AN ONLINE INVESTIGATION WITH DIVERSE ASIANS LIVING IN THE UNITED STATES DURING THE COVID-19 PANDEMIC ON EXPERIENCES OF HATE, HATE CRIMES, AND MICROAGGRESSIONS: IDENTIFYING PREDICTORS OF MICROAGGRESSIONS

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ABSTRACT

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The study explored experiences of hate, hate crimes and microaggressions among diverse Asian adults living in the United States during the COVID-19 pandemic for a sample (N = 831) that was 26.7% Chinese, 13.6% Japanese, 13.4% Korean, 12.4% Taiwanese, 10.6% Filipino, 10.3% Indian, 8.5% Thai, 54.9% female, and 86.8% U.S. born, with a mean age of 33. Findings showed participants had: better overall physical health before COVID-19 pandemic versus currently; mental/emotional health declined from before the pandemic to currently; moderate social support; closest to moderate past-year mental distress; closest to “more than once” for experiences of microaggressions; a high level of ability for perceiving racism and oppression; and were in the action stage for coping and responding to racism and oppression. Also, 79% (N = 831) personally experienced hate once to a great number of times, and 43.5% (N = 362) endorsed moderate to very high impact; 79.2% (N = 664) witnessed HATE against someone else once to a great number of times, and, 44.5% (N = 370) endorsed moderate to very high impact. Those who received counseling in the past experienced more microaggressions than those who did not seek counseling. The higher the frequency of experiencing of microaggressions then higher the age, darker the skin color, lower the self-rating of mental health pre-COVID-19, lower the self-rating of physical health pre-COVID-19, lower the self-rating of mental health during COVID-19, higher the past year depression, anxiety and trauma and overall mental distress, greater the
feeling of being unable to control important things in life, higher the ability to perceive racism and oppression, higher the stage of change for coping and responding to racism and oppression, greater the impact of hate, and lower the social desirability. Backward stepwise regression showed significant predictors of a higher frequency of experiences of microaggressions were being born in the U.S, not being a student, past year counseling, older age, lower education, higher overall mental distress, and higher ability to perceive racism and oppression— with 77.4% of variance explained by the model. Implications of findings and recommendations are provided for addressing anti-Asian hate.
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VS
Chapter I

INTRODUCTION

Racism has been occurring in tandem with the global coronavirus disease (COVID-19) pandemic, including anti-Asian racism (Lim et al, 2023; Han et al, 2023; Lantz & Wenger, 2023; Ho, 2021). The Stop Asian American and Pacific Islander Hate project reported over 1,497 reports of anti-Asian harassment that were related to COVID-19 from March 19 to April 23, 2020 (Arora & Kim, 2020). Asian Americans reported being verbally abused, denied service, being coughed and spat on, along with being glared at (Arora & Kim, 2020). Early in the pandemic, the Federal Bureau of Investigation (FBI) released a statement warning of “rampant anti-Asian hate crimes due to the growing association” that the public had linked between the spread of COVID-19, Asian Americans and China (Arora & Kim, 2020, p.388).

Given the enormous effect of elite rhetoric on public opinions and behaviors, it is probable that the rampant anti-Asian sentiment is partially a “byproduct of the anti-Asian rhetoric” from Former President Donald Trump “and others” (Arora & Kim, 2020 p.388). “Racial inflammatory comments” made by the President can have a profound effect on his supporters (p.388). The vast majority of racism and discrimination arising from the public health crisis have been geared directly at the Asian American community and the surge of anti-Asian bigotry and violence have soared in the United States (Arora & Kim, 2020).

During the COVID-19 pandemic, there were also in the United States (U.S.) national protests in response to anti-Black racism, as well as global protests (Ho, 2021). All of this constituted “fighting against white supremacy” (p.149). Although racism and White supremacy
are not exactly the same, they “act in mutually beneficial ways” for the White population (p.151). The pervasiveness of “white normativity, white privilege and white supremacy” has meant that any threats—whether real or imagined—to the body of politics of the U.S. (which remains overwhelmingly White) were dealt with forcefully and without apparent forethought (p.152). Anytime there is a threat to America from an Asian country or nation, people in the U.S. have directed their fear and anxiety against “any subjects associated with the Asian-enemy,” whether they are from that country or not (p.152). The racism that Asian Americans in the U.S. and Asians from around the world are experiencing right now, during the ongoing COVID-19 pandemic, is acute and real in ways that have not felt this acute and real for decades (Ho, 2021).

COVID-19 is a global pandemic in which the burden of mortality and morbidity has fallen disproportionately on minority populations (Wang et. al, 2020). Asian American and Pacific Islanders have a higher susceptibility for COVID-19 transmission due to their over-representation within the essential workforce; and, due to cultural factors such as “intergenerational residency and other social determinants of health” including poverty and lack of health insurance (p.3685). Along with facing higher risk for COVID-19 transmission, Asian American and Pacific Islanders (AAPIs) have also experienced “rising xenophobia and racism across the country,” which only serves to aggravate the rampant emerging disparities that exist within this community (p.3685). AAPIs have had a lengthy history of being “scapegoated and marginalized” during public health crises in United States history (Wang et. al, 2020, p.3687). Around the United States, many reports of racially motivated violence targeting AAPIs have not only surfaced, but have also risen both in severity and frequency—ranging from racist tirades, rants, to brutal stabbings and assaults (Wang et. al, 2020).

Incidents of racism and xenophobia have occurred globally, including toward people of
East Asian descent and appearance during the COVID-19 pandemic (Abidin & Zeng, 2020). Since the outbreak occurred in early 2020, “disheartening incidents from people of East Asian appearance” have been reported worldwide (p.2). Subtle Asian Traits (SAT) is a Facebook group that has become a congregational node for the Asian diaspora community. This exemplifies how the ongoing health crisis has “shaped what it means and feels to be Asian” (p.1). Members of SAT reflected their experiences as East Asian diaspora members and shared observations of “meaning-making, identity-making and community-making,” as East Asians who were collectively coping with COVID-19 aggression between January and May 2020 (p.1). Amid the pandemic of #COVIDRacism, Subtle Asian Traits (SAT) has become an arena for members to share grievances and seek support within the East Asian diaspora community. In the fight against COVID-19 racism, social media served as the “key arena where Asians can speak out about encounters” and launch different counter campaigns (p.2). In response to their shared struggles, it was observed that SAT members, together, as a group coped with the rising prejudice against Asians through “Catharsis, Escalation and Problem solving” (p.2). SAT, as a Facebook group, provided its members a sense of companionship during the COVID-19 pandemic and the “impressions of normalcy, fun and the semblance of unity” were demonstrated through laughter, together, despite the looming crisis that occurred offline and that was outside of their control (Abidin & Zeng, 2020).

According to Takasaki (2020), government policies and media representations fueled xenophobia, which ultimately led to attacks against Asian communities. Asian Americans of all communities including in the Southeast and East Asians faced “shunning, harassment, and assaults” (p.345). This equated to 12 percent of all hate crime incidents in the U.S. Asian American women were harassed 2.3 times more than Asian American men. Both Asians and
Asian Americans said that they were “afraid both to wear masks and not to wear masks” in public because of being racially profiled (p.347). The success of Stop Asian American Pacific Island Hate emerged during the pandemic, as it served as a clearinghouse for reports about pandemic-related anti-Asian racism. This has resulted in the expansion of the center’s reliance on “people power and national networks of Asian American studies scholars” (p.349). Although the multiple impacts of Stop AAPI Hate are not fully known, its success serves as a reminder of what can happen when community organizations join forces with academic institutions and when Asian American studies scholars come together and work with one another (Takasaki 2020).

In this manner, alongside the rapid spread of COVID-19, there has been a significant increase in xenophobia and discriminatory acts against Asian Americans (Le et. al, 2020). Although the rise of racism has been alarming, the “association between disease, racism and Asian Americans” is not new in the history of the United States (p. 1371). The contemporary acts of xenophobia carried out against Asian Americans are very concerning due to racism, which is a well-known social determinant of health that can amplify health disparities already present in the Asian American community. Those Asian Americans most adversely affected during the COVID-19 pandemic included the undocumented, elderly, low-income, limited English proficient Asian Americans, along with those who were afraid to “seek care because of anti-Asian xenophobia” (p.1371). It is vital to “understand the unique cultural and language considerations” for Asian Americans. The ongoing COVID-19 pandemic has intensified anti-Asian xenophobia and health disparities for Asian Americans—in particular, the medically underserved (Le et. al., 2020).

The COVID-19 pandemic has contributed to a rise in “stigma, discrimination and even hate crimes” that targeted distinct populations in the Chinese-language speaking world (Xu et. al,
When the number of COVID-19 cases outside of China exceeded and surpassed mainland China, stigmatization was immediately placed upon Africans in China. In this study, researchers examined how different factors such as political ideologies, wearing masks, food, racism, and other factors affected the “stigmatization of different victim” groups (p.1). Drawing from existing literature, several factors have been classified as “shaping the bestowing of stigma” amongst patients and the surrounding community where the infectious diseases began (p.13). “Rooted racism” was a main factor which led to hate incidents and crimes committed against overseas Asians—and also a factor in the stigma confronted by Africans in China (p.18). What emerged from the study was how “sociopolitical factors” can affect the output of hate crimes (p.1). This study found that alongside the spread of COVID-19, many mainland Chinese, Africans in China, and overseas Chinese and other Asians had become “targets of stigma, discrimination and even hate crimes” (Xu et. al, 2021, p. 20).

According to Ren and Feagin (2021), for several decades in the United States, there have been thousands of hate crimes directed annually at Americans of color. A 2018 Federal Bureau of Investigation (FBI) report indicated that the number of hate crimes reported was 7,120. The most substantial hate crimes—which included crimes that targeted Asian Americans—were reported to private organizations such as Stop Asian American and Pacific Islander Hate; they received 1,900 hate crime reports of “coronavirus-related discrimination against Asian Americans” between March 19 to May 15, 2020 (p. 748). There was a total of 82 reports of anti-Asian incidents that involved discriminatory actions, which arose from Asians not wearing or wearing face masks. The data revealed that the perpetrators’ racial characteristics for the 82 incidents involved “white perpetrators at 61 percent and black perpetrators at 39 percent” (p.749). Asian Americans interviewed by media expressed great fear that “wearing protective
face masks publicly marked them as diseased;” and, an analysis revealed that people of color utilized anti-Asian stereotypes against Asian Americans that were originally crafted by Whites in the nineteenth century (Ren & Feagin, 2021, p.749).

As the COVID-19 pandemic escalated across the United States, Asian Americans reported a drastic surge in racially motivated hate crimes which entailed harassment and physical violence (Gover et al., 2020). Asian Americans have experienced both physical and verbal violence motivated by “individual level racism and xenophobia” from the time that they started arriving in America in the late 1700s until the present day (p.1). The COVID-19 pandemic has has included the spread of racism and generated national insecurity, general xenophobia, and a fear of foreigners; and, all of this has played a pivotal role in the surging rise of Asian American hate crimes during the pandemic. Hate Crime Data spanning a 16-year period from 2003 to 2018 provided annual counts of racially motivated hate crimes. The results indicated that, for the most recent 5-year period from 2014-2018, there was an average of 7,690 single biased hate crime victims and 59.6% (n=4,581) were targeted due to racial/ethnic and ancestral bias—of which 3.8% involved anti-Asian bias (p.10). Racially dominant along with well-established groups in America have historically held social power; and, have resented the arrival of lesser influential groups, such as Asian Americans. Due to xenophobic resentment that overlaps with racism, the “othering of Asian Americans” has been “historically repetitive,” given bigoted exclusionary practices and violence (Gover et al, 2020, p.15).

According to federal law enforcement data, the number of hate crimes against Asian Americans had been decreasing for 15 years (Edara, 2020). But, with the onset of the COVID-19 pandemic, a warning was issued by law enforcement that “hate crimes against Asian Americans would increase” (Edara, 2020, p. 19).
According to Gao and Liu (2020), discrimination based on race towards Chinese and many others with an Asian ethnicity has “risen sharply in number and severity” on a worldwide scale during the COVID-19 pandemic (p.1). This dramatic rise in racial discrimination in the United States against Asians has been “fueled by xenophobic political rhetoric and racist language” that run rampant on social media (p.1). Anti-Asian hate crimes rose at a staggering rate with a total of 2,583 reported from March to August 2020 across the U.S.; and, this included 40 percent of reports coming from Chinese Americans. Despite the staggering number of reported cases, numerous victims choose not to report their cases for fear of retaliation or due to emotional trauma that they experienced from the hate crime incidents. Forms of racial discrimination reported were verbal harassment, name calling, physical assaults, being spat or coughed upon, being barred from establishments, vandalism and online discrimination (Gao & Liu, 2020).

**History of Asian Hate Crimes in the United States**

Even before the COVID-19 pandemic, there was a focus on hate crimes in the United States. Perry (2002) emphasized that as with any human activity, hate crimes derived their impact and meaning through a broader array of institutional as well as social patterns. Interethnic violence that occurs between subordinate groups tends to transform, as fields of possibilities for “transcending class and race discrimination” (p.73). The dynamics of violent interactions “differ substantially from White on non-White violence” (p.73). Violence is deemed the “physical expression of the endemic racism” that permeates race relations in the United States (p.78). The practice of racism encompasses “exclusion, marginalization, subordination and not least of all, violence” (p.78). Stereotypes that are associated with identifying features of racial minorities suggested “inferiority, irresponsibility, immorality” as a “rationale for injurious verbal and
physical assaults” (p.80). Regardless of their uneven performances and diversity in the United States, Asians are “inscribed with the mantle of prosperity” irrespective of their foreignness (p.88). However, because Asians are not seen as Americans, they pose a risk that they will become viable or superior competitors to their White counterparts (Perry 2002).

According to Cheng et al. (2013), based on Federal Bureau of Investigation (FBI) data collected from 1996 to 2008, findings indicated that the categories pertaining to “anti-race, antireligion, and anti-sexual orientation” represented the three most frequent types of hate crimes committed (p.764). Threats to a group’s resources, values, ideologies, images and existence are more likely to “lead to increased prejudice and discrimination toward relevant out-groups” (p.763). As per Terror Management Theory (TMT), the “dislike and hatred of out-group members” is deeply rooted in basic fears about death that humans possess (p.763). By examining the phenomenon of hate crimes committed in the United States, the FBI data derived from 1996-2008 revealed that the “incidence of anti-racial hate crimes varied among different racial groups” (p.761). Cheng et al. (2013) concluded that potential solutions to hate crimes could be established by focusing on the predictive factors that emerge as most relevant.

Since the mid-1990s, there had been a noticeable rise in hate crimes and racial attacks against Asian Americans (Lee et. al, 2007). Anti-American incidents of hate crimes and racial attacks included the use of “racial slurs, property defacement, beatings,” as well as robberies and even murders (p. 277). The connection between negative stereotypes towards Asian Americans and hate crimes committed against them is this: negative stereotypes “may lead to bias or prejudice” which can cause violence or discriminative behavior towards innocent group members (p.277). Racial violence was a “common occurrence for early Chinese immigrants” in the United States” (p.278). Asian Americans who are seen as submissive are more culturally
prone to be “physically passive, politically docile,” as well as accommodating (p.278). Negative stereotypes of Asian Americans could serve as a “catalyst to violence” when dominate group members become hostile against Asian Americans (p. 278-279). To combat rising hate crimes, various Asian American groups and organizations have advocated for strengthening hate crime laws to “better protect Asian-Americans from biased-related crimes” (Lee et. al, 2007, p. 288).

**Historical Negative Myths and Stereotypes Against Asians**

Asian Americans have been frequently viewed as a “model minority who have made it in society” and thus, experience little to no form of racism (Sue et. al., 2007, p.72). Various forms of “othering practices, deep-seated stereotypes of Asians” and the roles of media and politicians have either contributed or exacerbated anti-Asian hate (Li & Nicholson, 2020).

For example, others have discussed the “model minority” myth, as well as the “yellow peril” and “forever foreigners” stereotypes, and the negative impacts on Asians in the U.S. (Li & Nicholson, 2020). Such stigmatizing negative stereotypes are in contrast to a significant body of scholarship that has claimed that some Asian groups are assimilating into mainstream American and are becoming more White, numerous studies have suggested that Asian Americans are still viewed as “forever foreigners” (Li & Nicholson, 2020, p. 3). The “racialization of Asians” has been heavily influenced through an extensive Western tradition known as “Orientalism;” this concept was constructed by the Western world, allowing the West to deem itself the more superior civilization, as opposed to the inferior Orientals who were seen as a threat to the welfare of Westerns (p.3). Asian Americans are often stereotyped as the model minority or the “yellow peril,” because they are not considered to be what is deemed “American” (p.3). The model
minority myth has contributed to the marginalization and racialization of Asian ethnics and played a pivotal role in dividing minority groups by “pitting Asians and other minorities against each other” (p. 4). This has led to disregarding the structural and ongoing disadvantages that other minority communities have encountered (Li & Nicholson, 2020, p.4).

Since the outbreak of COVID-19, there has been an increase in displays and acts of racism, xenophobia and discrimination; and, in particular, “Sinophobia, a sentiment against China, its people, culture and traditions” (Edara. 2020, p.13). The COVID-19 virus was termed “Wuhan virus” or “Chinese virus” which were closely associated with Chinese communities; and, therefore, led to the process of racialization which included racism, xenophobia and Sinophobia (Edara, 2020, p.13). According to Tsai et. al (2020), negative racial stereotypes along with the prevailing rhetoric blaming China for the COVID-19 pandemic have played critical roles in activating and promoting prejudice against Asians.

Racial Trauma Directly or Indirectly Experienced Via Varied Media—Or, Vicariously

As a deeply rooted feature of human societies, racism has been present and even more rampant during the COVID-19 pandemic (Edara, 2020). Psychologists have viewed racism as an “individual or collective psychological defensive mechanism” that is typically generated due to feelings of insecurities, anxiety and fear in the face of internal or external threat whether imminent or presumed (Edara, 2020, p. 13).

Given the higher rates of COVID-19 infections, as well as mortality, for Indigenous and Black people, in particular, there has been a focus on systemic racism (Miu & Moore, 2020). The pandemic has brought to light racial disparities. Black, Indigenous and People of Color (BIPOC)—which includes Asians—have had their communities disproportionately negatively
impacted by the pandemic. This includes facing “systemic inequalities due to lack of healthcare access,” such as a lack of testing site availability, a lack of staff with linguistic and cultural competencies, and a lack of well-resourced hospitals in BIPOC communities (p.1). When former President Donald Trump referred to COVID-19 as the “Chinese virus,” this stigmatized Asian Americans as proliferating and spreading COVID-19 (p.1). Varied BIPOC professionals have also encountered racism and threats, which demonstrates that they are equally as vulnerable to racism as members of communities of color, given racism. Despite BIPOC professionals being familiar with self-care and coping strategies, they are still highly susceptible to racial trauma. This racial trauma comprises humiliation, threats of harm, actual injury, or witnessing the destruction done to others in the community. Miu and Moore (2020) emphasized that professionals of color are “exposed to all forms of race-based stress,” which can range from their patients’ experience of discrimination, direct experiences of racism stemming from society, and indirect exposure from news media reports of personal accounts of racial trauma (p. 2).

During the COVID-19 pandemic, as cases rose all throughout the United States and around the world, elite conservatives in America “racialized the pandemic” and often referred to the coronavirus as the “Wuhan Virus” or “Chinese Flu” (Reny & Barreto, 2020, p. 2). While this pandemic served as a threat to the economy and public health, prominent Republicans such as President Trump “added fuel to the fire by demonizing Chinese” and many other Asian Americans through his repeated verbal references to COVID-19 as the “Wuhan virus,” “Chinese virus” or “Kung Flu” (p.2). The demonization of foreigners as a threat and danger was a part of a larger political strategy carried out by some prominent Republican leaders. This “elite rhetoric” in the early stages of the COVID-19 pandemic was suspected to have caused negative attitudes towards Asian Americans and perpetuated a newfound worry over the coronavirus, which in turn
manifested in xenophobic as well as racially charged sentiments (p.2). A racialized behavior that linked the spread of the COVID-19 to Asians consisted of avoiding certain spaces and areas “associated with Asian Americans” such as Chinese restaurants (p.13). This research study found evidence that Anti-Asian attitudes were connected with worries about the disease, xenophobic behaviors along with policy preferences (Reny & Barreto, 2020).

In their study (Tsai et. al, 2020), two psychological mechanisms underlying the activation of prejudice against Asians and Asian Americans were examined in the United States during the COVID-19 pandemic. The findings indicated that relying on “traditional news media was positively related to prejudice” towards Asians which supported the television news’ ability to reinforce widespread racial stereotypes (p.10). Study participants were more likely to hold “unfavorable attitudes towards negatively portrayed groups” on television because of repeated exposure to various politicized messages (p.10). Furthermore, there was a “positive link between social media trust and prejudice” (p.11). Further, social media along with well-known news brands consumed by Americans have more “complex relationships with their disease-ignited prejudice towards minority groups” than what was previously assumed (Tsai et. al, 2020, p. 11).

Increased stigmatization and blame on Asians for the spread of COVID-19 brought upon by media and government officials have increased incidents of racism, discrimination and violence against Asians who particularly reside within the United States (Croucher et. al, 2020). Asian Americans have reported suffering physical violence, extreme physical distancing, racial slurs, workplace termination, being spat on, etc. as Anti-Asian sentiments increased during the pandemic. Due to links with social media, Anti-Asian hate crimes are increasingly transparent with reports of anti-Asian sentiment spreading and Asian Americans “fighting hate via social media” (p. 1). The more a social media user believes that the social media platform they use is
accurate or factual, the more the user will likely believe that Chinese “pose a realistic and symbolic threat to America” (p.1). Furthermore, Americans tend to appropriate the opinions of their tribal elites such as political leaders and celebrities whose “opinions once shared via social media are deemed facts” (p.10). The findings from this study provide further evidence that social media use “reinforces the elements of intergroup threat which could lead to prejudice” (Croucher et. al, 2020, p. 9).

When the COVID-19 pandemic was spreading at an alarming rate in the United States, at the same time, “hate crimes against Asian Americans have been surging” (Zhang et al., 2021, p. 2). Although Asian Americans are a small minority group, they are in fact “one of the fastest growing racial/ethnic groups in the United States (p.2). The purpose of this study conducted was to explore and delve into the characteristics along with the nature of hate crimes that have been committed against Asian Americans and drawing comparisons of them with hate crimes committed against Hispanics and African Americans. When comparing hate crimes that were committed against Asian Americans and African Americans, the results showed no significant differences regarding the victims’ characteristics for the hate crimes committed towards Asian Americans and African Americans (p.12). Furthermore, the findings suggested that “the correlates of hate crime against minorities” may be influenced by the characteristics of target minorities (p.6). It is important to acknowledge that Asian Americans have many different ethnic backgrounds and distinctive social as well as historical experiences in America (Zhang et al., 2021).

Others emphasized the negative impact of tweets during the pandemic that conveyed cultural racism (Nguyen et al., 2020). Racism can have profound economic, social and health effects, but there has been minimal systematic investigation on the rise in anti-Asian prejudice.
Anecdotal reports have also substantiated an increase in anti-Asian racial attitudes and discrimination with regards to COVID-19. Cultural racism is conveyed through stereotyping, media and the norms within our society and its various institutions. To this end, “cultural racism is systemic” and creates an environment where discrimination can thrive both at the institutional and individual level (p.2). Important aspects of cultural racism include “prejudicial attitudes and speech” (p.2). The findings from this research study indicated that many tweets argued that racism was “exacerbating the negative effects of the pandemic” (p.8). Furthermore, the findings drawn from this study align with reports from the FBI, newspapers and other commentaries documenting the “rise in anti-Asian hate crimes” during this same period (p.9). This study is crucial because it provides empirical evidence that supports the notion that there may be “effects of COVID-19 on a special group” such as Asian Americans, while not seeming to affect other racial groups, such as African Americans (p.10). A noteworthy finding indicated that placing blame on the Chinese government or Chinese people was the “primary justification for racist rhetoric” that encompassed prejudicial languages and attacks on Chinese people (p.8). Nguyen et al. (2020) further suggested that “awareness of negative racial attitudes” may have policy implications that are crucial for the health and well-being of marginalized and stigmatized racial groups in the United States (p.10).

