Cronbach's alpha was .81 in African Americans (Lincoln et al., 2011). The K6 is included as Appendix E.

The Patient Health Questionnaire (PHQ-9) comprises the BRFSS anxiety and depression module. The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring, and measuring the severity of depression (Kroenke & Spitzer, 2002). It incorporates DSM-IV depression diagnostic criteria with other leading major depressive symptoms into a brief self-report tool. The diagnostic validity was established in multiple studies and, for scores greater than or equal to 10, has a sensitivity of 88% and a specificity of 88% for major depression which

requires treatment (Kroenke, Spitzer, & Williams, 2001). Further, scores can be classified as: 0–4 (no or minimal depressive symptoms), 5–9 (mild), 10–14 (moderate), 15–19 (moderately severe), and 20–27 (severe) (Pratt & Brody, 2014). The ninth item was deleted as it asks about suicidal attempts and ideation deemed inappropriate for nonclinical research; omitting this item does not have a major impact on the assessing depression (McKnight-Eily et al., 2009; Kroenke & Spitzer, 2002). In this study, ≥ 10 was used as the criteria for moderate depression. The PHQ is included as Appendix F.

Coping strategies. Coping strategies were quantitatively assessed using the Brief Coping Orientations to Problems Experienced (Brief COPE) (Carver, 1997). The 28-item instrument includes 14 scales: Self-distraction, Active coping, Denial, Substance use, Use of emotional support, Use of instrumental support, Behavioral disengagement, Venting, Positive reframing, Planning, Humor, Acceptance, Religion, and Self-blame. Participants were instructed to rate the frequency of each coping behavior on a 4-point Likert scale that ranged from, “I haven’t been doing this at all” to “I’ve been doing this a lot.” The Brief COPE is an abbreviated form of the 60-item COPE Inventory; two scales from the long version were omitted and scales were reduced from four to two items per scale. One additional scale was added. Although each scale only includes two items, each scale’s reliability met or exceeded the minimal recommendation of .5 (Nunnally, 1978) with most exceeding .6 (Carver, 1997). The Brief COPE has been used in health research with diverse samples and demonstrates high internal reliability (Carver, 1997) and has been used with college women (Eisenbarth, 2012; Straight, Harper, & Arias, 2003). Sample items include: “I’ve been getting emotional support from others,” “I’ve been giving up trying to deal with it,” and “I’ve been making jokes about it.” The Brief COPE is included as Appendix G.

Data Analyses

Data cleaning involved two phases, deleting data and mean imputation. Data were deleted for participants who were not eligible to participate based on race, age and student status ($n = 14$). Data were also deleted for participants who indicated after the debriefing that they did not want to be included in the study ($n = 3$). In total, 17 cases were deleted prior to examining the outcome variables leaving a sample size of 196. To avoid complete case analysis, mean imputation was conducted manually. On the K6 (psychological distress) if more than two of the six items were missing, the data were not included in the analysis. For those missing two or less items, the mean value of the remaining items was imputed ($n = 33$), leaving the K6 outcome variable with a sample size of 139. This is similar to the rule based on the K10 where five of eight items are acceptable for imputing the mean (Wooden, 2009). Similarly, on the PHQ-9 (depression) research suggest imputing the mean when less than 25% of the scale is missing, or six of eight are completed (Lowe et al., 2008; Lowe et al., 2004). Thus missing values were replaced with the mean for 26 participants, leaving the PHQ-9 outcome variable with a sample size of 112. The preliminary data cleaning also included reverse scoring the MIBI (racial identity) and summing the subscales on the GRMS.

Analysis consisted of descriptive statistics, correlations and regression using International Business Machines (IBM®) Statistical Package for Social Sciences (SPSS) Version 23. The descriptive statistics were used to select the participants eligible for phase two, interviewing. Correlations showed the relationships between the variables while regression was used to explore variance. The first (What is the relationship between gendered racism and mental health?) and second (Does racial identity predict gendered racism?) questions required correlational/regression analysis. The regression analysis is conducted within the correlation model (Daniel &

Cross, 2013). The correlational model may involve two or more variables that are not distinguished by dependent or independent, rather the co-relationship views the variables on equal footing. However, the regression analysis, although the computational analysis is the same for correlation, requires a logically sound argument for distinguishing between the variables (Daniel & Cross, 2013). In this study, the goal was to test if racial identity predicted the stress appraisal of gendered racism.

The population correlation coefficient, Pearson Product Moment Correlation, is used to measure the strength of the linear relationship between the variables and may assume any value between -1 and +1; with standard recommendations of very weak (.00-.019), weak (.2-.39), moderate (.4 -59), strong (.60-.79), and very strong (.80-1.0) accepted (Evans, 1996). The correlational model contain assumptions of normality, equal variance, and linearity (Daniel & Cross, 2013). For the first research question, the correlation assessed the relationship between gendered racism and mental health; mental health was operationalized as psychological distress and depression. A significant correlation coefficient does not imply causation thus careful attention was paid during data interpretation.

After the strength of the relationship was determined, the goal of the regression analysis was to predict or estimate the value of one variable corresponding to a given value of another variable (Daniel & Cross, 2013). To analyze the second research question, correlation tested the strength between racial identity and gendered racism then the linear regression was conducted. Both the predictor variable, racial identity, and outcome, gendered racism are continuous variables based on Likert scales. Linear regression analysis involve assumptions of normality, linearity and equal variance.

The third research question (Does racial identity (indirectly, partially or fully) mediate the effect of gendered racism on mental health?) was answered with mediated regression analysis using linear regression. Mediated regression seeks a more accurate explanation of the “causal effect” the predictor has on the outcome; it extends the correlation to make inferences about causation in non-experimental studies. Mediation justifies the order of the variables and reasonably excludes the influence of outside factors (Baron & Kenny, 1986). To conduct a mediation analysis, each predictor variable must be significantly correlated with the outcome. In this study, gendered racism (stress appraisal) and racial identity were the predictors and mental health (PHQ and K6) was the outcome. The null hypothesis was that racial identity would not mediate the relationship between gendered racism and mental health, either indirectly, partially or fully. To reduce the influence of outside factors, several demographic variables were controlled for such as age, income level, year in school, etc. This question served as the primary focus of the quantitative phase because racial identity, as a unitary construct, was not expected to account for the experience of gendered racism, a hybrid form of oppression based on racism and sexism. Additionally, research on racism and sexism in Black women have called for additional research to better establish directional order among the variables. That is, more research is needed to rule out that individuals with high levels of distress may be more susceptible to and or perceive of racial and gender discrimination (Stevens-Watkins et al., 2014).

Phase Two: Qualitative

Participants. Participants were a subsample of the first, quantitative, phase. Selection criteria for the qualitative phase required purposeful intensity sampling. Patton (2002) defined intensity sampling as selecting very informative cases that represent a phenomenon of interest. For this study, the phenomenon of interest was gendered racism and intensity sampling involved

scoring within the top 25% on the GRMS. Selecting participants with a higher perception of the frequency of gendered racism kept the focus of the study on the ordinariness of racism and social justice as aligned with the goal of the transformative design and critical race theory. Within the range of suggestion by Maxwell (2013), twelve participants were purposively selected for one individual narrative interview. The individual interviews lasted between 90 minutes to nearly four hours with most lasting approximately 2 hours. All twelve of the participants were invited to attend a focus group following the interview analyses. Eight participants indicated interest in the focus group but two declined due to scheduling conflicts; therefore, six participants participated in the focus group. Table 1 includes background information on the interview and focus group participants.

Table 1 Background Information on Qualitative Participants

Participant	Age	Year in school	Major	Home State	Date of Interview & No. of minutes
Alauna	19	Sophomore	Psychology	AL	10/25/16; 93 mins
Alicia	30	6 th -Yr Doctoral	Social Work	MO	11/10/16; 150 mins
*Ashley	19	Sophomore	Telecommunication & Film	LA	10/24/16; 99 mins
Blair	28	Senior	Exercise science	IL	11/8/16; 95 mins
Brittany	19	Sophomore	Bus. Mgmt & Marketing	FL	10/18/16; 120 mins
*Evelyn	20	Senior	Athletic Training	GA	10/25/16; 225 mins
*Jada	31	2 nd -Yr Master	American Studies	KY	10/19/16; 135 mins
Mercedes	24	2 nd -Yr Master	Social Work	AL	11/22/16; 85 mins
Morgan	19	Freshman	Criminal Justice	AL	11/9/16; 135 mins
*Serena	19	Junior	Public Health	AL	11/18/16; 143 mins
*Tera	19	Sophomore	International Studies	SC	10/21/16; 140 mins
*Tiana	18	Freshman	Undeclared	AL	10/18/16; 130 mins

Note. Pseudonyms used. * Denotes participants who participated in the focus group

Recruitment. After completing the surveys, participants indicated if they were willing to participate in the QUAL phase. Survey responses were cross-referenced, so that only participants who had indicated they were willing and those eligible based on the GRMS score were eligible for recruitment. Participants were also selected for interviews based on a range of factors, including variations on mental health scales, year in school, and in-state or out-of-state residency. The researcher emailed 23 eligible participants a recruitment script describing phase two of the study. The recruitment script included a thorough description of gendered racism as well as example interview questions (Graham et al., 2011). Twelve participants responded and indicated consent to participate and to have the interview audio recorded as well as a convenient time and location for the interview. Interview participants received a monetary incentive of \$10 in cash.

Data Collection. Based on participants' availability and preference, individual interviews were scheduled and conducted at the researcher's campus office. The office space provided confidentiality for sharing sensitive information. Interviews primarily focused on the meaning and awareness of gendered racism; racial identity, and mental health coping strategies were also explored. Individual narrative interviews were used to thoroughly understand the individual's lived experience of gendered racism and allowed the participant to reflect, construct meaning and encouraged action (Brinkmann, 2013; Riessman, 2008). The interview guide was inspired by previous research on how gender and race impact identity (Thomas, Hacker & Hoxha, 2011) and it included prompts on racism and gendered racism from childhood through their present-day experiences. Sample questions included (a) Tell me about the first time you remember having to think about your own race. (b) Tell me a story about how you have come to understand gendered racism. (c) Tell me a story that portrays how gendered racism makes you feel. (d) How do you

encounter gendered racism? General prompts were: (a) Tell me more about that. (b) Is there anything else you would like to say on that? Clarifying and probing questions were asked throughout the interview (Ackerman-Barger & Hummel, 2015). The interview guide is included as Appendix H.

After data transcription and analysis, member checks were conducted. Member checking is used to reduce the risk of data misinterpretation (Maxwell, 2013). Participants were given the opportunity to member check, which included providing the transcription and researcher notes although no additional input was provided. Additionally, participants were invited to attend a focus group. The focus group provided additional data but served the main purpose of empowerment and support for the participants. Thus, data from the focus group was not thoroughly analyzed.

Instrumentation

The researcher. The researcher as instrument is a distinctive feature of qualitative research emphasizing the researcher's knowledge, perspective, and subjectivity in data acquisition (Denzin & Lincoln, 2003). The data depend on the researcher's perceptual acuity and capacity to elicit detail from respondents (Barrett, 2007). The researcher strives to capture aspects of a phenomena with fidelity by selecting important aspects of the shared experience (Barrett, 2007). Yet, data are mediated through the human instrument therefore relevant aspects of the researcher, including biases, experiences, and assumptions, are described to qualify her ability to conduct the research (Greenbank, 2003). The researcher's subjectivity statement is included later in this chapter.

Narrative Interviewing. Semi-structured, in-depth interviews have been used as a method of data collection because they are sharply focused, highly intensive and productive in

understanding lived experiences (Roulston, 2010). The goal of narrative interviewing, as opposed to traditional interviews, is to create detailed accounts of a phenomenon (Riessman, 2008). Narratives marry reason and emotion and are powerful teaching and learning tools (Schaafsma & Vinz, 2011). Narrative interviewing is a commonly used in CRT (Andrews, Squire, & Tamboukou, 2008; Bernal, 2002); it focuses on the multiple-perspective accounts within communities (Graham, Brown-Jeffy, Aronson, & Stephens, 2011). Narrative studies involve the researcher providing minimal prompting on topics related to oppression; whereas in traditional interviews, the researcher asks a series of questions on various topics with limited time dedicated to each item (Graham et al., 2011). Traditional interviews allow the researcher to be more efficient and maintain control over the process by focusing on the pre-planned interview questions (Riessman, 2008). Narrative interviewing requires the researcher to share control of the interview by following the participants lead. Oftentimes one story may lead to another, in traditional interviewing these are seen as digressions (Brinkmann, 2013; Riessman, 2008). However in narrative interviewing, the researcher interprets meaning by asking participants about associations and connections between stories (Brinkmann, 2013; Riessman, 2008). Narrative interviewing often include participants being privy to the interview questions before the interview. There are little time constraints on the interview as narrative interviewing allow and encourage participants to reflect and elaborate uninterrupted (Graham et al., 2011).

Narratives. Narratives are used to recount an individual's experience with various forms of oppression to create individual or composite accounts within social, historical, and political situations in an effort to resist deficit-based master narratives that serve as normal (Fernández, 2002; Solorzano & Yosso, 2002). Tuck (2009) suggested that deficit-based narratives are inevitable when addressing health issues at an individual level without full consideration of the

historical and socio-cultural context (Calderon, 2016; Dutta, 2016; Johnston-Goodstar, 2013). Damage-centered research produce deficit-based narratives by emphasizing need in order to explain poor health; this may be both effective and necessary in order to secure funding. However, the danger is that the lack or need singularly defines marginalized communities through this pathologizing approach that over-researches the individual with scarce attention to the historical and socio-cultural causes within society (Tuck, 2009). Counter-stories (or counter narratives) are used within the critical race theoretical framework. It is defined as a method of telling the stories of those whose experiences are not often told, those on the margins of society (Ladson-Billings, 1998; 2009; Solorzano & Yosso, 2002). Counter-narratives were collected through individual interviews, using narrative inquiry, in order to better understand how Black women perceive of and cope with multiple forms of gendered racism.

Counter-narratives and Critical Race Theory. Critical race theory posits that counter-narratives recognize people of color as important holders and creators of knowledge based on their lived experiences (Bernal, 2002). Traditionally, experiences of people of color have been devalued, discredited, misinterpreted or omitted from research (Bernal, 2002). Institutions of health and research often function based on values, perspectives, and principles that are not culturally diverse or representative. Dominant cultural customs are frequently presented as universal and normal discrediting the perspectives of people of color (Graham et al., 2011). Thus inequalities persist through the centering and privileging of dominant perspectives presented as aracial, neutral, and merit-based (Graham et al., 2011). Traditional research that center dominant perspectives tell stories about merit, responsibility, and causation which masquerade as universal truths and scientific facts. In comparison, the stories, perspectives, and experiences of people of color are ignored (Bernal, 2002). Counter-narratives, gathered through in-depth interviews, are

insightful (Kim, 2015), can document injustice, and allow the ability to see the world through the eyes of the others' (Delgado, 1989). Counter-narratives shatter complacency, challenge the dominant understanding of a post-racial society and seek to emancipate the oppressed. Sharing these experiences can help strengthen traditions of social, political, and cultural survival and resistance (Delgado, 1989; Ladson-Billings, 1998; 2009; Solorzano & Yosso, 2002).

Specifically, counter-narratives are used to legitimize the perspectives and stories of those at the bottom, the oppressed (Matsuda, 1987) and to affirm agency and self-empowerment (Kim, 2015). They also maintain the connection between theory and lived experiences necessary to create social change (Kim, 2015). Counter-narratives are important in decentering dominant perspectives and valuing the lived experiences of people of color (Bernal, 2002) and are potentially liberating (Fernandez, 2002).

Narrative Inquiry. Narrative inquiry works well to situate the counter-narratives in CRT (Ladson-Billings, 1998; 2009; Solorzano & Yosso, 2002), therefore this study used both the approach of counter-narratives and narrative inquiry as its grounding methodology. Narrative inquiry values the narratives of lived experience. Narrative inquiry allows for the study of human lives while honoring lived experience as an important source of knowledge (Clandinin, 2013). A fundamental assumption of narrative inquiry is that stories are an essential way of understanding human experience. Narrative inquiry is founded on relational experiences as researchers think about their own personal story, the stories participants tell and the stories that are made visible due to the telling of stories (Clandinin, 2013). In this study, the relational experience that narrative inquiry offered the researcher and participants helped to not only reveal but push back against the persistence of gendered racism.

Notes & Memos. Observation notes were taken during the interview. Observation notes captured inaudible data, such as body language, silence, and facial expressions as well as my own thoughts during the interview (Maxwell, 2013). Reflexive memoing throughout the iterative process of data collection and analysis also provided data. Memoing is a flexible methodological strategy that reveals the conceptual leaps from raw data to the researchers' discussions and conclusions (Birks, Chapman, & Francis, 2008). Memos may include reflections on relevant readings, current issues, ideas, and personal reactions to interviews, conversations, and methodological issues (Maxwell, 2013). At the end of the interview, participants were provided the opportunity to participate in member checking. Member checking involves the process of engaging participants in order to validate interpretations or for data clarification (Sandelowski, 1993). Member checking is noted as the most effective way of attaining representation and credibility (Charmaz, 2006). No additional data was gathered through the member checking process.

Focus Group. Following the interviews, participants were invited to attend a focus group to discuss how they deal with gendered racism and reflect on data interpretation. The focus group provided additional data but primarily served the purposes of empowerment, group reflection, and support (Krueger, 1994; Lewis, 2013; Pini, 2002) and to transform the way participants view themselves in relation to gendered racism. Focus groups allow researchers to gain a rich understanding of the collective experiences and often result in rich, experience-near data that offer cohesion and a sense of support (Everett, Hall, & Hamilton-Mason, 2010). They are especially effective due to the oftentimes subtle nature of gendered racism because participants validate each other's experiences and deepen the understanding of the phenomenon (Harwood, Hunt, Mendenhall, & Lewis, 2012). Focus groups participation make what is invisible, visible

by transforming individual experiences to collective experiences (Pini, 2002). Participation in focus groups challenged dominant beliefs and provided space for reflexivity (Pini, 2002). Focus groups have been utilized to address gendered racism because literature suggest that they provide a supportive environment for women to discuss sensitive issues related to stress and coping (Everett, Hall, & Hamilton-Mason, 2010; Jarrett, 1993; Woods-Giscombé, 2010). Thus, increased understanding, support, and empowerment align well with the goal of transformative research (Mertens, 2009).

Data Analysis

A thematic narrative analysis was conducted to answer the third and fourth research questions (what stories do Black women in college who perceive of gendered racism tell to describe its mental health impact and meaning and what coping strategies are used for gendered racism?). The purpose of thematic analysis is to focus on the content of the intact story in order to theorize from the case as opposed to gaining knowledge from coding or categorizing (Riessman, 2008). Case analysis allows for understanding of the meaning-making process; where each individual serves as a case (Castro, Kellison, Boyd, & Kopak, 2010). Case analysis is not meant to be statistically representative of a larger group (Riessman, 2008). The researcher works with a single interview at a time, reads and rereads the transcription in search of hidden meanings and assumptions then labels them with themes (Riessman, 2008). CRT also guides the interpretive process by framing the themes through the types of questions asked in the interview (Fernandez, 2002).

The interviews were audio recorded and transcribed verbatim for analysis. The interviews, memos, and observation notes were used for complementarity; it suggests gathering multiple sources to gain information broadens the understanding of a phenomenon (Greene, 2008). The

transcriptions were read and the audio recordings were listened to multiple times in search of hidden meanings and assumptions in line with Riessman's thematic analysis (Riessman, 2008). The transcriptions were then labeled with themes based on the CRT framework. Though typically, language is viewed as a resource in thematic analysis where transcriptions are "cleaned up" (Riessman, 2008), in this analysis specific attention was paid to pauses, utterances, and emotional tone to gather thick description (Roulston, 2010 & Tracy, 2010). Integrating participants' language, themes, researcher notes and memos synthesizes the data rather than separating them into parts (Polkinghorne, 1995). Relevant memos and observation notes were integrated into the construction of themes. The analysis involved recursive movement from the data to an emerging thematic plot (Polkinghorne, 1995) understood through the lens of counter-narratives used in CRT.

Narrative analysis involves a collaborative relationship between participants and researcher in order to co-construct meaning). Additionally, narrative inquiry is founded on relational experiences as researchers think about their own personal story, the stories participants tell and the stories that are made visible due to the telling of stories (Clandinin, 2013). Memoing was used to capture the researcher's experiences while in relation with participants and the data. Data analysis and interpretation are intertwined with the researcher's conceptual understanding, experiences and logic, thus the researcher is key in interpreting what data mean (Barrett, 2007). Further, the researcher is responsible for relating the analyses and interpretations to other sources of insight including those in the literature and common experience (Barrett, 2007).

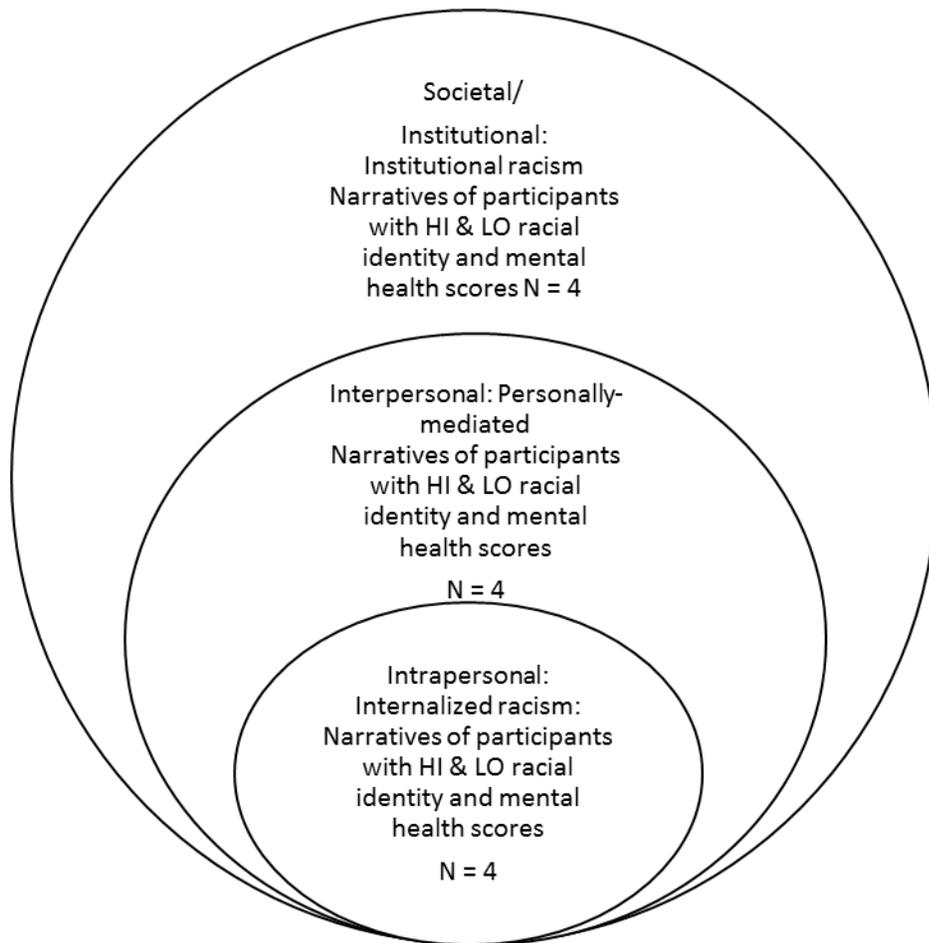
In order to address credibility, the interpretation emerged from the rigorous, iterative, and interactive process of comparing observation notes to reflexive memos to transcription (Charmaz, 2006). Reflexivity throughout the analysis process as well as member checking was

used to assess authenticity. Credibility is marked by thick description, explication of tacit data, concrete details, and member reflections throughout and after the interview (Tracy, 2010).