Museus and Park (2015) focused on the experience and impact of vicarious racism. A study which analyzed how racism shaped the daily experiences of Asian American college students found that racial hostility experienced by participants included instances of “racial bullying, racial slurs and racial profiling” (p. 557). The students also recalled experiencing acts of “racial hostility in their interactions” with both peers and police on campus (p.557). The findings from this study served to provide one of the first systemic empirical examinations of the
various ways that “racism shapes the experiences of Asian Americans college students” (p.565). Furthermore, the findings suggest that “vicarious racism can have a significant influence” on Asian American college students’ feelings of safety along with their level of comfort on their respective campuses (Museus & Park, 2015).

**Anti-Asian Discrimination and Microaggressions**

Regarding discrimination, according to Dhanani and Franz (2020), COVID-19 has activated bias towards Asians and individuals of East Asian descent. In America, Americans of Asian descent have reported “growing fear of being in public” due to the harassment they have encountered in response to COVID-19 (p.748). People of Asian descent have felt a “double burden” because they must fear for their health while simultaneously also enduring any racial backlash and discrimination (p.748). The findings from this research study indicated that negative attitudes associated with Asian people in response to COVID-19 were common among the participants; and, this finding aligned with the “growing number of discrimination and harassment allegations” that were brought forth during the pandemic (p.753). Furthermore, findings from this study demonstrated that “stigmatized groups may be uniquely vulnerable” both due to physical threats and detrimental effects of discrimination on mental health (p.753). The COVID-19 pandemic has had significant impacts that have “permeated physical, economic, mental and social well-being” (Dhanani & Franz, 2020, p.753).

Nguyen (2021) also reported on an analysis of Twitter data as evidence of racial discrimination that was linked to hate crimes. Noted was the existence of racism, which spans numerous levels ranging from individual to institutional levels; and, which represents normative beliefs, stereotypes and attitudes in relation to minority groups and discriminatory treatment leads to unequal access to resources and opportunities. Racial identity along with aspects of an
individual’s personality, traits, and coping mechanisms are factors that influence racial discrimination. Cultural racism is demonstrated through various media outlets, norms that exist within a society, alongside various stereotypes and the institutions that are connected to them. In this study, racial sentiments were acquired from data retrieved through Twitter as researchers aimed to evaluate the distinctive associations among state-level hate crimes and any ongoing levels of racial prejudice that were present at the individual level by using an analysis of a data set that was retrieved from Twitter. The findings of this study revealed that “area-level negative racial sentiment” was associated with hate crimes that were specifically geared towards ethnic and racial minorities (Nguyen et al., 2021, p.5).

A dramatic rise in discrimination against Asians has occurred not only in the U.S., but also worldwide during the COVID-19 pandemic—creating a form of socially mediated “secondary contagion” (Chen et al, 2020, p.1624). The cumulative increase in incidents of hate crimes against Asian Americans, as reported by the FBI (Federal Bureau of Investigation) along with media coverage has the potential to “exert significant negative health effects” (p.1624). Current attacks against Asian Americans have occurred in the context of “historically entrenched attitudes regarding race and social structures” that reinforce racially based disparities rooted in power (p.1624). The experience of racial discrimination felt by Asian Americans has been “associated with worsened psychological and physical health outcomes” (p.1625). Direct racist encounters can “inflict emotional trauma on minorities” and trigger a post-traumatic stress response (p.1626). Specifically, for Asian Americans, discrimination is a consistent predictor of heightened mental health problems along with diminished well-being (Chen et. al, 2020).
Asian Americans in the United States experience discrimination across many institutional settings including health care and housing (McMurtry et al., 2019). Experiences of discrimination, whether through interpersonal interactions or institutional barriers, have negative impacts on health by “operating as an outgoing stressor,” which causes progressive wear and tear on the body and eventually worsen health outcomes (p.1420). The findings from this research study indicated that Asians in the United States experience discrimination across numerous areas of life, but in particular, in the “interpersonal interactions and institutional domains,” such as housing and health care (p.1426). Furthermore, the findings demonstrated that Asians may face “more discrimination than others” (p.1426). Asian Americans also have significantly higher odds compared to Whites of “avoiding the doctor due to fear of racial discrimination” (p.1426). This study concluded that more than one in seven Asian adults reported having experienced discrimination in clinical encounters; and, this adds to a growing body of studies that document patients’ perception of unfair treatment in health care (McMurtry et al, 2019).

The discrimination faced by Asians in the U.S. has been discussed from the perspective of microaggressions (Sue et al, 2007). Sue et. al, (2007) defined microaggressions as “everyday exchanges that send denigrating messages” to people of color simply because they belong to a particular racial minority group (p.72). Despite the long history of racism against Asian Americans, there has been minimal attention given to the prejudice and discrimination directed toward this group, resulting in the psychological needs of Asians Americans being overshadowed by the experiences of other racial groups, such as Whites and Blacks. A study, which examined the dynamics of racial microaggressions experienced by Asian Americans, provided strong support that “microaggressions are not minimally harmful and possess detrimental consequences” for the recipients (p.77). Most participants revealed lasting negative
reactions to the constant microaggressions that they endured from friends, teachers, neighbors, and colleagues. Findings also suggested that microaggressions often play a role in denying the racial reality of Asian Americans and serve to strongly perpetuate the “model minority” myth (Sue et. al, 2007, p.78).

The incidence of microaggressions against Asian Americans during the COVID-19 pandemic increased, as did evidence of anti-Asian racism and xenophobia in the U.S.—as well as globally (Kim & Shah, 2020). Although anti-Asian sentiments are not new occurrences during COVID-19, the perceptions about people of Asian descent as “foreign threats have become more visible” due to the pandemic (p.604). For people of Asian-descent, and, in particular, for Asian Americans, the imagery of threatening foreigners who look different, who share “strange” cultures, who look “dirty” or “carry diseases” has existed throughout the history of the United States (p.606). The current incidents of discrimination against Asian Americans reflect their being considered the “other who are different” in a threatening way or intriguing way, depending on the context (p.607). The Stop Asian American Pacific Island Hate reported receiving 750 cases of harassment, discrimination and racism in the span of 8 days between March 19 to March 27, 2020. COVID-19 is an equalizer and has the power to affect all people, but the impact of “racialization is not erased by the pandemic” (p.607). Verbal, taunting and name-calling were the most frequent and common forms of harassment identified, while there was evidence of intensifying forms of racial microaggressions that Asian Americans typically experienced in everyday lives (Kim & Shah, 2020).

During the COVID-19 pandemic, the incidence rates of experiences of negative bias along with microaggressions against Asian Americans have increased (Tessler et. al, 2020). This has elevated the risks of the Asian community experiencing hate crimes. Patterns of hate crimes,
microaggressions, and other negative responses against Asian individuals during the COVID-19 pandemic occurred because Asian Americans were seen as the “embodiment of China and potential carriers of COVID-19” (p. 637). This is irrespective of their ethnicity or generational status in America. The COVID-19 pandemic has revealed the “negative perceptions of Asian Americans that have long been prevalent” in American society (p.637). Hate crimes during the COVID-19 pandemic have increased the “anxiety of Asian Americans during already uncertain times” with many fearing for their physical safety when running everyday errands (p.642). Asian Americans are now very cautious about even “coughing while Asian” and deeply concerned about being targeted for hate crimes (p.642). As highlighted by hate crimes committed against them during the pandemic, Asian Americans continue to be viewed as “foreign and suspect” (p.643). This may be an additional burden on Asian Americans beyond anxiety, economic instability and the increase risk of illness that all Americans have encountered during the COVID-19 (Tessler et. al, 2020).

**Negative Mental Health Impacts on Asians**

As per Edara (2020), the psychological implications and mental impact of “racism instigated by the virus” has also been on the rise (p. 20). Common mental and psychological responses to the COVID-19 for Asian American communities included fear, helplessness, loneliness, depression, falling ill and dying, and becoming infected with COVID-19, as well as losing loved ones (Edara, 2020).

Depression and anxiety symptoms reported among Asian Americans have increased sevenfold during the COVID-19 outbreak compared to the year 2019 (Woo & Jun, 2021). Regarding relevant factors, there has been a “spike of anti-Asian American racial discrimination
and violent attacks” since the outbreak of COVID-19 (p.1). As of May 2020, the Asian Pacific Policy and Planning Council received over 1,800 reports from Asian Americans of racial discrimination associated with COVID-19 across the United States. Stress research paradigm along with existing literature indicates that racial discrimination is a known chronic social stressor that “negatively impacts racial minorities’ mental health status” (p.1). Asian Americans carry an added mental burden of being “targets of misinformation surrounding the virus” (p.1). Furthermore, this study found that for those who shared their COVID-19 racial discrimination experiences in online forums and communities exhibited “stronger depressive symptoms” (p.6). Racial and ethnic minority users online may be more exposed to the increasingly “blatant online racism targeting Asians” during the COVID-19 pandemic; and, as a result, may encounter more disparaging comments as they share their stories and experiences of discrimination. This can lead to a more severe mental health burden (Woo & Jun, 2021, p.6).

**Statement of the Problem**

The problem that this study addresses is the rise in anti-Asian hate, hate crimes, discrimination, and microaggressions during the COVID-19 pandemic, and the potential negative health impacts upon diverse Asians living in the United States, including to mental health. According to the Pew Research Center (Budiman & Ruiz, 2021), there is tremendous diversity among the 22 million Asian Americans with roots in greater than 20 countries in both East and Southeast Asia, as well as the Indian subcontinent. Further, the Asian American population is projected to reach some 46 million by the year 2060—suggesting that Asian Americans are a diverse and growing population in the U.S.

The theoretical framework guiding the research includes the following: Pierce’s original
theory of racism (Pierce et al, 1977), including introduction of the concept of microaggressions; the elaboration of microaggressions as occurring against Asians (Sue et al, 2007); the biopsychosocial model of perceived racism by Clark, Anderson, Clark and Williams (1999) that has roots in the stress and coping work of Lazarus and Folkman (1984); and, the stages of change theory of Prochaska and DiClemente (1983). In Chapter II, Review of Literature, there will be a more in-depth review of the aforementioned theories that provide a framework for this research study.

**Purpose of the Study**

The purpose of the study is to identify the significant predictors of the study outcome variable of a high prevalence of experiences of microaggressions for diverse Asians living in the United States (U.S.), during the COVID-19 pandemic (i.e. 2020-2022). To predict the study outcome variable of a high prevalence of experiences of microaggressions for Asians living in the U.S. during the COVID-19 pandemic, backward stepwise regression analysis will be used, while controlling for social desirability.

**Research Questions, Survey Parts and Data Analysis Plan**

Given a sample of volunteers (N=831) who respond to a social media campaign inviting Asians to complete an online survey (“ALL diverse Asians Living in the US During the COVID-19 Pandemic Invited to Take a 10-15 Minute Online Survey at [https://tinyurl.com/HATE-Toward-Asians](https://tinyurl.com/HATE-Toward-Asians) for chance to enter in a raffle for 1 of 3 $100 Amazon gift cards”), this study will answer the following research questions:
1-What were their demographic characteristics (i.e. gender, age, race/ethnicity, skin color, birthplace (US born yes/no), annual household income, employment status, student status if applicable, etc.)?  
   **Part I: Basic Demographics (BD-9)**  
   *Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages*

2-What did they report as their personal health background (i.e. rating for overall physical health status, rating for overall mental/emotional health status, Body Mass Index)? And, was there a difference in health status when comparing before the pandemic and during the pandemic?  
   **Part II: Personal Health Background (PHB-CABP-9)**  
   *Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, percentages and Paired t-test*

3-Regarding the provision of socially desirable answers, to what extent was this a risk? **Part III: Single Item Rating of Risk of Providing Socially Desirable Responses (SIR-RPSDR-1)**  
   *Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages*  
   *NOTE: This is variable is controlled for in the regression analysis*

4-To what extent did they report experiencing social support?  
   **Part VI: Perceived Social Support Scale (PSSS-1)**  
   *Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages*

5-To what extent did they report experiencing depression, anxiety, and trauma in the past year, along with any receipt of counseling?  
   **Part V: Retrospective Depression, Anxiety, Trauma and Receipt of Counseling Scale (RDATS-4)**  
   *Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages*

6-To what extent did they report any past month experience of perceived stress?  
   **Part VI: Perceived Stress Scale (PSS-4)**  
   *Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages*

7-What did they report as their experience of microaggressions—as perceived in relation to their being Asian?  
   **Part VII: Ratings of Experiences of Microaggressions (REM-6)**  
   *Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages*  
   *NOTE: This is the study outcome variable*

8-What was their level of ability for perceiving racism and oppression?  
   **Part VIII: Perception of Racism and Oppression Scale (PROS-10)**
Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages

9-What was their stage of change (i.e. precontemplation, contemplation, preparation, action, or maintenance stage) with regard to coping and responding to racism and oppression?

Part IX: Coping and Responding to Racism and Oppression Staging Scale (CROSS-7), Data Analysis Plan: Descriptive statistics, including means, standard deviation, frequencies, and percentages

10-To what extent did they report experiences of hate (i.e. personally live/in-person or online; personally witnessed; or to someone close to them; or to someone in their neighborhood; or to a member of their racial/ethnic community; or watching a video)? And, to what degree did they report their experiences of hate as having an impact upon them that was stressful or traumatic?

Part X: Experiences of Hate (EOH-12)
Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages

11-Were there any significant relationships between selected independent variables and the study outcome variable of a higher prevalence of the experience of microaggressions in the United States?

Data Analysis Plan: Independent t-tests, Pearson Correlations

12-When controlling for social desirability, what were the significant predictors of the study outcome variable of a higher prevalence of the experience of microaggressions in the United States?

Data Analysis Plan: Backward Stepwise Regression Analysis
NOTE: Controlling for social desirability.

Anticipated Findings

When predicting the study outcome variable of a higher prevalence of experiences of microaggressions for Asians living in the U.S. during the COVID-19 pandemic (2020-2021), it is anticipated that when controlling for social desirability the following will be significant predictors: US born – no; lower annual household income; employed - yes; student – yes; lower rating of physical health status now; lower rating of physical health during pandemic years 20-21; lower rating of mental health status now; lower rating of mental health during pandemic years 20-21; lower level of social support; higher mental health distress (higher anxiety,
depression, trauma); higher past month perceived stress; higher ability to perceive racism and oppression; higher stage of change for coping and responding to racism and oppression; higher prevalence of experience of hate; higher rating of stressful and traumatic impact from experiences of hate.

**Delimitations**

This study is delimited to those who self-identify as Asian adults and lived (minimum of 6 months) in the U.S. during the years 2020 to 2021 of the COVID-19 pandemic. Further, it is delimited to those able to answer survey questions in English, and also have access to a computer and Internet, as well as access and complete the online survey.

**Limitations**

There are a number of study limitations that should be kept in mind. First, this is an online study that may present obstacles to participation for those who lack computer and Internet access. Second, those who lack English proficiency are not able to participate. Third, the study uses a sample of convenience obtained via a social media campaign, suggesting those who are not on social media (e.g. Facebook, Twitter, etc.) may not have access to the study opportunity.

**Conclusion**

This chapter introduced the topic of Anti-Asian hate with a specific focus on the experiences of hate, hate crimes and microaggressions among diverse Asians living in the United States during the COVID-19 pandemic. It also provided the purpose of the study, statement of
the problem, research questions, survey parts, data analysis plan, treatment of the data, and anticipated findings. Moreover, it also included the study’s delimitations and limitations.

Chapter II will provide a review of the literature that is relevant to the research study. Chapter III will provide a description of the methods and procedures that were utilized by this study. Chapter IV will provide the results of the data analysis. Lastly, Chapter V will provide a summary of the study including a discussion of the results, implications, recommendations for future research and a conclusion.
Chapter II

REVIEW OF THE LITERATURE

This chapter will provide a review of the literature on the following topics: 1). Prevalence of Asian Hate Crimes during the COVID-19 Pandemic; 2). Asian American health impacts from the COVID-19 era rise of hate and hate crimes; 3). Mental health impacts for Asian Americans exposed to hate and hate crimes; 4). Research covering the stress of racism, microaggressions, discrimination and protective factors (i.e. social support for Asian Americans during the pandemic; and 5). Summary of those theories providing a framework for the research study.

Prevalence of Asian Hate Crimes during the COVID-19 Pandemic

Although pandemics and epidemics were experienced throughout the start of the 21st Century, the COVID-19 pandemic was the first in which “a certain racial/ethnic group or nationality” was blamed for the pandemic (Lim et al., 2023, p. 3). Anti-Asian racism and violence all around the world are “not new but are on the surge” during the COVID-19 pandemic (p.4). The United States in particular, have been “spotlighted, and many innocent Asians have been ambushed” by other citizens (p. 4). The “increasing rates” of harassment, bullying and hate crimes against Asian Americans and Pacific Islanders have contributed to stigma and unfounded fears about AAPI persons (Lim et al., 2023, p4).

Han et al. (2023) elaborated on the Anti-Asian American hate crimes spike during the early stages of the COVID-19 pandemic, utilizing data from four cities in the United States that have large Asian American populations, and found that hate crimes against Asian Americans “increased considerably “in 2020 compared to 2019 (p.3513). Specifically, hate crimes against
Asian Americans temporarily soared after March 16, 2020 when labels such as “Kung Flu” or “Chinese Virus” were publicly used (p.3514). According to the Anti-Asian Hate Crime Report (2021), the number of hate crimes committed against Asians “increased by 145%” in the largest cities in America in 2020 when compared to 2019 (p.3517). Findings from this study based on descriptive statistics indicated three out of the four cities in the sample study experienced a “dramatic increase in hate crime against Asian Americans,” while the overall hate crime incidents have decreased during the period the study was conducted between 2019 and 2020 (p.3525-3526). Hate crime has a lengthy history, and significant events likely “triggered labels on a certain group of people” in society because of their different identities (Han et al., 2023, p3527).

Powers et al. (2023) focused on national news coverage (2010-2021) of specific anti-Asian hate crime incidents along with articles that discussed the “rise in hate crime against the Asian American” community (p. 32). The study further explored the extent of coverage, portrayals of perpetrators and victims, in addition to the stereotypes of Asian Americans; and how the incidents are “situated in a larger context of violence” against minorities (p.32). The purpose of this study was to examine the national news coverage of anti-Asian American hate crimes through content analysis (p.33). The findings from the study revealed that the situational motive for the “rise in anti-Asian sentiment and violence” was tied to COVID-19. Moreover, articles that explicitly recognized an incident as a hate crime were “less likely to do so for Asian American incidents” when compared to Hispanic incidents (Powers et al., 2023, p. 47).

According to Wong-Padoongpatt et al. (2022), racism against people who are of Asian descent “increased by over 300% after the COVID-19 pandemic” in the United States (p.1). Asian Americans reported “direct experiences with overt discrimination” (p.1). Two studies were conducted to track the distinct relationships between psychosocial factors, such as “experiencing
everyday racism,” along with the self-reported well-being of Asians Americans living in America; and, these associations were then compared to Latinx Americans (p.1). Findings from this study suggested that Asian Americans have “experienced and still are experiencing multi-faceted forms of racism” (p.13). Moreover, Asian Americans in this sample study reported “more experiences with the slow violence of racism” than compared with Latinx Americans (p.13). This study also revealed some of the “negative effects that racist and xenophobic words and acts” can have on Asian Americans—most of whom encountered more consistent distress and fear during the COVID-19 pandemic (Wong-Padoongpatt et al., 2022, p. 13).

As the COVID-19 pandemic emerged and spread, so did “fear, xenophobia and biased hate crimes” that targeted Asian Americans (Lantz & Wenger, 2023, p.1090). The ‘Stop Asian American Pacific Islander Hate’ forum have documented hundreds of instances of anti-Asian abuse and prejudice during the COVID-19 pandemic and incidents ranged from the boycotting of various Asian restaurants to “verbal and physical assaults” towards Asian Americans in public settings (p. 1091). Assessing the “nature of bias” and “Anti-Asian prejudice and bias victimization” during the COVID-19 pandemic, Lantz and Winger (2020) examined in detail the experiences with bias and discrimination, both criminal and non-criminal among Asian and Asian American individuals living in the U.S. during the pandemic (p.1093). Data was collected through a web-based survey that was administrated in May 2020 with a large sample size (N=4,188) of people throughout the country, and the sample was divided into two categories: non-Asian respondents (N=3,163) and Asian/Asian American respondents (N=575). Study 1 examined various indicators of anti-Asian xenophobia among non-Asian respondents, while study 2 focused on the subsample of Asian/Asian American respondents and investigated experiences with fear of bias crime, bias crime and discrimination (Lantz and Wenger, 2023).
Lantz and Wenger (2023) discovered that experiences of “anti-Asian xenophobia were common” among Asian respondents (p.1104). Furthermore, results indicated that 33% of non-Asian respondents agreed with at least one of the “Anti-Asian statements (p.1104). While 33.9% of Asian respondents experienced at least one bias victimization incident themselves, that percentage rose to 55.8% when it came to respondents who knew someone else who had been victimized and 61.7% for those who feared victimization. This suggested bias victimization was “ubiquitous among the Asian population” during the COVID-19 pandemic (Lantz & Wenger, 2023, p. 1104).

According to Gover et al. (2020), as COVID-19 spread across the United States, Asian Americans declared a “surge in racially motivated hate crimes” that involved harassment and physical violence (p.1). Asian Americans encountered “verbal and physical violence” propelled by individual xenophobia and racism from the time that they entered America in the late 1700s to the very present day (p.1). As Americans grew very accustomed to what was deemed a new normal—involving stay at home orders and social distancing requirements, etc. — Asian Americans were increasingly “burdened by heightened racial tension and racist microaggressions,” despite COVID-19 impacting people of all race/ethnicities (p.2). Asian Americans found themselves battling a “second epidemic targeting them specifically” with the experience of hate crimes that were racially motivated, including harassment and physical violence (p.2). COVID-19 had allowed for the “spread of racism and created national insecurity” with xenophobia and a fear of foreigners which were strongly linked to the increase in Anti-Asian hate crimes during the pandemic (p.3). This reflects how, despite having a long history in North America with an increase in numbers and growing political influence, Asian Americans have continuously experienced a “reoccurring dynamic of othering” (Gover et al., 2020, p.15).
Shimkhada and Ponce (2022) focused on anti-Asian American and Native Hawaiian/Pacific Islander (AANHPI) hate during COVID-19; and measured the associations of anti-AANHPI hate with “mental health, health access and public safety” among AANHPI adults (p.1404). Methods used for this study included analyzing the 2020 California Health Interview Survey (CHIS) AANHIP COVID-19 module. They introduced a variable of “experiencing or witnessing a hate incident” and evaluated associations with serious psychological distress, perceived neighborhood safety, and forgone care (p.1404). The study found “significant associations” between experiencing or witnessing a hate incident and serious psychological distress—with young adults reporting more distress than older adults (p.1451). Furthermore, the California Health Interview Survey Analysis reported that 28% of AANHPIs (1.5 million) experienced or witnessed a hate incident with a “higher rate among young adults” who were 18-25 years of age (59%) versus the other age groups (p=<.001) (p.1449). Also, among all age groups, male and female respondents had “similar reported levels of experiencing or witnessing hate incidents” which were between 24%-28% (Shimkhada & Ponce, 2022, p.1449).

**Asian American Health Impacts from COVID-19 ERA**

Twitter communications played a role in providing proxy measures for the “typical racial attitude” in locations demonstrated the prevailing racial climate that could impact health beyond individual attitudes (Nguyen et al., 2021, p.2). The results demonstrated that in locations with racial climates less receptive to minorities, there was a strong association with elevated racial bias incidents. Racial bias that occurred at the individual and community levels were both linked to “adverse health outcomes” (p.5). Structural racial bias along with interpersonal bias are prime explanations for the continuance of inequities based on race that were connected with a variety of negative health outcomes (Nguyen et al., 2021).
Zhou et al. (2023) explored the rapid surge in anti-Asian Pacific Islander discrimination and assault that occurred during the COVID-19 pandemic and its potential to “exacerbate mental health disparities already pervasive” among the Asian Pacific Islander communities (p. 346). This study was done in order to understand the “impact of the pandemic and COVID-related discrimination” on API college and university student mental health (p. 346). The elevated levels of unmet need for mental health treatment services among the API student population was deemed even “more troubling in the current racialized context” of the API experience during the COVID-19 pandemic (p.347). Findings indicated that API students reported a significant “increase in clinically-significant mental health symptoms” and a decrease in the utilization of treatments (p.346). Among API students who witnessed or experience discrimination due to COVID-19, about 60% screened “positive for one or more clinically significant mental health symptoms” (p. 350). Also, in both the Spring 2020 and Fall 2020 semesters, discrimination related to COVID-29 that was experienced among API students was correlated with increased odds of “both moderate and severe anxiety and depression” (Zhou et al., 2023, p.350).