Mixed Methods Analysis

The mixed methods analysis answered the final research question (How do the perspectives of Black women in college who perceive of gendered racism enhance the understanding of gendered racism on mental health outcomes and coping behaviors). Figure 2 is a portrayal of how the mixed methods approach enhanced the understanding of gendered racism's impact and coping strategies used to address it. The COPE was used to quantitatively investigate the coping strategies Black women use. In addition, narratives were gathered to more thoroughly understand the coping strategies and participants views on effectiveness. The narratives and the descriptive quantitative analyses were used to make inferences about the individual cases. For example, participants with optimal mental health scores may cope with gendered racism differently than ones with mental health challenges and coping was explored quantitatively and qualitatively.

Figure 2 Joint Display: Mental Health Impact and Coping Strategies of Gendered Racism



Ethical Issues

Ethical issues were addressed through the Institutional Review Board and throughout the study using qualitative techniques such as reflexive memos, complementarity, and member checking. Consent was discussed and given prior to participating in both phases. The subjectivity statement addresses additional ethics related to power differences and is included in qualitative studies (Maxwell, 2013).

Subjectivities Statement

I am both the researcher and the researched. As a student on this campus, I made the dean's list in classes that taught me how unlikely it would be for me to "succeed" having been

born to and being a “single” mother and student; apparently I was “at risk” for failure. I have selected this topic to uncover the ways in which white supremacy is manifest in various forms. I also hope to uncover the strategies that women use to deal with gendered racisms. This brings the assumption that the strategies can be learned and shared in order to empower others who face similar systems of unjust power. I have often felt disempowered when having to face these systems alone, especially within higher education.

As a member of the University of Alabama, I have a unique perspective to offer transitioning from student, staff, to faculty back to student. These roles provide me with access to emic perspectives regarding representations of gendered racism on this campus. The emic perspective provided a sense of familiarity with participants and was thought to have eased the potential tension associated with sensitive topics. Through my own lived experiences, I am privy to examples of how gendered racism manifests. For example, Black female students have described attending white fraternity parties and being judged based on their physical appearance to determine entrance into parties. Black women are asked to pose, turn, and dance so that members of the fraternity can view them from various angles. Comments are then made publicly and a score is offered; women must score above an 8 to be included in the party. Women who score below an 8 have confided in me describing the humiliation of having their friends enter the party before them and feeling rejected. No other site provides this type of relationship for me as the researcher.

As a student, I have had multiple experiences where I had to strategically decide how to deal with and resist gendered racism. I have had to find my voice, through the power imbalances: Black to white, female to male, student to professor, economically disadvantaged to economically privileged. I am careful not to reveal a deep level of race-consciousness around

those who claim (or perform) colorblindness. I am an expert at code-switching, performing the role that is needed at the time but careful to protect my innermost being from the pain caused by gendered racism. I have been trained in the postpositivist fields of Human Development and Family Studies (master's) and Health Education and Health Promotion (doctoral); simultaneously learning (in classrooms) and knowing (intuitively) that their (the departments and the disciplines) truths were not my truths. I am an expert at code-switching and *shifting*. I have also learned about health disparities and the social and structural determinants of health in the classroom and in life.

Critical race theory (CRT) was the theoretical foundation for this study. CRT chose me rather than me choosing it. I did not want to accept white supremacy, patriarchy and capitalism as normative and the basis for social injustices. I did not even want to think of those negative things at all; I want to be happy. I hoped to produce action-oriented research that helps others like me. I hoped that through the co-construction of meaning, participants would be emancipated through their own voice. I wanted to see Black women who are often silenced and marginalized with deficit frameworks in health research, use their voice to create change and go about the business of pursuing happiness. It is possible that my education, age, perceived class status and language created differences, power imbalances, between the participants and myself. Therefore, in regards to quality, I carefully reflected on my thoughts before, during and after the interviews, transcription and analysis. I acknowledged myself within the context of this research so that the relationship between the researcher and participants generated collaborative knowledge that contributes to personal and social transformation (Maxwell, 2013). To establish credibility, clarification and accuracy of understanding of the participants' responses were verified throughout the interview (Ackerman-Barger & Hummel, 2015). As an effective way of attaining

representation and credibility, participants were provided an opportunity to engage in member checking (Charmaz, 2006). Although no additional comments were provided, participants did not object to how they were represented. Additionally, the transcriptions and notes were shared with members of the research team for input.

It was possible that due to my role as an instructor, especially given the dearth of race-focused research in the College of Human Environmental Sciences, may have influenced the participants. I took care in describing the primary goal of the study, to understand their perspective. I had a relationship with one of the interview participants prior to the study and gave her the opportunity to decline participation, although she wanted to participate. I also recognized some of the survey participants during recruitment however, it is unclear how many participated and if that had any influence on their participation. As an instructor, I have had to code-switch and it is possible that former students of mine may have perceived me as too mainstream to fully disclose experiences of racism especially those that occurred within the institution. My age may have formed a barrier especially with undergraduate students who may be fearful of providing the “wrong” answer. Critical preparatory and reflexive post-interview memoing was used to help create an ongoing awareness of myself within the research. I engaged in mindfulness and other coping strategies prior to interviewing to ensure that I have quieted my own experiences so that I can critically focus on the participants’ experiences. After hearing painful experiences of gendered racism, I wrestled with ways to care for myself so as not to become too overwhelmed in order to complete the dissertation process. This became especially difficult after the election of Donald Trump, who has engaged in racist and sexist’s behaviors.

CHAPTER 4. RESULTS

Chapter 4 includes three manuscripts. The first is a commentary that includes a brief review of the literature on the importance of racial identity and mental health. The second manuscript is based on the survey results and the quantitative research questions. The last manuscript is qualitative and based on the individual interviews. The titles of each manuscript are listed below along with each journal to which they will be submitted.

Manuscript 1: Racial Identity, Perception of Racism, and the Mental Health of Black Americans: Perspectives for Consideration – *Journal of Community Health*

Manuscript 2: The Role of Racial Identity within Gendered Racism: Centering Black College Women’s Mental Health – *Health Education & Behavior*

Manuscript 3: Talking Back through Counter-Narratives: Resisting Gendered Racism across the Social Ecological Model – *Ethnicity & Disease*

The final mixed methods question (How do the perspectives of Black college women who perceive of gendered racism enhance the understanding of gendered racism on health outcomes (mental health) and behaviors (coping strategies)?) is addressed below with a brief summary based on results from the survey (Brief COPE), interviews, and focus group. Table 2 includes the correlations between coping strategies, mental health and gendered racism.

Table 2 Correlations between Coping Strategies, Mental Health & Gendered Racism

Coping Strategy	K6	PHQ	GR-Stress	GR-Frequency
Self-distraction	.085 (n=132)	.297**(n= 108)	.277**(n= 114)	.225** (n= 138)
Active coping	-.084 (n=131)	.047 (n= 108)	.140 (n= 114)	.096 (n= 137)
Denial	.310** (n=132)	.226 (n= 108)	.316**(n= 114)	.356** (n= 138)
Substance use	.165 (n= 131)	.235*(n= 107)	.279**(n= 113)	.330** (n= 137)
Emotional support	.067 (n= 131)	.184 (n= 107)	.168 (n= 113)	.154 (n= 137)
Instrumental support	.179* (n= 130)	.090 (n= 107)	.126 (n= 114)	.122 (n= 136)
Behavioral disengagement	.320** (n= 129)	.397** (n= 106)	.250** (n= 113)	.363** (n= 137)
Venting	.217* (n= 132)	.402** (n= 108)	.294** (n= 114)	.228** (n= 137)
Positive reframing	.068 (n= 129)	.137 (n= 106)	.170 (n= 112)	.217* (n= 136)
Planning	.128 (n= 127)	.173 (n= 105)	.241* (n= 111)	.189* (n= 134)
Humor	.039 (n= 132)	.309** (n= 108)	.193* (n= 114)	.198* (n= 138)
Acceptance	.139 (n= 131)	.274** (n= 108)	.142 (n= 114)	.140 (n= 138)
Religion	-.099 (n= 131)	-.052 (n= 108)	-.102 (n= 114)	-.102 (n= 137)
Self-blame	.278** (n= 131)	.398** (n= 107)	.408** (n= 113)	.353** (n= 137)

Note. Significant correlation coefficients. ** $p < .01$. * $p < .05$

Findings from the Brief COPE suggest that all significant correlations between coping strategies and mental health challenges are positive. As the stress appraisal and frequency of gendered racism increase, so do the coping strategies and mental health challenges. Thus, based on the quantitative results alone, neither of the coping strategies decrease with the occurrence of depression and psychological distress. There are several significant correlations that range from

weak to moderate that increase with mental health challenges. Behavioral disengagement involves the idea of “giving up” as a method of trying to cope; it has the strongest significant correlation with psychological distress, $r = .320$, $p \leq .01$ ($n = 129$). However for depression, venting involves verbally expressing negative feelings. There is a moderate positive relationship between venting and depression, $r = .402$, $p \leq .01$ ($n = 108$). Thus depression scores are more impacted by venting than any other coping strategy. Although not significant, religion is negatively correlated with both depression, psychological distress, and gendered racism.

It is difficult for quantitative measures alone to address internalized oppression. Even when Black women are given the opportunity to report on their own behaviors, it is nearly impossible to know how much of their thoughts and behaviors have been compromised by institutional and internalized gendered racism. For example, belief in the SBW ideology impacts how one views themselves. If a participant endorses the SBW ideology, then a form of active coping might include an acceptance or willingness to take on additional demands, regardless of whether or not they admit to themselves that the demands are burdensome. However, participants who do not endorse the SBW ideology might be more willing to admit and accept when they are stressed. Consequently, they may be more likely to refuse demands that are within their control. Thus, quantitative measures such as the Brief COPE cannot adequately describe one’s behaviors because of the impact of institutional gendered racism and the way that it becomes internalized. In fact, additional research suggests that the use of denial as a coping strategy increases mental health problems (Thomas et al., 2008). This suggests that as Black women “deny” the stressfulness of gendered racism, which occurs when the SBW is internalized, they are more likely to experience psychological distress.

Although the Brief COPE is an established measure in mental health research (Eisenbarth, 2012; Carver, 1997; Straight, Harper, & Arias, 2003), findings from the interviews and focus group revealed coping strategies not included on the instrument. Individual interviews suggested that Black women overwhelmingly use increased education specifically about gendered racism as a way to cope with it. Participants stated that they often enrolled in academic classes where they could learn about how racism and sexism are embedded in society and impact them personally. In their leisure time, they described watching documentaries as a way to increase their education on the impact of structural oppression. Several participants even stated that they wanted to participate in the interview after completing the survey so they could learn more about gendered racism. Understanding the way that gendered racism works in society through increased education was a key finding from the interviews with participants.

In addition to increased education, social support and humor were also revealed in the focus group as an effective coping strategy. For example, being perceived as “the help” was viewed as an anomaly prior to the discussions in the interviews and focus group. However, the focus group, more so than the individual interview, validated “the help” experience as a form of gendered racism when participants saw how many others had undergone it. During the focus group, being perceived as “the help” was better understood as a way gendered racism manifests. Following the increased understanding, “the help” was deconstructed and resisted through the use of humor in the focus group. Participants discussed how while shopping at Target, they were sought out to help primarily by White women even though they were not wearing the traditional Target uniform of a red collar shirt and khaki pants. Participants ridiculed the irony of being perceived as “the help” even though they were not in uniform. Thus, the focus group

environment revealed humor as an effective coping strategy once deconstruction had taken place. Deconstruction, however, required a comprehensive understanding and education.

It was also noteworthy that the support in the focus group did not emphasize an oversharing of the negative impact of gendered racism, as results from the quantitative surveys show that venting increases with depression. In this way, the quantitative results guided the way the focus group was facilitated providing balance between sharing the impact of gendered racism with effective coping behaviors. Findings from both the quantitative and qualitative phases suggest that increased education on gendered racism is essential prior to the use of effective coping such as humor and social support. Therefore the mixed methods approach to coping is most appropriate because it uncovered the nuances associated with coping with internalized oppression.

Manuscript One: Racial Identity, Perception of Racism, and the Mental Health of Black Americans: Perspectives for Consideration

Healthy People 2020 calls attention to the powerful and complex relationship between health outcomes, individual behavior, and the social determinants of health. Increasingly, racism has been receiving attention as a determinant of racial health disparities in an attempt to understand negative health outcomes (Braveman, Egerter, & Williams, 2011; Mays, Cochran, & Barnes, 2007). As a social determinant of health, racism can be understood as a phenomena that results in avoidable and unfair inequalities in power, resources and opportunities across racial or ethnic groups. The study of race and racism extends far beyond the health fields, thus the goal of reaching health equity may be realized sooner with an interdisciplinary approach. The goal of this paper is to offer transdisciplinary research on racial identity as a protective factor for the mental health of African Americans against racism. In what follows, I will define racism and its impact on health, introduce racial identity development theory specific to Black identity and provide evidence to support its significance in community health and health education fields.

Racism is defined as a system of advantage based on race (Wellman, 1977). Race and racism are recognized as social constructions intensely entrenched within the structure of American society (Tatum, 1992). Race scholars contend that racism has largely shifted away from covert acts as a result of the advances during the Civil Rights Movement of the 1950s and 1960s (Dovidio & Gaertner, 1986; Neville, Lilly, Duran, Lee, & Browne 2000) to those that are more subtle (Pierce, 1974). Though at times, it manifests in both blatant and subtle behaviors that permeate the daily lives of individuals (Essed, 1991; Sue, 2010). Moreover, institutional racism is defined as differential access to goods, services, and opportunities based on race. It manifests materially as differential quality in education, housing, and medical facilities (Jones, 2000).

Institutional racism is understood as a fundamental cause of racial health disparities through its interaction with socio-economic conditions, societal and institutional structures, racial prejudice and discrimination, and stress (Berman & Paradies, 2010; Braveman, Egerter, & Williams, 2011; Carty et al., 2011; Gee & Ford, 2011).

Krieger's Life-course perspective posits that racism can affect health both directly and indirectly (Krieger, 2000) even beyond differences based on socioeconomic status (Krieger, 2008; Krieger, Rowley, Herman, & Avery, 1993). Racism becomes "embodied" over the life-course, adversely affecting the health of oppressed populations through five pathways:

1. Economic and social deprivation;
2. Toxic substances and hazardous conditions;
3. Socially inflicted trauma (mental, physical, and sexual, directly experienced or witnessed, from verbal threats to violent acts);
4. Targeted marketing of commodities that can harm health, e.g. junk food and psychoactive substances (alcohol, tobacco, and other licit and illicit drugs);
- and 5. Inadequate or degrading medical care. (Krieger, 2008, p. S22)

Krieger's model emphasizes the dual impact of racism on health by harming the subordinate group and benefitting the dominant one (Carty et al., 2011; Krieger, 2012). "Racism may be conceptualized as a tool employed by those in power to maintain privilege and control over resources (for example, wealth, knowledge, prime land and housing) that ultimately benefit health" (Link & Phelan, 2014; Lukachko, Hatzenbuehler, & Keyes, 2014).

The Life-course perspective suggests that early and long-term exposure to stress, like racism, provide wear and tear on the body's allostatic system and may negatively impact birth outcomes in Black women (Lu & Halfon, 2003). Further, in a meta-analytic review of 134 studies, perceived discrimination had a significant negative effect on both mental and physical health (Pascoe & Smart Richman, 2009). Mental health included, but was not limited to,

depressive and anxiety symptoms, posttraumatic stress symptoms, and psychological distress. Physical health included, but was not limited to, a multitude of diseases and physical conditions such as hypertension, cardiovascular disease, diabetes, and respiratory conditions, as well as other general indicators of illness (e.g., nausea, pain, and headaches) (Pascoe & Smart Richman, 2009).

The impact of racism on health is documented (Kreiger, 2014; Williams & Williams-Morris, 2000). However, how one perceives of racism also impacts health (Mays, Cochran & Barnes, 2007). Perceived racism is the extent to which individuals are aware of racism as a social element (Ford et al., 2009). It reflects an individuals' assessment of everyday occurrences of racist practices, commonly referred to as micro-aggressions (Pierce, 1974; Sue, 2010). Microaggressions are often subtle forms of prejudice and discrimination that operate on an unconscious level for the perpetrator but negatively impact people of color (Sue, 2010). Racial discrimination is a pervasive phenomenon (Sellers & Shelton, 2003). Research suggest that recognizing perceived discrimination may in some cases be detrimental to health while in other cases it is self-protective (Mays et al., 2007). To denote the significance of race in a race-based society, non-Hispanic African Americans will be referred to as Black Americans.

Racial Identity Development Theory

Racial identity and racial identity development theory are defined by Helms (1990) as a sense of group or collective identity based on one's perception that he or she shares a common racial heritage with a particular racial group... racial identity development theory concerns the psychological implications of racial-group membership, that is belief systems that evolve in reaction to perceived differential racial-group membership. (p. 3)

In societies where racial-group is emphasized, racial identity will develop in some form for everyone, but in different ways depending on the dominant/subordinate group membership (Helms, 1990).

William Cross's (1978, 1991) model of Black identity, known as the Nigrescence model of racial identity, provides a more detailed examination of racial identity specific to Black Americans. Racial identity is defined as an understanding of the racial self-concept in a race-based society (Cross, 1991). According to Cross, there are five stages in the development of Black racial identity: Preencounter, Encounter, Immersion/Emersion, Internalization, and Internalization-Commitment. Though presented in stages, the development process is more spiral than linear. The first stage consists of an internalized acceptance of white supremacy that may be outside of the individual's conscious awareness (Cross, 1991). During the first stage, individuals seek to assimilate and actively or passively distance her/himself from other Blacks. There is a de-emphasis on one's racial-group membership because it is believed that race is not a relevant factor. The encounter stage is second; it is usually precipitated by an event or series of events that forces the individual to acknowledge race (Cross, 1991). This encounter forces the individual to acknowledge their membership of a group targeted by racism. Individuals in the third stage, Immersion/Emersion, actively seek out opportunities to explore their own history and culture. It is characterized by the simultaneous desire to immerse one's self in visible symbols of racial identity, glorifying Black people, while actively avoiding symbols of Whiteness, denigrating White people. Eventually, anger towards Whites dissipates and a newly defined sense of self emerges (Cross, 1991). The emergence marks the beginning of the fourth stage, Internalization, characterized by more openness and less defensiveness. With a secure sense of self, internalized racial identity allows individuals to establish meaningful relationships with

Whites and build coalitions with other oppressed groups. Cross suggested that the fifth stage is similar to the fourth but that individuals here have found ways to translate their personal sense of Blackness into action and is sustained across time. Internalization-Commitment is characterized by a positive racial identity that both proactively perceives and transcends race (Cross, 1991).

The Multidimensional Model of Racial Identity (MMRI) offers significant differences from the Nigrescence theory (Cross, 1991). It does not assume that race is the defining characteristic for all Black Americans, or that there is an optimal race-based identity (Sellers, Smith, Shelton, Rowley, & Chavous, 1998). Instead, it focuses on the significance and qualitative meaning that Blacks or African Americans attribute to their membership within the Black racial group within their self-concepts (Sellers, Rowley, Chavous, Shelton, & Smith 1997). This understanding of racial identity comprises two elements: the importance of race in the individual's perception of self and the meaning the individual ascribes to being a member of this racial group (Phinney, 1990). The individual's ascriptions and perceptions about their racial groups likely serve as personal guides for making individual decisions, depending upon the strength of racial identity (Harvey & Afful, 2011).

The MMRI delineates four dimensions of racial identity in Black Americans that are both independent and interrelated suggesting that certain dimensions are more relevant to certain phenomena than other dimensions (Sellers et al., 1998). The dimensions are salience, centrality, ideology and regard. Salience refers to the extent to which one's race is a relevant part of one's self-concept within a particular situation; it varies depending on the context (Sellers et al., 1998). Salience is understood as a process variable contingent not only on the situation, but also on personal factors, such as centrality. Centrality refers to the extent to which a person defines her or himself with regard to race; it measures race as a core part of an individual's self-concept.

Inherent in centrality is a ranking of hierarchical identities with respect to the individual's main definition of self. Thus centrality is concerned with the importance of race in the self-concept (Sellers et al., 1998). Racial ideology is the meaning that individuals ascribe to being Black; it includes the general attributes, characteristics, and values associated with Black people. It represents the personal philosophy about the ways in which Black Americans interact in society (Sellers et al., 1998). Sellers suggest that there are at least four ideologies that capture Black Americans' view on the importance of racialized group membership (Sellers et al., 1998). A nationalist ideology stresses the uniqueness of being of African descent; an oppressed minority ideology stresses the similarities of being Black Americans with other oppressed groups; an assimilationist ideology stresses the similarities between Black Americans and American mainstream society; and a humanist ideology stresses the commonalities of all humans (Sellers et al., 1998). While centrality and ideology have to do with how an individual views herself, regard accounts for social interaction and is comprised of two elements, private and public regard. Private regard examines the extent to which an individual has positive feelings toward Black Americans in general and public regard is the extent to which an individual feels that other groups have positive feelings toward Black Americans (Sellers et al., 1998).

Racial Identity's Role in Perceiving Racism and Protecting Mental Health

While racial discrimination seems to be a prevalent experience for people of color (Kessler, Mickelson, & Williams, 1999; Landrine & Klonoff, 1996), there are individual differences in how people appraise an incident as discriminatory (Sellers & Shelton, 2003). Racial identity has been linked to different emotional states, personal beliefs, and how individuals process racial information (Carter, Pieterse, & Smith, 2008). Findings on racial group identification suggest the more an individual identifies with their racial group, the more vigilant

and sensitive they are to perceiving discrimination, with or without the presence of evidence (Crocker & Major, 1989; Sellers & Shelton, 2000). Quantitative findings require a way to measure racial identity.

Racial centrality is most often used to operationalize Black racial identity (Pascoe & Smart Richman, 2009). Usually, it is assessed with the Multidimensional Inventory of Black Identity (MIBI) Racial Centrality subscale (Sellers et al., 1997). Sellers' research suggests that racial centrality provides protection from the negative mental health consequences of perceived discrimination. In a study with 267 Black American college students, participants specifically identified racial centrality as being positively associated with how much discrimination an individual report that they have experienced. At the same time, individuals with high racial centrality perceive of racial discrimination more often but are protected by the negative consequences of exposure; similar results were found in a study of Black adolescents (Sellers et al., 2003; Sellers, Copeland-Linder, Martin, & Lewis, 2006). Sellers surmised that for young Black-American adults, racial identity overall was a protective factor in buffering the negative impact of discrimination on psychological distress.