Ramos (2022) explained how the COVID-19 pandemic led to “serious impacts on the psychological well-being” of older adults (p.1). Factors such as disruptions pertaining to daily routines, social distancing guidelines, and minimal access to mental health and medical health care produced an “unprecedented risk for worsening mental health” (p.1). The COVID-19 pandemic was also seen as a “potential stressor”, especially for older adults with chronic post-traumatic stress disorder (PTSD) (p.1). As public health officials implemented some recommendations to lower transmission risk, for many older adults, the mandate for social distancing led to “unintended consequences impacting their psychological well-being” (p.2).

Further, Asian Americans experienced “compounding stressors during the pandemic” due to hate
crimes, racial discrimination and stigma (p.5). Asian American adults exhibited “higher levels of emotions distress”, food insecurity, and lower rates of delayed medical care compared to White older adults (p.5). There was a clear “need for mental health or supportive interventions” that could provide the older adult populations with opportunities to socially engage with others via telephone calls, videos and/or through social media platforms (Ramos 2022, p. 6).

**Mental Health Impacts for Asian Americans Exposed to Hate**

Kim et. al, (2023) explored, analyzed and assessed 23 different peer-reviewed articles that explored “hate-motivated crime/incidents against Asians” in the United States between 2000 and 2020; and discovered that all studies in this systematic review examined discrimination and/or microaggressions (p.9). This study provided an overview of the recent status of scholarly research on “hate-motivated incidents against Asian Americans” and examined the types of incidents—such as hate crimes, discrimination, and bias, etc. (p.10). Findings showed that a majority of the 23 studies primarily focused on the consequences of “hate-motivated incidents, such as mental and physical health” (Kim et. al, 2023, p.9). And, during the COVID-19 pandemic, hate crimes against Asians received a tremendous amount of media attention. Kim et. al, (2023) emphasized that although the reported number of hate related discrimination and hate crimes towards Asians had “increased in recent years”, it could not be considered a new occurrence (p.10). Other findings suggested that “racial microaggressions predicted participants’ well-being” through cultural distrust as a mediating factor (p.17). Most importantly, this study provided confirmation that “racial-ethnic microaggressions are statistically associated with increased psychological distress” among the population sampled (Kim et al., 2023, p.17).

Lozano et al. (2021) investigated the prevalence of depression symptoms among Asian Americans before and during the COVID-19 pandemic, while exploring differences based on
“socio-economic factors” (p. 909). The rise in racial discrimination against Asian Americans in relation to the COVID-19 pandemic was viewed as potentially having “serious long-term effects on mental health” (p.910). In particular, Asian Americans experienced “compounding stressors” during the COVID-19 pandemic that resulted from racial discrimination and stigma (p.909). The findings from this cross-sectional study among South Asian and Chinese adults (N=636) in Chicago indicated that depression had “increased more than two-fold”, from 9% to 21% during the COVID-19 pandemic (Lozano et al., 2021, p.909).

A study conducted by Kim and Epstein (2020) tested a theoretical model “portraying simultaneous mediational paths from racism exposure” for impacts on general mental and physical health through racism-related stress. (p. 103). The results from the two-step structural equation modeling (SEM) analysis supported the model demonstrating how “racism exposure can simultaneously have a negative indirect effect” on Asian Americans’ mental and physical health in relation to exposure to racism-related stress (p. 103). Kim and Epstein (2020) emphasized that having exposure to racism in different interpersonal contexts can often lead to “racism-related internal stress” and this could trigger negative affect such as fear, anger and anxiety (p.112). When the negative affect is repeated often, it can lead to “deterioration in the mental health” of the individual and could potentially cause mental health disorders; and, along with chronic activation of the body’s response to stress this can also contribute to physical health problems (Kim & Epstein, 2020, p.112).

**Stress of Racism, Microaggressions and Discrimination**

Stigmatization and discrimination may impact individuals by preventing them from seeking medical or professional help (Gao & Liu, 2020). A panel study that was conducted in June 2020 found that a total of 26 % of Asian Americans were fearful that they would be
threatened or physically attacked by someone, which could lead to immense anxiety, worsened physical health and/or depression. Based upon statistical reports, research findings indicated that youth, women, immigrants, international students and people with limited English Proficiency were more “likely to be targeted and victimized” (p.2). Racial discrimination has long-lasting “negative impacts on physical health and psychological well-being” on a person—whether the discrimination was experienced or perceived (p.2). Findings showed 60% of Asian Americans reported having “witnessed someone blaming Asian people” for the pandemic (p.1). They concluded that racial discrimination is not only a “human rights violation”, but also a form of social injustice and exclusion that should be deemed profoundly wrong (Gao & Liu, 2020, p.2).

There has also been stress from the long-standing supposed positive model minority myth (MMM), regarding how Asian Americans are perceived to be “problem free” as a minority group (Yi et al, 2022). The MMM has cultivated unfair racial hierarchies, while dishonoring the pervasiveness of systemic racism endured by Asian Americans, as a shared experience with other Black, Indigenous, and People of Color (p. 123). Yi et al. (2022) investigated the role of the internalized Model Minority Myth (MMM) in Asian/Asian Americans’ (A/AA) experiences during the pandemic of COVID-19 and society’s “racial reckoning” (p.123). Using a mixed methods approach, Yi et al. (2022) analyzed (N=314) A/AA college students’ responses to open-ended questions about their experiences as A/AA during the COVID-19 pandemic. They identified “qualitative themes” of: 1) personal and vicarious discrimination; 2) vigilance; 3) safety due to ethnicity; 4) safety due to environment; and 5) no difference during COVID-19 (p. 123). The most frequently endorsed theme was vicarious discrimination (30.4%) that reflected “the negative impact of witnessing COVID-related discrimination” faced by fellow Asian/Asian
Americans through the news, social media, and reports from friends and family (Yi et al., 2022, p.130)

Other long-standing stress has followed from the yellow peril “negative and conspicuously racist trope” derived from Orientalism (Li & Nicholas, 2020, p.4). Throughout history, immigrants of Asian descent were strongly associated with “disease and filth” and considered a threat to Whites (p.4). Often swaying from “yellow peril to model minority”, the stereotypes placed on Asians resulted in “dialectical relationships” where stereotypes that were opposites coexisted (p.4). During a public health crisis, people resorted to “othering” and disconnecting themselves from those that they saw as a threat such as foreigners, groups that were stigmatized, along with other countries and other minorities (p.5). Anti-Asian discrimination rose due to the outbreak of COVID-19. Asian Americans from different ethnic backgrounds experienced harassment, attacks, and racial hostility due to Covid-19. Due to shared COVID-19 related discrimination, there was the “emergence of a grassroots movement” led by Asian Americans to promote racial solidarity among minority groups (Li and Nicholas, 2020, p.9).

Liang and Li (2004) acknowledged an ignored area of mental health research involving the experiences of Asian Americans with the “psychological stress that arises from experiences with racism” (p.104). Psychological stress can develop when the relationship between an environment and the person is “perceived and appraised by that individual to be harmful” (p.104). This study, which focused on “Asian American racism-related stress”, utilized and developed a 29-item Asian American Racism-Related Stressed Inventory (p.103). From the first study, data retrieved from (N=161) Asian American respondents which were subject to an “exploratory factor analysis” yielded 3 subscales that consisted of 1) Socio-Historical Racism
(14 items); 2) General Racism (8 items); and 3) Perpetual Foreigner Racism (7 items) (p.103). In the second study, Asian American respondents’ data were subjected to a “confirmatory factor analysis” which provided support for the factor structure derived from the first study (p.103). For the third study, data from 28 Asian American respondents served to “yield evidence” of the AARRSI’s test-retest reliability (p.103). Findings revealed that the three factors underlying the AARRSI “accurately reflect Asian Americans’ experiences with racism (Liang & Li, 2004, p.111).

As a source of stress, microaggressions can be “decisively linked to individual prejudice in offenders” and the mental-health outcomes pertaining to the targets (Williams, 2020, p. 5). The concept of microaggressions is connected to “pathological stereotypes”, “power structures”, “structural racism” and multiple forms of “racial prejudice” (p.5). A microaggression does not typically involve physical harm, and is often defined by “socially conditioned racial biases and prejudices” (p.6). Although microaggressions are sometimes “rebuffed by the target”, they must often be acknowledged without any challenges due to the power differential between the parties (p.7). Also, microaggressions are not forms of cultural missteps, but function as a form of oppression “designed to reinforce the traditional power differential” among groups (Williams 2020, p. 8).

Social Support for Asian Americans During the COVID-19 Pandemic

Nie (2023) noted how Asian cultural values place great emphasis on “collectivism and social relationships” (p. 692). Asian cultural values include not only “collectivism”, but also emotional restraint, dependence on relationships, and respect for hierarchy” (Nie, 2023, p.683). In this study, negative religious coping “emerged as the sole consistently robust religious predictor” of mental health outcomes among this group (p.692). Further, the Asian cultural value
of “emotional restraint, along with reduced social interaction” during the pandemic may have escalated the effects of negative religious coping (p.693). Nie (2023) also explained that when one is “confronted with traumatic experiences, such as racism”, the need for social support as a form of coping is necessary and needed (p.696). This was certainly the case in the aftermath of the March 16, 2020 murder of six women in Atlanta, Georgia where there were no charges of a hate crime having been committed—which Nie (2023) discussed.

**Theoretical Framework for Research**

A number of theories provided a framework for the present research study. These theories are summarized in this section.

**Pierce’s Original Theory of Racism**

Within the theory of racism presented by Pierce et al. (1977), it is understood that in the United States, “racism is a mental and public-health illness” in which an individual’s skin color determines whether or not another individual is expected to operate from an inferior or superior vantage point (p.64). This results in members of both races being “proracist”, in that they encourage, permit, insist, and sustain that the black will be “deferential and dependent” in every interpersonal interaction (p.65). The main vehicle for proracist behaviors is microaggressions—as a concept first proposed by Pierce, as a Harvard psychiatrist. Microaggression were first defined as “subtle, stunning, often automatic and non-verbal exchanges” that are “put downs” of black people by offenders (p.65). In support of this, research was presented highlighting the “numerous and excessive negative representations” of blacks in television commercials (p.86).
Most of these representations were “gratuitous and unnecessary” and could easily be changed with no interferences to the creativity of artists nor the profits of its sponsors (p.86). Pierce et al. (1977) emphasized how the insights gained from this study could be applied to the problem of “improving race relations” in the United States (p.65).

**Concepts of Microaggressions**

Building on the pioneering work of Pierce, Sue et al. (2007) defined racial microaggressions as “brief and commonplace daily verbal, behavioral or environmental indignities” whether done intentionally or unintentionally, that convey derogatory, hostile or negative racial slights and insults directed towards individuals of color (p. 271). Perpetrators of microaggressions are typically “unaware that they engage in such communications” when they interact with minorities of a different race/ethnicity (p.271). Moreover, microaggressions seem to occur in three forms: “microassault, microinsult and microinvalidation” (p.271). When one considers that “people of color are exposed continually to microaggressions” and that their effects are cumulative, one can begin to understand the psychological toll that this might have on well-being, including being traumatic (Sue et al. 2007, p. 279). Convert racism in the form of microaggressions has “dramatic and detrimental impact on people of color” (p.271). When a microaggression occurs, the victim is “usually placed in a catch-22” due to the following: 1) a person must determine if a microaggression has occurred; 2) how a person reacts to a microaggression can have different effects on both the perpetrator and the person of color as well; and, 3) responding with anger such as striking back is more likely to cause negative consequences for the person who is of color (p.271). Almost all forms of interracial encounters are “prone to the manifestation of racial microaggressions” (p.284). Sue et al. (2007) also noted that racial microaggressions are not limited to just White-Latino, White-Black or White-Person
of Color interactions, but additionally, “interracial microaggressions” can transpire between people of color as well. (p.284).

**Elaboration of Microaggressions against Asians**

Despite the belief that Asian Americans have somehow “made it” in our society and are “immune” to racism, widespread discrimination and prejudice continue to negatively impact their standard of living, psychological well-being and self-esteem (Sue et al., 2007, p. 72). Being denied the rights to citizenship, prohibited from owning land, and being incarcerated in internment camps, this group has historically been the target of wide-ranging governmental actions “to deny them basic civil and human rights” (p.72). Since microaggressions often take place outside the level of conscious awareness, individuals who are well-intentioned can participate in these bias acts “without guilt or knowledge of their discriminatory actions” (p.73). Despite the “intentions of the perpetrator”, these acts of discrimination can profoundly harm the victims (Sue et al., 2007, p.73).

Racial microaggressions toward Asians can take the form of verbal statements such as, “You speak such good English,” or “But you speak without an accent”, and “So where are you really from” (Sue et al., 2007, p.73). Research documents how Asian Americans and Latino/Hispanic Americans have perceived these statements as “invalidating and insulting,” because they reflect a worldview that racial/ethnic minorities are aliens in their own country (p.73). The “cumulative effects” of racial microaggressions can be quite devastating (p. 73). Further, Sue et al. (2007) asserted that when an Asian American is complimented for being able to speak good English or where Blacks are deliberately warned not to be overly sensitive, the underlying message can be interpreted as “Asians are perpetual foreigners in their own country” (Sue et al., 2007, p.73).
Findings from a study lead by Sue et al. (2007) aimed to identify the dynamics and types of racial microaggressions experienced by Asian Americans with a sample pool of (N=10) Asian American participants; and, findings provided strong support that “microaggressions are not minimally harmful and possess detrimental consequences” for the recipients (p.77). Most participants described “strong and lasting negative reactions” to the consistent racial microaggressions that they experienced from well-intentioned neighbors, teachers, co-workers, colleagues and friends (p.77). In addition, participants reported feelings of “belittlement, anger, rage, frustration, alienation” and how they felt constantly “invalidated” (p.77). Many participants “expressed severe conflicts” about whether or not they should respond to microaggressions given that most were deemed unintentional and outside of the awareness level of the perpetrator (p.78). For example, when pointing out a microaggression to a peer, it typically resulted in “denial, defensiveness, and a negative outcome” for the relationship (p.78). Furthermore, participants of all Asian ethnic backgrounds shared that numerous microaggressions “invalidate their experience of discrimination” (p.76). Sue et al. (2007) further suggested that Asian Americans have a higher likelihood of experiencing microaggressions centered around the themes of being “alien” in their own land”, and “invisibility”, as well as “invalidation of interethnic differences” in comparison to African Americans (p.78).

**Biopsychosocial Model of Perceived Racism**

Racism is operationally defined as “beliefs, attitudes, institutional arrangements and acts” that tend to diminish individuals or groups due to their ethnic group affiliations or their phenotypic characteristics (Clark et al., 1999, p. 805). Examining the effects of “intergroup racism and intragroup racism in African Americans” is warranted for three crucial reasons (p.806). First, if “exposure to racism is perceived as stressful”, it may produce negative
biopsychosocial sequelae (p.806). Second, differential “exposure to and coping responses following perceptions of racism” that may help to account for broad within-group variability in the health outcomes of African Americans (p.806). Third, if “exposure to racism” is among the factors strongly associated to negative health outcomes in African Americans, specific prevention strategies and interventions could be established and implemented to lessen its harmful impact (p.806). Clark et al., (1999) also emphasized that these strategies would provide a “needed supplement to efforts aimed at reducing health disparities” in American society (p.806).

In terms of the principle tenet of this proposed model, it is deemed that the “perception of an environmental stimulus as racist” results in amplified physiological and psychological stress responses that are influenced by sociodemographic factors, constitutional factors, and psychological and behavioral factors (Clark et al., 1999, p.806). Over a period of time, these stress responses are “posited to influence health comes” (p.806). Furthermore, Clark et al. (1999) expressed that the “perception of environmental stimuli” as racist and the development of coping responses are presumed to be a function of a rather “complex interplay” between a variety of psychological, constitutional, behavioral and sociodemographic factors (p.806).

Perceived racism refers to the “subjective experience of prejudice or discrimination (Clark et al., 1999, p. 808). It is not limited to the experiences that may “objectively” be viewed as representing racism (p.808). For example, subtler forms of racism include symbolic behaviors and belief systems that promote the ideology of “free will” (Clark et al, 1999, p.808). Socioeconomic status is associated with “perceptions of racism, ethnicity and biopsychosocial functioning” (p.807). Among African Americans, “skin tone” has been strongly associated with perceptions of ethnic discrimination along with occupational health and personal income (p.808).
Psychological stress responses that may follow perceptions of racism include “anger, paranoia, anxiety, helplessness-hopelessness, frustration, resentment and fear” (p.811). Studying the biopsychosocial effects of “perceived racism” within a stress and coping model can be potentially useful in terms of examining the physiological, psychological and social effects of it (Clark et al., 1999, p. 813).

**Roots in the Stress and Coping Work of Lazarus and Folkman**

According to Lazarus and Folkman (1984), the concept of stress is “extensively discussed in the health care fields” and found in economics, political science, business and even education (p. 1). The term “stress” antedates its systematic or scientific use (p.2). Since the 1960s, it has been recognized that while stress is an “inevitable aspect of the human condition”, it is coping that makes a “profound difference” in adaptational outcome (p. 6). It was utilized as early as the 14th century and can imply “hardships, straits, adversity, or affliction” (p.2). On the psychological side of an individual, stress was, for a lengthy time, “implicit as an organizing framework” for thinking about psychopathology (p.4). Stress or anxiety can also be viewed as a “factor that influences culture or that is conducive” to social order (p. 224). In 1966, it was suggested that stress be “treated as an organizing concept” for understanding a broad range of phenomena of substantial importance in human and animal adaptation (Lazarus & Folkman, 1984, p.11).

Stress stimuli are commonly thought of as “events impinging on a person” (Lazarus & Folkman, 1984, p.12). The most common definition of stress accepted by psychologists has been that it is a “stimulus” (p.12). Stress, coping and their adaptational outcomes must be examined in the context of an individual’s “relationship to society” (p.259). Stress is produced by “mismatches” between an individual and social identities (p.259). The social environment also
establishes social relationships which are “imperative” if the individual is to “survive and flourish (p.258). Perceived social report refers to the nature of “interactions occurring in social relationships”, especially if they are evaluated as to supportiveness on a subjective basis (p.259). Lazarus and Folkman (1984) noted that social change “can lead to stress” by generating new demands on people, producing the loss of what seems familiar or predictable and establishing a sense of “isolation, or creating new threats” (p.260).

Traditional models of coping typically emphasize styles or traits that once created, “presumably operate as stable dispositions” to cope in this or that over the life course (Lazarus & Folkman, 1984, p.128). “Coping traits” often refers to “properties or persons” that dispose them to react in distinctive ways (p.139). When the concept of coping was composed within the tradition of psychoanalytic ego psychology, it was concerned primarily with “cognition, differentiating” among a number of processes utilized by people to managed troubled relationships (p.139). A process to coping has “three main features” which are: 1) assessment and observation that are more concerned with what a person actually does or think as opposed to what a person usually does; 2) what a person usually does or think is examined over a specified context; and, 3) to speak of a coping process signifies speaking of change in coping thoughts and acts as a stressful encounter unravels (p.142). Lazarus and Folkman (1984) reiterated that coping should not be equated with mastery over environment; and, many sources pertaining to stress cannot be mastered, and under these conditions, “effective coping” is what enables a person to “tolerate, minimize, accept, or ignore” what cannot be mastered (p.139).

Stages of Change Theory

The notion that behavior change involves a process that occurs in “increments and that
involves specific and varied tasks” defines the transtheoretical model of intentional human behavior change (DiClemente & Velasquez, 2002, p.201). The stages of change present a vital component of the Transtheoretical Model of Change and describes a “series of stages” that people pass through when they change a behavior (p.201). In this model, change is viewed as a “progression” from a 1) precontemplation stage, where an individual is not currently considering any changes; next, to 2) contemplation stage, where an individual undergoes a serious evaluation of considerations for or against change; then, to 3) preparation stage, where planning to change along with commitment are secured; then, to an 4) action stage, where an individual makes a specific behavioral change; and, then to the 5) maintenance stage, where an individual works to maintain as well as sustain long-term changes (p.201). These stages are applicable to the “larger process of behavioral change”, despite the changes taking place with or without the help of an intervention, a treatment program or a therapist (p.202). Application of these stages of changes include several behaviors ranging from the cessation of smoking, alcohol, drugs, or gambling to exercise adoption, mammography screening, condom use, pregnancy prevention and dietary modification (p.202). Although behavior might differentiate among individuals, the structure of the change process “appears to be the same” (DiClemente and Velasquez, 2002, p.202).

For example, Wallace (2005) has extended the stages of change to coping with racism and oppression. Here, individuals can be in a stage of precontemplation, contemplation, preparation action or maintenance for actively coping with perceived racism and oppression.
Conclusion

This chapter provided a review of the literature on the following topics: 1). Prevalence of Asian Hate Crimes during the COVID-19 Pandemic; 2). Asian American health impacts from the COVID-19 era rise of hate and hate crimes; 3). Mental health impacts for Asian Americans exposed to hate and hate crimes; 4). Research covering the stress of racism, microaggressions, discrimination and protective factors (i.e. social support for Asian Americans during the pandemic; and, a 5) Summary in those theories providing a framework for the research study.

The next Chapter III will present the study methods.
Chapter III

METHODS

This chapter presents the procedures and methods utilized in this study. It also provides an overview of the study design and procedures, the description of participants, and a detailed description of the research instrumentation, the data treatment plan along with the data analysis plan.

Overview of The Study Design and Procedures

This study used a cross-sectional design and an online survey administered through Qualtrics with a convenience sample of diverse Asian adults living in the United States during the COVID-19 pandemic who were ages 18 and older. The section presents an overview of all study procedures.

IRB Approval

On April 12, 2022, this study received approval under the category exempt from the Teachers College, Columbia University Institutional Review Board IRB as Protocol # 22-228 (see Appendix A for IRB Approval Letter). Data collection began after receiving IRB approval.

Recruitment of Study Participants

The recruitment of participants for this study occurred primarily online via a social media campaign which included the use of Facebook, Twitter and Instagram, as well as emails (See Appendix B for recruitment Email). The social media campaign involved sending out a specific
core message that invited diverse Asian adults age 18 and above living in the United States
during the COVID-19 pandemic to take part in filling out the online survey, while also
describing the opportunity to win the prize of an Amazon gift card. The recruitment message was
as follow (See in Appendix C):

ALL diverse Asians Living in the US During the COVID-19 Pandemic Invited to Take a
10-15 Minute Online Survey at https://tinyurl.com/HATE-Toward-Asians
for chance to enter in a raffle for 1 of 3 $100 Amazon gift cards

Other Study Procedures

Participants who were interested in participating in the study were able to click on an
electronic link to begin the survey on Qualtrics. Once directed to the study, participants were
asked to read and electronically sign an Informed Consent (See Appendix D for Informed
Consent).

Study Inclusion/Exclusion Criteria: Screening Tool

After signing the informed consent, participants then completed a short questionnaire
(See Appendix E) in order to determine if they met the inclusion criteria for the study, as
follows:

1. Are you at least 18 years of age or older? Yes__ No__

2. Have you been or were you living in the United States—for at least 6 months
continually without travel outside the country—during the years 2020 and/or 2021,
or during the COVID-19 pandemic? Yes__ No__

3. Do you self-identify as Asian? Yes__ No__

4. Do you feel able to read and answer questions in English (on a 12th grade level)?
Yes__ No__

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5. Are you able to devote **10-15 minutes** to this study at this time? Yes__ No__

Participants who met these criteria were then invited to continue to the study survey (See Appendix F for the Study Survey). Participants who did not meet these criteria were disqualified from the study and were thanked for their interest in the study, while told that they did not qualify to participate in the study. Finally, they were also asked to share and forward the study link with others who might qualify to participate in the study.

**Generating Prizes: The Study Incentive for Participation**

After participants completed the survey, they were invited to submit their e-mail address in order to be officially entered into a drawing for a chance to receive a prize (i.e., a 3 in 250 chance to win 1 of 3 $100 barcoded Amazon gift certificates). Data collection for this study began on April 13, 2022 and closed on April 30, 2022. Upon the closing of the study, participants who entered the lottery and won were notified of their winnings and told how to redeem their Amazon gift cards. As part of the research protocol for the Research Group on Disparities in Health (RGDH), the enter prize process was administered by RGDH’s webmaster, Dr. Rupananda Misra. The principal investigator was not able to view any identifying participant data (i.e. their email addresses) nor associate them with the study results. This allowed participant privacy to be maintained.

**Description of the Study Participants**

A convenience sample of volunteers who completed the study comprised the final study sample (N = 831). Initially, there were 1,274 adults who started the survey, but 184 were excluded because they came from an IP address that was used more than once; indeed, one IP
address was used 63 times. After eliminating these problematic IP address surveys, the resultant 
N = 1090. Next, 144 surveys were eliminated because they were not eligible, given the screening 
questions (i.e. inclusion/exclusion criteria), resulting in a sample of N = 946. Then 2 were 
eliminated for lacking an answer to a single demographic question, resulting in N = 944. From 
among these 944, some 113 were considered study non-completers; and, more specifically, these 
113 were eliminated for reasons such as not being Asian, for endorsing that COVID-19 was a 
hoax, or not having proceeded far enough into the survey to provide data for the primary 
outcome variable on experiences of microaggressions. Hence, the final sample was N = 831.

A comparison was made of the study completers (N = 831) to study non-completers (N = 
113). Compared to “completers” (N = 831), the “non-completers” (N = 113) were significantly 
more likely to be male, less likely to have a partner, were younger, had lighter skin color, and a 
higher annual household income. The findings when comparing completers (N = 831) to non-
completers (N= 113) follow in two tables.

See Table 1.

Table 1. Comparing Survey of Completers (N=831) to Non-Completers (N=113) Via 
Independent T-Tests

<table>
<thead>
<tr>
<th>Has Primary Outcome Variable?</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>t</th>
<th>Df</th>
<th>P</th>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td>831</td>
<td>33.2</td>
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<td>942</td>
<td>.001***</td>
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<td>72.112</td>
<td>.045*</td>
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<td>3.60</td>
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*p<.05, **p<.01, ***p<.001 Bonferroni Adjustment Significance (.05/4, p= .0125)
See Table 2.

<table>
<thead>
<tr>
<th>Has Primary Outcome Variable?</th>
<th>Chi-Square test of independence</th>
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<tr>
<td>Yes=Completer</td>
<td>N</td>
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<tr>
<td>Male</td>
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<td>Female</td>
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<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Has a Partner</td>
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<tr>
<td></td>
<td>No</td>
</tr>
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</table>

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

**Table 2. Comparing Survey of Completers (n=831) to Non-Completers (N=113) Via Chi-Square Tests**

**Description of Research Instrumentation**

A wide array of diverse tools made up the study survey for this study, including those that were developed and designed by Professor of Health Education, Dr. Barbara Wallace, who is the director of the Research Group on Disparities in Health (RGDH), Department of Health and Behavior Studies, Teachers College, Columbia University. All surveys in this study have been previously utilized by former and current fellows of the RGDH, and were adopted for use in this study. This section will describe each of the survey parts in detail (See Appendix F for the full study survey).

**Part I: Basic Demographics (BD-10)**

The Basic Demographics (BD-10) scale followed a common tool used by the Research
Group on Disparities in Health (RGDH), as in Ingram (2017), for example. Questions are tailored for the study population of focus. This part of the survey contained 10 questions, covering as follows: gender, age, race/ethnicity, skin color, U.S. born (yes/no), partner status, household income, education level, employment status, if a student (year in undergraduate or graduate school).

**Part II: Personal Health Background—Current and Before the Pandemic (PHB-CABP-9)**

This is a tool created for use by the Research Group on Disparities in Health (RGDH). The present study uses a modified version with options for before and currently during the COVID-19 pandemic, permitting a paired t-test to compare ratings of: physical health before pandemic versus currently; and mental/emotional health before pandemic versus currently. This scale asks participants questions covering the following: have COVID-19 (yes/no); height (feet and inches) and weight (pounds) to determine Body Mass Index; and changes in weight during COVID-19 pandemic. Other questions use a Likert scale (1=very poor, 2=poor, 3=fair, 4=good, 5=very good, 6=excellent), permitting determining a mean for overall physical health status, mental/emotional health status, and Body Mass Index (BMI), including a standard deviation, and minimum and maximum scores.

**Part III: Single Item Rating of Risk of Providing Socially Desirable Responses (SIR-RPSDR-1)**

This is a scale created by Dr. Barbara Wallace for studies conducted by the Research Group on Disparities in Health (RGDH). For example, this one-item tool was used by Torez (2019) and Laryea (2019). Laryea (2019) found that the new one item measure of social desirability was one of two significant predictors of nurses’ higher personal skill/ability for managing patients’ pressure ulcers. This one-item measure of social desirability has been ideal
for use for research conducted during the pandemic where the emphasis has been placed on reducing the participant burden of time, while replacing a longer well-known 13-item measure of social desirability (Crowne & Marlowe, 1960).

The one-item measure of social desirability (scale from 0=low to 10=high) asked:

1-I sometimes say things that I think will please people, or what I think they want to hear versus the honest truth, which might be difficult or painful for other people to hear and accept, or might lead them to judge me harshly.....

I rate myself on a scale of 0 to 10, as follows:

0 1 2 3 4 5 6 7 8 9 10
0-I am not like this at all 10-I am like this at all

The scale permits determining the sample’s mean social desirability including the minimum and maximum scores. Of note, the regression analysis will control for social desirability.

Part IV: Perceived Social Support Scale (PSSS-1)

This is a common tool used by the Research Group on Disparities in Health (RGDH), having been used by Lian (2017), for example. For this study, to reduce the burden of time during the stress of the ongoing pandemic, a new one item version of the scale was created by combining the essence of 5 questions into one description of what having social support “means.” Participants then indicate the number of people they have in their life, using the 5-option scale, as follows:

Having SOCIAL SUPPORT means having people in your life who provide the following kinds of support and assistance: you can ask them for advice, or receive words of encouragement; get money or get food in an emergency; or have a place to temporarily wait for help, or stay or live in an emergency.
1-Please indicate the extent to which you experience SOCIAL SUPPORT in your life at this time (i.e., right now): 1-5
   1. I have no one like this in my life right now
   2. I have at least 1 one person like this in my life right now
   3. I have at least 2 people like this in my life right now
   4. I have 3-5 people like this in my life right now
   5. I have 6 or more people like this in my life right now

For interpretation of social support, a rating of 1 for “low level of social support” means having at least 1 person, while a rating of 5 for “very high level of social support” means having 6 or more people for social support.

**Part V: Retrospective Depression, Anxiety, Trauma and Receipt of Counseling Scale (RDATS-4)**

This is shorter version of a scale that follows the work of Tirhi (2019) and others (e.g. Hall, 2021)—as a common tool used by the Research Group on Disparities in Health (RGDH).

Further, going beyond dichotomous options, a new 0-4 Likert rating scale in year 2022 RGDH research was used, while there is also a receipt of counseling question, as follows:

1-Do you think you experienced any depression in the past year or 12 months?
   0-No___
   1-Yes, a very mild level___
   2-Yes, a moderate level___
   3-Yes, a severe level___
   4-Yes, a very severe level___

2-Do you think you experienced any anxiety in the past year or 12 months?
   0-No___
   1-Yes, a very mild level___
   2-Yes, a moderate level___
   3-Yes, a severe level___
   4-Yes, a very severe level___

3-Do you think you experienced any trauma or trauma symptoms in the past year or 12 months?
   0-No___
   1-Yes, a very mild level___
   2-Yes, a moderate level___
   3-Yes, a severe level___
4-Yes, a very severe level__

Receipt of Counseling

4-In the past year, did you seek out any kind of counseling or advice for any depression, anxiety, or trauma—such as from a mental health professional or other helper?
____Yes ____No  ___Not Applicable/ No experience of depression/anxiety/trauma

In addition, scoring can permit creation of the Overall Mental Health Index, or Mental Distress Index for the past year—combining the ratings for depression, anxiety and trauma for a mean score. The internal consistency for this 4-item scale was determined using Cronbach’s Alpha, as well as the mean, standard deviation, minimum and maximum scores being determined

Part VI: Perceived Stress Scale (PSS-4)

The PSS-4 is a short version of the PSS-10 created by Cohen, S., Kamarck, T., Mermelstein, R. (1983). The shorter PSS-4 utilized or this study was also used by Karen et al. (2012) in a study with pregnant women, finding acceptable internal consistency (Cronbach’s alpha coefficient = .79), and alternate forms stability reliability with the 10-item PSS (Pearson correlation coefficient \( r = .63; p < .001 \)), while concluding it was a valid and useful tool.

The questions in this scale asked participants about their feelings and thoughts during the last month, and for each item, participants indicated how often they felt or thought this way, using a 5-point scale, as follow: 0 to 4: 0=never (No Stress at All), 1=almost never (Low Stress), 2=sometimes (Moderate Stress), 3=fairly often (High Stress), 4=very often (Very High Stress).

The 4 items of the PSS-4 follow:

1. In the last month, how often have you felt that you were unable to control the important things in your life?
   ____0=never ___1=almost never ___2=sometimes ___3=fairly often ___4=very often

2. In the last month, how often have you felt confident about your ability to handle your personal problems?
In the last month, how often have you felt that things were going your way?

0 = never 1 = almost never 2 = sometimes 3 = fairly often 4 = very often

In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

0 = never 1 = almost never 2 = sometimes 3 = fairly often 4 = very often

PSS-4 scores are obtained by reverse coding the positive items (0=4, 1=3, 2=2, etc.) and then summing across all 4 items. Items 2 and 3 are the positively stated items.

This PSS-4 will produce the mean of perceived stress in the past 30 days as well as a standard deviation, minimum and maximum score.

Part VII: Ratings of Experiences of Microaggressions (REM-6)

This is a scale previously used in Lian (2017) and created for use by the Research Group on Disparities in Health by Dr. Barbara Wallace. Instructions were modified to account for the participants’ demographics in this study. Due to the pandemic and social distancing, also added in places was this: in-person or online. A question on intersectional experiences was deleted (also due to appearance, etc.). Also, a final question 6 was added to capture the original work of Pierce et al (1977) on microaggressions, as shown, below:

For the following questions, please indicate to what extent you experienced any of the following in the United States (e.g. campus/college setting, work settings, shopping in stores, online/social media interactions, etc...) and it seemed related to your being Asian:

1-Brief exchanges or brief interactions (in-person or online) where you felt you were receiving messages that were a put down, denigrating, or conveyed something negative:

0 = Never/Not At All 1 = At Least Once 2 = More Than Once 3 = A Few Times 4 = Many Times

2-A verbal attack that was hurtful and caused mental or emotional pain, whether this involved name-calling, or some act of discrimination performed on purpose:

0 = Never/Not At All 1 = At Least Once 2 = More Than Once 3 = A Few Times 4 = Many Times
A nonverbal attack, or some behavior that was hurtful and caused mental or emotional pain, whether this involved someone avoiding contact and interaction, or avoiding communication, or some act of discrimination performed on purpose:

0-Never/Not At All  1-At Least Once  2-More Than Once  3-A Few Times  4-Many Times

A communication that was insulting, or conveyed rudeness and insensitivity, put downs or demeaning language:

0-Never/Not At All  1-At Least Once  2-More Than Once  3-A Few Times  4-Many Times

A communication that excluded you, cancelled out your existence, made you invisible, or ignored the reality of your thoughts, feelings, and existence as a diverse person:

0-Never/Not At All  1-At Least Once  2-More Than Once  3-A Few Times  4-Many Times

How often have you experienced various media messages on television, in commercials, on billboards, in magazines, and other online platforms as putting down people like YOU—denigrating them, spreading negative stereotypes, or conveying something negative about people like YOU?

0-Never/Not At All  1-At Least Once  2-More Than Once  3-A Few Times  4-Many Times

The REM-6 in this study will be used to determine the mean, standard deviation, minimum and maximum score, as well as for evaluating internal consistency using Cronbach’s Alpha.

Part VIII: Perception of Racism and Oppression Scale (PROS-10)

The Perception of Racism and Oppression Scale (PROS-10) was previously used in numerous studies (e.g., Ingram, 2017) conducted by the Research Group on Disparities in Health (RGDH), having been created as a culturally appropriate research tool by Dr. Barbara Wallace. It has roots in the work of Clark et al. (1999) and Wallace (2005). This scale was designed to learn about participants’ level of ability for perceiving racism and oppression. After reading the introduction about racism and oppression, participants were asked to rate their perceptions of racism and oppression on a 5-point scale of 1 to 5 (1=strongly agree, 2=agree, 3=undecided, 4=disagree, and 5=strongly disagree) on items 1 to 6. Among the 10 items of PROS-10, items 7 to 10 were reverse scored (i.e., 5=strongly agree, 4=agree, 3=undecided, 2=disagree, and 1=strongly disagree). The PROS-10 instructions and items were, as follows:
For Your Information: Racism and oppression are potentially stressful, negative, harmful experiences where the injured party is sent the message they are “less than,” “unequal,” or “inferior.” For racism, injury is suffered due to one’s race or ethnicity (e.g., Asian). For oppression, injury is suffered due to one’s characteristics (e.g. skin color, immigrant status, race, religion, etc.…). Racism/oppression may include: prejudice, discrimination, harassment, violence, exclusion, disadvantage, or lack of access to opportunity (e.g. housing, employment), etc.

Please answer the following questions.
In terms of experiences of RACISM AND OPPRESSION….

1- I am not sure it is really exists or happens to people.
   1-Strongly Agree  2-Agree  3-Undecided  4-Disagree  5-Strongly Disagree

2- When incidents are talked about, I am not sure what makes something racist or oppressive.
   1-Strongly Agree  2-Agree  3-Undecided  4-Disagree  5-Strongly Disagree

3- I think it never happens to me.
   1-Strongly Agree  2-Agree  3-Undecided  4-Disagree  5-Strongly Disagree

4- There are times when I “don’t get it,” or I can’t really tell when it is happening to me.
   1-Strongly Agree  2-Agree  3-Undecided  4-Disagree  5-Strongly Disagree

5- I think it never happens to others.
   1-Strongly Agree  2-Agree  3-Undecided  4-Disagree  5-Strongly Disagree

6- There are times when I “don’t get it,” or I can’t really tell when it is happening to others.
   1-Strongly Agree  2-Agree  3-Undecided  4-Disagree  5-Strongly Disagree

7- I can usually see or sense when it is happening to me.
   1-Strongly Agree  2-Agree  3-Undecided  4-Disagree  5-Strongly Disagree

8- I can usually see or sense when it is happening to others.
   1-Strongly Agree  2-Agree  3-Undecided  4-Disagree  5-Strongly Disagree

9- When incidents are talked about, I think “That could happen to me or someone I love.”
   1-Strongly Agree  2-Agree  3-Undecided  4-Disagree  5-Strongly Disagree

10- When incidents are talked about, I can identify with and understand the experience.
    1-Strongly Agree  2-Agree  3-Undecided  4-Disagree  5-Strongly Disagree

ITEMS # 7-10 ARE REVERSE SCORED
According to Ingram (2017), the PROS-10 internal consistency was found to be good (Cronbach’s Alpha = .848). The PROS-10 in this study will produce a mean with standard deviation, minimum and maximum score, as well as Cronbach’s Alpha.

**Part IX: Coping and Responding to Racism and Oppression Staging Scale (CRROSS-7)**

The Coping and Responding to Racism and Oppression Staging Scale (CRROSS-7) was previously used in many studies (e.g., Ingram, 2017), as it was created by Professor Barbara Wallace for use by the Research Group on Disparities in Health (RGDH). Building on prior work (i.e. Clark et al, 1999; Wallace, 2005), and intended for administration after completing the Perception of Racism and Oppression Scale (PROS-10)—described above, Dr. Wallace based the creation of the CRROSS-7 on Prochaska and DiClemente’s (1983) Stages of Change theory, in order to evaluate participants’ stage of change for coping and responding to racism and/or oppression. For this study, the scale was shortened to 7 questions given the stress of the pandemic and goal of reducing the burden of time for participants. For the first six items of this scale, participants rated their coping with and response to any experiences of racism and/or oppression using a Likert scale (1= strongly agree, 2=agree, 3=undecided, 4=disagree, 5=strongly disagree). These six items showed which stage of change (i.e., precontemplation, contemplation, preparation, action) the participants had experienced. For the final question (question 7), participants scored the length of time that they had been actively working on their ability to cope to further investigate the participants’ being in the maintenance stage. The instructions and CRROSS-7 items were as follows:

**Now, for the next set of questions, think about how you cope or respond to any experiences of racism and/or oppression:**

1. I don’t think they exist, so there is nothing to learn how to cope with or respond to.
   
   *1-Strongly Agree  2-Agree  3-Undecided  4-Disagree  5-Strongly Disagree*
   
   [score of 1 or 2 as #1=precontemplation stage]
2. I never thought about how to cope with and respond to it.
   1-Strongly Agree  2-Agree  3-Undecided  4-Disagree  5-Strongly Disagree
   [score of 1 or 2 as 1=precontemplation stage]

3. I have thought about how to cope with and respond to it.
   1-Strongly Agree  2-Agree  3-Undecided  4-Disagree  5-Strongly Disagree
   [score of 1 or 2 as #2=contemplation stage]

4. I never took steps to learn more about how to cope with and respond to it.
   1-Strongly Agree  2-Agree  3-Undecided  4-Disagree  5-Strongly Disagree
   [score of 1 or 2 as #2=contemplation stage]

5. I am planning to take steps to learn more about how to cope with and respond to it.
   1-Strongly Agree  2-Agree  3-Undecided  4-Disagree  5-Strongly Disagree
   [score of 1 or 2 as #3=preparation stage]

6. I have been actively learning how to cope with and respond to it.
   1-Strongly Agree  2-Agree  3-Undecided  4-Disagree  5-Strongly Disagree
   [score of 1 or 2 as #4=action stage]

7. Learning how to cope with and respond to it is something that I have been actively working on:
   _never in my life _< 1 month _< 6 months _> 6 months
   _1-3 years _ 4-6 years _ 7-9 years _ 10-20 years _ 21-30 years _ >31 years __ unsure
   [score > 6 months as #5 =maintenance stage]

The CRROSS-7 in this study will produce a mean with standard deviation, minimum and
maximum score

**Part X: Experiences of Hate (EOH-12)**

This is a new scale created by Hyorim Lee and Dr. Barbara Wallace and for first time use
in Lee (2021) by the Research Group on Disparities in Health (RGDH), being based on a review
of literature. This new tool has two scales: 1) *Experiences of Hate Scale* composed of 6- items,
or the odd numbered items; and, 2) *Stressful or Traumatic Impact from Hate Scale* composed of
6-items, or the even numbered items. The instructions and items, follow:

The experience of HATE involves someone reacting to another human being with extreme
dislike, revulsion, disgust, aversion, or loathing. HATE often leads to HATE CRIMES, or to
violent attacks, or verbal abuse, or attempted and actual murders.

For example, attacks on Asians can be thought of as involving other people feeling and acting
on their feelings of HATE.

Please indicate all that you have experienced since the beginning of the COVID-19 pandemic, or in the past 2 years. And, then rate the impact on you.

1-I **personally experienced** HATE (live, in-person—or while online)

0-Never 1-Once 2-Twice 3-Few Times 4-Many Times 5-Great Number of Times
6-Not Applicable/Did not experience this

2-I **rate the impact on me**, given how stressful or traumatic it was for me:

0-No impact 1-Very low impact 2-Low impact 3-Moderate impact 4-High impact
5-Very high impact 6-Not Applicable/Did not experience this

3-I **personally witnessed** HATE against someone else (live, in-person—or while online)

0-Never 1-Once 2-Twice 3-Few Times 4-Many Times 5-Great Number of Times
6-Not Applicable/Did not experience this

4-I **rate the impact on me**, given how stressful or traumatic it was for

0-No impact 1-Very low impact 2-Low impact 3-Moderate impact 4-High impact
5-Very high impact 6-Not Applicable/Did not experience this

5-A person **CLOSE to me** (e.g. family member, friend, etc.) experienced HATE (live, in-

person—or while online)

0-Never 1-Once 2-Twice 3-Few Times 4-Many Times 5-Great Number of Times
6-Not Applicable/Did not experience this

6-I **rate the impact on me**, given how stressful or traumatic it was for me:

0-No impact 1-Very low impact 2-Low impact 3-Moderate impact 4-High impact
5-Very high impact 6-Not Applicable/Did not experience this

7-A person **in my neighborhood or in the area where I live experienced** HATE (live, in-

person—or while online)

0-Never 1-Once 2-Twice 3-Few Times 4-Many Times 5-Great Number of Times
6-Not Applicable/Did not experience this

8-I **rate the impact on me**, given how stressful or traumatic it was for me:

0-No impact 1-Very low impact 2-Low impact 3-Moderate impact 4-High impact
5-Very high impact 6-Not Applicable/Did not experience this

9-A person **I consider to be a part of my racial/ethnic community experienced** HATE (live, in-

person—or while online)

0-Never 1-Once 2-Twice 3-Few Times 4-Many Times 5-Great Number of Times
6-Not Applicable/Did not experience this

10-I **rate the impact on me**, given how stressful or traumatic it was for me:

0-No impact 1-Very low impact 2-Low impact 3-Moderate impact 4-High impact
5-Very high impact 6-Not Applicable/Did not experience this

11-I **saw a VIDEO** (e.g. television, YouTube, on social media) of someone I did not know

being victim of HATE

0-Never 1-Once 2-Twice 3-Few Times 4-Many Times 5-Great Number of Times
6-Not Applicable/Did not experience this

12-I **rate the impact on me**, given how stressful or traumatic it was for me:

0-No impact 1-Very low impact 2-Low impact 3-Moderate impact 4-High impact
5-Very high impact 6-Not Applicable/Did not experience this

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This study will determine the internal consistency of the two scales, using Cronbach’s Alpha, as well as mean, standard deviation and minimum and maximum scores.

The Data Treatment Plan

The section presents data management procedures and the data analysis plan that this study followed.

Data Management

For this research study, the data was collected via an online survey hosted on the Qualtrics online platform. After data collection, data was transferred from the Qualtrics platform to the latest version of SPSS 28, permitting data analysis.

Data Analysis Plan

For each research question there was a data analysis plan (see bold), as follows, below each research question:

1-What were their demographic characteristics (i.e. gender, age, race/ethnicity, skin color, birthplace (US born yes/no), annual household income, employment status, student status if applicable, etc.)?
   Part I: Basic Demographics (BD-9)
   Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages

2-What did they report as their personal health background (i.e. rating for overall physical health status, rating for overall mental/emotional health status, Body Mass Index)? And, was there a difference in health status when comparing before the pandemic and during the pandemic?
   Part II: Personal Health Background (PHB-CABP-9)
   Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, percentages and Paired t-test

3-Regarding the provision of socially desirable answers, to what extent was this a risk?
   Part III: Single Item Rating of Risk of Providing Socially Desirable Responses (SIR-
RPSDR-1)

Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages

NOTE: This is variable is controlled for in the regression analysis

4-To what extent did they report experiencing social support?
Part VI: Perceived Social Support Scale (PSSS-1)
Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages

5-To what extent did they report experiencing depression, anxiety, and trauma in the past year, along with any receipt of counseling?
Part V: Retrospective Depression, Anxiety, Trauma and Receipt of Counseling Scale (RDATS-4)
Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages

6-To what extent did they report any past month experience of perceived stress?
Part VI: Perceived Stress Scale (PSS-4)
Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages

7-What did they report as their experience of microaggressions—as perceived in relation to their being Asian?
Part VII: Ratings of Experiences of Microaggressions (REM-6)
Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages

NOTE: This is the study outcome variable

8-What was their level of ability for perceiving racism and oppression?
Part VIII: Perception of Racism and Oppression Scale (PROS-10)
Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages

9-What was their stage of change (i.e. precontemplation, contemplation, preparation, action, or maintenance stage) with regard to coping and responding to racism and oppression?
Part IX: Coping and Responding to Racism and Oppression Staging Scale (CRROSS-7)
Data Analysis Plan: Descriptive statistics, including means, standard deviation, frequencies, and percentages

10-To what extent did they report experiences of hate (i.e. personally live/in-person or online; personally witnessed; or to someone close to them; or to someone in their neighborhood; or to a member of their racial/ethnic community; or watching a video)? And, to what degree did they report their experiences of hate as having an impact upon them that was stressful or traumatic?
Part X: Experiences of Hate (EOH-12)
Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages

11-Were there any significant relationships between selected independent variables and the study outcome variable of a higher prevalence of the experience of microaggressions in the United States?

Data Analysis Plan: Independent t-tests, Pearson Correlations

12-When controlling for social desirability, what were the significant predictors of the study outcome variable of a higher prevalence of the experience of microaggressions in the United States?

Data Analysis Plan: Backward Stepwise Regression Analysis

NOTE: Controlling for social desirability.

Conclusion

This chapter described in detail the methods used in the present study. The methods included an overview of the study design, the study procedures, the recruitment of participants and the descriptions of the research instruments utilized in the study. Moreover, the data management and data analysis plan were also included in this chapter.