Other research provides support for racial identity as a buffer for the deleterious consequences of racial discrimination (Galliher, Jones, & Dahl, 2011; Jones, Cross & DeFour, 2007; Rivas-Drake, Hughes, & Way, 2008). A meta-analysis (Smith & Silva, 2011) and a review of the literature (Rivas-Drake, et al., 2014) contend that for Black adolescents, a stronger racial identity is related to positive psychosocial factors, academic achievement, and health outcomes. However, results from a meta-analysis of 68 studies found that while 18% of the studies support racial identity as a buffer for mental health against racism, 12% showed higher levels of racial identity was associated with negative mental health outcomes. Further the majority of the studies

(71%) found no effect of group identification on the relationship between perceived discrimination and mental health (Pascoe & Smart Richman, 2009). It is note-worthy, however, that the meta-analysis findings (Pascoe & Smart Richman, 2009) are not limited to Black racial identity. Due to the inconsistencies in these findings, a brief and more recent review of the literature is provided in order to better understand the role of Black racial identity as a protective factor against perceived racism on mental health in Black Americans.

A review of the literature was conducted to gather articles on the protective role of racial identity on the mental health of Black Americans. Inclusion criteria for this review were studies published between 2007 and 2016. Keywords included: (1) racial identity, (2) racial centrality, (3) Black or African American, (4) mental health. Both racial identity and racial centrality were used in the search to theoretically limit the broad concept of racial identity to the MMRI model. The literature search was delimited to (1) peer-reviewed articles, (2) studies published in the English language, and (3) studies published between January 2007 and January 2016. A previous study that included a meta-analysis that examined racial identity as a protective factor against racism was published in 2009 and included studies published from 1986 to 2007 (Pascoe & Smart Richman, 2009). Therefore the search for articles resumed with 2007. Exclusion criteria included (1) qualitative studies and (2) studies with insignificantly small samples of Black or African Americans. Restricting the sample by race and ethnicity helps to center the experience of those who are usually marginalized in adolescence and college student samples and was viewed as essential in order to more fully understand the social construction of race specific to Black Americans. The following databases were used to retrieve data: Psych Info, Cumulative Index to Nursing and Allied Health Plus with Full Text (CINAHL), Education Resources Information

Center (ERIC), and Academic Search Premier. Additionally, reference lists of the articles were reviewed to identify articles not included in the electronic search.

Racial Identity & Psychological Health

While findings from the review show support for racial identity as a buffer against perceived racism on mental health, research suggests there are some nuances that should be considered. One study suggests that racial identity plays a significant role in perceiving racial discrimination and that certain categories of racial identity (or low racial identity) in Black college students was associated with increased stress and depression (Sanchez & Awad, 2016). This study found that certain categories of racial identity (or low racial identity) in black college students is associated with increased stress and depression (Sanchez & Awad, 2016).

In one study, 229 Black American adults from the community responded to a mail survey on conformity and internalization on mood (Carter & Reynolds, 2011). Conformity was conceptualized as a devaluing of one's Blackness. Internalization was defined as a positive commitment to other Blacks. Results from the canonical correlation analyses found that conformity was positively related to feelings of anger, depression, confusion, fatigue, and tension among Black Americans. This study also found that internalization was positively related to less intense emotional reactions (Carter & Reynolds, 2011).

Another study found that racial identity predicted more of the variance in mental health than race-related stress (Franklin-Jackson & Carter, 2007). This study included 255 Black American adults and used regression analyses. Its findings suggest that racial identity impacts how one perceives of and experience race-related stress. It found that racial identity may offer protection for mental health against racism. However, results also showed that individual differences in

how Black people see and value their own race is related to psychological distress and well-being.

A more recent study of Black American adults examined the role of racial identity on mental health (Hughes, Kiecolt, Keith, & Demo, 2015). This study used data from the National Survey of American Life that included data from 3,570 African Americans age 18 and older to explore racial identity based on social identity theory. Social identity theory encompasses more than race; it is a multifaceted social psychological theory of the role of group-identified self-conception in intergroup experiences (Ellemers & Haslam, 2012; Hogg, 2006). Racial identity was linked to mastery, defined as a sense of control over one's outcomes, self-esteem, and depression symptoms; however internalized racism was also examined (Hughes et al., 2015). Internalized racism, characterized as self-stereotyping, includes an acceptance of the dominant society's negative racial stereotypes of cultural and biological inferiority (Williams & Mohammed, 2013). Poor mental health outcomes, including higher depressive symptoms and lower mastery, may result from having a strong racial identity when negative racial stereotypes have been internalized (Hughes et al., 2015). Yet when African Americans strongly identify with their group and view it positively, rejecting internalized racism, they report greater self-esteem, mastery and fewer depressive symptoms. These findings highlight the importance of including the role of internalizing racism in considerations of racial identity (Hughes et al., 2015)

Another study suggested that racial identification coupled with positive group evaluation is related to lower depressive symptoms (Ida & Christie-Mizell, 2012). Using data from the National Survey of American Life, the study examined the relationship among racial identity, psychosocial resources and depressive symptoms. Psychosocial resources included self-esteem, mastery, and social support. The sample included nearly 3,000 Black Americans. Results from

the regression analyses suggested that the impact of racial identity and psychosocial resources reduced depressive symptomatology.

One longitudinal study found that racial identity was strongly correlated with self-esteem for Black American male youth (Mandara, Gaylord-Harden, Richards, & Ragsdale, 2009). That study also found that an increase in racial identity in seventh and eighth grade students (age 12 – 14 years of age) was associated with a decrease in the prevalence of depressive symptoms for that age group, even with self-esteem controlled (Mandara et al., 2009). A correlational study supports that while there is an indirect link between racial identity and depressive symptoms through perceived stress, the significance and meaning that Black American adolescents attribute to racial identity may be critical to their psychological well-being (Caldwell, Zimmerman, Bernat, Sellers, & Notaro, 2002). The correlational study also examined maternal support in 521 twelfth grade African American adolescents. Their findings were related to both racial centrality as well as private regard; though racial centrality was not significant, private regard was related to perceived stress. Thus, developing positive feelings about ones' racial group may be more important than how central race is to one's concept. These findings also emphasize the importance of measuring racial identity as a multidimensional construct as opposed to singularly measuring centrality (Caldwell et al., 2002). The development of private regard typically occurs within families; a related construct is racial pride.

Racial socialization and racial pride may be viewed as antecedents of racial identity. Racial socialization often precedes pride; socialization is conceptualized as a common family setting process where parents of color orient their children to implicit and explicit attitudes and beliefs about race, and how to cope with racial discrimination (Boykin & Toms, 1985). In a sample of Black American college students, findings suggest that parental messages emphasizing the

importance of religion, Black history, and the benefits of kinship for coping with racism reduced the impact of racism on psychological stress (Bynum, Burton, & Best, 2007). One theme that is often born out of racial socialization is racial pride (Bowman & Howard, 1985). And research supports that racial pride is related to depressive symptoms in African American young adults (Neblett et al., 2013). Findings from a study with 211 African American college students suggest that frequent messages of racial pride increased private regard; in turn participants were less likely to report depressive symptoms than those who had received fewer racial pride messages. Further, individuals who reported that their parents engaged in racial socialization, such as attending cultural events, were also more likely to feel positive about their race and report fewer depressive symptoms (Neblett et al., 2013). Thus racial identity, racial socialization and racial pride have been linked to positive psychological health.

CONCLUSIONS & IMPLICATIONS

This review highlights the potential protective role of racial identity on the mental health of Black Americans against race-related stress and racism in general. However, the review revealed several key findings. Racial identity is better assessed with a multidimensional lens, since research supports the centrality and private regard constructs (Neblett et al., 2013). Internalized racism should also be studied as opposed to making the assumption that African Americans identity is based on an authentic African American experience and not one impacted by self-stereotyping (Hughes et al., 2015) or conformity (Carter & Reynolds, 2011). Finally, racial socialization and pride have important implications for adults although they are typically associated with adolescents and college students (Bynum et al., 2007; Hughes et al., 2015). Given these nuances, there is still support for racial identity as a protective factor for mental health against perceived racism.

The study of racial identity is fairly new to health education and community health fields; its use in these fields may be beneficial as we strive for health equity. Research focused on health equity suggest fourth generation research take action to eliminate health disparities by moving beyond documenting differences to focusing on the impact of race (Ford & Airhihenbuwa, 2010; Gilmore, 2007; Thomas, Quinn, Butler, Fryer, & Garza. 2011). One such action might include health education programs that focus on the impact of racism on mental health (Kreiger, 2014; Williams & Williams-Morris, 2000). Another strategy might include health promotion programs with an emphasis on positive racial group identification. These strategies could be implemented in school health programs similar to calls for multicultural citizenship education that tend to focus on international students, globalization and the importance of diversity (Banks, 2015; Banks, 2008; Lareau & Goyette, 2014). In addition to school health settings, partnering with mental health organizations to reach the community should also be considered given that most people with a mental illness do not have contact with mental health care providers and tend to go undiagnosed (Kessler et al., 2010; Wang et al., 2005).

This review may also be helpful for mental health education interventions. Given the impact of racism on mental health, intervention program should address race and racial identity. The Public Health Critical Race Praxis (PHCR) should be considered in the planning, design, implementation and evaluation phases of programs addressing racism (Ford & Airhihenbuwa, 2010). The PHCR provides methodology guidance for research addressing health equity based on racialized disparity; it has been described in detail elsewhere (Ford & Airhihenbuwa, 2010). A key aspect of health programs that focus on race is the cultural competence of the researcher and those implementing the program. One way to address cultural competence is to assess

critical self-awareness especially regarding personal privilege when addressing issues such as racism (Burton, White & Knowlden, 2017; Ford & Airhihenbuwa, 2010).

Although there is ample quantitative research support for racial identity in perceiving of racism and protecting mental health specifically in Black Americans (Galliher, Jones, & Dahl, 2011; Hughes et al., 2015; Jones, Cross & DeFour, 2007; Rivas-Drake, Hughes, & Way, 2008; Sellers et al., 2003; 2006; Sellers & Shelton, 2003), additional research is needed. Specifically, longitudinal research would add to support for racial identity as a protective factor against racism. Additionally, research with long term mental health outcomes are lacking. Research on the role of racial identity in protecting against the impact of racism on physical health is also an area in need of research.

This review was restricted to quantitative studies; however, qualitative studies may provide a more comprehensive view of the impact of racism from those who report being victimized. Sellers & Shelton (2003) called for a more nuanced understanding of qualitative meanings of racial identity in order to authentically portray the normalcy of resiliency. Importantly, few of the studies in the review used an intersectional lens to complicate how race is entangled with gender, class, and other social conceptions of identity and the ways in which they may coincide and impact health. For example, what is the role of racial identity in Black women who experience gendered racism? Gendered racism was coined by sociologist, Philomena Essed (1991) and refers to the simultaneous experience of racism and sexism (Lewis, Mendenhall, Harwood, & Hunt, 2013). Gendered racism explains the complexity of oppression specific to women of color based on gendered and classed forms of racism. Some studies reported that gendered racism increase mental health problems (Szymanski & Lewis, 2015;

Watson & Hunter, 2015; Thomas, Witherspoon, & Speight, 2008). It is unclear if racial identity will maintain its buffering effect in the face of multiple forms of oppression.

Several of the studies examining racial identity focused on adolescents within the context of identity development. However, given the life-course perspective, racial identity and exposure to racism over time may have an accumulative impact on the mental health of Black Americans beyond adolescence and college students. Additionally, most of the quantitative studies have focused on perceived racial discrimination, an interpersonal form of racism. More research is needed to understand how other forms of racism, including institutional and internal, may impact Black Americans.

Manuscript Two: The Role of Racial Identity within Gendered Racism: Centering Black College Women's Mental Health

Depression is the most common type of mental illness. Data from the American College Health Association National College Health Assessment (ACHA - NCHA) show that nearly 14% of college students have been diagnosed or treated for depression within the last 12 months (ACHA-NCHA, 2016). However, most people with a mental illness do not have contact with mental health care providers and tend to go undiagnosed (Kessler et al., 2010; Wang et al., 2005). Due to the challenges of measuring mental illness in general populations, nonspecific psychological distress is often studied as an indicator of mental illness (Kessler et al., 2010; Lincoln, Taylor, Watkins & Chatters, 2011; Szymanski & Lewis, 2015; Thomas, Witherspoon & Speight, 2008; Watson & Hunter, 2015). The CDC reports, in a study of adults from 35 states, approximately 40% of women and men over age 18 indicated nonspecific psychological distress (2013).

Characterized by persistent sadness and sometimes irritability, depression can be costly and debilitating to sufferers. It can adversely affect common chronic conditions such as arthritis, asthma, cardiovascular disease, cancer, diabetes and obesity. It is also related to increased work absenteeism, short-term disability, and decreased productivity (CDC, 2010). The CDC characterizes psychological distress as a reactive disorder affected by external stress; it includes a range of symptoms including lack of enthusiasm, sleep problems, feeling blue, hopeless or emotional (Decker, 1997; Pratt, Dey, & Cohen, 2007).

In the U. S., depression is twice as likely to occur in women as in men (CDC, 2013; Nolen-Hoeksema, 2001) and one in ten women report some level of depression with the highest rates concentrated in the southeast (CDC, 2010). Similarly, college women report having been treated or diagnosed with depression more than men, 15.6% vs. 8.7%, respectively (ACHA-

NCHA, 2016). Nearly 13% of Blacks are diagnosed with depression (CDC, 2010). Like depression, psychological distress is also higher in women than in men (CDC, 2013; Health, US, 2011). College women report experiencing above average or tremendous levels of stress more so than men (ACHA-NCHA, 2016). A report from the Office of Minority Health states that Blacks are 20% more likely to report having serious psychological distress as their white counterparts (OMH, 2016). Among Blacks, mental health status is also affected by income, with those below the poverty level three times more likely to report psychological distress (OMH, 2016).

Mental Health & Black Women

There have long been inconsistencies in reporting on the mental health of Black women. In 2001, the U.S. Department of Health and Human Services suggested that Blacks were less likely to suffer from major depression. Rates of depression in Black women, 13.85%, nearly double that of Black men, 7% (Cutrona et al., 2005; Williams et al., 2007). Several studies have found that primary care physicians are less likely to diagnose depression in Black women in comparison to their white counterparts (Nicolaidis et al., 2010; Snowden & Pingitore, 2001; Brooks, 1997).

Further, other studies posit that African American women are at increased risk for psychological distress because of racism and sexism (Greer, Laseter, & Asiamah, 2009; Woods-Giscombé & Lobel, 2008). One study of 204 Black women with low income found that 22% of the sample reported significant mental health problems. Nearly 20% of the sample reported seriously considering or attempting suicide in their lifetimes (Perry, Pullen, & Oser, 2012). Another study assessed 144 Black women who sought mental health treatment and found that sexual objectification experiences, racist events and gendered racism significantly contribute to depression (Carr et al., 2014). Sexual objectification included unwanted sexual advances, body

evaluation, sexual harassment and sexual assault. Further, another study found a strong correlation between sexism-related stress and racism-related stress, $r(202) = .61, p < .001$, (Stevens-Watkins et al., 2014). More stress was associated with sexism and racism than with employment and finances, lifetime victimization and social network loss.

Yet, there remains a persistent myth that mental disorders are rare for Black women. This myth persists largely for two primary reasons. First, Black women have been historically underdiagnosed, misdiagnosed and untreated in mental health investigations (Brooks, 1997; Snowden & Pingitore, 2001). Second, the ideology of the *StrongBlackWoman* (SBW) has implications for mental health specific to Black women (Morgan, 1999). While it might be considered by some as a positive image, it can also be understood as the super-human capacity to endure inordinate amounts of stress and lead to essentialist notions that all Black women are inherently strong (Woods-Giscombe, 2010). SBW is presented as one word to show the embedded and inseparableness of the three elements, whereas strength is understood when one speaks of Black women. The SBW ideology permeates every aspect of Black womanness (Collins, 1990).

Gendered Racism

Gendered racism, in some form, may be experienced by all women and men of color, but this study centers the experiences of Black women. Gendered racism manifests through constructed ideologies and stereotypes of Black womanhood (Collins, 1990). Typically, Black women have been stereotyped as inherently strong, physically and mentally. The projected and internalized stereotype of the SBW is thought to lead to suppressed emotions and negative health effects that are specific to Black women (Woods-Giscombe, & Black, 2010; Collins, 1990).

Collins explained that the construction of the SBW equipped to endure hardship served as the justification for oppression, in the form of gendered racism (Collins, 2000).

Several studies report that gendered racism increases mental health problems in Black women (Szymanski & Lewis, 2015; Thomas, Witherspoon, & Speight, 2008; Watson & Hunter, 2015). However, one study found no correlation between gendered racism and mental health when other factors are considered (Carr, Szymanski, Taha, West, & Kaslow, 2014). Yet another found that the impact of gendered racism on mental health is not the same for all Black women (Perry, Pullen, & Oser, 2012). Other studies have focused on the experience of gendered racism and found that it most often occurs at the interpersonal level (Thomas, Witherspoon, & Speight, 2008; Jones & Shorter-Gooden, 2003; Essed, 1991), which include being sexually harassed, hearing inappropriate jokes related to being a Black woman, and being mistaken for “the help.” At the intrapersonal level, internalizing gendered racism is also described as endorsing the SBW ideology (Watson & Hunter, 2015).

Gendered racism grew out of intersectionality theory and taps into oppressive sexual experiences and racism among women of color (Buchanan, 2005). Feminist legal scholar, Kimberlé Crenshaw coined the term intersectionality in 1989 to complicate understandings of race and gender. Crenshaw argued that for women of color multiple marginalizations of race and gender intersect (Crenshaw, 1989); thus the experiences of women of color could not be fully understood through any single lens (exploring race OR gender). Feminists and critical race theorists use intersectionality to describe the simultaneous experiences of oppression, whereby race, class, gender, sexuality, ethnicity, nation, age, and disability intersect and form mutually constructing features of social organization (Collins, 1998; Erevelles & Minear, 2010). Crenshaw (1991) explained that the antiracist and feminist movements not only fail women of color by not

acknowledging the additional issues of race or patriarchy, but both discourses are inadequate in articulating the experiences of women of color. Black women, for example, experience racism that may not be the same as what Black men experience and sexism that may not be the same as what white women experience. Further, both often deny the existence of the other – white feminists regularly fail to interrogate racist practices just as antiracists fail to interrogate sexist practices (Crenshaw, 1991). These failures result in further subordination of women of color pushing them further to the margins.

The lack of attention to Black women in both movements is directly responsible for the silencing and erasure of Black women (Crenshaw, 1991). In the absence of their own voice and experience, the story that is written for and about them is not one that is genuine; instead it is one of inherent, super-human strength. The motivations that lie at the center of the SBW is not to lift up Black women as the standard of excellence in femininity or African American pride, but has ulterior motives that are very familiar to whiteness and patriarchy (Collins, 1990; 1998). Thus the mental health of Black women is negatively impacted by the stereotype of the SBW.

Mental Health, Racism & Racial Identity

Racial identity is described as the significance and meaning that Blacks attribute to their membership within the Black racial group within their self-concepts (Sellers, Rowley, Chavous, Shelton, & Smith, 1997). The individual's ascriptions and perceptions about their racial groups likely serve as personal guides for making individual decisions, depending upon the importance and meaning of racial identity (Harvey & Afful, 2011). Findings suggest that the more an individual identifies with their racial group, the more vigilant and sensitive they are to perceiving discrimination, with or without the presence of evidence (Sellers & Shelton, 2000; Crocker & Major, 1989). Often, racism is experienced as subtle or as microaggressions. Racial microaggressions was originally conceptualized by Pierce and others (1978) and expanded by

Sue and colleagues (2007; 2008). They are defined as subtle, everyday slights and insults based on various racial stereotypes and assumptions of criminality, intelligence, citizenship, and cultural values, as well as the denial or minimization of racialized experiences by people of color (Lewis, Mendenhall, Harwood, & Browne-Huntt, 2016; Sue, Capodilupo, & Holder, 2008). Microaggressions may also be experienced based on other forms of marginalized identities, such as gender and sexual orientation (Sue, 2010).

Racial centrality, one aspect of racial identity, is often used to operationalize racial identity (Pascoe & Smart Richman, 2009). It refers to the extent to which race is core to one's self concept (Sellers et al., 1998). Research suggest that racial centrality provides protection from the negative mental health consequences of perceived discrimination. (Sellers et al., 2003). Thus individuals with high racial centrality are protected from the negative impact of discrimination on psychological distress. This research provided the foundation for numerous other studies including a meta-analysis and a literature review (Rivas-Drake, et al., 2014; Smith & Silva, 2011).

A meta-analysis (Smith & Silva, 2011) and a review of the literature (Rivas-Drake, et al., 2014) contend that for Black adolescents, a stronger racial identity is related to positive psychosocial factors, academic achievement, and health outcomes, even when these findings are not consistent across other racial minority groups. However, one recent study found that racial identity positively correlated with perceiving racial discrimination and depression among Black college students (Sanchez & Awad, 2016). Still, much research support that racial identity may buffer the deleterious consequences of racial discrimination (Franklin-Jackson & Carter, 2007; Galliher, Jones, & Dahl, 2011; Rivas-Drake, Hughes, & Way, 2008; Sellers et al., 2006).

With sufficient support for racial identity in perceiving racism and protecting mental health, much less is known about the role of racial identity specifically in Black women who experience gendered racism. The purpose of this study was to understand the impact of gendered racism on the mental health of Black women in college and the role of racial identity. The research questions are:

1. What is the relationship between gendered racism and mental health in Black women in college?
2. Does racial identity mediate the effect of gendered racism on mental health in Black women in college?

METHOD

Participants

Participants were undergraduate and graduate Black female students at a large public, predominantly white institution (PWI) in the southeast. Black women make up about 8% (n = 2,703) with total enrollment near 32,000 students. Participants were recruited from a range of academic courses (including but not limited to African American studies, women's studies, public health, and social work courses) and student organizations that focused on Black women. Participants self-identified as Black/African American and as a woman, were at least 18 years of age, and currently enrolled full-time at the site of the study. Based on an a priori power analysis, using G*Power 3.1 for regression analyses (Faul, Erdfelder, Buchner, & Lang, 2009) 103 participants were required for 80% power, with a medium effect size of .15 and .05 criterion of statistical significance. Two-hundred and thirteen Black college women participated in the study. The sample in this study included nearly 8% of Black college women attending the university.

The average age of the participants was 21.67 years ($SD = 4.93$), ranging from 18 – 49. About 81% ($n = 132$) were undergraduates. Sociodemographic data are included in Tables 1 and 2.

Measures

There were four variables included in this study: gendered racism, racial identity, depression and psychological distress. In addition, demographic data was also gathered.