The next Chapter IV will provide the results of data analysis.
Chapter IV

RESULTS

This chapter provides a detailed presentation of the study results organized by research question. Additionally, findings are presented in table format.

Data Analysis Results by Study Question

Results for Research Question #1-What were their demographic characteristics (i.e. gender, age, race/ethnicity, skin color, birthplace (US born yes/no), annual household income, employment status, student status if applicable, etc.)? (BD-10)

Part I: Basic Demographics (BD-10). The study sample used for final data analysis consisted of 831 diverse Asians ages 18 and over (N = 831). Of note, there were 1,274 adults who started the survey, but 184 were excluded because they came from an IP address that was used more than once; indeed, one IP address was used 63 times. After eliminating these problematic IP address surveys, the resultant N = 1090. Next, 144 surveys were eliminated because they were not eligible, given the screening questions (i.e. inclusion/exclusion criteria resulting in a sample of N = 946. Then 2 were eliminated for lacking an answer to a single demographic question, resulting in N = 944. From among these 944, some 113 were considered study non-completers; and, these 113 were eliminated for reasons such as not being Asian, for endorsing that COVID-19 was a hoax, or not having proceeded far enough into the survey to provide data for the primary outcome variable on experiences of microaggressions. Hence, the final sample was N = 831. The analysis comparing study completers (N = 831) to study non-completers (N = 113) was presented in Chapter III.

The final sample (N = 831) was 44.3% male (n = 368) and 54.9% female (n = 456). The
The age range reported was 18-65 with a mean age of 33.23 years (SD = 6.708, min = 18, max = 65). The most frequently reported Asian ethnicities were 26.7% Chinese (N = 222), 13.6% Japanese (N = 113), 13.4% Korean (N = 111), 12.4% Taiwanese (N = 103), 10.6% Filipino (N = 88), 10.3% Indian (N = 86) and 8.5% Thai (N = 71). A total of 86.8% of participants reported that they were born in the United States (N = 721). For those born outside of the United States (N = 110, 13.2%); the most frequently reported countries of origin were China at 4.9% (N = 41) and South Korea at 3.1% (N = 26). Self-reported skin color tone (N = 831) ranged from white (1) to very dark (7), with the mean of 3.90 (SD = .896, min = 1, max = 6) which was closest to category 4 for “medium to light.”

In terms of marital status, 87.2% were married (N = 725). The majority of participants were employed for wages (87.4%, N = 726). For educational level, the mean was 3.84 (SD = 1.313, min = 1, max = 7) which was closest to category 4 for having an Associate’s or technical degree. Of note, 27.6% had a bachelor’s degree (N = 229). The mean household income was 4.69 (SD = 1.291, min = 1, max = 11), or between category 4 ($40,000 to $49,000) and category 5 ($50,000 to $99,999). For example, 41% (N = 341) reported annual household income for category 5 of $50,000 to $99,000.

Of note, 6.9% indicated that they were students (N = 57). For students, the majority fell between category 6 which was 1st year in grad school (1.3%, N = 11) and category 7 which was 2nd year in grad school (1.3%, N = 11).

See Table 3.
<p>| Table 3. <em>Basic Demographics (BD-10) (N=831)</em> |
|------------------|----------|--------|
|                  | N        | %      |
| <strong>Gender (N=831)</strong> |  |  |
| Male             | 368      | 44.3   |
| Female           | 456      | 54.9   |
| Transgender      | 1        | 0.1    |
| Non-binary/gender non-conforming | 6  | 0.7 |
| <strong>Age (N=831)</strong>  |  |  |
| 18-25            | 116      | 13.8   |
| 26-30            | 193      | 23.3   |
| 31-35            | 214      | 25.8   |
| 36-40            | 195      | 23.5   |
| 41-45            | 96       | 11.6   |
| 46-50            | 7        | 0.8    |
| 51-55            | 6        | 0.6    |
| 56-65            | 4        | 0.5    |
| <strong>Mean age (33.23), SD (6.708)</strong> |  |  |
| <strong>Race/Ethnicity (N=831)</strong> |  |  |
| Bangladeshi      | 4        | 0.5    |
| Burmese          | 3        | 0.4    |
| Cambodian        | 6        | 0.7    |
| Chinese          | 222      | 26.7   |
| Indian           | 86       | 10.3   |
| Indonesian       | 5        | 0.6    |
| Filipino         | 88       | 10.6   |
| Japanese         | 113      | 13.6   |
| Korean           | 111      | 13.4   |
| Malaysian        | 6        | 0.7    |
| Maldivian        | 4        | 0.5    |
| Nepalis          | 2        | 0.2    |
| Pakistani        | 5        | 0.6    |
| Polynesian       | 2        | 0.2    |
| Singaporean      | 12       | 1.4    |
| Sri Lankan       | 2        | 0.2    |
| Taiwanese        | 103      | 12.4   |
| Thai             | 71       | 8.5    |
| Vietnamese       | 12       | 1.4    |
| Chinese American | 1        | 0.1    |
| Okinawan         | 2        | 0.2    |
| <strong>Skin Color (N=831)</strong> |  |  |
| 1-White          | 5        | 0.6    |</p>
<table>
<thead>
<tr>
<th>Color Level</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-Very Light</td>
<td>34</td>
<td>4.1</td>
</tr>
<tr>
<td>3- Light</td>
<td>240</td>
<td>28.9</td>
</tr>
<tr>
<td>4- Medium to Light</td>
<td>317</td>
<td>38.1</td>
</tr>
<tr>
<td>5- Medium to Dark</td>
<td>229</td>
<td>27.6</td>
</tr>
<tr>
<td>6- Dark</td>
<td>6</td>
<td>.7</td>
</tr>
<tr>
<td>7-Very Dark</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Mean (3.90), SD (.896)**

**min (1), max (6)**

### U.S.-born (yes/no) (N=831)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>721</td>
<td>110</td>
</tr>
<tr>
<td>86.8</td>
<td>13.2</td>
</tr>
</tbody>
</table>

### Other Country of Origin (N=110)

<table>
<thead>
<tr>
<th>Country</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>2</td>
<td>.2</td>
</tr>
<tr>
<td>Burma</td>
<td>1</td>
<td>.1</td>
</tr>
<tr>
<td>Cambodia</td>
<td>1</td>
<td>.1</td>
</tr>
<tr>
<td>Canada</td>
<td>1</td>
<td>.1</td>
</tr>
<tr>
<td>China</td>
<td>41</td>
<td>4.9</td>
</tr>
<tr>
<td>France</td>
<td>1</td>
<td>.1</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>4</td>
<td>.5</td>
</tr>
<tr>
<td>India</td>
<td>3</td>
<td>.4</td>
</tr>
<tr>
<td>Indonesia</td>
<td>2</td>
<td>.2</td>
</tr>
<tr>
<td>Iran</td>
<td>1</td>
<td>.1</td>
</tr>
<tr>
<td>Japan</td>
<td>9</td>
<td>1.1</td>
</tr>
<tr>
<td>North Korea</td>
<td>1</td>
<td>.1</td>
</tr>
<tr>
<td>South Korea</td>
<td>26</td>
<td>3.1</td>
</tr>
<tr>
<td>Malaysia</td>
<td>1</td>
<td>.1</td>
</tr>
<tr>
<td>Mexico</td>
<td>1</td>
<td>.1</td>
</tr>
<tr>
<td>Nepal</td>
<td>1</td>
<td>.1</td>
</tr>
<tr>
<td>Pakistan</td>
<td>1</td>
<td>.1</td>
</tr>
<tr>
<td>Philippines</td>
<td>4</td>
<td>.5</td>
</tr>
<tr>
<td>Singapore</td>
<td>3</td>
<td>.4</td>
</tr>
<tr>
<td>Taiwan</td>
<td>6</td>
<td>.7</td>
</tr>
</tbody>
</table>

### Marital Status (N=831)

<table>
<thead>
<tr>
<th>Status</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Have a partner (married, domestic partners, etc.)</td>
<td>725</td>
<td>87.2</td>
</tr>
<tr>
<td>2-Do not have a partner (single, divorced, etc.)</td>
<td>106</td>
<td>12.8</td>
</tr>
</tbody>
</table>

### Annual Household Income (N=826)

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Less than 10,000</td>
<td>14</td>
<td>1.7</td>
</tr>
<tr>
<td>2-$10,000-$19,000</td>
<td>18</td>
<td>2.2</td>
</tr>
<tr>
<td>3-$20,000 to $39,000</td>
<td>27</td>
<td>3.2</td>
</tr>
<tr>
<td>4-$40,000 to $49,000</td>
<td>313</td>
<td>37.7</td>
</tr>
<tr>
<td>5-$50,000 to $99,999</td>
<td>341</td>
<td>41.0</td>
</tr>
<tr>
<td>6-$100,000 to $199,999</td>
<td>63</td>
<td>7.6</td>
</tr>
<tr>
<td>Income Range</td>
<td>Count</td>
<td>Percentage</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>7-$200,000 to $299,000</td>
<td>20</td>
<td>2.4</td>
</tr>
<tr>
<td>8-$300,000 to $399,000</td>
<td>10</td>
<td>1.2</td>
</tr>
<tr>
<td>9-$400,000 to $499,999</td>
<td>12</td>
<td>1.4</td>
</tr>
<tr>
<td>10-$500,000 to $799,000</td>
<td>6</td>
<td>.7</td>
</tr>
<tr>
<td>11-$800,000 or more</td>
<td>2</td>
<td>.2</td>
</tr>
<tr>
<td>I do not know</td>
<td>5</td>
<td>.6</td>
</tr>
</tbody>
</table>

*Mean (4.69), SD (1.291)*
*min (1), max (11)*

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Some high school, or less</td>
<td>4</td>
<td>.5</td>
</tr>
<tr>
<td>2-High school graduate or GED</td>
<td>150</td>
<td>18.1</td>
</tr>
<tr>
<td>3-Some college credit, no degrees</td>
<td>214</td>
<td>25.8</td>
</tr>
<tr>
<td>4-Associate or technical degree (e.g. AS)</td>
<td>157</td>
<td>18.9</td>
</tr>
<tr>
<td>5-Bachelor’s degree (e.g., BA, BS)</td>
<td>229</td>
<td>27.6</td>
</tr>
<tr>
<td>6-Master’s degree (e.g., MA, MS, MEd)</td>
<td>64</td>
<td>7.7</td>
</tr>
<tr>
<td>7-Doctorate or Professional degree (e.g., PhD, EdD, MD, DrPH, DDS)</td>
<td>13</td>
<td>1.6</td>
</tr>
</tbody>
</table>

*Mean (3.84), SD (1.313)*
*min (1), max (7)*

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed for wages</td>
<td>726</td>
<td>87.4</td>
</tr>
<tr>
<td>Self-employed</td>
<td>49</td>
<td>5.9</td>
</tr>
<tr>
<td>Unemployed</td>
<td>14</td>
<td>1.7</td>
</tr>
<tr>
<td>Homemaker</td>
<td>9</td>
<td>1.1</td>
</tr>
<tr>
<td>Military</td>
<td>4</td>
<td>.5</td>
</tr>
<tr>
<td>Retired</td>
<td>1</td>
<td>.1</td>
</tr>
<tr>
<td>Disabled/Unable to work</td>
<td>1</td>
<td>.1</td>
</tr>
<tr>
<td>Student</td>
<td>57</td>
<td>6.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Student</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-In high school, GED Program</td>
<td>1</td>
<td>.1</td>
</tr>
<tr>
<td>2-College Freshmen</td>
<td>3</td>
<td>.4</td>
</tr>
<tr>
<td>3-College Sophomore</td>
<td>5</td>
<td>.6</td>
</tr>
<tr>
<td>4-College Junior</td>
<td>7</td>
<td>.8</td>
</tr>
<tr>
<td>5-College Senior</td>
<td>8</td>
<td>1.0</td>
</tr>
<tr>
<td>6-1* year in grad school</td>
<td>11</td>
<td>1.3</td>
</tr>
<tr>
<td>7-2* year in grad school</td>
<td>11</td>
<td>1.3</td>
</tr>
<tr>
<td>8-3* year in grad school</td>
<td>3</td>
<td>.4</td>
</tr>
<tr>
<td>9-4* year in grad school</td>
<td>3</td>
<td>.4</td>
</tr>
<tr>
<td>10-5* year in grad school</td>
<td>2</td>
<td>.2</td>
</tr>
<tr>
<td>11-6* year in grad school</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>12-7* year in grad school</td>
<td>3</td>
<td>.4</td>
</tr>
</tbody>
</table>
Results for Research Question #2—What did they report as their personal health background (i.e. rating for overall physical health status, rating for overall mental/emotional health status, (Body Mass Index)? And, was there a difference in health status when comparing before the pandemic and during the pandemic? (PHB-CABP-9)

Part II: Personal Health Background – Current and Before Pandemic (PHB-CABP-9) scale. The Personal Health Background - Current and Before Pandemic (PHB-CABP-9) showed a mean body mass index (BMI) of 22.393 for the healthy weight range for both males and females (SD = 4.418, min = 8.24 = underweight category, max = 39.86 = obese range).

Some 35.7% (n = 297) gained weight during the COVID-19 pandemic, while 27.6% (n = 229) reported that they lost weight, and 38.3% (n=318) indicated their weight remained the same. In the past 2 years, 13.4% (n = 111) reported they have now or had COVID-19, with 85.2% (n = 708) did have COVID-19. Only 5.4% (n=45) indicated they currently have or had long COVID-19. For overall physical health status before the COVID-19 pandemic, the mean was 4.09 (SD = 1.297, min = 1, max = 6) for closest to good. However, for overall physical health status now/during the COVID-19 pandemic, the mean was 3.85 (SD = 1.305, min = 1, max = 6), or between fair and good, but closest to good.

For overall mental/emotional health status before the pandemic, the mean was 3.97 (SD = 1.326, min = 1, max = 6), closest to good. For overall mental/emotional health status now/during the COVID-19 pandemic, the mean was 3.79 (SD = 1.370, min = 1, max = 6) or between fair and good.

See Table 4.
Table 4. Personal Health Background-Current and Before Pandemic (PHB-CABP-9) (N=831)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-I have now, or had COVID-19 in past 2 years (N=831)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-Yes</td>
<td>111</td>
<td>13.4</td>
</tr>
<tr>
<td>2-No</td>
<td>708</td>
<td>85.2</td>
</tr>
<tr>
<td>3-Not sure</td>
<td>12</td>
<td>1.4</td>
</tr>
<tr>
<td>1-I Currently have, or had, long COVID-19 (N=831)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-Yes</td>
<td>45</td>
<td>5.4</td>
</tr>
<tr>
<td>2-No</td>
<td>769</td>
<td>92.5</td>
</tr>
<tr>
<td>3-Not sure</td>
<td>17</td>
<td>2.0</td>
</tr>
<tr>
<td>1-I think COVID-19 is a hoax; it does not exist, Cannot answer questions about COVID-19 (N=831)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-No</td>
<td>825</td>
<td>99.3</td>
</tr>
<tr>
<td>3-Not sure</td>
<td>6</td>
<td>.7</td>
</tr>
<tr>
<td>BMI (N=811)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (22.393), SD (4.418)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>min (8.24), max (39.86)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-For years 2020-2021, during COVID-19 pandemic, my weight (N=831)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My weight stayed about the same</td>
<td>318</td>
<td>38.3</td>
</tr>
<tr>
<td>I gained weight</td>
<td>297</td>
<td>35.7</td>
</tr>
<tr>
<td>I lost weight</td>
<td>229</td>
<td>27.6</td>
</tr>
<tr>
<td>6-For BEFORE the COVID-19 pandemic, I rate my overall physical health status as: (n=831)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-Very poor</td>
<td>1</td>
<td>.1</td>
</tr>
<tr>
<td>2-Poor</td>
<td>120</td>
<td>14.4</td>
</tr>
<tr>
<td>3-Fair</td>
<td>158</td>
<td>19.0</td>
</tr>
<tr>
<td>4-Good</td>
<td>222</td>
<td>26.7</td>
</tr>
<tr>
<td>5-Very Good</td>
<td>188</td>
<td>22.6</td>
</tr>
<tr>
<td>6-Excellent</td>
<td>142</td>
<td>17.1</td>
</tr>
<tr>
<td>Mean (4.09), SD (1.297)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>min (1), max (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7-For NOW, DURING the COVID-19 pandemic, I rate my overall physical health status as: (N=831)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-Very poor</td>
<td>3</td>
<td>.4</td>
</tr>
<tr>
<td>2-Poor</td>
<td>153</td>
<td>18.4</td>
</tr>
<tr>
<td>3-Fair</td>
<td>191</td>
<td>23.0</td>
</tr>
<tr>
<td>4-Good</td>
<td>217</td>
<td>26.1</td>
</tr>
<tr>
<td>5-Very Good</td>
<td>155</td>
<td>18.7</td>
</tr>
</tbody>
</table>
6-Excellent  
*Mean (3.85), SD (1.305)*  
*min (1), max (6)*  

8-For BEFORE the COVID-19 pandemic, I rate
My overall mental/emotional health status as: (N=831)
1-Very poor 5 .6  
2-Poor 141 17.0  
3-Fair 161 19.4  
4-Good 215 25.9  
5-Very good 182 21.9  
6-Excellent 127 15.3  
*Mean (3.97), SD (1.326)*  
*min (1), max (6)*

9-For NOW, DURING the COVID-19 pandemic, I rate
My overall mental/emotional health status as: (N=831)
1-Very poor 5 .6  
2-Poor 141 17.0  
3-Fair 161 19.4  
4-Good 215 25.9  
5-Very Good 182 21.9  
6-Excellent 127 15.3  
*Mean (3.79), SD (1.370)*  
*min (1), max (6)*

**Paired T-Tests Comparing Time Periods.** Findings showed a statistically significant difference (t = 3.994, df = 830, p = < .001) using paired sample t-tests comparing overall physical health status *before* the COVID-19 pandemic (mean = 4.09, SD = 1.297) versus ratings for *now/during* the pandemic (mean = 3.85, SD = 1.305), *indicating better overall physical health before COVID-19 pandemic.*

Also, when using a paired sample t-test comparing overall mental/emotional health status for *before* the COVID-19 pandemic (mean = 3.97, SD = 1.326) versus for *now/during* the COVID-19 pandemic (mean = 3.79, SD = 1.370), there was a significant difference (t = 2.984,
df = 830, p = .003), indicating a decline in mental/emotional health status for now/during the COVID-19 pandemic.

See Table 5.

<table>
<thead>
<tr>
<th>Table 5. Comparison of Personal Health Background-Current and Before Pandemic (PHB-CABP-9) (N=831)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Before vs During COVID-19 Pandemic</strong></td>
</tr>
<tr>
<td><strong>Personal Health Background</strong></td>
</tr>
<tr>
<td>Physical Health</td>
</tr>
<tr>
<td>Pre-COVID 19</td>
</tr>
<tr>
<td>During COVID-19</td>
</tr>
<tr>
<td>Mental Health</td>
</tr>
<tr>
<td>Pre-COVID 19</td>
</tr>
<tr>
<td>During COVID-19</td>
</tr>
</tbody>
</table>

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

Results for Research Question #3-Regarding the provision of socially desirable answers, to what extent was this a risk? (SIR-RPSDR-1)

Part III: Single Item Rating of Risk of Providing Socially Desirable Responses (SIR-RPSDR-1). The mean for social desirability rating was 5.04 (SD=2.407, min=0, max=10) which indicates a moderate risk for providing socially desirable responses. Of note, the regression analysis will control for social desirability.

See Table 6.

<table>
<thead>
<tr>
<th>Table 6. Single Item Rating of Risk of Providing Socially Desirable Responses (SIR-RPSDR-1) (N=831)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N</strong></td>
</tr>
</tbody>
</table>
| 1- I sometimes say things that I think will please people, or what I think they want to hear - versus the honest truth, which might be difficult or painful for other people to hear and accept or might lead them to judge me harshly….

I rate myself on a scale of 0 to 10, as follows (N=831)

| 0- I am not like this at all | 4 | .5 |
Results for Research Question #4 - To what extent did they report experiencing social support? (PSSS-1)

Part IV: Perceived Social Support Scale (PSSS-1). The mean for Perceived Social Support Scale was 3.03 (SD=.919, min=1, max=5) for having at least two people who provide social support in their lives at this time, or a moderate level of social support. Some 33.6% (N=279) of participants reported having at least two people who provide social support in their lives at this time.

See Table 7.

<table>
<thead>
<tr>
<th>Please indicate the extent to which you experience SOCIAL SUPPORT in your life at this time (i.e., right now): (N=831)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>1-I have no one like this in my life right now</td>
</tr>
<tr>
<td>2-I have at least 1 person like this in my life right now</td>
</tr>
<tr>
<td>3-I have at least 2 people like this in my life right now</td>
</tr>
<tr>
<td>4-I have 3-5 people like this in my life right now</td>
</tr>
<tr>
<td>5-I have 6 or more people like this in my life right now</td>
</tr>
</tbody>
</table>

Mean (3.03), SD (.919)
in (1), max (5)
Results for Research Question #5—To what extent did they report experiencing depression, anxiety, and trauma in the past year, along with any receipt of counseling? (RDATS-4)

Part V: Retrospective Depression, Anxiety, Trauma and Receipt of Counseling Scale (RDATS-4). The Retrospective Depressive Anxiety, Trauma and Receipt of Counseling Scale (RDATS-4) using four items had a questionable internal consistency (i.e. Cronbach’s Alpha of .600). The mean was 1.82 (SD = .949, min = 0, max = 4) for experiencing any depression in the past year for closest to a moderate level. Of note, combining some categories, 60.7% (N = 504) of participants experienced at least a moderate level, a severe level or very severe level of depression within the past 12 months. The mean was 1.84 (SD = .937, min = 0, max = 4) for experiencing any anxiety in the past year for closest to a moderate level. Combining some categories, 60.4% (N = 502) of participants experienced at least a moderate level, a severe level or very severe level of anxiety within the past 12 months. The mean was 1.71 (SD = .994, min = 0, max = 4) for experiencing any trauma or anxiety in the past year for closest to a moderate level. Some 85.2% (N=708) of participants reported having received counseling in the past year.

When creating the Mental Distress Index, or Mental Health Index for the past year—combining depression, anxiety, and trauma—the mean was 1.787 (SD = .716, min = 0, max = 4) for closest to a moderate level of past-year mental distress.

Further, 85.2% indicated “yes” for receiving mental health counseling in the past year (N=708), while only 14.8% (N=123) indicated “no.”

See Table 8.
Table 8. Retrospective Depression, Anxiety, Trauma and Receipt of Counseling Scale (RDATS-4) (N=831)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cronbach’s Alpha (.600)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Past Year Mental Distress Index mean = 1.787; SD = .716; min = 0, max = 4</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-Do you think you experience any depression in the past year or 12 months? (N=831)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-No</td>
<td>65</td>
<td>7.8</td>
</tr>
<tr>
<td>1-Yes, a very mild level</td>
<td>262</td>
<td>31.5</td>
</tr>
<tr>
<td>2-Yes, a moderate level</td>
<td>269</td>
<td>32.4</td>
</tr>
<tr>
<td>3-Yes, a severe level</td>
<td>229</td>
<td>27.6</td>
</tr>
<tr>
<td>4-Yes, a very severe level</td>
<td>6</td>
<td>.7</td>
</tr>
<tr>
<td><strong>Mean (1.82), SD (.949)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>min (0), max (4)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-Do you think you experienced any anxiety in the past year or 12 months? (N=831)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-No</td>
<td>50</td>
<td>6.0</td>
</tr>
<tr>
<td>1-Yes, a very mild level</td>
<td>279</td>
<td>33.6</td>
</tr>
<tr>
<td>2-Yes, a moderate level</td>
<td>272</td>
<td>32.7</td>
</tr>
<tr>
<td>3-Yes, a severe level</td>
<td>216</td>
<td>26.0</td>
</tr>
<tr>
<td>4-Yes, a very severe level</td>
<td>14</td>
<td>1.7</td>
</tr>
<tr>
<td><strong>Mean (1.84), SD (.937)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>min (0), max (4)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-Do you think you experienced any trauma or trauma symptoms in the past year or 12 months? (N=831)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-No</td>
<td>97</td>
<td>11.7</td>
</tr>
<tr>
<td>1-Yes, a very mild level</td>
<td>269</td>
<td>32.4</td>
</tr>
<tr>
<td>2-Yes, a moderate level</td>
<td>256</td>
<td>30.8</td>
</tr>
<tr>
<td>3-Yes, a severe level</td>
<td>200</td>
<td>24.1</td>
</tr>
<tr>
<td>4-Yes, a very severe level</td>
<td>9</td>
<td>1.1</td>
</tr>
<tr>
<td><strong>Mean (1.71), SD (.994)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>min (0), max (4)</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Receipt of Counseling**

4 – In the past year, did you seek out any kind of counseling or advice for any depression, anxiety or trauma – such as from a mental health professional or other helper? (N=831)

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Yes</td>
<td>708</td>
<td>85.2</td>
</tr>
<tr>
<td>2-No</td>
<td>104</td>
<td>12.5</td>
</tr>
<tr>
<td>3-Not Applicable</td>
<td>9</td>
<td>2.3</td>
</tr>
</tbody>
</table>
Results for Research Question #6 - To what extent did they report any past month experience of perceived stress? (PSS-4)

Part VI - Perceived Stress Scale (PSS-4). The Perceived Stress Scale (PSS-4) using four items had a low internal consistency (i.e., Cronbach’s Alpha of .349). Due to a low Cronbach’s Alpha, the Perceived Stress Scale (PSS-4) was not used subsequent bivariate and multivariate analyses. Instead, only one item from the PSS-4 was selected for use in subsequent bivariate and multivariate analysis, with this single item (question #1, “in the last month, how often have you felt that you were unable to control the important things in your life?”), showing a mean of 2.00 (SD = 1.326, min = 1, max = 4) for ‘sometimes’ they were unable to control the important things in their life. This suggested a moderate level of past-month perceived stress for feeling unable to control important things in their life.