The Gendered Racial Microaggressions Scale (GRMS) was recently developed by Lewis and Neville (2015) to assess both frequency and stress appraisal of gendered racial microaggressions in two separate studies. Gendered racial microaggressions are subtle and everyday verbal, behavioral, and environmental expressions of oppression based on the intersection of race and gender (Lewis & Neville, 2015). The 26-item scale assesses frequency and stress appraisal of slights, insults and invalidations based on stereotypes, assumptions and marginalization. In the initial study, an exploratory factor analysis using a sample of 259 Black women resulted in a multidimensional scale with four subscales: Assumptions of Beauty and Sexual Objectification, Silenced and Marginalized, Strong Black Woman Stereotype, and the Angry Black Woman Stereotype. In the second study, confirmatory factor analysis using an independent sample of 210 Black women suggested that the 4-factor model was a good fit of the data for both the frequency and stress appraisal scales (Lewis & Neville, 2015). Construct validity was supported by the Racial and Ethnic Microaggressions Scale (Nadal, 2011) and the Schedule of Sexist Events (Klonoff & Landrine, 1995). The Racial and Ethnic Microaggressions Scale (REMS) assesses microaggressions based singly on race and ethnicity and has a reliability estimate of .92 in a study with Black participants (Nadal, 2011). The Schedule of Sexist Events (SSE) examines everyday experiences of sexism and has reliability estimates of .88 to .94 (Klonoff & Landrine, 1995). Reliability coefficient estimates with the GRMS ranged from

acceptable to moderate on frequency and stress appraisal for both the SSE and the REMS (Lewis & Neville, 2015), range from .29 to .64 across subscales of frequency and stress appraisal (Lewis & Neville, 2015). The GRMS explicitly addresses gendered racism as experienced by Black women; it is based on an intersectional framework acknowledging that for Black women, racism and sexism cannot be fully understood separately (Jones, 2016). The overall Cronbach alpha is .93 and reliability alphas range from .75 to .88 on each of the subscales (Jones, 2016). Sample items include: “Someone accused me of being angry when I was speaking in a calm manner,” “I have felt unheard in a work, school or other professional setting,” and “Someone has assumed that I should have a certain body type because I am a Black woman.” Participants indicated how often these experiences occurred over their lifetime (frequency) and how stressful they were (stress appraisal). Stressful was defined as feelings of upset, bothered, offended or annoyed. Frequency ranged from “Never” to “Once a week or more” on a 6-point Likert scale. Appraisal ranged from “This has never happened to me” to “Extremely stressful” on a 6-point Likert scale. The GRMS was significantly related to psychological distress, such that greater perceived gendered racial microaggressions were related to greater levels of reported psychological distress (Lewis & Neville, 2015).

Racial identity was measured using the centrality subscale of the Multi-Inventories of Black Identity (MIBI) (Sellers et al., 1998). The 8-item subscale assesses the degree to which being Black is central to respondents’ self-concept. The 7-point Likert scale responses range from ‘strongly agree’ to ‘strongly disagree.’ It is established in the literature with acceptable validity and a Cronbach alpha .77 (Sellers et al., 1998) and with extensive use among college students (Cronbach’s alpha = .88) (Hardeman et al., 2016; Jones, 2014; Seaton, Upton, Gilber & Volpe, 2014; Chavous, Rivas-Drake, Smalls, Griffin, & Cogburn, 2008). Sample items include:

“In general, being Black, is an important part of my self-image”, “Being Black is an important reflection of who I am”, and “I have a strong attachment to other Black people.”

Mental health was operationalized as depression using the Patient Health Questionnaire (PHQ-9) (Kroenke & Spitzer, 2002) and psychological distress using the Kessler 6 (K6) (Kessler, 2002). The PHQ-9 is a 9-item, multipurpose instrument for screening, diagnosing, monitoring, and measuring the severity of depression (Kroenke & Spitzer, 2002). It incorporates DSM-IV depression diagnostic criteria with other leading major depressive symptoms into a brief self-report tool. The diagnostic validity was established in multiple studies and, for scores greater than or equal to 10, has a sensitivity of 88% and a specificity of 88% for depressive disorder which requires treatment (Kroenke, Spitzer, & Williams, 2001). Further, scores can be classified as: 0–4 (no or minimal depressive symptoms), 5–9 (mild), 10–14 (moderate), 15–19 (moderately severe), and 20–27 (severe) (Pratt & Brody, 2014). The ninth item was deleted as it asks about suicidal attempts and ideation deemed inappropriate for nonclinical research; omitting this item does not have a major impact on the assessing depression (McKnight-Eily et al., 2009; Kroenke & Spitzer, 2002). In this study, ≥ 10 was used as the criteria for moderate depression. Responses are included on a 4-point Likert scale.

The K6 (Kessler, 2002) is a 6-item scale that measures non-specific psychological distress within the past 30 days. Higher scores indicate worse psychological functioning. The K6 is intended to identify persons with mental health problems severe enough to cause moderate to serious impairment in social and occupational functioning and to require treatment. Each item is measured on a 5-point Likert-type scale ranging from 0 (none of the time) to 4 (all of the time). Cronbach’s alpha was .81 in African Americans (Lincoln et al., 2011). The K6 was originally established using a cut-point of 13 to signify severe psychological distress (Kessler et al., 2002,

2003). However, those who score within the range of 5 to 12 are considered moderately, yet still clinically significant, distressed (Prochaska et al., 2012). The extending cut-point provided a balance between sensitivity (0.76) and specificity (0.75) with an overall classification accuracy of 0.74 and little variance by ethnic/racial group (Prochaska et al., 2012). For this analysis, a score of 5 or greater signified moderate psychological distress.

Analysis

Correlations and regression analyses were conducted to address the research questions. The population correlation coefficient, Pearson Product Moment Correlation, was used to measure the strength of the linear relationship between the variables; with standard recommendations of very weak (.00-.019), weak (.2-.39), moderate (.4-.59), strong (.60-.79), and very strong (.80-1.0) accepted (Evans, 1996). For the first research question, the correlations assessed the relationship between gendered racism overall, both frequency and stress appraisal, and mental health. Mental health was operationalized as psychological distress (K-6) and depression (PHQ). To address the second research question, a regression analysis was performed to test if racial identity protects mental health (psychological distress and/or depression) from gendered racism (frequency and stress appraisal).

Procedures

Participants were recruited from academic classes and student organizations through nonrandom convenience sampling. Student organizations were located online through the institution's database by searching terms such as "African American," "Black," and "women." Classes were identified by reviewing data from the institution's research and assessment office that quantified the enrollment of Black women based on college, followed by an online search within colleges and departments using similar terms as described. Instructors and representatives

of student organizations were contacted via email regarding the study. Classroom recruitment consisted of the instructor forwarding an email that included a link to participate to students who indicated they were interested in learning about the study. Snowball sampling occurred with participants forwarding the email link to other potential participants. The researcher was invited to attend student organization meetings and participants were provided iPads to complete the survey during their meetings. Data were self-reported through a web-based survey via Qualtrics (2015), an online survey software. Consent forms were included as the first page of the web-based survey and included general information about the study, such as gender and race related stress. Participants had to select 'yes' in order to provide consent. Participants were allowed to stop taking the survey at any time. Those who completed the survey were provided a more thorough description of gendered racism including examples and had the opportunity to participate in a raffle. If participants correctly answered a question on their understanding of gendered racism, they were entered into a drawing to receive one of eight \$25 Amazon gift cards. Participants in the raffle included their email addresses. Prior to data collection, we received institutional review board approval.

RESULTS

The study included 164 participants and 30% reported major depression with a score of 10 or greater on the PHQ (n = 164). On the K6, 54% reported severe psychological distress, 31% reported moderate distress and 15% scored 4 or less indicating mild to no distress (n = 139). Most of the participants were in-state, but nearly 43% (n = 164) were out-of-state students representing 17 other states across the U.S. Annual household incomes varied and are included in Table 3. Household income included financially independent and dependent students. Year in

school is included in Table 4. Table 5 includes the means and standard deviations for the predictors and outcome variables.

Table 4 Self-reported household income

Income Ranges	N	%
≤ \$29,999	59	36%
\$30,000 - \$59,999	37	23%
\$60,000 - \$89,999	26	16%
≥ \$90,000	36	22%
Unreported	6	3%

Table 3 Year in school

Undergraduate	132	81%
Freshman	29	18%
Sophomore	38	23%
Junior	37	22%
Senior	28	17%
Graduate	32	19%
Masters	15	9%
Doctoral	17	10%

Table 5 Means and standard deviations

Descriptive Statistics									
	N	Minimum	Maximum	Mean	Std. Deviation	Skewness	Std. Error	Kurtosis	Std. Error
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic
Psych. Distress (K6)	139	.00	24.00	12.5813	6.22461	-.251	.206	-.850	.408
Depression (PHQ)	112	.00	23.00	7.3860	5.14091	.729	.228	.532	.453
Racial Identity	132	3.393	8.000	6.39056	.974037	-.448	.211	-.349	.419
GRMS_Stress	118	.28	4.32	2.1407	.95751	.155	.223	-.520	.442
Appraisal									
Subscales:									
Sexual Objectification	156	.10	4.80	2.0397	1.10171	.459	.194	-.304	.386
Silenced & Marginalized	152	.00	5.00	2.0320	1.20751	.469	.197	-.492	.391
SBW	157	.00	5.00	2.4637	1.24654	.031	.194	-.751	.385
ABW	161	.00	5.00	2.3602	1.37436	.129	.191	-.982	.380
GRMS_Frequency	143	.09	4.57	2.0538	1.02694	.512	.203	-.380	.403
Subscales:									
Sexual Objectification	132	.20	4.70	2.0727	1.07739	.269	.211	-.413	.419
Silenced & Marginalized	134	.00	5.00	2.4158	1.20513	.070	.209	-.816	.416
SBW	132	.00	4.67	1.6970	1.07596	.462	.211	-.399	.419
ABW	135	.00	5.00	2.3160	1.28282	.123	.209	-.741	.414
Valid N (listwise)	63								

The first research question examined the relationship between gendered racism and mental health using correlational analysis. Both factors of gendered racism (stress appraisal and frequency) were correlated with depression. Results suggest a weak but significant relationship between stress appraisal and depression, $r(82) = .371, p \leq .01$. There is a moderate significant relationship between frequency and depression, $r(95) = .405, p \leq .01$. There are weak but significant relationships with both stress appraisal and frequency and psychological distress, $r(97) = .221, p \leq .05$ and $r(118) = .285, p \leq .01$, respectively. Both depression and psychological distress increase with an increase in frequency and stress appraisal of gendered racism. For both outcome variables, frequency seems to impact mental health more than stress appraisal. The correlations are included in Table 6.

Table 6 Correlations of Demographics, Mental Health and Overall GRMS

Variables	1	2	3	4	5	6	7
1 Age							
2 Year in school	.746** n = 164						
3 Income	-.278** n = 158	-.325** n = 158					
4 GRMS Stress Appraisal	.016 n = 118	.02 n = 118	-.148 n = 112				
5 GRMS Frequency	-.055 n = 143	-.093 n = 143	-.105 n = 137	.828** n = 113			
6 Racial ID	.116 n = 132	.078 n = 132	-.064 n = 130	.223* n = 95	.172 n = 117		
7 Psych. Distress	-.191* n = 139	-.326** n = 139	.092 n = 134	.221* n = 99	.285** n = 120	.038 n = 111	
8 Depression	.138 n = 112	.137 n = 112	-.228* n = 108	.371** n = 84	.405** n = 97	.077 n = 88	.308** n = 112

** . Correlations significant at the .01 level * . Correlations significant at the .05 level.

To further address the relationship between gendered racism and mental health, regressions were conducted. All variables significantly correlated with the outcomes were included in multiple linear regression analyses, however the models for both depression and psychological distress were problematic due to multicollinearity. The best regression model to explain the amount of variance in the mental health outcome variables consisted of simple linear regressions. The stress appraisal of gendered racism explained about 16% of the variance in depression and is included in Table 7, ($\hat{Y} = 2.041(7.6395) + 2.956$, $F = 15.29$, $p < .001$, $CI 1.002 - 3.08$). Frequency of gendered racism explained approximately 10% of the variance in psychological distress and is included in Table 8, ($\hat{Y} = 1.775(12.1149) + 8.230$, $F = 9.869$, $p = .002$, $CI .653 - 2.898$).

Table 7 Linear Regression Model Summary Coefficients of Depression

Independent Variables	B	Stand Error	T	<i>p</i>
Intercept	2.956	1.295	2.282	.025
GR-Stress Appraisal	2.041	.522	3.910	.000

Note. Dependent variable = Depression.
 $R^2 = .164$

Table 8 Linear Regression Model Summary Coefficients of Psychological Distress

Independent Variables	B	Stand Error	T	<i>p</i>
Intercept	8.230	1.370	6.009	.000
GR-Frequency	1.775	.565	3.142	.002

Note. Dependent variable = Psychological Distress.
 $R^2 = .097$

Correlations were conducted to examine the relationships between the GRMS subscales and mental health outcome variables, included in Table 9. The strongest correlations were between the stress appraisal subscales ‘silenced and marginalized’ and ‘strong black woman’ and depression, respectively, $r(101) = .422$, $p \leq .001$, $r(106) = .423$, $p \leq .001$. However, all of the

subscales in both stress appraisal and frequency were significantly correlated with depression. As stress appraisal and frequency increased, so did depression. For psychological distress, all of the stress appraisal subscales were positively and significantly correlated but none of the frequency subscales were significant.

The correlation between depression and psychological distress was weak but significant, $r(110) = .308, p \leq .001$. As psychological distress increased so did depression.

To examine the role of racial identity with gendered racism and mental health, a correlation was conducted. Analysis showed a weak but significant correlation between racial identity and stress appraisal, $r(93) = .223, p = .03$. However, no other variables were significantly correlated with racial identity. A linear regression suggests a significant relationship between racial identity and stress appraisal but not for frequency. Racial identity explained 5% of the variance in stress appraisal ($F = 4.853, p = .03$), with little difference between the $r^2 (.05)$ and the adjusted $r^2 (.039)$. The regression equation ($y = .223X + .790$) shows that as racial identity increases so does the stress appraisal of gendered racism; the confidence interval ranges from $.022 - .423$, indicating a good estimate. Since racial identity was not significantly correlated with mental health, the assumptions for a mediation were not met. It appears that racial identity does not mediate the impact of gendered racism on mental health.

Table 9 Correlations of GRMS Subscales and Mental Health

Variables	Depression	Psychological Distress
Stress Appraisal Subscales		
Beauty Assumptions & Sexual Objectification	.332** n = 107	.218* n = 131
Silenced & Marginalized	.422** n = 103	.197* n = 128
Strong Black Woman	.423** n = 108	.209* n = 133
Angry Black Woman	.377** n = 110	.267** n = 136
Frequency Subscales		
Beauty Assumptions & Sexual Objectification	.250* n = 91	.166 n = 110
Silenced & Marginalized	.300** n = 91	.037 n = 113
Strong Black Woman	.299** n = 90	.154 n = 112
Angry Black Woman	.306** n = 92	.170 n = 113

** . Correlations significant at the .01 level. * . Correlations significant at the .05 level.

DISCUSSION

In the current study, gendered racism significantly impacted the mental health of Black women in college, with the strongest relation reported between the overall frequency of gendered racism to depression. Both the frequency and stress appraisal of gendered racism significantly increased psychological distress and depression. It is important to note the prevalence of both depression and psychological distress. In this sample, 30% of participants scored within the range of major depression, dwarfing the national average of 7.6% of adults. Moreover, 31% of this sample reported moderate and 54% reported severe psychological distress. Nationally, serious psychological distress is reported at 3.9% in adult women (CDC, 2014).

Though prevalence rates of depression and psychological distress are high, it is unclear if this sample is seeking mental health treatment. National data from ACHA - NCHA reported that about 14% of students were diagnosed with or treated for depression within the past 12 months, with rates of females nearly doubling that of males (15.6% vs. 8.7%). However, these scores are not reported using an intersectional lens, therefore it is unclear if Black college women are seeking treatment. Treatment seeking was beyond the scope of this study and thus should be examined in the future with a similar sample.

Findings from the current study align with research suggesting that gendered racism places Black college women at an increased risk of psychological distress and depression (Greer, Laseter, & Asiamah, 2009; Woods-Giscombé & Lobel, 2008). Yet, there is a difference between the appraisal of gendered racism and frequency. Our findings suggest that even when Black women verbally report that they are unbothered by gendered racism, the frequency or exposure

to it still has significant impact on their mental health. Research suggest that for African American women, stress appraisals (Jackson, Hogue, & Phillips, 2005) and depression (Nicolaidis, et al, 2010; Mollow, 2006) are distinctively connected to their history, sociocultural experiences and position in society. Though psychological distress is physically evident by lack of enthusiasm, sleep problems, feeling blue, hopeless or emotional (Decker, 1997) worry, tension, headaches, and weakness (Dohrenwend & Dohrenwend, 1974), admitting weakness is unacceptable within the SBW ideology (Nicolaidis, et al, 2010). Thus, the internalized notion of strength embedded within Black womanhood, may make it more difficult for Black women to appraise and admit to themselves that gendered racism is problematic for their mental health. Similarly, a study examining the coping behaviors of Black women related to gendered racism found that those who tried to forget, minimize or detach from the experience increased psychological distress (Thomas, Witherspoon, & Speight, 2008).

Yet, further examination of the GRMS subscales suggested that depression was significantly impacted by both stress appraisal and frequency, while psychological distress was only impacted by stress appraisal. This suggests an unexpected difference between psychological distress and depression. While depression and non-specific psychological distress are often used as indicators of mental illness (CDC, 2013; Cochran, Sullivan, & Mays, 2003; Lincoln et al., 2011), social science investigations of general populations often use depression or depressive symptoms as a measure of psychological distress (Dyrbye, Thomas, & Shanafelt, 2006; Lincoln et al., 2011). Findings here suggest that for this sample of Black women, depression and psychological distress are not interchangeable. The difference could be in the timespan, where the psychological distress instrument focused on symptoms over the past 30 days and depression instrument focused on symptoms within the past 2 weeks. Perhaps participants found it easier to

recall events within a shorter timeframe. Furthermore, in the construction and validation of the GRMS, psychological distress was significantly and positively related to all subscales in both stress appraisal and frequency (Lewis & Neville, 2015). However, psychological distress was measured with the Mental Health Inventory 5 (MHI-5; Veit & Ware, 1983). It measures psychological well-being and distress. Additional research is needed to examine how this sample or this instrument may be different.

It is also important to note that racial identity, in this sample, was not associated with mental health. This is inconsistent with previous research that support racial identity as a buffer for race-related mental health challenges (Galliher, Jones, & Dahl, 2011; Rivas-Drake, Hughes, & Way, 2008; Sellers et al., 2006). Our findings are in line with research that suggest the significance of gender and race, within an intersectional framework (Carr et al., 2014; Lewis, Mendenhall, Harwood, & Hunt, 2013; Szymanski & Lewis, 2016; Williams & Fredrick, 2015). Thus a protective factor that uses a single lens cannot account for the multifaceted experience of gendered racism common among Black women. These findings support the need for a gendered racial identity measure. A qualitative study of Black women using focus groups found that gendered racial identity had greater salience than single-lens constructs based on racial or gender identity (Thomas, Hacker, & Hoxha, 2011). Focus group participants indicated that race and gender simultaneously influence their perceptions of themselves.

Limitations

A nonrandom convenience sample was used in this study limiting the generalizability of the results beyond this sample. It is unclear if similar findings would be present in Black college women attending historically Black colleges and universities. However, the sample included nearly 8% of the population and far exceeded the recommendation based on the power analysis.

A cross-sectional correlation design was also used which hinders causal implications. Finally, the sample was contained at a single university, although participants reported being from all over the U.S. with 17 other states represented.

CONCLUSIONS & IMPLICATIONS

This study shows the significant impact gendered racism has on the mental health of Black women. It also emphasizes the importance of intersectional quantitative measures. This study adds to the existing body of literature in support of gender and race as inseparable identities among Black women. Because of oppression related to both race and gender, Black women are at an increased risk for mental health challenges. Health education programs that specifically focus on Black women may be a way to reduce these challenges. Health educators should be well-versed in intersectionality theory in order to fully understand gendered racism and its impact. Research suggests that having the opportunity to discuss subtle forms of microaggressions validates the participants' experiences and helps them to cope (Holder, Jackson, & Ponterotto, 2015; Lewis et al., 2016). Thus, health education programs can provide support groups in the college and community settings.

With additional research, gendered racial identity may be protective for the mental health of Black women just as racial identity has a protective mechanism against race-related stress on mental health. Therefore gendered racial identity should be examined and evaluated on its potential to buffer the negative impact of gendered racism on mental health. Thus health education might include strategies that strengthen gendered racial identity. Further health promotion programs should seek ways to validate the experiences of women of color as an additional way to protect their mental health and well-being. Qualitative research is needed to further define the types of health education programs that might be beneficial. The Public Health

Critical Race Praxis (PHCR) provides guidance for researchers and program planners who focus on the impact of race and racism; the PHCR has been described in detail elsewhere (Ford & Airhihenbuwa, 2010). In addition, future research should also include longitudinal and designs to further understand the impact of gendered racism on mental health. Qualitative research should also examine the ways that Black women cope with gendered racism, perhaps more can be learned by exploring the resiliency of their mental health using a strengths-based approach.

Manuscript Three: Talking Back through Counter-Narratives: Resisting Gendered Racism across the Social Ecological Model

You gotta go in there and you gotta do what you have to do. Anything they say is like, it goes off, like water off a duck's back. They're gonna come at you. There are gonna be situations where you may not even know what's gonna happen, but just know it happens and you do what you have to do. Know that when they deny you, it was them. It was never you.

- Tiana, Interview, October 18, 2016

Gendered racism refers to the simultaneous experience of racism and sexism (Essed, 1991; Lewis, Mendenhall, Harwood, & Hunt, 2016; 2013) and it encompasses the complexity of oppression specific to people of color based on gendered and classed forms of racism. Intersectionality theory (Crenshaw, 1991) provides a helpful lens through which gendered racism might be situated as it states that the experiences of women of color cannot be fully understood with single identity lenses that focus on race *or* gender. Instead, their identities and corresponding oppressions intersect uniquely creating a hybrid form of oppression (Essed, 1991). Though gendered racism can impact all people of color, this article focuses on the experiences of Black women.

Racism and gendered racism have been studied in various settings with adult women in the community (Beauboeuf-Lafontant, 2008; Perry, Pullen & Oser, 2012; Thomas, Witherspoon, & Speight, 2008) and in college (Lewis et al., 2016; 2013). Previous research shows that racism is particularly prevalent at predominantly white institutions (PWI) and it contributes to lower classroom performance, self-doubt, and mental health challenges (Harwood, Hunt, Mendenhall, & Lewis, 2012; Nadal, 2011). Further, research on gendered racism in college women emphasized microaggressions which primarily occur through interactions with others (Lewis et

al., 2016; 2013). Additional research is needed on the experience of gendered racism at the institutional level, and consequently, when it is internalized.

Gendered Racism & Black Women's Health

Previous research on gendered racism indicates the affect that it can take on Black women's health. Experiences of gendered racism among Black women have been related to higher levels of psychological distress (Thomas, Witherspoon, & Speight, 2008) and overall poor mental health (Beauboeuf-Lafontant, 2008; Carr, Szymanski, Taha, West, & Kaslow, 2014; Everett, Hall, & Hamilton-Mason, 2010; 2008; Watson & Hunter, 2015; Woods-Giscombe, 2010). Additionally, Black women report that experiencing gendered racism result in sleep deprivation, hair loss, hypertension, and problems with eating (Everett et al., 2010). These studies of gendered racism cross disciplines and have largely been contained in race studies, psychology, sociology, Black feminist, and women's studies. However, in public health, the weathering hypothesis should also be considered. The weathering hypothesis posits that Blacks experience early health deterioration as a consequence of the cumulative exposures to racialized stressors (Geronimus, 1991). These stressors are associated with repeated experiences of social and economic adversity and political marginalization inherent in a racialized society that disadvantages people of color (Geronimus, 1991). Physiologically, persistent high-effort coping with acute and chronic stressors have an overwhelming impact on health; thus Black individuals' health is typical of white individuals' who are significantly older (Geronimus, Hicken, Keene, & Bound, 2006; McEwen, 1998). This concept is known as allostatic load, which is the cumulative wear and tear on the body's system due to repeated adaption to stressors (Geronimus et al., 2006; McEwen, 1998; McEwen & Seeman, 1999). Allostatic racial differences are less pronounced in early years but quickly widen in young adults, and are especially prevalent in educated Black

women (Geronimus et al., 2006). Moreover, Black women had higher allostatic load than Black men or white women at every age. Differences were especially noticeable in economically privileged Black women which adds support to the idea that multiple strains associated with gendered racism impact the health of Black women (Geronimus, 1991; Geronimus et al., 2006; Mays, Cochran & Barnes, 2007). The weathering hypothesis and allostatic load have been used to explain adverse health outcomes in Black women including pregnancy outcomes (Rauh, Andrews & Garfinkel, 2001), excess mortality (Astone, Ensminger & Juon, 2002; Geronimus, Bound, Waidmann, Hillemeier, & Burns, 1996), and disability (Geronimus, Bound, Waidmann, Colen, & Steffick, 2001); however, the weathering hypothesis has not been viewed within an intersectional lens to examine gendered racism.