See Table 9.

<table>
<thead>
<tr>
<th>Table 9. Perceived Stress Scale (PSS-4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Cronbach’s Alpha (.349)</strong></td>
</tr>
<tr>
<td>*1-In the last month, how often have you felt that you were unable to control the important things in your life? (N=831)</td>
</tr>
<tr>
<td>0-never</td>
</tr>
<tr>
<td>1-almost never</td>
</tr>
<tr>
<td>2-sometimes</td>
</tr>
<tr>
<td>3-fairly often</td>
</tr>
<tr>
<td>4-very often</td>
</tr>
<tr>
<td><strong>Mean (2.00), SD (1.326)</strong></td>
</tr>
<tr>
<td>min (1), max (4)</td>
</tr>
<tr>
<td>2-In the last month, how often have you felt confident about your ability to handle your personal problems? (N=831)</td>
</tr>
<tr>
<td>0-never</td>
</tr>
<tr>
<td>1-almost never</td>
</tr>
<tr>
<td>2-sometimes</td>
</tr>
<tr>
<td>3-fairly often</td>
</tr>
<tr>
<td>4-very often</td>
</tr>
</tbody>
</table>
3 – In the last month, how often have you felt that things were going your way? (N=831)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-never</td>
<td>107</td>
<td>12.9</td>
</tr>
<tr>
<td>1-almost never</td>
<td>140</td>
<td>16.8</td>
</tr>
<tr>
<td>2-sometimes</td>
<td>250</td>
<td>30.1</td>
</tr>
<tr>
<td>3-fairly often</td>
<td>197</td>
<td>23.7</td>
</tr>
<tr>
<td>4-very often</td>
<td>137</td>
<td>16.5</td>
</tr>
</tbody>
</table>

4 – In the last month, how often have you felt difficulties were piling up so high that you could overcome them? (N=831)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-never</td>
<td>108</td>
<td>13.0</td>
</tr>
<tr>
<td>1-almost never</td>
<td>170</td>
<td>20.5</td>
</tr>
<tr>
<td>2-sometimes</td>
<td>240</td>
<td>28.9</td>
</tr>
<tr>
<td>3-fairly often</td>
<td>187</td>
<td>22.5</td>
</tr>
<tr>
<td>4-very often</td>
<td>126</td>
<td>15.2</td>
</tr>
</tbody>
</table>

*NOTE: Perceived Stress Scale was not used in subsequent Bivariate and Multivariate Analysis due to a low Cronbach’s Alpha. However, the single item # 1 was used, instead.

Results for Research Question #7-What did they report as their experience of microaggressions-as perceived in relation to their being Asian? (REM-6)

Part VII: Ratings of Experiences of Microaggressions (REM-6). The Ratings of Experiences of Microaggression Scale (REM-6) demonstrated acceptable internal consistency (Cronbach’s Alpha=.705). The mean was 1.804 (SD=.691, min=0, max=4.00), or closest to category 2 which is “more than once” for participants’ having experiences of microaggressions perceived in relation to their being Asian. In addition, data was examined by combining categories:

- For example, for experiencing “Brief exchanges or brief interactions (in-person or online) where you felt you were receiving messages that were a put down, denigrating, or conveyed something negative,” 92.3% (N=767) experienced it at least once, more than once, a few times, or many times.
- For experiencing, “A verbal attack that was hurtful and caused mental or emotional pain, whether this involved name-calling, or some act of discrimination performed on purpose” 91.8% (N = 763) of participants experienced it at least once, more than once, a few times, or many times.
- In terms of, “A nonverbal attack, or some behavior that was hurtful and caused mental or emotional pain, whether this involved someone avoiding contact and interaction, or avoiding communication, or some act of discrimination performed on purpose: 91.4% (N = 759) of participants experienced it at least once, more than once, a few times, or many times.
- Of note, pertaining to, “A communication that was insulting, or conveyed rudeness and insensitivity, put downs or demeaning language:92.3% (N = 768) of participants experienced it at least once, more than once, a few times, or many times.
See Table 10.

<table>
<thead>
<tr>
<th>Table 10. Ratings of Experiences of Microaggressions (REM-6) (N=831)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cronbach’s Alpha (.705)</strong></td>
</tr>
</tbody>
</table>

1-Brief exchanges or brief interactions (in-person or online) where you felt you were receiving messages that were a put down, denigrating, or conveyed something negative: (N=831)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-Never/Not at all</td>
<td>64</td>
<td>7.7</td>
</tr>
<tr>
<td>1-At Least Once</td>
<td>256</td>
<td>30.8</td>
</tr>
<tr>
<td>2-More Than Once</td>
<td>245</td>
<td>29.5</td>
</tr>
<tr>
<td>3-A Few Times</td>
<td>239</td>
<td>28.8</td>
</tr>
<tr>
<td>4-Many Times</td>
<td>27</td>
<td>3.2</td>
</tr>
</tbody>
</table>

2-A verbal attack that was hurtful and caused mental or emotional pain, whether this involved name-calling, or some act of discrimination performed on purpose: (N=831)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-Never/Not at all</td>
<td>68</td>
<td>8.2</td>
</tr>
<tr>
<td>1-At Least Once</td>
<td>247</td>
<td>29.7</td>
</tr>
<tr>
<td>2-More Than Once</td>
<td>250</td>
<td>30.1</td>
</tr>
<tr>
<td>3-A Few Times</td>
<td>248</td>
<td>29.8</td>
</tr>
<tr>
<td>4-Many Times</td>
<td>18</td>
<td>2.2</td>
</tr>
</tbody>
</table>

3-A nonverbal attack, or some behavior that was hurtful and caused mental or emotional pain, whether this involved someone avoiding contact and interaction, or avoiding communication, or some act of discrimination performed on purpose: (N=831)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-Never/Not at all</td>
<td>72</td>
<td>8.7</td>
</tr>
<tr>
<td>1-At Least Once</td>
<td>270</td>
<td>32.5</td>
</tr>
<tr>
<td>2-More Than Once</td>
<td>222</td>
<td>26.7</td>
</tr>
<tr>
<td>3-A Few Times</td>
<td>244</td>
<td>29.4</td>
</tr>
<tr>
<td>4-Many Times</td>
<td>23</td>
<td>2.8</td>
</tr>
</tbody>
</table>

4-A communication that was insulting, or conveyed rudeness and insensitivity, put downs or demeaning language: (N=831)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-Never/Not at all</td>
<td>63</td>
<td>7.6</td>
</tr>
<tr>
<td>1-At Least Once</td>
<td>253</td>
<td>30.4</td>
</tr>
<tr>
<td>2-More Than Once</td>
<td>233</td>
<td>28.0</td>
</tr>
<tr>
<td>3-A Few Times</td>
<td>256</td>
<td>30.8</td>
</tr>
<tr>
<td>4-Many Times</td>
<td>26</td>
<td>3.1</td>
</tr>
</tbody>
</table>

5-A communication that excluded you, cancelled out your existence, made you invisible, or ignored the reality of your thoughts, feelings, and existence as a diverse person: (N=831)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-Never/Not at all</td>
<td>217</td>
<td>26.1</td>
</tr>
<tr>
<td>1-At Least Once</td>
<td>195</td>
<td>23.5</td>
</tr>
</tbody>
</table>
6-How often have you experienced various media messages on television, in commercials, on billboards, in magazines, and other online platforms as putting down people like YOU—denigrating them, spreading negative stereotypes, or conveying something negative about people like YOU? (N=831)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-Never/Not at all</td>
<td>177</td>
<td>21.3</td>
</tr>
<tr>
<td>1-At Least Once</td>
<td>187</td>
<td>22.5</td>
</tr>
<tr>
<td>2-More Than Once</td>
<td>215</td>
<td>25.9</td>
</tr>
<tr>
<td>3-A Few Times</td>
<td>195</td>
<td>23.5</td>
</tr>
<tr>
<td>4-Many Times</td>
<td>56</td>
<td>6.7</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>.1</td>
</tr>
</tbody>
</table>

Mean (1.804), SD (.691)
min (0), max (4.00)

Results for Research Question #8-What was their level of ability for perceiving racism and oppression? (PROS-10)

Part VIII: Perception of Racism and Oppression Scale (PROS-10). This scale demonstrated acceptable internal consistency with a Cronbach’s Alpha of .623. The mean was 2.328 (SD = .538, min = .8, max = 4.40) indicating participants’ perception of racism and oppression fell between category 1 (strongly agree) and category 2 (agree) which demonstrates that participants have a high level of ability for perceiving racism and oppression. For example, when responding to, “I am not sure it really exists or happens to people” 63.9% (N = 531) of participants either disagreed or strongly disagreed with this statement. In terms of, “I think it will never happen to me”, 64.7% (N = 538) of participants either disagreed or strongly disagreed that it could never happen to them.

See Table 11.
### Table 11. Perceptions of Racism and Oppression Scale (PROS-10) (N=831)

<table>
<thead>
<tr>
<th>Cronbach’s Alpha (.623)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>1-I am not sure it really exists or happens to people. (N=831)</td>
</tr>
<tr>
<td>1-Strongly Agree</td>
</tr>
<tr>
<td>2-Agree</td>
</tr>
<tr>
<td>3-Undecided</td>
</tr>
<tr>
<td>4-Disagree</td>
</tr>
<tr>
<td>5-Strongly Disagree</td>
</tr>
<tr>
<td>Missing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2-When incidents are talked about, I am not sure what makes something racist or oppressive. (N=831)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Strongly Agree</td>
</tr>
<tr>
<td>2-Agree</td>
</tr>
<tr>
<td>3-Undecided</td>
</tr>
<tr>
<td>4-Disagree</td>
</tr>
<tr>
<td>5-Strongly Disagree</td>
</tr>
<tr>
<td>Missing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3-I think it will never happen to me. (N=831)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Strongly Agree</td>
</tr>
<tr>
<td>2-Agree</td>
</tr>
<tr>
<td>3-Undecided</td>
</tr>
<tr>
<td>4-Disagree</td>
</tr>
<tr>
<td>5-Strongly Disagree</td>
</tr>
<tr>
<td>Missing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4-There are times when I “don’t get it,” or I can’t really tell when it is happening to me. (N=831)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Strongly Agree</td>
</tr>
<tr>
<td>2-Agree</td>
</tr>
<tr>
<td>3-Undecided</td>
</tr>
<tr>
<td>4-Disagree</td>
</tr>
<tr>
<td>5-Strongly Disagree</td>
</tr>
<tr>
<td>Missing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5-I think it never happens to others. (N=831)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Strongly Agree</td>
</tr>
<tr>
<td>2-Agree</td>
</tr>
<tr>
<td>3-Undecided</td>
</tr>
<tr>
<td>4-Disagree</td>
</tr>
<tr>
<td>5-Strongly Disagree</td>
</tr>
<tr>
<td>Missing</td>
</tr>
</tbody>
</table>
6-There are times when I “don’t get it,” or I can’t really tell when it is happening to others. (N=831)
1-Strongly Agree 13 1.6
2-Agree 223 26.8
3-Undecided 186 22.4
4-Disagree 193 23.2
5-Strongly Disagree 210 25.3
Missing 6 .7

7-I can usually see or sense when it is happening to me. (N=831)
1-Strongly Agree 61 7.3
2-Agree 264 31.8
3-Undecided 191 23.0
4-Disagree 166 20.0
5-Strongly Agree 143 17.2
Missing 6 .7

8-I can usually see or sense when it is happening to others. (N=831)
1-Strongly Agree 63 7.6
2-Agree 273 32.9
3-Undecided 201 24.2
4-Disagree 146 17.6
5-Strongly Disagree 142 17.1
Missing 6 .7

9-When incidents are talked about, I think “That could happen to me or someone I love.” (N=831)
1-Strongly Agree 84 10.1
2-Agree 225 27.1
3-Undecided 189 22.7
4-Disagree 169 20.3
5-Strongly Disagree 158 19.0
Missing 6 .7

10-When incidents are talked about, I can identify with and understand the experience. (N=831)
1-Strongly Agree 195 23.5
2-Agree 317 38.1
3-Undecided 175 21.1
4-Disagree 134 16.1
5-Strongly Disagree 3 .4
Missing 7 .8

Mean (2.328), SD (.538)
min (.8), max (4.40)
Results for Research Question #9 - What was their stage of change (i.e. precontemplation, contemplation, preparation, action, or maintenance stage) with regard to coping and responding to racism and oppression? (CRROSS-7)

Part IX: Coping and Responding to Racism and Oppression Staging Scale (CRROSS-7). The mean was 4.35 (SD=1.038, min=1 which is precontemplation stage, max=5 which is maintenance stage) for participants’ stages of change with regard to coping and responding to racism and oppression, indicating closest to ‘action stage’. For example:

- For item #2, “I never thought about how to cope with and respond to it,” 51.6% (N = 428) of participants either agreed or strongly agreed—as a score of 1 or 2 for being in stage #1, or the precontemplation stage

- For item #3, “I have thought about how to cope with and respond to it,” 68.4% (N = 569) of participants either agreed or strongly agreed—as a score of 1 or 2 for being in stage #2, or the contemplation stage.

- For item #5, “I am planning to take steps to learn more about how to cope with and respond to it,” 64.3% (N = 534) of participants either agreed or strongly agreed—as a score of 1 or 2 for being in stage #3, or the preparation stage

- For item #6, “I have been actively learning how to cope with and respond to it,” 66.9% (N = 556) of participants either agreed or strongly agreed—as a score of 1 or 2 for being in stage #4, or the action stage

- For item #7, “Learning how to cope with and respond to it is something that I have been actively working on,”—specifically, for endorsing 6 months or more, 62.2% (N = 517) were in stage #5, or the maintenance stage

Of note, it is possible to endorse items suggestive of more than one stage of change.

See Table 12.
<table>
<thead>
<tr>
<th>1-I don’t think they exist, so there is nothing to learn how to cope with or respond to. (N=831) [score of 1 or 2 as #1=precontemplation stage]</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Strongly Agree</td>
<td>181</td>
<td>21.8</td>
</tr>
<tr>
<td>2-Agree</td>
<td>245</td>
<td>29.5</td>
</tr>
<tr>
<td>3-Undecided</td>
<td>201</td>
<td>24.2</td>
</tr>
<tr>
<td>4-Disagree</td>
<td>82</td>
<td>9.9</td>
</tr>
<tr>
<td>5-Strongly Disagree</td>
<td>113</td>
<td>13.6</td>
</tr>
<tr>
<td>Missing</td>
<td>9</td>
<td>1.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2-I never thought about how to cope with and respond to it. (N=831) [score of 1 or 2 as #1=precontemplation stage]</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Strongly Agree</td>
<td>206</td>
<td>24.8</td>
</tr>
<tr>
<td>2-Agree</td>
<td>223</td>
<td>26.8</td>
</tr>
<tr>
<td>3-Undecided</td>
<td>213</td>
<td>25.6</td>
</tr>
<tr>
<td>4-Disagree</td>
<td>108</td>
<td>13.0</td>
</tr>
<tr>
<td>5-Strongly Disagree</td>
<td>72</td>
<td>8.7</td>
</tr>
<tr>
<td>Missing</td>
<td>9</td>
<td>1.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3-I have thought about how to cope with and respond to it. (N=831) [score of 1 or 2 as #2=contemplation stage]</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Strongly Agree</td>
<td>252</td>
<td>30.3</td>
</tr>
<tr>
<td>2-Agree</td>
<td>317</td>
<td>38.1</td>
</tr>
<tr>
<td>3-Undecided</td>
<td>214</td>
<td>25.8</td>
</tr>
<tr>
<td>4-Disagree</td>
<td>29</td>
<td>3.5</td>
</tr>
<tr>
<td>5-Strongly Disagree</td>
<td>10</td>
<td>1.2</td>
</tr>
<tr>
<td>Missing</td>
<td>9</td>
<td>1.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4-I never took steps to learn more about how to cope with and respond to it. (N=831) [score of 1 or 2 as #2=contemplation stage]</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Strongly Agree</td>
<td>175</td>
<td>21.1</td>
</tr>
<tr>
<td>2-Agree</td>
<td>276</td>
<td>33.2</td>
</tr>
<tr>
<td>3-Undecided</td>
<td>219</td>
<td>26.4</td>
</tr>
<tr>
<td>4-Disagree</td>
<td>98</td>
<td>11.8</td>
</tr>
<tr>
<td>5-Strongly Disagree</td>
<td>54</td>
<td>6.5</td>
</tr>
<tr>
<td>Missing</td>
<td>9</td>
<td>1.1</td>
</tr>
</tbody>
</table>
5-I am planning to take steps to learn more about how to cope with and respond to it. (N=831)  
(score of 1 or 2 as #3=preparation stage)

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Strongly Agree</td>
<td>226</td>
<td>27.2</td>
</tr>
<tr>
<td>2-Agree</td>
<td>308</td>
<td>37.1</td>
</tr>
<tr>
<td>3-Undecided</td>
<td>248</td>
<td>29.8</td>
</tr>
<tr>
<td>4-Disagree</td>
<td>34</td>
<td>4.1</td>
</tr>
<tr>
<td>5-Strongly Disagree</td>
<td>4</td>
<td>.5</td>
</tr>
<tr>
<td>Missing</td>
<td>11</td>
<td>1.3</td>
</tr>
</tbody>
</table>

6-I have been actively learning how to cope with and respond to it. (N=831)  
(score of 1 or 2 as #4=action stage)

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Strongly Agree</td>
<td>230</td>
<td>27.7</td>
</tr>
<tr>
<td>2-Agree</td>
<td>326</td>
<td>39.2</td>
</tr>
<tr>
<td>3-Undecided</td>
<td>228</td>
<td>27.4</td>
</tr>
<tr>
<td>4-Disagree</td>
<td>30</td>
<td>3.6</td>
</tr>
<tr>
<td>5-Strongly Disagree</td>
<td>6</td>
<td>.7</td>
</tr>
<tr>
<td>Missing</td>
<td>11</td>
<td>1.3</td>
</tr>
</tbody>
</table>

7-Learning how to cope with and respond to it is something that I have been actively working on: (N=831)  
(score > 6 months as # 5=maintenance stage)

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Never in my life</td>
<td>26</td>
<td>3.1</td>
</tr>
<tr>
<td>1 &lt;1 month</td>
<td>127</td>
<td>15.3</td>
</tr>
<tr>
<td>2 &lt;6 months</td>
<td>136</td>
<td>16.4</td>
</tr>
<tr>
<td>3 &gt;6 months</td>
<td>144</td>
<td>17.3</td>
</tr>
<tr>
<td>4 1-3 years</td>
<td>178</td>
<td>21.4</td>
</tr>
<tr>
<td>5 4-6 years</td>
<td>143</td>
<td>17.2</td>
</tr>
<tr>
<td>6 7-9 years</td>
<td>10</td>
<td>1.2</td>
</tr>
<tr>
<td>7 10-20 years</td>
<td>29</td>
<td>3.5</td>
</tr>
<tr>
<td>8 21-30 years</td>
<td>8</td>
<td>1.0</td>
</tr>
<tr>
<td>9 &gt;31 years</td>
<td>5</td>
<td>.6</td>
</tr>
<tr>
<td>10 Unsure</td>
<td>14</td>
<td>1.7</td>
</tr>
<tr>
<td>Missing</td>
<td>11</td>
<td>1.3</td>
</tr>
</tbody>
</table>

Mean (4.35), SD (1.038)  
min (1=precontemplation stage), max (5=maintenance stage)

Note: It is possible to endorse items suggestive of more than one stage of change.
Results for Research Question #10-To what extent did they report experiences of hate (i.e. personally live/in-person or online; personally witnessed; or to someone close to them; or to someone in their neighborhood; or to a member of their racial/ethnic community; or watching a video)? And, to what degree did they report their experiences of hate as having an impact upon them that was stressful or traumatic? (EOH-12)

Part X: Experiences of Hate (EOH-12). The Experience of Hate Scale (EOH-12) uses two different scales which are as follow: Experience of Hate Scale consisted of 6-items and Impact of Hate Scale also consisted of 6-items. The Experience of Hate Scale (EOH-12) produced an unacceptable internal consistency with a Cronbach’s Alpha of .548. Due to a low Cronbach’s Alpha, the Experience of Hate Scale was not used in subsequent Bivariate and Multivariate Analysis. However, the Impact of Hate Scale produced an acceptable internal consistency with a Cronbach’s Alpha of .618. The mean was 2.23 (SD = .943, min = .00, max = 5.00) for the Impact of Hate Scale which indicates participants have experienced closest to rating 2 for a low impact from experiences of hate.

As examples, on the Experience of Hate Scale, findings showed the following when combining categories for once, twice, a few times, many times, and a great number of times—followed by the findings for Impact of Hate Scale combining moderate, high, and very high impact:

- For hate item #1, “I personally experienced HATE”, 79% (N = 656) endorsed the combined categories for once, twice, a few times, many times, and a great number of times; and, for impact item #2, 43.5% (N = 362) endorsed moderate, high, and very high impact from this.
- For hate item #3, “I personally witnessed HATE against someone else (live, in-person, or while online)”, 79.2% (N = 664) endorsed the combined categories for once, twice, a few times, many times, and a great number of times; and, for impact item #4, 44.5% (N = 370) endorsed moderate, high, and very high impact from this.
- For hate item #11, “I saw a VIDEO (e.g., television, YouTube, on social media of someone I did not know being a victim of Hate at least once), 81.9% (N = 681) endorsed the combined categories of once, twice, a few times, many times or a great number of times; and, for impact item #5, 45.6% (N = 385) endorsed moderate, high, and very high impact from this.
times; and, for impact item #12 48.7% (N = 404) endorsed moderate, high, and very high impact from this.

See Table 13.

<table>
<thead>
<tr>
<th>Table 13. Experience of Hate (EOH-12)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Experiences of Hate Scale (Items 1, 3, 5, 7, 9, 11)</td>
</tr>
<tr>
<td>Cronbach’s Alpha (.548)</td>
</tr>
<tr>
<td>Impact of Hate Scale (Items 2, 4, 6, 8, 10)</td>
</tr>
<tr>
<td>Cronbach’s Alpha (.618)</td>
</tr>
<tr>
<td>1-I personally experienced HATE (live, in person or online) (N=831)</td>
</tr>
<tr>
<td>0-Never</td>
</tr>
<tr>
<td>1-Once</td>
</tr>
<tr>
<td>2-Twice</td>
</tr>
<tr>
<td>3-Few Times</td>
</tr>
<tr>
<td>4-Many Times</td>
</tr>
<tr>
<td>5-Great Number of Times</td>
</tr>
<tr>
<td>Missing</td>
</tr>
<tr>
<td>2-I rate the impact on me, given how stressful or traumatic it was for me:</td>
</tr>
<tr>
<td>0-No Impact</td>
</tr>
<tr>
<td>1-Very Low Impact</td>
</tr>
<tr>
<td>2-Low Impact</td>
</tr>
<tr>
<td>3-Moderate Impact</td>
</tr>
<tr>
<td>4-High Impact</td>
</tr>
<tr>
<td>5- Very High Impact</td>
</tr>
<tr>
<td>Missing</td>
</tr>
<tr>
<td>3-I personally witnessed HATE against someone else (live, in-person, or while online).</td>
</tr>
<tr>
<td>(N=831)</td>
</tr>
<tr>
<td>0-Never</td>
</tr>
<tr>
<td>1-Once</td>
</tr>
<tr>
<td>2-Twice</td>
</tr>
<tr>
<td>3-Few Times</td>
</tr>
<tr>
<td>4-Many Times</td>
</tr>
</tbody>
</table>
5-Great Number of Times | 34 | 4.1  
Missing | 15 | 1.8  

4-I rate the impact on me, given how stressful or traumatic it was for me: (N=831)  
0-No Impact | 161 | 19.4  
1-Very Low Impact | 137 | 16.5  
2-Low Impact | 148 | 17.8  
3-Moderate Impact | 190 | 22.9  
4-High Impact | 158 | 19.0  
5-Very High Impact | 22 | 2.6  
Missing | 15 | 1.8  

5-A person CLOSE to me (e.g., family member, friend, etc.) experienced hate (live, in-person, or while online) (N=831)  
0-Never | 170 | 20.5  
1-Once | 149 | 17.9  
2-Twice | 133 | 16.0  
3-Few Times | 158 | 19.0  
4-Many Times | 107 | 12.9  
5-Great Number of Times | 98 | 11.8  
Missing | 16 | 1.9  

6-I rate the impact on me, given how stressful or traumatic it was for me: (N=831)  
0-No Impact | 170 | 20.5  
1-Very Low Impact | 113 | 13.6  
2-Low Impact | 137 | 16.5  
3-Moderate Impact | 147 | 17.7  
4-High Impact | 139 | 16.7  
5-Very High Impact | 109 | 13.1  
Missing | 16 | 1.9  

7-A person in my neighborhood or the area where I live experienced HATE (live, in-person, or while online). (N=831)  
0-Never | 253 | 30.4  
1-Once | 104 | 12.5  
2-Twice | 94 | 11.3  
3-Few Times | 137 | 16.5  
4-Many Times | 131 | 15.8  
5-Great Number of Times | 94 | 11.3  
Missing | 18 | 2.2  

8-I rate the impact on me, given how stressful or traumatic it was for me: (N=831)  
0-No Impact | 235 | 28.3  
1-Very Low Impact | 110 | 13.2  
2-Low Impact | 108 | 13.0  
3-Moderate Impact | 155 | 18.7
<table>
<thead>
<tr>
<th>Rating</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-High Impact</td>
<td>114</td>
<td>13.7</td>
</tr>
<tr>
<td>5-Very High Impact</td>
<td>91</td>
<td>11</td>
</tr>
<tr>
<td>Missing</td>
<td>18</td>
<td>2.2</td>
</tr>
</tbody>
</table>

9-A person I consider to be part of my racial/ethnic community experienced HATE (live, in-person, or while online). (N=831)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-Never</td>
<td>183</td>
</tr>
<tr>
<td>1-Once</td>
<td>96</td>
</tr>
<tr>
<td>2-Twice</td>
<td>96</td>
</tr>
<tr>
<td>3-Few Times</td>
<td>162</td>
</tr>
<tr>
<td>4-Many Times</td>
<td>136</td>
</tr>
<tr>
<td>5-Great Number of Times</td>
<td>137</td>
</tr>
<tr>
<td>Missing</td>
<td>19</td>
</tr>
</tbody>
</table>

10-I rate the Impact on me, given how stressful or traumatic it was for me: (N=831)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-No Impact</td>
<td>197</td>
</tr>
<tr>
<td>1-Very Low Impact</td>
<td>100</td>
</tr>
<tr>
<td>2-Low Impact</td>
<td>112</td>
</tr>
<tr>
<td>3-Moderate Impact</td>
<td>160</td>
</tr>
<tr>
<td>4-High Impact</td>
<td>141</td>
</tr>
<tr>
<td>5-Very High Impact</td>
<td>102</td>
</tr>
<tr>
<td>Missing</td>
<td>19</td>
</tr>
</tbody>
</table>

11-I saw a VIDEO (e.g., television, YouTube, on social media of someone I did not know being a victim of Hate). (N=831)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-Never</td>
<td>125</td>
</tr>
<tr>
<td>1-Once</td>
<td>146</td>
</tr>
<tr>
<td>2-Twice</td>
<td>135</td>
</tr>
<tr>
<td>3-Few Times</td>
<td>159</td>
</tr>
<tr>
<td>4-Many Times</td>
<td>168</td>
</tr>
<tr>
<td>5-Great Number of Times</td>
<td>73</td>
</tr>
<tr>
<td>Missing</td>
<td>25</td>
</tr>
</tbody>
</table>

12-I rate the Impact on me, given how stressful or traumatic it was for me: (N=831)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-No Impact</td>
<td>133</td>
</tr>
<tr>
<td>1-Very Low Impact</td>
<td>131</td>
</tr>
<tr>
<td>2-Low Impact</td>
<td>138</td>
</tr>
<tr>
<td>3-Moderate Impact</td>
<td>185</td>
</tr>
<tr>
<td>4-High Impact</td>
<td>171</td>
</tr>
<tr>
<td>5-Very High Impact</td>
<td>48</td>
</tr>
<tr>
<td>Missing</td>
<td>25</td>
</tr>
</tbody>
</table>

**Mean (2.23), SD (.943)**

**min (.00), max (5.00)**

*NOTE: Two different scales were used: EOH-6 and IOH-6. EOH-6 was not used in Bivariate and Multivariate Analysis due to unacceptable Cronbach’s Alpha (.548)
Results for Research Question #11—Were there any significant relationships between selected independent variables and the study outcome variable of a higher prevalence of the experience of microaggressions in the United States?

The relationships between selected independent variables and a higher prevalence of the experience of microaggressions were examined using both independent t-tests and Pearson Correlations. The results for each are represented below.

Independent t-tests Comparing Groups with the Outcome Variable—Higher Prevalence of the Experiences of Microaggressions. Seven dichotomous variables were used (i.e. gender, if born in the United States, if currently has a partner, etc.) were compared to the outcome variable of experiences of microaggressions in the United States. The Bonferroni adjustment significance level was (p = .05/7 = .007). The results showed that one group had a significant relationship with the outcome variable as follow:

- comparing respondents who sought counseling (mean = 1.891, SD = .549) to those who did not seek counseling (mean= 1.300, SD = 1.098), there was a significant difference (t = 5.841, df = 132.787, p = <.001) where respondents who sought counseling experienced more microaggressions.

See Table 14.

| Table 14. Independent Group T-Tests Comparing Dichotomous Groups on the Study Outcome Variable-Expression of Microaggressions in the United States |
|-------------------------------------------------|----------------|----------------|----------------|-------|----------------|
|                                                  | Experiences of Microaggressions | t-test |
|                                                  | N   | M   | SD  | t   | Df  | P   |
| Gender                                          |     |     |     |     |     |     |
| Female                                         | 456 | 1.814 | .715 | .564 | 822 | .573 |
| Male                                           | 368 | 1.786 | .656 |     |     |     |
| If born in the US                               |     |     |     | .624 | 120.371 | .534 |

89
Pearson Correlations. Correlations between 19 independent variables and the primary outcome variable were explored using the Bonferroni Adjustment Significance (.05/19, p=.002) level. Significant correlations were observed, below. The higher prevalence of the experiences of microaggressions in the United States, then the:

- higher the Age (r = .168, p= <.001)
- darker the Skin Color (r = .002, p = .002)
- lower Self-Rating of Mental Health (pre-COVID-19) (r = -.147, p = <.001)
- lower Self-Rating of Physical Health (pre-COVID-19) (r = -.110, p = .001)
- lower Self-Rating of Mental Health (during-COVID-19) (r = -.193, p = <.001)
- higher the Depression in the past year (r =.259, p= <.001)
- higher the Anxiety in the past year (r =.271, p = <.001)
- higher the Trauma in the past year (r =.272, p = <.001)
- higher the past year Mental Distress Index (r =.358, p = <.001)
- higher for PSS-4 item # 1, Felt Unable to Control Important Things in Life (r =.205, p = <.001)
- higher the Perception of Racism and Oppression (r = .797, p = <.001)
• **higher** the Stages of Change for Coping and Responding to Racism and Oppression ($r = .797, p = <.001$)
• **higher** the score on the Impact of Hate Scale ($r = .435, p = <.001$)
• **lower** Social Desirability ($r = -.094, p = .007$)

See Table 15.

### Table 15. Correlations Between Selected Independent Variables and The Study Outcome Variable of Experiences of Microaggressions in the US

<table>
<thead>
<tr>
<th></th>
<th>Pearson’s R</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.168</td>
<td>.001***</td>
</tr>
<tr>
<td>Skin Color</td>
<td>.002</td>
<td>.002**</td>
</tr>
<tr>
<td>Income Level</td>
<td>.020</td>
<td>.571</td>
</tr>
<tr>
<td>Education Level</td>
<td>-.013</td>
<td>.709</td>
</tr>
<tr>
<td>Body Mass Index (BMI)</td>
<td>.002</td>
<td>.960</td>
</tr>
<tr>
<td>Self-Rating of Physical Health (pre-COVID-19)</td>
<td>-.082</td>
<td>.018</td>
</tr>
<tr>
<td>Self-Rating of Mental Health (pre-COVID-19)</td>
<td>-.147</td>
<td>.001***</td>
</tr>
<tr>
<td>Self-Rating of Physical Health during COVID-19</td>
<td>-.110</td>
<td>.001**</td>
</tr>
<tr>
<td>Self-Rating of Mental Health during COVID-19</td>
<td>-.193</td>
<td>.001***</td>
</tr>
<tr>
<td>Social Support Scale</td>
<td>.027</td>
<td>.430</td>
</tr>
<tr>
<td>Depression in the Past Year</td>
<td>.259</td>
<td>.001***</td>
</tr>
<tr>
<td>Anxiety in the Past Year</td>
<td>.271</td>
<td>.001***</td>
</tr>
<tr>
<td>Trauma in the Past Year</td>
<td>.272</td>
<td>.001***</td>
</tr>
<tr>
<td>Past Year Mental Distress Index</td>
<td>.358</td>
<td>.001***</td>
</tr>
<tr>
<td>PSS-4 # 1,Felt Unable to Control Important Things in Life</td>
<td>.205</td>
<td>.001***</td>
</tr>
<tr>
<td>Perception of Racism &amp; Oppression Scale</td>
<td>.797</td>
<td>.001***</td>
</tr>
<tr>
<td>Stage of Change for Coping &amp; Respdng to Racism &amp; Op.</td>
<td>.128</td>
<td>.001***</td>
</tr>
<tr>
<td>Impact of Hate Scale</td>
<td>.435</td>
<td>.001***</td>
</tr>
<tr>
<td>Social Desirability</td>
<td>-.094</td>
<td>.007**</td>
</tr>
</tbody>
</table>

*p<.05, **p<.01, ***p<.001 Bonferroni Adjustment Significance (.05/19, p=.002).

Note: All p values above .002 are considered non-significant; and only those below below .002 are considered statistically significant.

**Results for Research Question #12**-When controlling for social desirability, what were the significant predictors of the study outcome variable of a higher prevalence of the experience of microaggressions in the United States?
Backward Stepwise Regression Analysis—Independent Variables, Rationale for Use, Findings. This study sought to identify the significant predictors of the outcome variable, a high prevalence of experiences of microaggressions in the United States for diverse Asians living in the U.S. during the COVID-19 pandemic. The analysis controlled for social desirability using Backward Stepwise Regression.

The Backward Stepwise Regression Model. The model used the following 21 independent variables:

1- Gender (female/male; dichotomous); 2- U.S. born (yes/no; dichotomous); 3- Currently Has a Partner (yes/no; dichotomous); 4- Currently Employed (yes/no; dichotomous); 5- Currently a Student (yes/no; dichotomous); 6- Had/Has COVID-19 in past 2 years (yes/no; dichotomous); 7- Sought Counseling (yes/no; dichotomous); 8- Age (continuous); 9- Skin Color (continuous); 10- Annual Household Income (categories as continuous); 11- Education Level (continuous); 12- Body Mass Index (BMI; continuous); 13- Overall Physical Health (continuous); 14- Overall Mental Health (continuous); 15- Social Support (continuous); 16- Mental Distress Index (continuous); 17- PSS-4 Item # 1- Felt Unable to Control Important Things In Life for the past month (continuous); 18- Perception of Racism and Oppression Scale (continuous); 19- Stage of Change for Coping and Responding to Racism and Oppression (continuous); 20- Impact of Hate Scale (continuous); 21- Social Desirability (continuous control variable forced into model at every step).

This study followed a backward selection approach typically used to find the relative association among multiple variables within one domain (Mantel, 1970). As outlined by Mantel (1970), the backward stepwise approach starts with a full model where all variables are included from the beginning. The variables that are non-significant (p < .05) are then removed one at a time until the model has only significant variables remaining. The usage of the backward selection procedure minimizes the degrees of freedom and eliminates noise caused by including variables that are unrelated or highly correlated variables (Mantel, 1970).

In this study, the analysis started with all 21 independent variables for this sample size of (N =831), while removing the variable at each step that displayed the weakest association with a
high prevalence of experiences of microaggressions in the United States—doing so one step at a
time. This particular process was completed until the remaining variables in the model were
statistically significant (p < .05). Since social desirability acted as a control variable, it was also
included (forced) into each step, regardless of its significance level.

Of note, the use of 21 independent variables risked overfitting the model and potential
prediction errors, following Hawkins (2004). On the other hand, Babyak (2004) indicated the use
of a liberal p < .05 level in backward stepwise regression might be considered the least harmful
approach—as only those most important predictors are likely to be retained in the model.

Keeping this in mind, the regression analysis proceeded.

Findings. The results of the backward stepwise regression analysis for this study
demonstrated that the significant predictors for the study outcome variable, a high prevalence of
experiences of microaggressions in the United States were, as follows:

- Yes, for being born in the U.S. (b = .117, SE = .056, p = <.001)
- No, for being a student (b = .265, SE = -.094, p = <.001)
- Yes, for Sought Mental Health Counseling in past year (b = .451, SE = .230, p = <.001)
- Older age (b =.004, SE = .042, p = .020)
- Lower education level (b= -.030, SE = -.057, p = .002)
- Higher Mental Distress Index (b = .076, SE = .834, p = <.001)
- Higher ability for Perception of Racism and Oppression (b = 1.063, SE = .834, p =
  <.001)

For this model the R² was .776 and the adjusted R² was .774, indicating that 77.4% of the
variance was explained by this model.

See Table 16.

<table>
<thead>
<tr>
<th>Variables</th>
<th>B</th>
<th>SE of B</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, for being born in the U.S</td>
<td>.117</td>
<td>.040</td>
<td>.003</td>
</tr>
<tr>
<td>No, for being a student</td>
<td>-.265</td>
<td>.052</td>
<td>.001**</td>
</tr>
</tbody>
</table>

Table 16. Backward Stepwise Regression Predicting Higher Prevalence of Experiences of
Microaggressions in the United States
Yes, Sought Mental Health Counseling past year  .451  .041  .001**
Older Age  .004  .002  .020
Lower Education level  -.030  .010  -.057
Higher Mental Distress Index  .076  .020  .001**
Higher ability for Perception of Racism & Oppressn. 1.063  .024  .001**
*p<.05, **p<.01, ***p<.001. \( R^2 = 0.776 \), Adjusted \( R^2 = 0.774 \) – meaning 77.4% of variance was explained by this model. \( F=334.472 \) \( p=.001 \)

Conclusion

This chapter described the results of the data analysis for each research question. The results were summarized for each research questions and displayed in tables.

Chapter V will provide a discussion for the results of this study along with the implications, recommendations, limitations, and a conclusion.
Chapter V

DISCUSSION, IMPLICATIONS, RECOMMENDATIONS, AND CONCLUSION

This chapter will present a discussion of the study findings, including implications and recommendations. In addition, the chapter will present the study limitations and a final conclusion.

Discussion of Results

Discussion of Demographic Findings

The study was a cross-sectional online research study that investigates for diverse Asians living in the United States during the COVID-19 pandemic their experiences of hate, hate crimes and microaggressions, while seeking to identify significant predictors of experiences of microaggressions. The study findings on demographics may be compared to those of Lee (2022)—who used similar measures and had a comparable diverse sample. For the present study, the final sample (N = 831) was 44.3% male (n = 368) and 54.9% female (n = 456). Lee (2022) had 59.2% male respondents and 40.6% female respondents.

This study’s sample had a mean age of 33.23 years (SD = 6.708, min = 18, max = 65). Lee (2022), while examining Black, Latinx and Asian college students’ experiences of microaggressions, stress, perceived racism, oppression and coping strategies, had a slightly lower mean age of 26.6 years (SD=6.752, min 18, max 59).

The most frequently reported Asian ethnicities in the present study were 26.7% Chinese (N = 222), 13.6% Japanese (N = 113), 13.4% Korean (N = 111), 12.4% Taiwanese (N = 103), 10.6% Filipino (N = 88), 10.3% Indian (N = 86) and 8.5% Thai (N = 71). This is notably similar
to a study on Asian hate, minority stress and religious coping conducted during the COVID-19 pandemic by Nie (2023) where the largest Asian ethnicities reported were Chinese (N = 72, 21.82%), Asian Indian (N = 76, 23.03%) and Filipino (N = 60, 18.18%).

In the present study, a total of 86.8% of participants reported that they were born in the United States (N = 721). For those born outside of the United States (N = 110, 13.2%), the most frequently reported countries of origin were China at 4.9% (N = 41) and South Korea at 3.1% (N = 26). Lee (2022) also had foreign born respondents from China (N = 31, 9.1%) and South Korea (N = 13, 3.8%). Yet, Lee’s (2022) sample had a smaller proportion of U.S. born respondents with 66.9% of participants being born in the U.S.

The mean annual household income in the present study was 4.69 (SD = 1.291, min = 1, max = 11), or between category 4 ($40,000 to $49,000) and category 5 ($50,000 to $99,999). For example, 41% (N = 341) reported annual household income for category 5 of $50,000 to $99,000. Lee (2022) reported, in comparison, a higher mean annual household income level which was 5.54 (min=2, max=11, SD=2.091) for between $50,000 to $99,999 and $100,000 to $199,999.

In addition, the present study found that only 6.9% of the Asians were students (N = 57). For students, the majority fell between category 6 which was 1st year in grad school (1.3%, N = 11) and category 7 which was 2nd year in grad school (1.3%, N = 11). In comparison, Lee (2022) focused on a college/university student sample of Black, Latinx and Asian participants, finding most reported being a sophomore in college (N = 59, 17.3%) followed by being in the 2nd year in graduate school (N = 57, 16.7%). In the present study, a majority of students (N = 57) were between the 1st year of graduate school and 2nd year in graduate school.
**Discussion of Findings on Social Desirability**

In considering findings using the scales in this study, it should be kept in mind that the sample’s mean for social desirability was 5.04 (SD=2.407, min=0, max=10) which indicates a moderate risk for providing socially desirable responses in the present study. Using the same tool, Lee (2022) found with a sample of Black, Latinx and Asian college students that the social desirability mean was 6.39 (min=1, max=10, SD=1.818) indicating a moderately high level of social desirability.

**Discussion of Findings on Health Status**

The Personal Health Background - Current and Before Pandemic (PHB-CABP-9) showed a mean body mass index (BMI) of 22.393 for the healthy weight range for both males and females (SD = 4.418, min = 8.24 = underweight category, max = 39.86 = obese range) for the present study. Of note, the Centers for Disease Control and Prevention (CDC, 2022) interpreted BMI as follows for both men and women who are above 20 years old: <18.5=underweight, 18.5–24.9=normal or healthy weight, 25.0–29.9=overweight, and >30.0=obese (CDC, 2022). This was similar to Lee’s (2022) sample where the mean body mass index (BMI) was 23.14 (min=7.86, max=58.99, SD=7.653) for normal or healthy weight.

In the present study, 35.7% (n = 297) gained weight during the COVID-19 pandemic, while 27.6% (n = 229) reported they lost weight, and 38.3% (n=318) indicated their weight remained the same. Khubchandani et al. (2022) conducted a study to examine weight gain in American adults during the pandemic and the findings were similar to the present study. For example, out of a total of 2,473 individuals, 48% gained weight, 34% remained the same weight and 18% lost weight during the COVID-19 pandemic. Results also revealed that weight gain was
“statistically significantly higher” in those with anxiety (53%), depression (52%), or symptoms of both at 52% (Khubchandani et al. 2022, p.1).

In the present study, for the past 2 years, only 13.4% (n = 111) reported they have now or had COVID-19; and, 5.4% (n=45) indicated they currently have or had long COVID-19. In another pandemic era study with a Black sample of adults (N = 188), Williams-Gunpot (2021), 19.1% (N = 36) had experienced COVID-19 in the past year; and 6.9 had long COVID-19. In yet another pandemic era study with teachers (N = 159) where 69.8% identified as White, 9.4% as Asian, 9.4% as Black, and 8.8% Latino, D’Mello (2021) found 17.6% (N = 28) had contracted COVID-19 in the past year.

Findings in the present study showed statistically significant differences (p = < .001) when using paired sample t-tests to compare overall physical health status ratings before the COVID-19 pandemic (mean = 4.09, SD = 1.297) versus ratings for now/during the pandemic (mean = 3.85, SD = 1.305), indicating better overall physical health before COVID-19 pandemic. D’Mello’s (2021) also reported a significant difference (p =.000) where overall physical health status was better before the COVID-19 pandemic. Williams-Gunpot (2021) similarly found this same pattern of better physical health status, before the pandemic (p =.000).

The present study found via paired sample t-tests comparing overall mental/emotional health status for before the COVID-19 pandemic (mean = 3.97, SD =1.326) versus now/during the COVID-19 pandemic (mean = 3.79, SD = 1.370) a significant difference (p = .003), indicating a decline in mental/emotional health status for now/during the COVID-19 pandemic. Both D’Mello’s (2021) findings and those of Williams-Gunpot (2021) indicated this same pattern (p = .000).
Thus, across pandemic-era studies, declines in both physical health and mental/emotional health emerge as commonplace.

**Discussion of Findings on Social Support**

In the present study, the mean for Perceived Social Support Scale (PSSS-1) was 3.03 (SD=.919, min=1, max=5) for having at least two people who provide social support in their lives at this time—or a moderate level of social support. Lee (2022) similarly found a moderate level of social support (mean = 3.21, min=1, max=5, SD= 1.193). Furthermore, D’Mello (2021) found this same level of moderate social support (mean = 3.21, min = 1 max = 5, SD = .930), and Williams-Gunpot (2021) reported closest to moderate social support (mean = 2.71, min=0, max=4, SD=1.172)—suggesting commonalities across these pandemic-era samples.

**Discussion of Findings on Retrospective Depression, Anxiety and Trauma**

The Retrospective Depressive Anxiety, Trauma and Receipt of Counseling Scale (RDATS-4) using four items had questionable internal consistency (i.e. Cronbach’s Alpha of .600) in the present study—as a scale modified to be continuous for the first time in year 2022 years by the Research Group on Disparities in Health (RGDH); hence, comparisons are limited. However, comparisons of the Mental Distress Index, combining depression, anxiety and trauma, are possible. In this study, the Mental Distress Index mean was 1.787 (SD = .716, min = 0, max = 4) for closest to a moderate level of past-year mental distress. Williams-Gunpot (2021) also found for the Mental Distress Index a mean of 1.94 (min=0, max=3, SD=1.066) for closest to a moderate level of past-year mental distress. Also, in the present study a very high percentage of the Asian sample (85.2%) indicated “yes” for receiving mental health counseling in the past year (N=708), while the Black adults in the Williams-Gunpot (2021) indicated just 43% (N=81)
sought counselling in the past year. This suggests the extent to which the present study on Asians’ experiences of hate, hate crimes and microaggressions may have drawn those who were so impacted as to seek out counseling from a mental health professional or other helper.

**Discussion of Findings for Perceived Stress**

For the present study, the Perceived Stress Scale (PSS-4) using four items had unacceptable internal consistency (i.e., Cronbach’s Alpha of .349) with the sample of Asian adults, leading to use of just item # 1 (i.e., In the last month, how often have you felt that you were unable to control the important things in your life?) in the subsequent bivariate and multivariate analyses. Lee’s (2022) diverse sample, for the same-4 item Perceived Stress Scale (PSS-4), also found an unacceptable internal consistency (i.e. Cronbach’s Alpha of .509). Only D’Mello (2021) found adequate to good internal consistency (Cronbach’s Alpha = .756).