Gendered Racism & the Social Ecological Model

The social ecological model has been used to explain how individual behavior is influenced by multiple environmental factors. First characterized by Bronfenbrenner (1979), the SEM was later adapted for health behavior change (McLeroy, Bibeau, Steckler, & Glanz 1988). The Centers for Disease Control and Prevention uses a multifaceted approach to complex issues such as violence prevention and recognizes four levels of influence: individual, relationship, community, and societal (Dahlberg & Krug, 2002). The SEM shows the complex interplay between the levels and how factors at one level are entangled with the others. Additionally, the model also suggests that health promotion programs are more effective when they work across multiple levels simultaneously (Dahlberg & Krug, 2002).

Racism has also been studied using a multilevel approach (Berman & Paradies, 2010; Jones, 2000; Krieger, 2014; Williams, 1999). Studying racism across levels is useful in examining its contributions to racialized health disparities as well as for working toward

eliminating its effects (DHHS, 2000; Jones, 2000). Jones' (2000) levels of racism are: internalized, personally-mediated, and institutionalized. The first level, internalized racism, is the acceptance of racist attitudes, beliefs or ideologies into one's worldview. It involves accepting limitations to one's own full humanity, right to self-determination and range of allowable self-expression. It may manifest as embracing "whiteness" through the use of hair straighteners, bleaching creams, and skin tone stratification (colorism) within communities of color. Personally-mediated racism involves interactions between individuals, including name calling, threats and personal violence. It is also referred to as personally-mediated racism to indicate a clear and direct perpetrator. However, intentional and unintentional acts of commission as well as omission are included at this level. Institutionalized racism, on the other hand, is normative and does not require an identifiable perpetrator. Jones explained that institutionalized racism is often evident as inaction in the face of need. It is defined as differential access to goods, services, and opportunities based on race and it manifests materially as differential quality in education, housing, and medical facilities. Additionally, it may be seen as differential access to information, such as one's own history. Jones' levels can also be understood across the SEM levels in which internalized racism can be thought of at the individual level and personally-mediated racism at the relationship or interpersonal level, whereas institutionalized racism can be thought of on the broader, societal level.

Past research described the impact of internalizing gendered racism. At the individual level, internalizing gendered racism may be understood as accepting and endorsing negative racialized ideologies such as the *Strong Black Woman (SBW)* (Morgan, 1999). Though on the surface it may seem complimentary, it can also be understood as the super-human capacity to endure inordinate amounts of stress and lead to essentialist notions that all Black women are

inherently strong (Woods-Giscombe, 2010). Collins explains that the construction of the SBW ideology equipped to endure hardship served as the justification for oppression, in the form of gendered racism (Collins, 1990). This projected and internalized stereotype is thought to lead to suppressed emotions and negative health effects that are specific to Black women (Collins, 1990; 2000; Woods-Giscombe, & Black, 2010).

Personally-mediated racism, on the other hand, is what people tend to think when they hear of racial discrimination (Jones, 2000) because it is more clearly evident. At the interpersonal level, gendered racism can manifest as being sexually harassed, hearing inappropriate jokes related to being a Black woman, and being mistaken for “the help” in shopping centers (Essed, 1991; Jones & Shorter-Gooden, 2003; Thomas, Witherspoon, & Speight, 2008). Examples of gendered racism at the interpersonal level include insults (“Black bitch,” “nappy-headed bitch”), rude remarks made about one’s body (“your big Black ass”) and hearing offensive comments (“Black women are rude”) (Buchanan, 2005).

Though the health impact of racism in general has been examined, less research has been done on gendered racism at the macro-level. Structural racism is one such macro-level manifestation that occurs through conditions that constrain opportunities, resources, and well-being of socially disadvantaged groups (Link & Phelan, 2001). Operationalized as neighborhood segregation and redlining practices, structural racism has been associated with elevated blood pressure (Harburg et al., 1973), myocardial infarction (Lukachkko, Hatzenbuehler, & Keyes, 2014), and hypertension (Kershaw et al., 2011; Thorpe, Brandon, & LaVeist 2008). Thus sufficient research at the macro-level shows the adverse impact structural racism has on physical health (Kreiger, 2014). Though scarce and not directly stated, some research has examined gendered racial microaggressions on mental health. It has largely focused on Eurocentric

standards of beauty which was suggested as an institutional level factor due to its wide acceptance as normal and universal (Lewis et al., 2016).

Most of the health research provided has been based on quantitative studies that more clearly align with a single SEM level. Qualitative research, however, blurs and complicates the lines between the levels and shows how the environment impacts relationships which influences how one acts in response. In one study using focus groups (Everett et al., 2010), several participants described the difficulty of being themselves in professional settings or being understood by coworkers while others described feeling as if they lived in two worlds and feelings of loneliness of being Black in a White society. In the focus groups, participants described a commonly used method of “acting White” in order to be accepted or advance in the workplace; they also reported a myriad of health challenges (Everett et al., 2010).

Reframing Black Women through Counter-narratives

Though gendered racism engenders potential mental and physical health problems, it is not the goal of this study to characterize Black women as damaged. Tuck (2009) defined damage-centered research as emphasizing deficits and lack to explain poor health. While it may in some cases be necessary to emphasize need in order to secure funding for health programs, it may also dangerously and singularly define marginalized communities through pathologizing. Meaning, this damage-centered focus has the potential to over-research the individual with scarce attention to the historical, political, and social context and causes (Tuck, 2009). Thus, it is the goal of this study to reveal the multilevel experience of gendered racism through counter-narratives and how Black women resist through talking about and through their experiences, or talking back.

Coined by bell hooks (1989), “talking back”, or “back talk”, refers to speaking as equal to an authority figure; to disagree. Hooks uses talking back to reference her childhood experience of “old school” parenting when children were meant to be seen and not heard. In this way, talking back was viewed as bold and daring because it interrupted the normative social protocol. She surmised that moving from silence to speech is for the oppressed; however, for Black women specifically, the goal is not just to move from silence but rather to be heard in order to create change. Thus, change is contingent on the content of what is said by Black women. Black women share their private experiences in order to heal the hurts caused by oppression such as gendered racism (hooks, 1989). Being open about these experiences make the way for self-healing and validate the experiences of others. Talking back is empowering. It is liberating (hooks, 1989).

Further, due to the scarcity of literature on this topic, more research is needed on the various experiences of gendered racism and how Black women understand and resist it. While previous research on gendered racism have provided a rich foundation of knowledge, most of it has focused on interpersonal experiences of gendered racism (Harwood et al., 2012; Lewis et al., 2013; 2016) with little attention to how it manifests internally and institutionally. The current study sought to diminish the gaps in the literature by qualitatively exploring how Black women in college experience gendered racism. The purpose of this study is to add to the dearth of literature that focuses on the complexity of gendered racism specific to Black women across the individual, interpersonal and institutional levels of the social ecological model (SEM). A second purpose of this study is to show how Black women resist gendered racism through counter-narratives. Here, the use of counter-narratives allow Black women the opportunity to talk back.

The research questions were: How does gendered racism impact Black college women across the SEM levels? How do stories allow Black college women to resist gendered racism?

RESEARCH APPROACH & BACKGROUND

This study uses Critical Race Theory (CRT) and Black feminist theory to center the experience of gendered racism within a transformative paradigm. The goal of research within the transformative paradigm is to increase social justice by emphasizing systems of oppression (Mertens, 2009). CRT, then, is an iterative methodology designed to activate change. Further, it has inspired theories like the aforementioned intersectionality theory which seeks to explore intergroup differences among oppressed peoples and to explain multiple forms of oppression (Crenshaw, 1991). Similarly, Black feminist theory research seek to empower participants through the research process in order to empower and create social change (Collins, 1990; hooks, 1989).

Applied to research, CRT has been used to expose the ways racism on college campuses persist (Ackerman-Barger & Hummel, 2015; Yosso, Smith, Ceja, & Solorazano, 2009). CRT also provides the foundation for fourth-generation research aimed at eliminating health disparities (Ford & Airhihenbuwa, 2010; Thomas, Quinn, Butler, Fryer, & Garza, 2011). Originating from critical legal studies (Crenshaw, Gotanda, Peller, & Thomas, 1995), CRT has also been adapted to education (Ladson-Billings, 1998) and to public health (Ford & Airhihenbuwa, 2010). In public health, it provides guidance for understanding the impact of racism on health outcomes as well as the research process (Ford & Airhihenbuwa, 2010). CRT posits that, while white supremacy is ordinary and engrained in the foundation of our nation, racism is ordinary as opposed to an aberrational experience (Delgado & Stefancic, 2001; Ladson-Billings, 1998). Therefore exposing racism at its structural levels is necessary in striving for

health equity (Ford & Airrihihenbuwa, 2010; Thomas et al., 2011) and to create social change (Collins, 1990; Kreiger, 2014).

One way to create social change through research is through the use of counter-narratives. Defined in CRT research, counter-narratives challenge myths of meritocracy and a post-racial society by giving voice to the marginalized (Delgado, 1989; Ladson-Billings, 1998; Solorzano & Yosso, 2002). Counter-narratives focus on various forms of oppression and recognize people of color as important holders and creators of knowledge based on their lived experiences (Bernal, 2002). Often, dominant cultural customs are presented as universal and normal discrediting the perspectives of people of color; thus, inequalities persist through the centering and privileging of dominant perspectives presented as aracial, neutral, and merit-based (Graham, Brown-Jeffy, Aronson, & Stephens, 2011). Traditional research that centers dominant perspectives tell stories about merit, responsibility, and causation presented as universal truths and facts. Thus, when marginalized groups are judged by these standards, they are presented as at fault with little attention to the many historical and political contextual causes (Kreiger, 2014). In comparison, the stories, perspectives, and experiences of people of color are ignored (Bernal, 2002). These are called counter-narratives in that they speak against the metanarratives of the center, shattering complacency, challenging the dominant understanding of a post-racial society, and seeking to emancipate the marginalized. Specifically, counter-narratives are used to legitimize the perspectives and stories of those at the bottom, the oppressed (Matsuda, 1987), and to affirm agency and self-empowerment (Kim, 2015). They decenter dominant perspectives and value the lived experiences of people of color (Bernal, 2002) and are potentially liberating (Fernandez, 2002).

As a methodology that values the narratives of lived experience, narrative inquiry works well to situate the counter-narratives in CRT (Ladson-Billings, 1998; 2009; Solorzano & Yosso, 2002) and the use of voice in Black feminist theory (Harris, 1990). Narrative inquiry allows for the study of human lives while honoring lived experience as an important source of knowledge (Clandinin, 2013). Narrative analysis involves a collaborative relationship between participants and researcher in order to co-construct meaning (Clandinin, 2013). With these affordances in mind, this study uses both narrative inquiry and the approach of counter-narratives as its grounding methodology.

Narrative Interviewing

In conducting this study, narrative interviewing was selected to gather uninterrupted in-depth narratives (Graham et al., 2011). This method is sharply focused, highly intensive and productive in understanding lived experiences (Roulston, 2010). Narrative interviewing entails few time constraints to allow and encourage participants to reflect and elaborate uninterrupted (Graham et al., 2011). Further, this approach requires the researcher to share control of the interview by following the participants' lead. One story may lead to another, in traditional interviewing these are seen as digressions. However in narrative interviewing, the researcher interprets meaning by asking participants about associations and connections between stories (Brinkmann, 2013; Riessman, 2008).

Though other studies have used focus groups to understand gendered racism, some research suggest that group dynamics may inhibit divergent opinions and perspectives (Lewis et al., 2013; Woods-Giscombé, 2010). Therefore, in this study individual narrative interviews were used to thoroughly understand the individual's lived experience of gendered racism and allow the participant to reflect, construct meaning and encourage action (Brinkmann, 2013; Riessman,

2008). Prior to the interview, participants were provided a thorough description of gendered racism and were privy to example interview questions (Graham et al., 2011). The interview guide was inspired by previous research on how gender and race impact identity (Thomas, Hacker & Hoxha, 2011) and it included prompts on racism and gendered racism from childhood through their present-day experiences. Sample questions included (a) Tell me about the first time you remember having to think about your own race. (b) Tell me a story about how you have come to understand gendered racism? (c) Tell me a story that portrays how gendered racism makes you feel. (d) How do you encounter gendered racism? General prompts were: (a) Tell me more about that. (b) Is there anything else you would like to say on that? Clarifying and probing questions were asked throughout the interview (Ackerman-Barger & Hummel, 2015).

Participants and Representation

Participants in this study self-identified as a woman who is Black/African American, at least 18 years of age and a current student at the institution. The participants were selected through intensity sampling. Though six participants' data are referenced in this article, they have been crafted into two composite counter-narratives that bring together similar experiences and themes. Composite counter-narratives are a specific way to focus on oppression by drawing data from various experiences of people of color and present them in a single or multiple stories (Bell, 1987; DeCuir & Dixson, 2004; Solorzano & Yosso, 2002). Composite counter-narratives may provide social, historical and or political context of racism, sexism and other forms of oppression (Solórzano & Yosso, 2001; 2002).

Procedure

The study was conducted at a large, public university in the southeast. Academic classes and student organizations that had some focus on race and or gender were targeted for

recruitment and the researchers contacted instructors and student organization representatives for permission to recruit. As part of a larger mixed methods study, 213 Black women, undergraduate, graduate, and professional students, were recruited. The mixed methods study included a web-based survey. Participants were selected for interviews based on survey responses on their experiences of gendered racial microaggressions and mental health. Intensity sampling involves selecting very informative cases that represent a phenomenon of interest (Coyne, 1997; Patton 1990; Teddlie & Tashakkori, 2009). For this study, the gendered racial microaggression scale (GRMS) (Lewis & Neville, 2015) was used to operationalize gendered racism. Participants who scored above the mean on the GRMS frequency subscale were thought to be more aware of the ordinariness (Delgado & Stefancic, 2001) of gendered racism. Twelve participants were purposively selected for interviews based on their GRMS score and other factors. The current study primarily presents two participants' narratives that were similarly expressed in four additional interviews.

Data were collected during the fall 2016 semester. The interviews ranged from 90 minutes to 3 hours, and were conducted at the researcher's campus office. Participants received \$10 cash as compensation for their time. Pseudonyms were used to protect confidentiality. The Institutional Review Board approved all aspects of the study prior to data collection.

Data Analysis & Quality

During data collection, the interviews were audio recorded then transcribed. The transcriptions were read and the audio recordings were listened to multiple times in search of hidden meanings and assumptions in line with Riessman's thematic analysis (Riessman, 2008). The transcriptions were then labeled with themes based on the levels of the SEM and the CRT framework. The stories presented were primarily experienced at the site of the academic

institution, however, some off campus stories were included as additional evidence of the interpretations. The most prominent themes of gendered racism or racism from all six participants were included to construct composite counter-narratives. The purpose of thematic analysis is to focus on the content of the intact story in order to theorize from the case as opposed to gaining knowledge from coding or categorizing (Riessman, 2008). Thematic analysis also shows the meaning-making process (Castro, Kellison, Boyd, & Kipak, 2010).

Data analysis and interpretation are intertwined with the researcher's conceptual understanding, experiences and logic, thus the researcher is key in interpreting what data mean (Barrett, 2007). The researcher is responsible for relating the analyses and interpretations to other sources of insight (Barrett, 2007). Reflexive memoing was used to capture the researcher's thoughts while in relation with participants and the data, during the interviewing and transcribing processes (Birks, Chapman, & Francis, 2008). The memos then were integrated into the construction of themes (Birks, Chapman, & Francis, 2008; Maxwell, 2013; Polkinghorne, 1995) and were interpreted using thematic narrative analysis (Riessman, 2008). The analysis involved recursive movement from the data to an emerging thematic plot (Polkinghorne, 1995) in order to construct counter-narratives.

To establish credibility of the data, clarification and accuracy of understanding of the participants' responses were verified throughout the interview (Ackerman-Barger & Hummel, 2015). As an effective way of attaining representation and credibility, participants were provided an opportunity to engage in member checking (Charmaz, 2006). Although no additional comments were provided, participants did not object to how they were represented. Additionally, the transcriptions and notes were shared with members of the research team for input.

FINDINGS & DISCUSSION

Composite counter-narratives are presented and discussed here based on interviews with Brittany and Tiana, pseudonyms. Brittany is a 19-year old sophomore from Florida. She recently switched majors from engineering to business management and marketing and she enjoys shopping, cartoons, and making friends. Tiana is a freshman from Alabama. She is 18 years old and has not declared a major although she loves to dance, enjoys Disney movies and football. Tiana also appreciates art and does special effects make-up.

The counter-narratives of Tiana and Brittany expose the subtle and overt ways that Black women at a PWI experience multilayered gendered racism. The stories they tell show how oppression permeates through the SEM levels and disrupts their lives. For example, institutional gendered racism is normative and thus has impact on how one perceives of herself as well as how she interacts with others. For the young women in this study, gendered racism is complex and painful. Yet, the stories Brittany and Tiana tell also show the power of talking back as a way to resist gendered racism at each level. Although the stories blur the lines between the levels, several themes stick out across the SEM. In what follows, I will present the findings and discussions in response to the research questions. Using the SEM as a framework, I will present narratives representative of gendered racism at the individual, interpersonal, and institutional levels. The discussion will show the amount of interplay between the levels.

The first research question was to understand how gendered racism impacts Black college women across the SEM levels. At the individual level, gendered racism is internalized and manifests through ideas around autonomy and self-expression. At the interpersonal level, narratives depict how gendered racism impacts relationships across differences. At this level, sometimes the women are able to resist internalizing gendered racism, while other times the

social interactions create internal conflict and confusion. Lastly, at the institutional level, gendered racism manifests within multiple systems of the PWI including fraternity houses, administration, and the social environment of the campus as a whole. Gendered racism at the institutional level impacts both the individual and interpersonal levels.

Individual Level: Autonomy and the Right of Self-Expression

Parties at, or sponsored by, fraternities were often discussed as a space where Black women's autonomy is suppressed. Many of the women described what it is like to go out and party in male-dominated spaces. Black women express the need to conform to the standards set by Black and White men. Thus, the institutional level impacted the individual's behavior as well as how they interacted with others. Tiana described how gendered racism impacts her choice of clothing when she goes out with Black friends and the potential consequences of her style of dress:

I feel like a lot more aspects of my life are related to [gendered racism] than maybe I would even like to admit. Because I do find myself you know with pressures to, you know if I go to a party on the weekend I'm like, okay what do I have to wear? I *have to* dress up. Do I have to show my stomach? Like I don't want to show my stomach... if I don't then they're gonna be like, 'eww, what's wrong with her?' but if I do then they're gonna be like, 'ooh, let me push up on her.' And, it's like, I do think that it weighs in a lot more than I originally thought, especially before coming to college...

Like Tiana, many participants discussed the importance of appearance within the college experience and described deciding on what to wear using phrases like "have to" that indicate a perceived limited autonomy. In comparison, White women are perceived autonomous in their decision-making regarding dress. Brittany's story portrays Black women's limited autonomy as

internalized gendered racism and the authority White men have on campus. She described attending a White fraternity party:

[When we first arrived] it was weird 'cause White girls were looking and it was like you know, 'she shouldn't be here' quote unquote or you know, 'why is she wearing that?' ... But like the white guys they were *extra friendly*, like, 'oh girl come twerk for us' and I'm like... I'm not a twerker... We just walked in. They did turn some black girls around that they didn't find attractive...so they did like, they did turn some of them around...if they weren't 'up to their standards' they didn't want them at the party.

I asked Brittany about the 'standards' for attending a White frat party and she described how she came to learn what was acceptable.

I used to have, like my neighbors last year across from me, they were in [White] fraternities.... And, I asked them one time, like you know we want to come to your parties, *how do we go about doing it?* And they were like the main things is like, you know dress. Dress appropriate, don't come in like Playhouse, like ratchet you know like, they did know about the Playhouse and what girls wear to the Playhouse like, 'No, *come comfortable*, no heels, ...'. But then they were like we only want pretty girls in our party and he was like you and your friends, you know y'all are pretty but there are some girls that we just don't find attractive and so we just tell them you know you can't come to the party.

When asked if the judging standards were applied to both White and Black women, Brittany stated that only Black girls have to meet these standards. For clarification, I asked Brittany, "What is the Playhouse?"

The Playhouse is a club, it's like a Black club [here]. [They said] don't dress like that cause like the Playhouse is kind of like um it's like a Black club so you know when Black girls get dressed, you know, we put on top of the notch you know the whole fit, you know the whole beat face, the tight dress, the heels. White frat parties aren't like that. The white frat parties are real casual, you can go in tennis shoes, t-shirts. *People* don't dress up.

For clarification, I asked Brittany if White women dress up when going to fraternity parties.

Some do and some don't. But when you go to like a Black frat party, you know that you *have to* be on your Ps and Qs. Cause you know like you would get talked about. At a white frat party ...they're like 'come comfortable'. Come as you are because they're dancing. Some may have like foam coming down you know, so it's stuff like that so you know if you wear heels, wear like comfortable bootie heels like don't wear like the stilettos that you wear to the Playhouse.

In addition to the internalized gendered racism manifest as limited autonomy, Brittany's narrative also represents interpersonal gendered racism through her interaction with the White fraternity men who expected her to dance for them. Brittany described the men as *extra friendly*. I asked Brittany to describe how their comment, *oh girl come twerk for us*, made her feel.

I just felt, I was offended because I was like, you know that's not why we came. You know. I guess they just assumed that cause you know they're black girls, they want to twerk. Like no, that's not why we're here.

Brittany went on to describe what happened at the party. In regards to the comment, 'come twerk for us,' she and her friends first tried to "laugh it off." Similarly, other participants also described trying to laugh off uncomfortable experiences of gendered racism. Then, afterwards, they would discuss the experience with their closest friends. At the party, Brittany and her friends stayed for

about an hour although most of that time was spent talking to the bartender because “he was respectable.” She went on to describe the conversation with the bartender as different because he asked them about themselves, whether they were having fun, if they enjoyed the campus, etc. She and her friends were not publicly called on to perform for him as entertainment.

I further questioned Brittany on the difference between partying with White and Black fraternities.

It’s less comfortable physically [at Black frat parties], but I feel more comfortable over there cause like I know where I am. I know that there are people here, *if something were to happen*. Or like you know I feel like if a [white] person came in and start talking out the side of their neck, I would know that people would be there to *have my back*.

Brittany’s story is problematic on multiple levels. She first describes the unwelcoming looks she received from White women at the fraternity party, even though she had been invited. We then find out that Brittany and friends were invited by White men who saw them as “pretty enough” to be sexually objectified. That is, Black women must be judged by White men in order to enter a campus space. Further contextualizing this story, at this PWI, the fraternities are largely still segregated; therefore, White women did not expect to see Black women in attendance. Next, Brittany discusses the issue of clothing, explaining that while White women have the liberty to decide what to wear, Brittany sought advice in order to be accepted. This suggests her acceptance of the limitations that deny her self-expression and self-determination. Brittany’s acceptance of her limited rights, is in direct response to the normalized power White fraternity men, in this example, have on campus. Still, Brittany described White frat parties as “comfortable” in comparison to the judgmental atmosphere of the Black frat parties. She later clarified that while she feels physically more comfortable – with regards to how she’s dressed –

she's more socially comfortable around other Blacks. For her and others, being racially isolated induces a constant threat.

To unpack Tiana and Brittany's narratives of gendered racism at the individual level, I will begin by situating it in existing literature. Previous findings on gendered racism emphasize how Black women are reduced to assumptions about style and beauty (Lewis, Mendenhall, Harwood, & Hunt, 2016). Our findings also focus on this theme; yet autonomy and self-expression are centered to call attention to how gendered racism works. Autonomy refers to the extent to which a person acts in accordance to their authentic interests, values, and desires (Deci & Ryan, 1987; 2000). The opposite of autonomy is heteronomy, where one's actions are controlled by forces beyond the individual. Behavior is compelled regardless of one's values or interests (Chirkov, Ryan, Kim, & Kaplan, 2003). Jones (2000) characterized internalized racism as an acceptance of the limitations to one's range of allowable self-expression. Many participants use the phrase "have to" when "deciding" what to wear when going out. "Have to" shows their acceptance of limited self-expression. Deciding is in quotations to show that although the individual made decisions, their choices were limited by the rules fraternity men established. Tiana's words are exceptionally clear in that she has no desire to "show [her] stomach, but if she does not she may be judged as unattractive. Yet, by baring her midriff, Tiana may get too much unwelcomed attention. From Tiana's narrative, Black men have the authority to establish the guidelines for how Black women are to dress and what their dress means.

Brittany's narrative describes how the judgmental atmosphere ("you would get talked about") is enough of a consequence to keep Black women in line with the established rules. This became especially apparent in, and perhaps limited to, college life. This is similar to findings on how gendered racism marginalizes women of color (Lewis et al., 2016). Tiana's narrative also

shows how Black women are silenced and marginalized when they try to center their unique experiences of gendered racism within anti-racist conversations. The negative perception of natural hair is still a challenge for many Black women and explains how gendered racism is internalized. Not being able to wear natural hairstyles is a restriction on self-expression (Jones, 2000) and being interrupted and silenced while discussing it is an additional marginalizing experience (Lewis et al., 2016).

Brittany's narrative, at the individual level, speaks to the perceived autonomy White women have in regards to their appearance. Initially, Brittany stated, "*People* don't dress up" when attending the White fraternity parties. Brittany's use of the term "people" requires a more nuanced and profound understanding of the ways Black women are people and nonpeople. Black people have historically and persistently existed within a space where people can be re-presented as property. Black people are recognized as human without having access to their own full humanity. In this sense, Black women are both people and nonpeople (Audain, 1995). Whiteness as property, an essential concept of critical race theory, (Harris, 1995) suggests that owning whiteness provides the authority and pleasure to name and own property (Farley, 1997). In fact, by 1660, Blacks were by law recognized as chattel slaves. Moreover, Black women were both property and responsible for re-producing property (Harris, 1995). Black women were people when it came to reproduction, but were subjugated as property in regards to their rights and humanity. Black people were later re-presented as 3/5 a person by law. Thus, Brittany's claim of Black women as people, without full access to humanity, fits within the complex ways Blacks have been presented in order to meet the need of the time.

To further unpack Brittany's understanding of people with access to their humanity, I asked a follow up question to juxtapose Black women as people with White women as people. I

asked Brittany how White women dress when attending fraternity parties. She clarified that some White women dress up and some don't indicating that White women, as people, have full access to humanity and full access to self-determination and self-expression. Only Black women, as nonpeople, are subjected to the rules established by White men to attend White fraternity parties. White women as people, provides a stark contrast to Brittany's restricted humanity. White women are perceived as valued in that they are allowed autonomy with regards to attire. The rule for Black women, "come comfortable," suggests that White men have the authority to establish rules, based on their view of comfort, on how Black women should dress. The use of the term comfortable was later mimicked by Brittany in her description of how she physically felt at the White fraternity party. Potentially, this points to how gendered racism is internalized. White fraternity men define, establish and enforce the rules that are then internalized by Black women and unconsciously perceived as preference. I use "potentially" cautiously because it is unclear of Brittany's authentic preference for dress given that both spaces, Black and White fraternity parties, have established rules that are specific to Black women.

The enforcement of the rules is clearly evident in Brittany's narrative. If Black women do not follow the rules, they are not allowed entrance. Further, Brittany's perceived limited humanity is evident in that she inquired of White men what she needed to do in order to enter their party. Not only do White men have the authority to judge based on clothing style but Black women may be denied entrance for being Black and thus not meeting their set beauty standards. The response of her neighbors is both telling and extremely problematic. By stating that they only want attractive girls at their party suggests that White women, by being white, inherently meet their beauty standards while Black women must be judged. Black women are examined upon entrance. Since White men have the power to establish and enforce their rules, Black

women are subjected to internalizing the consequences of institutional gendered racism. After having been codified into our structural systems, a college campus in this case, institutionalized racism is normative (Jones, 2000). Therefore while White fraternity men are implicated here, institutional racism persists without them. Institutionalized racism reveals that even without Brittany's neighbors, any privileged, dominant, body can inherit the foundational ideals of white supremacy and benefit from it. In fact, laying the blame at individuals for institutional racism and gendered racism only impedes upon adequate forms of redress that should be afforded (Gotanda, 1991). Thus if the goal is dismantling oppression as a system, care should be taken to not focus punishment on any single individual(s). However, at the interpersonal level, the neighbors are the perpetrators of gendered racism.

Interpersonal Level: Friendships across Racial & Gender Differences

At the interpersonal level, interracial friendships require a desire to learn about the complexities of how race and racism work. In what follows, Brittany's story portrays the difficulties she experienced trying to sustain a friendship with White women who failed to think critically about how race and racism impact her. The White women she referred to as friends used offensive racial slurs in her presence. She explained,

I have some white friend girls like they'll say the N word and I'm like you cannot say that around me, like you just, I was like while 'I know you're not racist' I said, 'you just don't say that word, cause you don't see me you know saying Cracker.' I was like, 'you don't see me saying things like that, like Redneck like all that stuff, like around you guys.' I said but it's like the N word, you know *I'm not saying you're racist*, but that is a racist term that was once used, and I'm not saying that African Americans should say that

but... it's like you just can't say that. You just cannot say that. ...cause they were like, "this nigga" [I was] like NOOO! You can't say that.

Brittany said her friends assumed it was okay for them to use the racial slur. Even when she asked them not to, carefully explaining that it was offensive, they continued to use it in her presence. They also challenged Brittany as if her asking them not to say the N word was an abnormal request.

They were like, 'Well, I don't understand why.' I'm like you won't understand but just know that when you're around me, I don't want you to say it. Or we just cannot have a genuine friendship. Cause you can't respect my wishes. So, *they go back on it* ...so when they say it, I'm like, you know what, I'm gonna go, cause I said [it's offensive] and I've expressed to you before that I don't want you to say that around me personally. And they are like, "Oh well don't leave I'm sorry, blah blah blah" but it's like you're not really sorry cause you're saying it. I'm like if I know you're saying it around me, I know you're definitely saying it around like your white friends on a regular basis.

For clarification, I asked Brittany if she would be okay knowing that they use the term as long as they don't say it in her presence.

Mmmmm, not really *okay* but I would feel somewhat better cause it's like, I don't always know like their intention on like when they say it. Cause they could mean it in a derogatory way or they could just mean it as like a friend. But you know, they don't call their white friends like, "girl I'mma tell you 'bout this nigga" like, No they say, 'let me tell you about....' they address him with like a name. They don't address, they don't address like their black friends with like a name. ...I'm just like, "I've asked you before,

you know just got to, just remember that you know I am Black and that term does offend, like when you're White that term does offend Black people.”

Brittany's friendship with White women who, at minimum, fail to respect her wishes, but more appropriately, dehumanize her, cause internal conflict. Brittany did not know what to make of friends who repeatedly use racial slurs to describe people who look like her. She is also conflicted by their intent.

Intent was also mentioned in a different story when Brittany described being repeatedly watched and followed while shopping. She suspected race was the reason she was being followed but describes the challenges of labeling someone as racist.

...I just leave cause I just feel like it'll just be a bigger thing than I need. Cause you can't always pull the race card cause you really don't know everybody's intention. They could always say, 'oh you know she looks like she needs extra help....' so I guess, like, you can't just pull out the race card, you really can't pull out the race card unless you have like exact, you know facts...

I asked Brittany to tell me about the race card.

The race card is like you can't say, 'oh she said that to me because I'm Black' or you know, 'is this cause I'm Black?' And it's kind of like No, I just, it's kind of like, it's like I know deep down and like you *know deep down* what you generally meant but I'm not, I'm not gonna argue with you or make it an issue when I generally like do not know who you are. It's like I can't prove that you are doing it because you are a racist, I just can't prove that unless it's like proof there ... Or like continuous harassment type thing.

Though the race-card story was not directly related to Brittany's friends, it shows how Brittany grapples with confronting race-related issues. Ultimately, their friendship did not last. In addition

to using nigga in her presence, her friends also attempted to regulate her behavior by calling her *ratchet* and comparing her to reality TV show stars, as an insult. The label of ratchet and the comparison to reality TV star, NeNe Leaks, were intended to make Brittany act more like them in their presence. I asked her to tell me about a time when this occurred.

It was when one of my white friends befriended the girl that her boyfriend was cheating on her with... They found out about each other in April and they [became] friends. ...the girl moved in with her in August, sharing the same bed, closet, clothes. I'm like, stop doing that. And so like my closest friend group, we're all black, we were like... Y'all aren't friends. There is no way, there's no way that y'all are genuine friends. She was like y'all are attacking me. No, baby we're keeping it real. Keeping it honest. Y'all are not friends. She was like [Brittany], you know I feel like Nee Nee would do something like that... [you and NeNe] act just a like. I told her, I think that the other girl is an opportunist, so she's kind of on the come up, you know. She's not your friend.

I asked Brittany what she thinks of NeNe and the comparison made by her friends:

NeNe Leaks is one of my favorite characters. I love NeNe, not to say I idolize her, but from what she came from, what she went through, it's kind of like wow. But then it's some people that are like, you act just like [NeNe] and it's like, no I don't. We're two different people. It's just you know....., is it cause I'm black or [what]?

I also asked Brittany if she ever censored herself to avoid being accused of being like NeNe and she replied no, emphatically. Although the intended insult was meant to change Brittany's behavior, she resisted internalizing their beliefs of superiority. Brittany's view of NeNe is different from that of her friends. Brittany respects that NeNe has overcome many struggles in her past and values her right of self-expression. Brittany's view of NeNe is one without superiority and judgment.

When Brittany's concern for her friend went ignored, she decided to step back and re-evaluate their friendship. Brittany realized that her friend did not value her or her concern and decided to terminate their friendship, and now considers her an "associate" rather than a friend. Tiana's experience with White women as friends is, however, different from Brittany's. Tiana discussed how she is most comfortable around other Black women because they understand her perspective and do not attempt to invalidate her experiences of gendered racism. But when pressed about her friendships with White women specifically, she clarified. Here she describes who makes a good friend.

I do, [have friends who are White women] and that's probably why we're good friends, because I guess they're kind of woke. And uh, they do have a, they understand that there's somethings that we go through that we can both be on the same page on and there are gonna be some things where I, I'll never understand what you're going through.... So yea I do. And I appreciate them.

Tiana talked more about her struggles with maintaining friendships across gender differences. She described the marginalization she experiences at times when trying to discuss ideas around gendered racism with Black men who may not experience this form of racism. And while she does have relationships with Black men who are supportive, some of those friendships feel contingent on her silence. In this story, Tiana was interrupted by a Black male student who failed to recognize the many ways and forms oppression impacts lives.

"It's just, it's always backed up with the whole like, 'worry about us'.... It could be like, I wanna make, you know, I wanna make just as much as you, and they're like we're getting shot dead in the street. I'm like, I understand that. That is an issue that can get

taken care of as well. BUT I still wanna get paid just as much as my white coworker, my white male coworker. So, it's just kinda, that's just kinda like the, they're reason for everything really. It could be, we're not even talking about Black Lives Matter it could just be like 'I wish I could wear my afro at a work place without being looked at as unprofessional.' 'We're getting killed out in the streets!' I know, but I just wanna not have to straighten my hair.

Discussing hair, an important part of identity in general but especially a gendered identity, seems trivial in comparison to state-sanctioned murder. Here, the tradition of the anti-racist movement continues to ignore gendered aspects of how Black women are restricted from their own full humanity and self-expression.

I further asked Tiana to provide a story that shows how Black men center themselves in anti-racist conversations and to describe how it makes her feel.

In high school... And uh, them just talking, you know like, 'Honestly, this is why my dad doesn't want me to date any Black guys because all they do is get arrested and just have a lot of babies.' And I'm like, that's absolutely not true, like absolutely not true and I started calling out all of this stuff like you wouldn't be able to use the elevator without a Black man. You wouldn't be able to drive without a Black man, like, I mean well drive to a stop light. You wouldn't be able to use all these different things without Black men and Black women. And um, you know, knowing that well I got her to stand up for me, that's cool. And then a couple weeks later someone else said something about Black women, you know saying that we're just ratchet, loud and ghetto which I hear all the time, but it's just like we're not um like it's [not] funny. Like you're just laughing and it's like that's not funny to me because I stood up for you so why aren't you standing up for me? I mean

I can stand up for myself, but it helps to have support. ...It hurts when it comes from Black men... It's like, it's like every time they say it... Have you ever like written...on a white board? [I would] just be doodling and my brother would just come by and wipe it all off just to be annoying. And it feels like, when they call me ratchet that's what, that's what's happening. It's like, I'm doing all this stuff, we're doing all this stuff, we're making these strides and we're making all this progress, and then you come around and you're like, 'aw, they're just' you know, 'ratchet girls, they're just so loud or you just so ratchet' and it's like *you just wiped off all of my work*.

Tiana's narrative suggests that regardless of who the perpetrator is, gendered racism has the power to hurt, silence and render invisible. Her very use of the white board analogy shows the erasure she experiences when marginalized.

At the interpersonal level, we see how Brittany and Tiana struggle with relationships. The White fraternity men in Brittany's narrative enjoy the privilege of setting standards for Black women. If Black women are "up to their standards", they are further objectified by the expectation that their presence is for White men's entertainment. These findings are similar to the theme of the expectation of the Jezebel (Lewis et al., 2016) where Black women are presumed to be promiscuous and are sexualized unexpectedly. Brittany's narrative portrays gendered racism as unchanging and persistent across time. Though beyond the scope of this paper, it is clear that White men have historically and consistently viewed Black women's bodies as property which often manifests through sexual objectification and violence (Collins, 2000; Harris, 1995; Lewis et al., 2016; Spillers, 1987).

In returning to the narrative above, Brittany described her conversations with the bartender as respectable because he did not objectify her and her friends, rather he recognized

their humanity. At the interpersonal level, Brittany's narrative suggests that when White men are able to view Black women as humans, they are able to interact in a way that is nonthreatening. Additionally, the power White fraternity men have at the institutional level impacts Brittany at the intra- and interpersonal levels. She describes the safety she feels when surrounded by other Black students. In other words, Brittany's perception is that being surrounded by White students, places her at risk for safety concerns. Her preference for Black students might be autonomous but it might also be that her social choices are limited due to the perceived threat of isolation. This is evidenced by the narrative highlighting the racial tensions on campus around homecoming. Thus Brittany's perceived fear of violence is real given that another student received a death threat via social media. Further, the indifferent response to the death threat White students displayed on social media suggests to Brittany that Black students might *have her back* but White students do not. This finding is similar to previous research that found Black students at PWIs value sticking together as a source of security and empowerment (Collins, 2000; Fisher & Hartman, 1995; Johnson, 2012).

Brittany's narrative on interracial friendships provide a clear portrayal of the difficulties of maintaining relationships across racial differences when the complexities of race is not critically understood. Brittany was repeatedly disrespected and verbally abused by her White female friends' use of racial slurs. Their continued use of *nigga*, although portrayed as mistakes, made Brittany doubt the authenticity of their friendship. When Brittany was further questioned about the use of the term, it was revealed that her friends only used it in regards to Black men. When White men were the topic of conversation, their humanity was protected by referring to each by his own name. This suggests their use of the racial slur is in line with its historical use,

which was to dehumanize. It is possible that the gendering element here is associated with the dehumanization of Black men not Black women.

Brittany also displayed visible internal conflict at trying to understand why her friends did not respect her wishes and the intent behind their language. Additionally, Brittany's grappling with intent is evidenced by her interaction with White fraternity men and perceiving their language as "extra friendly" though she found it offensive. Brittany's confusion around these issues suggest that she may have endorsed dominant mainstream ideas of colorblindness. Critiquing colorblindness is a key component of Critical race theory (CRT). Colorblindness suggests that race is not important and that differences between groups can be explained by other factors (e.g., income). It is a dominant liberal narrative, and school of thought, where both institutions and individuals claim to not see race since it no longer plays a significant role (Bonilla-Silva & Embrick, 2006; Ford & Airiherbuwa, 2010). Claims of colorblindness make it nearly impossible to understand and interrogate racial privilege and make the dominant cultural customs appear universal and normal (Decuir & Dixson, 2004; Graham et al., 2011; Harris, 1990; Williams, 1997) and are certainly dismissive of intersectionality theory as a whole. Brittany's friends also tried to regulate her behavior by referring to her as ratchet or her behavior as being similar to NeNe Leaks. Her friends viewed their behavior as normal and NeNe's behavior as abnormal. In line with previous research, gendered racism is often associated with communication styles where Black women are reduced to verbal and nonverbal expressions (Lewis et al., 2016). However, Brittany resisted internalizing their proposed insults because where her friends perceive NeNe as inferior, she recognizes that NeNe's portrayal on reality TV is within her rights of self-expression and self-determination.

Endorsing colorblindness may have caused confusion for Brittany. She struggled with understanding why her friends would use a racist term when, she believed, they were not racist. Race-consciousness can be understood as the opposite of colorblindness; it suggests an explicit acknowledgement of the workings of race and racism in social context and in personal life (Ford & Airihienbuwa, 2010). It has erroneously been equated with racism in which acknowledging race makes one racist and, consequently, claims of colorblindness become synonymous with the absence of racism (Bonilla-Silva, 2006). However, adopting a colorblind ideology does not eliminate the possibility of racists' acts occurring (DeCuir & Dixson, 2004). If Brittany and her friends both endorsed colorblindness, it may have made it difficult for her to understand her friends' repeated use of the racial slur.

Brittany also grapples with intent behind her friends' language as well as being followed and watched while shopping. Though some may read both acts as clearly race-related, Brittany was careful not to bring up race for fear that she would be accused of *playing the race card*. Crenshaw (1998), in reference to legal matters, described this trope as an opportunistic ploy when one raises concerns about racial matters. Therefore, when one is race-conscious in colorblind spaces, one might be accused of playing the race card. Fear of playing the race card suggests that Brittany endorsed colorblind ideology. However, her narrative also suggests that she may be race-conscious *deep down*, yet she must be careful about suggesting that someone is racist. Though the consequences of *playing the race card* are not clear, Brittany may have found it difficult to be race-conscious around friends who claim to be colorblind. This suggests that students from various backgrounds need to critically understand the complexities of race in order to protect those who might be victimized by racism.

Research in higher education focused on interracial friendships suggests that there are benefits to both racially diverse and homogeneous groups (Antonio, 2001; Chang, Denson, Sáenz, & Misa, 2006; Shook & Fazio, 2008); however, the quality of the friendship and its impact on Black students is not as clear (Chang, Astin & Kim, 2004) especially when the benefits to White students seem to be the focus of the research (Camargo, Stinebrickner & Stinebrickner, 2010). Brittany's narrative suggests that interracial friendships may be harmful within colorblind frameworks.

Institutional Level: The Fall Semester: Brittany & Tiana in Context

While Brittany and Tiana struggled with the multifaceted gendered racism, the social environment of the campus was also impacted by racialized stressors. Brittany tells a story of the threat of racial violence, her and the University's response to it. During homecoming, some students sat during the national anthem in line with other national protests. A student made a comment on social media thanking others for participating in the protest and was sent a death threat in response.

The whole Facebook thing happened and it got extra heated. This white guy was like, 'I'll kill you nigger, watch who you talking to,' on Facebook messenger. So a boy like screen shot it and put it on Facebook ticket exchange and was like, 'is this how ...you allow your students to talk to other people? ...and then I guess the University sent out a thing saying you know, ...'we respect everybody's rights and we respect the freedom of speech' So you know everybody of course was kinda like, trying to brush it off. You know not saying he was right but trying to brush it off and then um, the white kids were making a joke, with like memes on there, you know like 'oops, I dropped all the Fucks I gave.' But you know it was serious, you threatened a student, saying *I'll kill you nigger, watch who you talking to*, you threatened another student... So [the president of the university] made an

announcement [via email] saying like you know we respect everybody's freedom and you know this student has been removed from campus.

But it was still kind of like, you got to see a glimpse of [the university] as a whole. You got to see the thoughts of the white students at [this university]. They were like, 'this page isn't for your personal beliefs and personal thoughts about racism.' He used a platform, he used what he knew, he used something with extra people on there to show this is what Black students are dealing with at this school, but the white kids were kind of like, 'it's not that deep,' you know, 'you need to delete that cause this page isn't for that.' I was like No! I think he did what he was supposed to do. He needed a platform, he used something that he knew would get a lot of talk about it. [He] couldn't post it on [his] own personal Facebook page and think that every body's going to see it. Post somewhere that people are going to see; that people are going to have an opinion and actually talk about it. Cause if he put it on his personal page, [administration] wouldn't say anything about it.

And, I guess the University is kind of like people didn't take it seriously, well the white people didn't take it seriously. And so like my black friends were like outraged, like you told this student you would kill him?! I said that you know, first of all that's a death threat [and] it's a hate crime. There's so much that can go into that and so they were like he's suspended from campus and we were like well when you're suspended you can come back after like community service after a semester. That's not fair. So I think he was just like suspended [but later], he got arrested, [and] was out on bail. So it's kind of like, you know you expect that at [this institution]..., but if you all let him back into the school, [the university] would be labeled as a school that allows open racism. [And to] know about it and not do anything about it, but to let him come back to the school, that's an issue.

I called my parents and I told them like you know, hey this is how I feel, this is what's going on. And my dad was like we didn't send you to school to do that, we sent you to school to learn. I was like you sound white-washed, let me hang up with you. I was like I don't get why you..., I'm not saying I'm gonna go out there and march... by myself. No, I said had that have been your daughter, it would be a huge issue. I said you would have been ready to come up here and would've been like, 'this child is leaving right?' I said while I know it was not your personal daughter or son, I said it was still a black student. When we're only 5,000 deep out of 36,000 people on this campus, we're very much outnumbered.

I told them, this is happening on campus, you know, this may not be as safe as we thought for Black students to come here.

The context of this story reaffirms the very notion of White privilege. Not only did Brittany's friends not take her concerns about the use of *nigga* as offensive, but the campus environment provides further evidence that some White students were unbothered by the public threat of racial violence against a Black student. Several other participants told stories that emphasized the need for Black friends, specifically women, because they could depend on them to "have their back." Black women depend on each other because they understand the ever-present risk of gendered racism. Due to the threat of violence, Brittany's mother pushed for her to transfer to another school. At the time of the interview, Brittany stated that she was still thinking about what she needed to do.

At the institutional level, the social environment during the fall semester around homecoming provides a backdrop for Brittany's narrative. While students from various racial and ethnic backgrounds took part in the protest during the national anthem, one Black male

student received a death threat. The response on social media to the threat suggested to Brittany that the campus was not a safe space. White students' posts suggested that the threat of racial violence was a personal issue. However, Brittany perceived the threat as both a personal and a political issue, both requiring action. Brittany recognized that public attention often inspires action and social change.

Brittany viewed the university's response to the threat as negligible since the perpetrator would have been allowed back to campus after a semester of completing community service hours. Thus, further subjecting next semester's students to potential death threats. Failure to address the severity of the threat shows institutional racism. Jones (2016) describes institutional racism as inaction in the face of need. The action the university provided was perceived as immaterial thereby supporting the perpetuance of white supremacy. Colorblindness, or failure to effectively deal with and prevent racism may place marginalized students at risk of danger. Brittany's comment, "this may not be as safe as we thought" suggests that she and her parents may not have carefully considered how racism would impact her college experience.

The response of Brittany's parents to the death threat can also be linked to gendered racism. Their goal for Brittany was for her to prioritize education over social justice. Findings on the SBW Independence is key to being a SBW therefore education is essential in reaching this goal. However, Brittany's actions show that she values social justice and education equally. Her parents' plea of not getting involved potentially implicates the consequences of being race-conscious in colorblind spaces. Being involved may place their daughter at greater risk of harm at a campus that is seemingly colorblind. Further, institutions' colorblind policies leave both parents and students dangerously unprepared for the reality of a race-based environment. Nevertheless, Brittany's narrative emphasizes that she feels unsafe. Regardless of whether she is

race-conscious or not, she is visibly Black and clearly *outnumbered*. Brittany also may be able to empathize with the threatened Black student, differently from her parents, given her experiences of gendered racism. Her narrative shows that she understands the importance of being surrounded by supportive Black friends who will *have her back*.

The Importance of Talking Back

In this final section, I will focus on what I see as the broader importance of talking back through counter-narratives. The second research question was to explore how talking back through stories allow Black college women to resist gendered racism. By describing what gendered racism means to herself personally, Tiana revealed how she understood gendered racism and how she is, therefore, able to resist it. Tiana expressed how the negative stereotypes of Black women have the specific goal of silencing so that oppression can persist. However, by recognizing gendered racism as a system, within an institutional framework, she comprehends how using her voice allows her to resist oppression.

...it's like they can speak and they have a louder voice than I do and they can completely... ignore us but it's all cool. And, if I say something it's like 'oh you're being the *angry black woman*' and it's like I understand that that's a part of it. And I can't..., I have a right to be angry but I have to go about it [in] a certain way or else they won't listen to me, and sometimes they won't listen to me anyways. And I know that that's how the system is, that's how the machine keeps going by operating off of me figuring out a way for me to talk and while I'm trying to figure that out, I'm silent and as long as the silence continues then the stereotypes and the systems keep going.

At the individual level, Tiana described how it feels to face unrelenting gendered racism throughout various aspects of her life. In this narrative she discussed how her hard work often

goes unnoticed and how gendered racism drains her physically and emotionally. At the same time, she wrestles with admitting how she feels.

I did what I had to do. Like I was two times better, you remember that, ‘you have to be two times better to get half as much?’ It’s like, I did what I had to do, like I did more than what I had to do. So there’d be no other reason that I got passed up other than that reason. It hurts.... I was just like I don’t, I don’t want to do this. I don’t know what else I have to do. Um, I don’t, like when people tell me you know like “oh get ready it’ll, it’s only gonna get worse, you’re gonna have to go through it again.” It’s like, I know that but, I’ve already been through so much. *I’m just telling you I’m tired, but I can’t tell anybody I’m tired.*

When probed about her reason for not being able to admit her fatigue, she unpacked the SBW ideology and gave voice to her pain.

I think it’s directly due to that strong black woman image...and I’m all, I’m all for black women being strong and independent and doing what they have to do but it reaches a point where that’s what you expect all the time and you can’t be vulnerable. But we’re still human, we’re not these, you know, I mean I love to say that we’re like goddesses and we’re queens and we’re divine, but we’re not. We’re not god-like creatures that can never experience anything. Like, we, we hurt. We do.

Given the chance to use her voice, Tiana resisted internalizing the myth that all Black women are inherently strong and should consequently and silently be oppressed. Her voice allowed her to defy validating the SBW ideology because she recognizes it as injurious.

Following the interview, all of the participants thanked the researcher for the experience and described it as meaningful or helpful in some way. Several participants sent emails in the

months following the interview to express further appreciation. Tiana's email below describes how the interview provided the opportunity to reflect on gendered racism. It shows that although gendered racism was experienced in multiple forms throughout her life, the interview itself was considered a valuable experience. While experiencing gendered racism is painful, talking back facilitated healing.

I just wanted to say happy New Year and hope you had [a] heavenly holiday season.

Also, I wanted to say thank you. Because of [the interview] I was able to address feelings and thoughts that I hadn't really dealt with until now. I've also become much more vocal with my counselor so I'm able to help myself better when dealing with my self-care. It's clear I hadn't really been practicing that but now I do. I appreciate you and the work that you're doing.

As I think about her words, I think of Audre Lorde who said: "and when we speak we are afraid our words will not be heard nor welcomed but when we are silent we are still afraid So it is better to speak remembering we were never meant to survive" (1978, p. 31-32). Therefore in order to change what is meant to happen, or the normative experience, Black women's back talk is necessary.

In this study, counter-narratives revealed gendered racism at the individual, interpersonal, and institutional levels and Black women's back talk that provide the opportunity for reflection and self-healing. As a form of talking back, counter-narratives are a method of telling the stories of those whose experiences are not often told, those on the margins (Solorzano & Yosso, 2002). They are used to maintain the connection between theory and lived experiences necessary to create social change (Kim, 2015). Brittany and Tiana recognized the value in talking back and, importantly, all of the interview participants thanked the researcher for the opportunity to speak

specifically about gendered racism. Hooks theorizes that talking back is not the same for Black and White women because of the different ways they have been socialized (hooks, 1989). White women have been historically socialized into silence, thus speaking out may be their form of talking back; however, for Black women, the act of speaking out may be misinterpreted as powerful without a nuanced understanding of their culture. For Black women, talking back has the power to create change when they are heard. When private subject matters are spoken of, meaningful transformation takes place (hooks, 1989). Thus, the interview itself created the opportunity to reflect and heal by discussing a topic others so often silence. By discussing the pain caused by gendered racism, participants interrupted its normalcy; therefore, regardless of the powerful ways institutional gendered racism may impact relationships and the self, talking back is still empowering and healing (hooks, 1989).

CONCLUSIONS

Disrupting colorblind politics across all levels is essential for creating safety for marginalized groups at PWI. Talking back is necessary and liberating. Thus, researchers need to be equipped with critical theories and paradigms that allow participants to use research as a way to work toward social justice and self-healing and it is especially useful in transformative research. College students need critical skills in understanding how racism works as a system of oppression. Marginalized students need safe spaces to connect with like members of identified groups in order to feel empowered. Resisting oppressive systems is impossible without an understanding of how the system works. Absent a critical understanding, even friendships have the power to damage.

Limitations of the study included the potential for limited thick description due to time constraints. In narrative interviews, multiple interview sessions are sometimes needed in order to

build trust. In this study, one interview was conducted with each participant. However, participants did not voice or appeared to have any concerns with discussing gendered racism. Further participants were given as much time as needed to feel comfortable and was offered follow up interviews if more time was needed. Although it did not seem likely, it is possible that given the role of the researcher as a representative of the institution, participants may have been less likely to divulge information that implicates the institution as a site of gendered racism. Limited attention was given to other identity issues such as sexual orientation and social class. Finally, data collection occurred at a single institution and having small sample size limits the generalizability of the findings. Though, the goal here was to adequately describe how gendered racism works and not to generalize to other samples (Maxwell, 2013).

This study is significant because it expands the literature and show how gendered racism persists across multiple levels and is internalized as well as institutionalized. Moreover, the use of the SEM to explicate gendered racism may make this topic more accessible for those in health fields. The study is also important because it provided participants with an opportunity to freely discuss a topic that is often silenced. Their understanding of gendered racism impacts their ability to care for themselves. This is important given the many detriments to physical and mental health associated with oppression. Additionally, this study highlighted marginalized experiences by validating them through the use of research.

In the future, research should continue using intersectionality theory as a way to understand marginalized groups. This understanding is critical in dismantling gendered racism and other forms of oppression. In addition to more research with Black women, all people of color need research specific to how they experience gendered racism. Similarly, focus groups may be helpful in uncovering the subtle ways gendered racism manifests. Transformative

research should be used so that participants have immediate reward for offering their time and input. Finally, the GRMS can be used in mixed methods research to show the breadth and depth of gendered racism.

We have goals that we're trying to achieve. And so by talking, we validate and encourage each other that we're gonna make it... and that [our struggles] will all be worth it.

- Brittany, Interview, October 25, 2016

CHAPTER 5. DISCUSSION

Reflections

Findings in this study point to the need for a greater understanding of how systems of oppression work. Jones' characterization of institutional racism as inaction in the face of need resonated with me throughout this study (2000). I understand this characterization to mean that health research that ignores structural causes allow health disparities to operate unchallenged – thereby perpetuating institutional racism through its appearance as normative. The Black women in this study have specific needs based on their gendered and raced identities. Understanding these complexities is a basic theme in health educators working toward cultural humility and cultural competence. Yet, there remains a persistent lack of understanding on behalf of health researchers to meet Black women where they are. This may be in part due to the way in which public health research is collected at the national level using single lenses - that erase Black women - to capture the health status of communities, such as “women” and “African Americans”. It may also be due to a lack of critical self-awareness in health researchers although health equity researchers consistently proclaim it as vital (Ford & Airhihenbuwa, 2010; Kreiger, 2014; Thomas et., 2011; Williams, 1996). Albeit beyond the traditional lens of health research, literature on gendered racism and intersectionality have been accessible for over 30 years. Moreover, research on racism's impact on health and as a cause for health disparities was suggested as early as the mid-1800s (Gee & Ford, 2011; Krieger, 2003; Williams, Lavizzo-Mourey, & Warren, 1994). Still, much of the research in health continue to ignore these complexities and focus on the individual as if one can be separated from their social identity and

position in a race-based society (Kreiger, 2014). Though the idea of social determinants of health have gained traction in recent years, very little public health research is devoted to structural determinants (Kreiger, 2014).

Health equity researchers' frustration with the little attention to structural causes of health outcomes is visible in their writings. In 2016(a), Jones reflected on state-sanctioned racial violence in a commentary in the *American Journal of Public Health* entitled "Overcoming helplessness, overcoming fear, overcoming inaction in the face of need." She begins with, "Again I find myself overwhelmed by sadness..." (p. 1717). Still, Jones ends the piece with "No more inaction in the face of need!" (p. 1717). Krieger's frustration was clearly evident in how she described the lack of attention to health disparities and the denial of human rights that help to cause them. She reported that only 46 of the 732 pages in the National Institutes of Health's 2008-2009 biennial report to Congress were dedicated to "Minority Health and Health Disparities" (Krieger, 2014). Further, she explains how focusing on the individual, with the still-dominant biomedical orientation, ignores the social and structural causes. The biomedical orientation is very much akin to understanding race as a biological construct that enabled slavery, eugenics, and the more recent Tuskegee study. Jee-Lyn Garcia and Sharif (2015) begin their commentary with a quote from Dr. Martin Luther King Jr., "The ultimate measure of a man is not where he stands in moments of comfort and convenience, but where he stands at times of challenge and controversy" (p. e27). And ends with a call to researchers to actively engage with communities of color in order to understand how structural racism impacts individual and community health. They also suggest that public health research should be leading the way toward healing racial pains.

All of these articles, though few in comparison to prioritized health issues, read like pleas for more to take up studying racism and structural oppression. Studying systemic causes must be understood critically and theoretically prior to eliminating racialized health disparities. The American Public Health Association highlights the Presidential Initiative, a National Campaign Against Racism (Jones, 2016b) on its website. The campaign strives to attain health equity through the elimination of racism and identifies three objectives in order to reach its goal:

- ***Put racism on the agenda.*** Name racism as a force determining the social determinants of health.
- ***Ask “How is racism operating here?”*** Identify how racism drives past and current policies, practices, norms and values that create the inequitable conditions in which we are born, grow, live, learn and age.
- ***Organize and strategize to act.*** Promote and facilitating conversation, research and intervention to address racism and its negative impact on the health of our nation.

I am pleased that I was able to use my dissertation as an avenue for reaching this goal. I named racism in the title to call attention to it as an important system with health implications. Through narrative analysis, I was able to show how gendered racism operated within the participants’ lives. And, through interview conversations as well as the focus group, the participants strategically took action on caring for themselves in order to address the impact of gendered racism. Further, findings from this study will be presented to members of student organizations that participated in the quantitative phase. The National Council for Negro Women and the Women of Excellence will have a combined meeting, approximately 300 members in total, where results will be discussed. Therefore, this dissertation sought to extend health education and promotion beyond the individual, beyond the college setting, and beyond any one

disease, in order to create positive change in the lives of people who are nearly always made invisible in health research. This study was by, for, and about Black women. This time their voices were heard and change followed. And in my celebration of Black women and in completing this dissertation, I reflect on the words of Zora Neal Hurston (1928, p. 215-216):

“But I am not tragically colored. There is no great sorrow dammed up in my soul, nor lurking behind my eyes...No, I do not weep at the world – I am too busy sharpening my oyster knife.”

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APPENDICES

Appendix A. Procedural Diagram

Transformative aims for Phase 1:

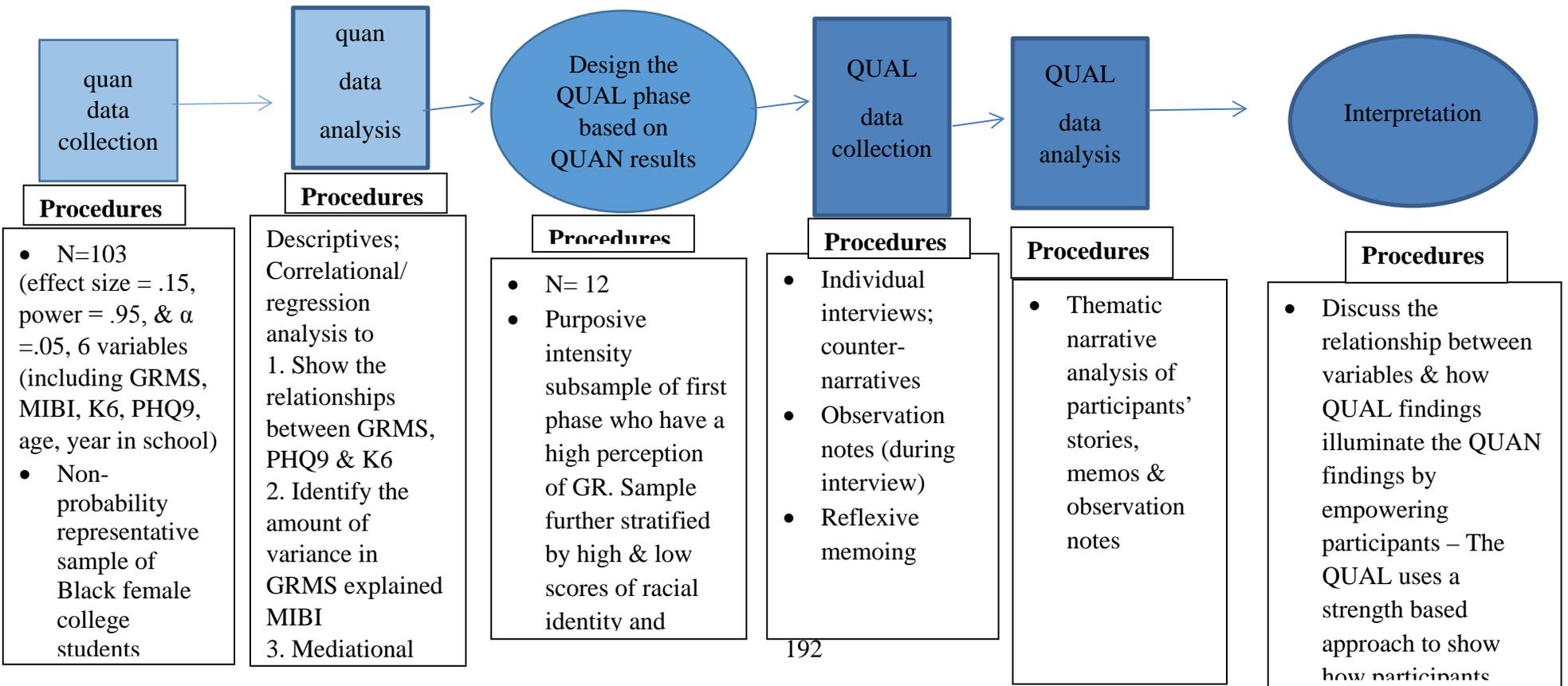
1. What is the relationship between gendered racism and mental health?
2. Does racial identity predict gendered racism?
3. Does racial identity mediate the effect of gendered racism on mental health?

Transformative aims for Phase 2:

4. What stories do Black college women tell about gendered racism to describe its mental health impact and meaning?
5. What coping strategies do Black college women use when they

Transformative aims for interpretation:

5. How do the perspectives of Black college women who perceive of gendered racism enhance the understanding of gendered racism on mental health outcomes and coping strategies?
 - Demonstrate the impact & meaning of gendered racism on mental health
 - Build a comprehensive picture of



Appendix B. Demographic Sheet

1. How do you identify either racially or ethnically?

African American American Black Black American Bi-/Multi-racial

Other: _____

2. Gender: Female (Cisgender) Transgender female

Other: _____

3. Age: _____

(If less than 18 is entered, the survey will be terminated)

4. Current year in school:

Undergraduate level:

1st 2nd 3rd 4th

Other: _____

Graduate level:

Master (Professional Degree) Doctorate (Terminal Degree)

1st 2nd 3rd 4th 5th

Other: _____

Professional Student: Medical Student Law Student

Other: _____

5. Income level:

If supported by your family (parent, spouse or other), please estimate your family's income: _____

If you consider yourself financially independent, please estimate your income:

6. Place of residence:

What do you consider your home state? _____

Is this where you are from originally?

What city of you from? _____

Do you consider your home city urban or rural? _____

Appendix C. Gendered Racial Microaggressions Scale (GRMS)

Directions: Please think about your experiences **as a Black woman**. Please read each item and think of how often each event has happened to you **in your lifetime**. In addition, please rate how stressful each experience was for you. Stressful can include feeling upset, bothered, offended, or annoyed by the event.

Frequency

0	1	2	3	4	5
Never	Less than once a year	A few times a year	About once a month	A few times a month	Once a week or more

Appraisal

0	1	2	3	4	5
This has never happened to me	Not at all stressful	Slightly stressful	Moderately stressful	Very stressful	Extremely stressful

Based on my experiences as a Black woman...

Item	Frequency	Appraisal
1. Someone accused me of being angry when I was speaking in a calm manner.		
2. Someone assumed that I did not have much to contribute to the conversation.		
3. I have been told that I am too independent.		
4. Someone has made me feel unattractive because I am a Black woman.		
5. In talking with others, someone has told me to calm down.		
6. My comments have been ignored in a discussion in a work, school, or other professional setting.		
7. I have been told that I am too assertive.		
8. Someone has made a sexually inappropriate comment about my butt, hips, or thighs.		
9. I have been perceived to be an "angry Black woman."		

10. Someone has challenged my authority in a work, school, or other professional setting.		
11. Someone made a negative comment to me about my skin color/skin tone.		
12. Someone made me feel exotic as a Black woman.		
13. Someone has imitated the way they think Black women speak in front of me (for example, "g-i-r-l-f-r-i-e-n-d").		
14. I have been disrespected by people in a work, school, or other professional setting.		
15. Someone made me feel unattractive because of the size of my butt, hips, or thighs.		
16. I have been assumed to be a strong Black woman.		
17. Someone has assumed that I should have a certain body type because I am a Black woman.		
18. I have felt unheard in a work, school, or other professional setting.		
19. I have received negative comments about my hair when I wear it in a natural hairstyle.		
20. I have been told that I am sassy and straightforward.		
21. Someone objectified me based on my physical features as a Black woman.		
22. I have felt someone has tried to "put me in my place" in a work, school, or other professional setting.		
23. Someone assumed I speak a certain way because I am a Black woman.		
24. I have felt excluded from networking opportunities by White coworkers.		
25. I have received negative comments about the size of my facial features.		

26. Someone perceived me to be sexually promiscuous (sexually loose).		
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Appendix D. Multi-Inventory of Black Identity – Centrality Subscale (MIBI)

Please tell us how much you personally agree or disagree with these beliefs and attitudes by circling a number. There are no right or wrong answers, we simply want to know your views and your beliefs.

1. Overall, being Black has very little to do with how I feel about myself.

1 2 3 4 5 6 7

2. In general, being Black, is an important part of my self-image.

1 2 3 4 5 6 7

3. My destiny is tied to the destiny of other Black people.

1 2 3 4 5 6 7

4. Being Black is unimportant to my sense of what kind of person I am.

1 2 3 4 5 6 7

5. I have a strong sense of belonging to Black people.

1 2 3 4 5 6 7

6. I have a strong attachment to other Black people.

1 2 3 4 5 6 7

7. Being Black is an important reflection of who I am.

1 2 3 4 5 6 7

8. Being Black is not a major factor in my social relationships.

1 2 3 4 5 6 7

Appendix E. Kessler 6 (K6)

The following questions ask about how you have been feeling during the **past 30 days**.

For each question, please circle the number that best describes how often you had this feeling.

During the past 30 days, about how often did you feel...	All of the time	Most of the time	Some of the time	A little of the time	None of the time
...nervous?	1	2	3	4	5
...hopeless?	1	2	3	4	5
...restless or fidgety?	1	2	3	4	5
...so depressed that nothing could cheer you up?	1	2	3	4	5
...that everything was an effort?	1	2	3	4	5
...worthless?	1	2	3	4	5

Appendix F. The Patient Health Questionnaire (PHQ-8)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest of pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you’re a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite- being so fidgety or restless than you have been moving around a lot more than usual	0	1	2	3

Appendix G. Brief Coping Orientations to Problems Experienced (Brief COPE)

There are many ways to try to deal with problems. These items ask what you've been doing to cope. Obviously, different people deal with things in different ways, but I'm interested in how you've tried to manage. Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says. How much or how frequently. Don't answer on the basis of whether it seems to be working or not—just whether or not you're doing it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

- 1 = I haven't been doing this at all
- 2 = I've been doing this a little bit
- 3 = I've been doing this a medium amount
- 4 = I've been doing this a lot

1. I've been turning to work or other activities to take my mind off things.
2. I've been concentrating my efforts on doing something about the situation I'm in.
3. I've been saying to myself "this isn't real."
4. I've been using alcohol or other drugs to make myself feel better.
5. I've been getting emotional support from others.
6. I've been giving up trying to deal with it.
7. I've been taking action to try to make the situation better.
8. I've been refusing to believe that it has happened.
9. I've been saying things to let my unpleasant feelings escape.
10. I've been getting help and advice from other people.
11. I've been using alcohol or other drugs to help me get through it.
12. I've been trying to see it in a different light, to make it seem more positive.
13. I've been criticizing myself.
14. I've been trying to come up with a strategy about what to do.
15. I've been getting comfort and understanding from someone.
16. I've been giving up the attempt to cope.
17. I've been looking for something good in what is happening.

18. I've been making jokes about it.
19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.
20. I've been accepting the reality of the fact that it has happened.
21. I've been expressing my negative feelings.
22. I've been trying to find comfort in my religion or spiritual beliefs.
23. I've been trying to get advice or help from other people about what to do.
24. I've been learning to live with it.
25. I've been thinking hard about what steps to take.
26. I've been blaming myself for things that happened.
27. I've been praying or meditating.
28. I've been making fun of the situation.

Appendix H. Interview Guide

Introduction:

Hello, thank you for coming to speak with me today. I'm Wanda Burton and I am a PhD student at the University of Alabama in Health Education and Health Promotion. I am studying how college students' deal with stress, specifically how African American women cope with stress related to both their race and gender. Your answers during this interview will be kept confidential but will be used as data for my dissertation. Is it okay for me to record this interview so that I may transcribe it later?

The audio and transcription will be kept confidential. I will analyze the data then share it with you to make sure that I have understood what you meant during the interview. Later in the semester, I will email you and ask you to look at the data analysis which will include the transcription and my notes. Is that okay with you? If at any time during the interview you feel uncomfortable or would like to stop or take a break for any reason, please let me know. This should take about 60-90 minutes.

You might remember from the survey, but just as a reminder, let me describe what I'm studying again. *Gendered racism is specific to women of color. It blends racism and sexism into one hybrid form of oppression. It may be intentional or unintentional. It may be perpetrated by someone or experienced as societal pressure to act or look a particular way. For example, gendered racism may include women of color being mistaken for "the help" in restaurants or shopping malls. It may also include the pressure to be a "strong black woman".*

Are you still okay with participating? Do you have any questions before we begin? I may jot down a few things while we talk but don't be nervous, it's just for my memory. Are you ready to start?

(Begin recording)

Any questions about this definition?

To protect your identity, I can use a pseudonym during the interview. What would you like to be called?

1. First, tell me about you – what do you like to do for fun? What are your favorite shows that you watch?
2. Tell me about the first time you remember having to think about your own race.
3. How do you encounter racism? Tell me about that experience.
4. What do you think of the term gendered racism? What does it mean to you?
5. Tell me a story about how you have come to understand gendered racism?
6. You seem to be describing (_____type of _____) gendered racism. How else does gendered racism show up?

If prompting is needed:

- a. Internalized: What do you think about natural hair? How would/do others view you if your hair was/is natural? Were you told to stop "switching" or called "fast" when you were younger? What do you think about that?

- b. Personally mediated: (Unintentional) Has anyone ever mistaken you for “the help”? Where were you? Was anyone else with you? What happened? Did you guys talk about it afterwards? What do you think about that experience now that you understand this as a form of gendered racism?

(Intentional) Have you ever been treated intentionally worse because you are a Black woman? Tell me about that experience.

- c. So there’s been a lot of talk about structural or institutional racism lately. Are you familiar with this term? What does it mean to you? I’m working from a definition meaning blocked access to opportunities, power, resources and even your own voice. Have you ever felt silenced because you are Black woman? Tell me about that. You mentioned you like to watch _____, in your opinion how are Black women are portrayed in the media? Tell me about how you’re impacted by Black women in the media.
7. Are you bothered by gendered racism? In what ways does it impact your health? Tell me more about that.
 8. How do you deal with gendered racism? What do you do to cope?
 9. You scored (high/low) on the racial identity survey, how have you learned about racial identity? How does racial identity influence your ability to cope with gendered racism?
 10. Tell me about a time that you discussed gendered racism with someone and it made you feel better.
 11. Tell me about a time when you needed this person but they weren’t available. What else did you do to cope?
 12. Who do you not feel comfortable talking to about gendered racism? Why are some people better at discussing this than others?
 13. In addition (_____), what other things do you do that help you cope with gendered racism?
 14. Is there anything else you want to add on the topic?

Thank you so much for your time! Remember that I will email you later when I’m done transcribing and analyzing so that you can review what I have. I really appreciate you taking time to meet with me.

Appendix I. Public Health Critical Race Praxis Principles

Principle	Definition	Conventional Approach	PHCR Approach
Race Consciousness	Deep awareness of one's racial stratification processes operating in colorblind contexts	Colorblindness-belief in the irrelevance of racism characterized by the tendency to attribute racial inequities to non-racial factors (e.g., SES	A researcher clarifies her racial biases before beginning research within a diverse community
Primacy of racialization	The fundamental contribution of racial stratification to societal problems; the central focus of CRT scholarship on explaining racial phenomena	Tendency to attribute effects to race rather than to racialization or racism	A study on neighborhood characteristics includes factors hypothesized to reflect structural racism
Race as a social construct	Significance that derives from social, political and historical forces	Biological determinism e the belief that race is meaningful because it provides insights about one's biology and propensities	A study assesses race not as a risk factor but to identify a population at risk for specific racism exposures
Ordinariness of racism	Racism is embedded in the social fabric of society	Racial exceptionalism- defines racism as rare, discrete and overtly egregious incidents	A study on racism and health operationalizes racism as routine exposures (e.g., being followed while shopping)
Structural determinism	The fundamental role of macro-level forces in driving and sustaining inequities across time and contexts; the tendency of dominant group members and institutions to make decisions or take	Emphasizing individual or interpersonal factors	A multilevel study considers policy factors that may promote residential segregation

	actions that preserve existing power hierarchies		
Social construction of knowledge	The claim that established knowledge within a discipline can be re-evaluated using antiracism modes of analysis	The belief that empirical research carried out properly is impermeable to social	A disparities-related literature review compares articles published in minority vs. majority journals
Critical approaches	To dig beneath the surface; to develop a comprehensive understanding of one's biases	To accept phenomena or explanations at face value	A researcher considers alternative explanations for findings than those previously posited
Intersectionality	The interlocking nature of co-occurring social categories (e.g., race and gender) and the forms of social stratification that maintain them	Additive model of co-occurring social categories (e.g., race and gender)	Efforts to reduce HIV risk behaviors among diverse men who have sex with men address racial stereotypes
Disciplinary self-critique	The systematic examination by members of a discipline of its conventions and impacts on the broader society	Limited critical examination of how a discipline's norms might influence the knowledge on a topic	Researchers examine implications for research of using 'health inequities' vs. 'health disparities' vs. 'health inequalities'
Voice	Prioritizing the perspectives of marginalized persons; Privileging the experiential knowledge of outsiders within	Routine privileging of majority perspectives	Responses of skepticism or anger when outsiders within speak truth to power

Appendix J. Institutional Review Board Approval (Original)

August 19, 2016

Wanda Burton
Dept. of Health Sciences
College of Human Environmental Sciences
Box 870311

Re: IRB#: 16-OR-284 "Coping at the Intersection: A Transformative Mixed Methods Study of Gendered Racism as a Root Cause of Mental Health Challenges in Black Female College Students"

Dear Ms. Burton:

The University of Alabama Institutional Review Board has granted approval for your proposed research.

Your application has been given expedited approval according to 45 CFR part 46. You have also been granted the requested waiver of written documentation of informed consent. Approval has been given under expedited review category 7 as outlined below:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies

Your application will expire on August 17, 2017. If your research will continue beyond this date, complete the relevant portions of the IRB Renewal Application. If you wish to modify the application, complete the Modification of an Approved Protocol Form. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants. When the study closes, complete the appropriate portions of the IRB Request for Study Closure Form.

Please use reproductions of the IRB approved stamped consent forms to provide to your participants.

Should you need to submit any further correspondence regarding this proposal, please include the above application number.

Good luck with your research.

Sincerely,



Director & Research Compliance Officer

Informed Consent
UNIVERSITY OF ALABAMA

Study Title: “An Investigation of Culture and Stress in Black Female College Students”

Researchers: Wanda Burton, Doctoral Student; Dr. David Birch, Department Chair and Professor of Health Science; Dr. Angelia Paschal, Associate Professor of Health Science

What is this study about? What will I be asked to do in this study?

The purpose of this study is to understand how cultural factors and stress impact mood and coping behaviors of Black women in college. The study consists of two phases. The first is a web survey that takes approximately 15 minutes to complete. The second phase is an interview with selected participants from phase 1.

Only students who identify as Black or African American and female are eligible for participation. Students may participate in the first phase without participating in the second phase. **You are being asked to complete a survey online.** If you agree to be in this study, you will be asked to respond to questions on stress, culture, and behaviors. You will also be asked to complete a brief survey that will request information about your gender, race, income, age, major, and other personal factors.

If you are selected, and agree, to participate in Phase 2, you will be asked to participate in an individual interview. **You do not have to participate in the interview in order to complete the survey. An audio recorder will be used during the interview.** Following the interview, there may be an opportunity to attend a focus group. If you are invited to a focus group, you may agree or decline.

Why is this study important or useful?

This information will help us learn about stress specific to Black college women and how it is managed. This information may help inform programming on college campuses to help college students remain happy, healthy, and successful during college.

Why have I been asked to be in this study?

You have been asked to be in this study because you may identify as a Black or African American woman and you are enrolled as a student at the University of Alabama.

How many people will be in this study?

About 200 people will participate in the first phase (survey). About 12 of the 200 people will participate in the second phase (interview).

How much time will I spend being this study?

The first phase will take approximately 15 minutes. If you are selected, and agree, to take part in the second phase, it will take approximately 60 to 90 minutes.

Will being in this study cost me anything?

The only cost to you for participation in this study is the time it will take to complete the survey.

UNIVERSITY OF ALABAMA IRB
CONSENT FORM APPROVED: 8/18/16
EXPIRATION DATE: 8/17/2017

Will I be compensated for being in this study?

You will not be compensated for being in this study.

Can the investigator take me out of this study?

Since Phase 1 is an online survey and participants will be completing the survey away from the classroom setting, the investigators will not know if the survey is upsetting you; however, you can choose to stop participating in the survey at any time without penalty. You may close the survey app if you wish to be taken out of this study.

You may stop participating in Phase 2, the interview, at any time by notifying me during the interview. You may also contact me after the interview and ask that your data not be included in the analysis. I will let you know when the analysis will be complete (approximately in January 2017).

What are the risks (dangers or harms) to me if I am in this study?

Minimal or no risk is foreseen by your participation in this study. Based on individual experiences or responses to the survey or interview, you may feel minor discomfort thinking about stressful experiences. If you are not comfortable answering a question contained within the survey or interview, you are free to skip the question. If you become uncomfortable and feel that you cannot continue, please feel free to stop participating in the survey or interview at any time. If further assistance with these problems is needed, you can contact the **Women and Gender Resource Center at (205) 348-5040** or the **Counseling Center at (205) 348-3863**.

What are the benefits (good things) that may happen if I am in this study?

There are no direct benefits from participating in this study.

What are the benefits to science or society?

Society may benefit from a greater understanding of the stressful conditions that impact and may be specific to Black college women.

How will my privacy be protected?

If you choose to participate, you will be asked to take an online survey in a setting of your choice. Participation in this study is anonymous, which means your name will not be recorded as part of Phase 1 of this research. **Unless** you agree to participate in phase 2, an interview. Your survey responses will be used to determine eligibility in Phase 2. If you agree to participate in Phase 2, you will be asked to provide contact information including your name and email address. The interview will be recorded but you may use a pseudonym to protect your identity on the audio recording. All other responses will be reported anonymously and in combination with all other participants.

How will my confidentiality be protected?

There will be no consent forms to sign so your survey responses can remain anonymous. Instead, if you choose to participate, you will click a box at the bottom of this page that indicates your willingness to participate in Phase 2. The surveys will be stored on a flash drive kept in a locked filing cabinet in a UA campus office belonging to the principal investigator. The

investigators of the study will be the only people that have access to this room and the locked cabinet. At the end of the study, you will be asked if I may contact you regarding the study. You will also be asked if you are interested in participating in the second phase of the study. If you agree, you will have to provide contact information. Your name and email address will be associated with your responses. However, this information is only needed to determine eligibility for those who agree to participate in phase 2. All contact information will be stored safely on a computer under password protection accessible only to the principal investigator. After Phase 2 is completed, all identifiable information will be destroyed.

What are the alternatives to being in this study? Do I have other choices?

Participation in this study is voluntary. There are no alternatives to this study but you do have the choice not to participate in this study.

What are my rights as a participant in this study?

Taking part in this study is voluntary. It is your free choice to participate. You can refuse to be in the study. Furthermore, if you start the study, you can skip any questions you feel uncomfortable answering or stop at any time. Whether or not you choose to participate in this study will have no effect on your grade in the current course or with your relations with your instructor, student organization or the University of Alabama. The University of Alabama Institutional Review Board (“the IRB”) is the committee that protects the rights of people in research studies. The IRB may review study records from time to time to be sure that those involved in research studies are being treated fairly and that the study is being executed as planned.

Who do I call if I have questions or problems?

If you have questions about the study right now, please ask them. If you have questions, concerns, or complaints about the study later on, please contact **Wanda Burton at 205-348-2486 or Dr. Paschal or Dr. Birch at 205-348-9087**. If you have questions, concerns, or complaints about your rights as a person in this research study, call Ms. Tanta Myles, the Research Compliance Officer of the University, at 205-348- 8461 or toll-free at 1-877-820-3066. You may also ask questions, make suggestions, or file complaints and concerns through the IRB Outreach website at http://osp.ua.edu/site/PRCO_Welcome.html or email us at participantoutreach@bama.ua.edu.

After you participate, you are encouraged to complete the survey for research participants that is online at the outreach website or you may ask the investigator for a copy of it and mail it to the UA Office for Research Compliance, Box 870127, 358 Rose Administration Building, Tuscaloosa, AL 35487-0127.

How do I agree to participate?

Checking the box at the bottom of this page is your consent to participate. If you agree with the following statement, please proceed with the survey:

*“I have been informed of this study and I have had a chance to ask questions. I agree to participate in this study, **identify as Black/African American and female and am either***

a undergraduate, graduate, or professional student at The University of Alabama, and understand that clicking the following box is my consent to participating in this study.”

UNIVERSITY OF ALABAMA IRB
CONSENT FORM APPROVED: 01/18/16
EXPIRATION DATE: 01/17/2017

Appendix K. Institutional Review Board Approval (Revision)

October 11, 2016

Wanda Burton
Department of Health Sciences
College of Human Environmental Sciences
The University of Alabama
Box 870311

Re: IRB # 16-OR-284 (Revision # 2) "Coping at the Intersection: A Transformative Mixed Methods Study of Gendered Racism as a Root Cause of Mental Health Challenges in Black Female College Students"

Dear Ms. Burton:

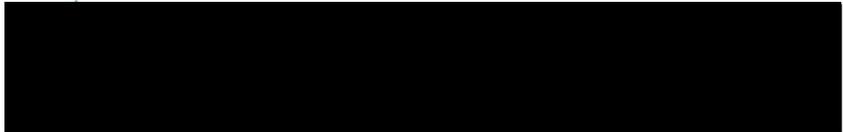
The University of Alabama Institutional Review Board has reviewed the revision to your previously approved expedited protocol. The board has approved the change in your protocol.

Please remember that your approval period expires one year from the date of your original approval, August 18, 2016, not the date of this revision approval.

Should you need to submit any further correspondence regarding this proposal, please include the assigned IRB application number. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants.

Good luck with your research.

Sincerely,



Director & Research Compliance Officer
Office of Research Compliance

Black College Women & Stress Study

Participate in an important study of gender & race related stress

- Do you identify as African American or Black **and** female?
- Are you at least 18 years of age?
- Are you currently enrolled at the University of Alabama?

If you answered yes to these questions, you may be eligible to participate in a research study, "An investigation of culture and stress in Black female college students."

The purpose of this research is to understand how cultural factors and stress impact the mood and coping behaviors of Black women in college. The study has 2 phases. Phase 1 is a web survey that takes 15 minutes, [click here to complete survey](#). If you are able to correctly answer a question at the end of the survey, you may be entered into a drawing to receive 1 of 8 \$25 Amazon gift cards.

Phase 2 is an interview with selected participants. You may agree to take the survey without agreeing to the interview.

Undergraduate, graduate and professional students are invited to participate.

Please contact Wanda M. Burton, wmburton@crimson.ua.edu for more information.

Wanda M. Burton is a PhD candidate in the Health Education and Promotion program at the University of Alabama. The consent form is included as the first page of the web survey and provides more information about the study.

UA IRB Approved Document
Approval date: 10-11-17
Expiration date: 8-17-17

**Information Sheet
UNIVERSITY OF ALABAMA**

Study Title: “An Investigation of Culture and Stress in Black Female College Students”

Researchers: Wanda Burton, Doctoral Student; Dr. David Birch, Department Chair and Professor of Health Science; Dr. Angelia Paschal, Associate Professor of Health Science

What is this study about? What will I be asked to do in this study?

The purpose of this study is to understand how cultural factors and stress impact mood and coping behaviors of Black women in college. The study consists of two phases. The first is a web survey that takes approximately 15 minutes to complete. The second phase is an interview with selected participants from phase 1.

Only students who identify as Black or African American and female are eligible for participation. Students may participate in the first phase without participating in the second phase. **You are being asked to complete a survey online.** If you agree to be in this study, you will be asked to respond to questions on stress, culture, and behaviors. You will also be asked to complete a brief survey that will request information about your gender, race, income, age, major, and other personal factors.

If you are selected, and agree, to participate in Phase 2, you will be asked to participate in an individual interview. **You do not have to participate in the interview in order to complete the survey. An audio recorder will be used during the interview.** Following the interview, there may be an opportunity to attend a focus group. If you are invited to a focus group, you may agree or decline.

Why is this study important or useful?

This information will help us learn about stress specific to Black college women and how it is managed. This information may help inform programming on college campuses to help college students remain happy, healthy, and successful during college.

Why have I been asked to be in this study?

You have been asked to be in this study because you may identify as a Black or African American woman and you are enrolled as a student at the University of Alabama.

How many people will be in this study?

About 200 people will participate in the first phase (survey). About 12 of the 200 people will participate in the second phase (interview).

How much time will I spend being in this study?

The first phase will take approximately 15 - 20 minutes. If you are selected, and agree, to take part in the second phase, it will take approximately 60 to 90 minutes.

Will being in this study cost me anything?

The only cost to you for participation in this study is the time it will take to complete the survey.

UNIVERSITY OF ALABAMA IRB
CONSENT FORM APPROVED: 10-11-17
EXPIRATION DATE: 8-17-17

Will I be compensated for being in this study?

You will not be compensated for being in this study. However, if you are able to correctly complete a task after you have finished the survey (Phase 1), you will be entered into a drawing to receive a \$25 Amazon gift card. If you participate in Phase 2, the interview, you may be compensated \$10 in cash.

Can the investigator take me out of this study?

Since Phase 1 is an online survey and participants will be completing the survey away from the classroom setting, the investigators will not know if the survey is upsetting you; however, you can choose to stop participating in the survey at any time without penalty. You may close the survey app if you wish to be taken out of this study.

You may stop participating in Phase 2, the interview, at any time by notifying me during the interview. You may also contact me after the interview and ask that your data not be included in the analysis. I will let you know when the analysis will be complete (approximately in January 2017).

What are the risks (dangers or harms) to me if I am in this study?

Minimal or no risk is foreseen by your participation in this study. Based on individual experiences or responses to the survey or interview, you may feel minor discomfort thinking about stressful experiences. If you are not comfortable answering a question contained within the survey or interview, you are free to skip the question. If you become uncomfortable and feel that you cannot continue, please feel free to stop participating in the survey or interview at any time. If further assistance with these problems is needed, you can contact the **Women and Gender Resource Center at (205) 348-5040** or the **Counseling Center at (205) 348-3863**.

What are the benefits (good things) that may happen if I am in this study?

There are no direct benefits from participating in this study.

What are the benefits to science or society?

Society may benefit from a greater understanding of the stressful conditions that impact and may be specific to Black college women.

How will my privacy be protected?

If you choose to participate, you will be asked to take an online survey in a setting of your choice. Participation in Phase 1 is anonymous, which means your name will not be recorded. Some participants will be eligible to participate in Phase 2, an interview. Participation in Phase 2 is voluntary, but if you agree to be contacted later about the study or you agree to participate in Phase 2, you will be asked to provide your name and email address. The interview will be recorded but you may use a pseudonym to protect your identity on the audio recording. All other responses will be reported anonymously and in combination with other participants.

Also, to participate in the raffle during Phase 1, you must provide your name and email address. Contact information for the raffle will be stored separately from your survey responses.

How will my confidentiality be protected?

There will be no consent forms to sign so your survey responses can remain anonymous. Instead, if you choose to participate, you will click a box at the bottom of this page that indicates your willingness to participate in Phase 2. The surveys will be stored on a flash drive kept in a locked filing cabinet in a UA campus office belonging to the principal investigator. The investigators of the study will be the only people that have access to this room and the locked cabinet. At the end of the study, you will be asked if I may contact you regarding the study. You will also be asked if you are interested in participating in the second phase of the study. If you agree, you will have to provide contact information. Your name and email address will be associated with your responses. However, this information is only needed to determine eligibility for those who agree to participate in phase 2. All contact information will be stored safely on a computer under password protection accessible only to the principal investigator. After Phase 2 is completed, all identifiable information will be destroyed.

What are the alternatives to being in this study? Do I have other choices?

Participation in this study is voluntary. There are no alternatives to this study but you do have the choice not to participate in this study.

What are my rights as a participant in this study?

Taking part in this study is voluntary. It is your free choice to participate. You can refuse to be in the study. Furthermore, if you start the study, you can skip any questions you feel uncomfortable answering or stop at any time. Whether or not you choose to participate in this study will have no effect on your grade in the current course or with your relations with your instructor, student organization or the University of Alabama. The University of Alabama Institutional Review Board (“the IRB”) is the committee that protects the rights of people in research studies. The IRB may review study records from time to time to be sure that those involved in research studies are being treated fairly and that the study is being executed as planned.

Who do I call if I have questions or problems?

If you have questions about the study right now, please ask them. If you have questions, concerns, or complaints about the study later on, please contact **Wanda Burton at 205-348-2486 or Dr. Paschal or Dr. Birch at 205-348-9087**. If you have questions, concerns, or complaints about your rights as a person in this research study, call Ms. Tanta Myles, the Research Compliance Officer of the University, at 205-348- 8461 or toll-free at 1-877-820-3066. You may also ask questions, make suggestions, or file complaints and concerns through the IRB Outreach website at http://osp.ua.edu/site/PRCO_Welcome.html or email us at participantoutreach@bama.ua.edu.

After you participate, you are encouraged to complete the survey for research participants that is online at the outreach website or you may ask the investigator for a copy of it and mail it to the UA Office for Research Compliance, Box 870127, 358 Rose Administration Building, Tuscaloosa, AL 35487-0127.

How do I agree to participate?

UNIVERSITY OF ALABAMA IRB
 CONSENT FORM APPROVED: 10-11-17
 EXPIRATION DATE: 8-17-17