Of note for item # 1 (i.e., In the last month, how often have you felt that you were unable to control the important things in your life?), in this study, 26.5% indicated ‘sometimes’ they were unable to control the important things in their life in the past month. In contrast, Lee (2022) found 52.8% in that diverse sample reported ‘sometimes’ they were unable to control the important things in life--and D’Mello (2021) found 44% in that diverse sample endorsed ‘sometimes’. The present study had a much larger sample than both the Lee (2002) and D’Mello (2021) samples, while an explanation for this difference is not clear. However, this analysis is based on a single item, which must be kept in mind.

**Discussion of Findings for the Prevalence of Microaggressions**

The Ratings of Experiences of Microaggression Scale (REM-6) demonstrated adequate internal consistency (Cronbach’s Alpha=.705) in the present study. Also, Lee’s (2022) study
found very good internal consistency (i.e. Cronbach’s Alpha of .847) using the same 6-item tool. In this study, the mean was 1.804 (SD=.691, min=0, max=4.00), or closest to category 2 for “more than once” participants had experiences of microaggressions perceived in relation to their being Asian. Lee (2022) found with diverse college students a mean of 1.82 (min=0, max=4, SD=0.913) for closest to experiencing them “more than once”—during the COVID-19 pandemic in the United States.

In the current study, when it came to, “A verbal attack that was hurtful and caused mental or emotional pain, whether this involved name-calling, or some act of discrimination performed on purpose” 91.8% (N = 831) of participants experienced it at least once, a few times, more than once or many times. Findings from a study conducted by Kim et al. (2022) on Asian American nursing students’ experiences with racial microaggressions during the COVID-19 pandemic revealed findings consistent with the present study. Examples of experiencing verbal attacks as microaggressions in clinical settings included patients stating, “You guys were not smart enough to be a nurse!”; “I don’t want an immigrant to take care of me”; and, other statements of blame for the pandemic (Kim et al., 2022, p.4).

Discussions of Findings for the Perception of Racism and Oppression

In the present study, the Perception of Racism and Oppression Scale (PROS-10) demonstrated acceptable internal consistency with a Cronbach’s Alpha of .623, whereas Lee’s (2022) study found a very good internal consistency (i.e. Cronbach’s Alpha = .848). The present study’s mean was 2.328 (SD = .538, min = .8, max = 4.40) indicating participants had a high level of ability for perceiving racism and oppression. Lee’s (2022) study with Black, Latinx and
Asian college students had a mean of 3.67 (min=2.5, max=5, SD=0.739) for closest to a high level of ability for perceiving racism and oppression.

When responding to, “I am not sure it really exists or happens to people” 63.9% (N = 831) of participants either disagreed or strongly disagreed with this statement. In terms of, “I think it will never happen to me”, 64.7% (N = 831) of participants either disagreed or strongly disagreed that it could never happen to them.

Such research on the level of ability to perceive racism and oppression when happening to one’s self or others emerges as important. Consider other research conducted on Anti-Asian violence where Kurashige (2000) discovered that by raising awareness of anti-Asian violence and the problems facing the Asian American communities by Asian Americans United (AAU), it served to “validate the concerns” of Asian Americans in Southwest Philadelphia and many others whose daily lives were structured by a climate of hostility and racism (p.178). Kurashige (2000) further emphasized that raising awareness is a “crucial and necessary” step in the “formation of organized community resistance” (p.178).

**Discussion of Findings on Coping and Responding to Racism and Oppression**

In the present study, the mean for Coping and Responding to Racism and Oppression Staging Scale (CRROSS-7) was 4.35 (SD=1.038, min=1 which is precontemplation stage, max=5 which is maintenance stage) for participants’ stages of change with regard to coping and responding to racism and oppression, indicating the sample was closest to the ‘action stage’. Lee (2022) found a similar mean of 4.29 (min=1 or precontemplation stage, max=5, maintenance stage, SD=1.159) for closest to the action stage.

Of note, for the item “Learning how to cope with and respond to it is something that I have been actively working on,” 62.2% (N=831) of participants reported that they have
been doing this for greater than 6 months or more which demonstrates they are in (5) the maintenance stage. Similarly, Lee (2021) found that 65.1% (N = 222) of participants were in a maintenance stage for the behavior of actively coping and responding to racism and oppression. Such findings provide hope for the vision of Kurashige (2000) for the “formation of organized community resistance” (p.178). The present study and the Lee (2021) study suggest how there are those who have long been actively engaged in coping and responding to racism and oppression, which is essential for moving toward the formation of organized community resistance to racism and oppression.

**Discussion of Findings on Experiences of Hate and Impact**

For the present study, The Experience of Hate Scale (EOH-12) had two sub-scales: Experience of Hate Scale and Impact of Hate Scale. Lee (2022) found that the EOH-12 produced a good internal consistency with a Cronbach’s Alpha of .774 when utilized to examine the experiences of hate among Black, Latinx and Asian college students. Contrary to Lee (2020), the Experience of Hate Scale (EOH-12) for the present study produced an unacceptable internal consistency with a Cronbach’s Alpha of .548. As a result, the Experience of Hate Scale was not used in subsequent bivariate and multivariate analyses. However, the Impact of Hate Scale, in contrast, produced acceptable internal consistency for the present study with a Cronbach’s Alpha of .618. Also, Lee (2022) found that the Impact of Hate Scale produced a good internal consistency with a Cronbach’s Alpha was .846.

The mean was 2.23 (SD = .943, min = .00, max = 5.00) for the Impact of Hate Scale which indicated participants had experienced closest to a low impact from experiences of hate.
Similarly, Lee’s (2020) study with Black, Latinx and Asian college students found for the Impact of Hate Scale a mean score of 3.02 for a moderate impact (min=0, max=5, SD=1.142).

For example, in this study, for hate item # 1, “I personally experienced HATE”, 79% (N = 831) endorsed the combined categories for once, twice, a few times, many times, and a great number of times; and, for impact item # 2, 43.5% (N = 362) endorsed moderate, high, and very high impact from this. Whereas Lee (2022) found 53.1% of the participants (n=181) reported that they personally experienced hate (live, in-person, or online) twice to a great number of times; and, 51% of the participants (n=174) reported a moderate, high or very high impact from personally experienced hate. Also, for hate item # 3, “I personally witnessed HATE against someone else (live, in-person, or while online)”, 79.2% (N = 664) endorsed the combined categories for once, twice, a few times, many times, and a great number of times; and, for impact item # 4, 44.5% (N = 370) endorsed moderate, high, and very high impact from this. Whereas Lee (2002) found 66.8% of the participants (n=228) responded that they personally witnessed hate against someone else (live, in-person or online) twice to a great number of times; and, 63.6% of the students (n=217) reported a moderate, high or very high impact from witnessing hate against someone else.

As the COVID-19 pandemic spread, so did xenophobia, fear and bias crimes that targeted Asian Americans (Lantz et al. 2023). This could explain the high percentage of participants who reported that they experienced, or witnessed it being done to someone else, or through a video they saw online. The results of the present study are also consistent with the research study conducted by Lantz et al. (2023), where in a sample of 3,163 there were 575 Asian American and Pacific Islander respondents. More than one-third of Asian respondents reported “bias
victimization during the pandemic,” while more than half of Asian respondents reported that they knew someone who had been a victim or who were victimized themselves (Lantz et al., p.1089).

A study by Han et al. (2023), which observed and analyzed Anti-Asian hate crime trends over a 116-week period of four large cities in the U.S. found that “hate crimes against Asian Americans increased considerably” in the year 2020 compared to 2019 (p.3526). Due to the surge in anti-Asian hate crimes, it not surprising that many Asian respondents reported witnessing HATE at such an alarmingly high percentage in the present study, which was also conducted during the time period of the COVID-19 pandemic.

**Discussion of Significant Relationships with the Microaggressions Outcome Variable**

Findings from independent t-test comparing respondents who sought counseling (mean = 1.891, SD = .549) versus those who did not seek counseling (mean= 1.300 , SD = 1.098) found a significant difference (t = 5.841, df = 132.787, p = <.001) where respondents who sought counseling experienced more microaggressions.

Significant Pearson correlations (Bonferroni Adjustment significance level, .05/19, p= .002) showed that the **higher** the experiences of microaggressions for Asians in the United States then: the **higher** the Age (r = .168, p= <.001); **darker** the Skin Color (r = .002, p = .002); **lower** the Self-Rating of Mental Health (pre-COVID-19) (r = -.147, p = <.001); **lower** the Self-Rating of Physical Health (pre-COVID-19) (r = -.110, p = .001); **lower** Self-Rating of Mental Health (during COVID-19) (r = -.193, p = <.001); **higher** the Depression in the past year (r =.259, p=<.001); **higher** the Anxiety in the past year (r =.271, p = <.001); **higher** the Trauma in the past year (r =.272, p = <.001); **higher** the Mental Distress Index (r =.358, p = <.001); **higher** for PSS-4 item # 1, Felt Unable to Control Important Things in Life (r =.205, p = <.001); **higher** the
Perception of Racism and Oppression (r = .797, p = <.001); higher the Stages of Change for Coping and Responding to Racism and Oppression (r = .797, p = <.001); higher the Impact of Hate Scale (r = .435, p = <.001); and lower Social Desirability (r = -.094, p = .007).

Lee (2022) had two similar findings for Pearson correlations. Lee (2022) found the higher the level of experiencing microaggressions, then the higher the Stages of Change for Coping and Responding to Racism and Oppression (r=.182, p=.001), and, the higher the score on the Impact of Hate Scale (r=.325, p=.000); and, of note, the variable excluded in this study showed in Lee (2022) the additional significant variable of the higher the score on the Experience of Hate Scale (r=.397, p=.000). A variable not in this study involved the finding of a lower the rating of college climate (r=-.185, p=.001).

The results of the backward stepwise regression analysis for the present study demonstrated that the higher the prevalence of experiences of microaggressions for Asians in the United States were, as follows: Yes, for being born in the U.S. (b = .117, SE = .056, p = <.001); No, for being a student (b = .265, SE = -.094, p = <.001); Yes, for Sought Mental Health Counseling in past year (b = .451, SE = .230, p = <.001); Older age (b =.004, SE = .042, p = .020); Lower education level (b= -.030, SE = -.057, p = .002); Higher Mental Distress Index (b = .076, SE = .834, p = <.001); Higher ability for Perception of Racism and Oppression (b = 1.063, SE = .834, p = <.001). For this model the R² was .776 and the adjusted R² was .774, indicating that 77.4% of the variance was explained by this model—as an important strength of this study.

Lee’s (2022) study found the significant predictors for the study outcome variable, a high prevalence of experiences of microaggressions were: Yes, Ever Attended HBCU/HSI (b=.447, SE=.109, p = .000); More Frequent Experiences of Hate (b=.360, SE=.059, p=.000); and More
Stressful and Traumatic Impact from Hate (β=.131, SE=.052, p=.013). According to Lee’s (2022) model, the $R^2$ was .274, and the adjusted $R^2$ was .263, indicating that 26.3% of variance was explained by this model.

Comparable to this study are findings by Yan et al. (2022). They used a mixed-methods study design to examine anti-Asian microaggressions experienced by East Asian Americans (N = 345) during the COVID-19 pandemic. Yan et. al (2022) found microaggressions were significantly associated with more stress, and microaggressions had a negative relationship with psychological well-being.

**Implications and Recommendations**

The study findings have implications for community and public health educators in both professional practice as well as academic and scholarly research, as follows:

- This study should be replicated post-pandemic in order to obtain a larger randomly selected and nationally representative sample. Such a study should be funded, given the results of this study with a large sample of conveniences—as a strength of this study relative to many other investigations. The study should expand to include Asians who are limited in English proficiency since they were excluded entirely from being able to able to participate in this study, given the inclusion criteria of being able to read and understand English on the 12th grade level. This language barrier creates a deficiency in this study. The study should use a methodology that goes beyond recruiting Asian adults through social media. The goal would be to include Asian adults who do not have access to technology, including computers, smartphones, tablets and the Internet.
• On the other hand, future researchers without major grant funding should be encouraged by this study’s methodology using social media platforms such as Twitter and Instagram. A large sample was obtained in less than 2 weeks, while the methodology for eliminating duplicate IP computer addresses added confidence in the final sample and resultant data.

• The Research Group on Disparities of Health (RGDH) has accumulated sets of findings that have relied upon subject recruitment using social media platforms, as well as a growing cache of measures (e.g. Lee, 2022; Williams-Gunpot, 2021; D’Mello, 2021; Ingram, 2017). The RGDH long-used methodology for conducting online research using social media platforms pre-dated the COVID-19 pandemic, yet emerged as ideal for conducting research during the pandemic with the emphasis on social-distance. Hence, online research of this kind has been demonstrated to have many benefits—and should continue post-pandemic.

• Future research should continue to utilize the measures used in the present study, as advanced by the RGDH—especially those with adequate to good internal consistency. Or, the measured emerged as having value for being short in length, reducing participant burden of time, and for producing important findings of great relevance to research into anti-Asian hate in this study and prior research by Lee (2022). For example, the following tools are highly recommended for use in future research:
  
  o The Retrospective Depressive Anxiety, Trauma and Receipt of Counseling Scale (RDATS-4) (i.e. Cronbach’s Alpha of .600)—which also produces a past-year Mental Distress Index
  
  o The Ratings of Experiences of Microaggression Scale (REM-6) (Cronbach’s Alpha=.705)
  
  o Perception of Racism and Oppression Scale (PROS-10) (Cronbach’s Alpha of .623)
  
  o Coping and Responding to Racism and Oppression Staging Scale (CRROSS-7)
• The Experience of Hate Scale (EOH-12) with two sub-scales: the *Experience of Hate Scale* (Cronbach’s Alpha of .548; but in Lee [2022] had Cronbach’s Alpha of .774); and the *Impact of Hate Scale* (Cronbach’s Alpha of .618; but in Lee [2022] had a Cronbach’s Alpha of .864).

• Using the Ratings of Experiences of Microaggression Scale (REM-6), the study built on findings by Lee (2022) in documenting a high prevalence of the experience of microaggressions in the United States among the Asian population. For the REM-6 item, “A communication that was insulting, or conveyed rudeness and insensitivity, put downs or demeaning language,” 92.3% (N = 831) of participants experienced it at least once, a few times, more than once or many times. In the present study, the mean on the Coping and Responding to Racism and Oppression Staging Scale (CRROSS-7) was 4.35 for closest to the ‘action stage’. For the CRROSS-7 item, “I have been actively learning how to cope with and respond to it,” 66.9% (N=831) of participants agreed or strongly agreed for being in the action stage. While this is encouraging, consider findings with the Perception of Racism and Oppression (PROS-10) scale where: 8.4% (n = 70) agreed or strongly agreed with the PROS-10 item that “I am not sure it really exists or happens to people;” 11.3% (n=94) agreed or strongly agreed that “When incidents are talked about, I am not sure what makes something racist or oppressive;” 21.3% (n = 177) agreed or strongly agreed that” I think it never happens to others;” and 14.5% (n=236) agreed or strongly agreed that “There are times when I “don’t get it,” or I can’t really tell when it is happening to me.” More recent immigrant arrivals and those with limited (or no) English proficiency may have more difficulty discerning the subtleties of microaggressions, racism, and acts of oppression against Asians and others. More education is needed to help bring awareness of
microaggressions, racism, and oppression—and interventions are needed that provide support in fostering effective coping with them. This is an especially urgent need in the COVID-19 pandemic era and post-pandemic era where there may continue to be high rates of anti-Asian hate, hate crimes, and microaggressions. Missing subtle cues or failing to perceive microaggressions, racism and oppression when they are occurring could leave Asians in a situation where they fail to take action, potentially making them more vulnerable to hate crimes, violence, and discrimination.

- Mental health professionals, community health educators, health education specialists, community health workers, and community advocates who are culturally sensitive, culturally competent, and bilingual—as well as high in the ability to perceive racism and oppression, and in a maintenance stage for coping and responding to racism and oppression—are needed. They can assist in creating and leading educational interventions to assist new immigrant arrivals, those who lack English proficiency, and all Asian Americans in learning how to recognize and cope with anti-Asian hate, hate crimes, microaggressions, racial bias, and discrimination.

- These mental health professionals, community health educators, health education specialists, community health workers, and community advocates should also work to ensure that health systems provide more linguistically and culturally appropriate services for Asian American patients—especially for those suffering mental distress in the aftermath of personally experiencing or witnessing anti-Asian hate and hate crimes. In this study, a surprisingly high percentage (85.2%) had sought out counseling from a mental health professional or other helper in the past year; and, when comparing respondents who sought counseling to those who did not seek counseling, there was a significant difference (p = <.001) where
respondents who sought counseling had experienced more microaggressions. It is important
that when Asians seek out counseling within formal health systems that they have access to
those capable of providing linguistically and culturally appropriate services—so they do not
have to rely on other helpers who may have less expertise in managing depression, anxiety
and trauma.

- Because Asians seeking out counseling may find easiest access to bilingual helpers in their
  communities, it is recommended that family, peers, friends, neighbors and community
  activists actively seek to mitigate the detrimental effects and mental distress from
  microaggressions, racism, discriminations, hate, and hate crimes. The findings in this study
  may be shared with individuals, families and communities in order to better prepare them as
  potential bilingual helpers sought out by Asians in need of counseling from helpers.

- Brochures, videos, and public service announcements should be funded by government and
  other agencies so as to widely disseminate this study’s findings; and, the materials
  disseminated can focus on teaching adaptive and empowering coping responses to
  microaggressions, racism, discriminations, hate, and hate crimes. These materials should
  cover how to proactively take actions to protect oneself, while disseminating practical and
  useful information, knowledge and education that can help protect Asians against hate
  crimes, etc.

- It is also necessary to establish more support groups for Asians and the Asian American
  communities who need them. The COVID-19 pandemic included a rise in the use of Zoom
  and telehealth interventions, which can be utilized to provide support groups. Also, since
  social media outlets are very powerful and beneficial, online platforms can be used to
advertise and/or host groups to provide support and care for Asians who need a safe place to go to in order to obtain support.

**Limitations of the Study**

There are a number of study limitations that should be kept in mind. This study utilized a cross-sectional study design with diverse Asians living in the United States during the COVID-19 pandemic to investigate their experiences of hate, hate crime and microaggressions with the aim of identifying the predictors of microaggressions. In addition, this study used a convenience sample which prevents the ability to generalize the results of the survey to the population as a whole. Convenience sampling also makes it impossible for the sample to be fully representative of the population being studied. There is also the possibility of selection bias. In convenience sampling, data obtained comes primarily from participants who are easiest to access which may prevent other important participants from participating in the study due to lack of accessibility. Since this entire study was conducted online, it is limited to only those who have a computer, tablet or smartphone with internet access to complete the study survey. This presented a great obstacle for participation, especially for individuals who do not have access to technology to be excluded from the study. For example, the most vulnerable Asian adults living in the United States may have lacked access to a computer, tablet or smartphone, but may have experienced hate in some shape or form during the COVID-19 pandemic; yet, they were prevented from participating in this study.

The study also used self-reported data; and although social desirability was used to control for socially desirable responses, there is still a risk of retrospective recall bias.
This study was limited to only to those who could read and write English at a high school proficiency level. This prevented those who do not know English from partaking in the study and those who are limited in English proficiency from filling out the online survey. Therefore, an entire group of Asian adults who lack English proficiency could not participate in this study due to language barriers.

Furthermore, this study obtained volunteers via a social media campaign, suggesting those who are not on social media may not have access to the study opportunity. For example, the main social media outlets used to recruit participants were Facebook, Instagram and Twitter. In order for participants to take part, they would need to use social media, which might prevent those who do not have an account on the aforementioned social media platforms from participating in the study.

Lastly, the usage of an incentive (e.g. three $100 Amazon gift certificates) for this study may have drawn individuals who were willing to participate in the study and complete the survey for the possibility of being a winner of one of the three $100 Amazon gift cards. By providing an incentive to be entered into a raffle to win a prize, this may have motivated individuals who wanted to win a gift card to partake in the study. During data collection, there were participants who took the survey more than once, perhaps in an attempt to increase their chance of winning a gift card. However, these participants and any other participant from a duplicate IP address who took the survey more than once were eliminated from the study altogether.

All of these study limitations need to be kept in mind when evaluating the results of the study—and when considering a replication of the study. Future studies may be improved.
Conclusion

The present study explored the experiences of hate, hate crimes and microaggressions among diverse Asian adults living in the United States during the COVID-19 pandemic. The purpose of the study was to identify the significant predictors of the study outcome variable of a high prevalence of experiences of microaggressions for diverse Asians living in the United States (U.S.), during the COVID-19 pandemic (i.e. 2020-2022). The large study sample (N = 831) was 26.7% Chinese, 13.6% Japanese, 13.4% Korean, 12.4% Taiwanese, 10.6% Filipino, 10.3% Indian, 8.5% Thai, 54.9% female, and 86.8% U.S. born, with a mean age of 33.

Findings showed participants had: better overall physical health before COVID-19 pandemic versus currently; mental/emotional health declined from before the pandemic to currently; moderate social support; closest to moderate past-year mental distress; closest to “more than once” for experiences of microaggressions; a high level of ability for perceiving racism and oppression; and were in the action stage for coping and responding to racism and oppression. Also, 79% (N = 831) personally experienced hate once to a great number of times, and 43.5% (N = 362) endorsed moderate to very high impact; 79.2% (N = 664) witnessed HATE against someone else once to a great number of times, and 44.5% (N = 370) endorsed moderate to very high impact.

Those who received counseling in the past experienced more microaggressions than those who did not seek counseling. The higher the frequency of experiencing of microaggressions then higher the age, darker the skin color, lower the self-rating of mental health pre-COVID-19, lower the self-rating of physical health pre-COVID-19, lower the self-rating of mental health during COVID-19, higher the past year depression, anxiety and trauma and overall mental distress, greater the feeling of being unable to control important things in life, higher the ability to
perceive racism and oppression, higher the stage of change for coping and responding to racism and oppression, greater the impact of hate, and lower the social desirability.

Backward stepwise regression showed significant predictors of a higher frequency of experiences of microaggressions were being born in the U.S, not being a student, past year counseling, older age, lower education, higher overall mental distress, and higher ability to perceive racism and oppression—with 77.4% of variance explained by the model. Implications of findings and recommendations are provided for addressing anti-Asian hate.

The findings of this study not only built on those of Lee (2022) who used many of the same measures, but also upon findings and scholarship by others. For example, Addo (2020) makes a crucial point that victims of discrimination in this pandemic era are likely to express feelings of “sadness, anger, depression, and constant fear” (p.3). These negative energies which are associated with experiences of racial discrimination can lead to lifelong “hatred and intolerance towards people of different racial categories” (Addo, 2020, p.3). Regardless of their pan-ethnic Asian identities, Asians have been “targets of derogatory language and attacks” on public social media platforms since the start of the pandemic (Layug et al. 2022, p. 3). Woo and Jun (2021) asserted that covert discrimination such as being treated with less respect and courtesy than others is “more prevalent” than overt discrimination such as being called names, threatened or being afraid among the older Asian adult population (p.78). Moreover, findings from a study conducted by Strassle et al. (2022) discovered COVID-19 related discrimination is common and apparently, the pandemic has “exacerbated preexisting resentment against racial/ethnic minorities” and especially communities that are marginalized (p.453).

Despite a range of limitations, the findings from the present study emerged as critical and important in directing and informing the future work needed to be performed by health
educators, public health professionals, healthcare administrators, academic/research scholars, and well as politicians. All need to work collaboratively to address the needs of the Asian American population residing in the United States. The findings in this study can be used to provide an important guide in this future work.

The findings justify an urgent call to action for community leaders, health educators, health advocates, clinicians, human rights activists, politicians, and policymakers to work to address racial discrimination, anti-Asian hate, hate crimes and microaggressions towards Asians living in the United States.
REFERENCES


Ingram, L. (2017). *Toward improving the health and academic outcomes of minority college students: Predictors of experiences of racism and/or oppression, stress, trauma, health status and level of academic achievement.* Doctoral Dissertation. Teachers College, Columbia University.


Appendix A:

Letter of IRB Approval

To: Varina Som
From: Kaikee Kodama Muacente, Administrative Coordinator
Subject: IRB Approval: 22-223 Protocol
Date: 04/12/2022

Thank you for submitting your study entitled, “An Online Investigation with Diverse Asians living in the United States during the COVID-19 Pandemic: Experiences of Hate, Hate Crimes, and Microaggressions: Identifying predictors of Microaggressions,” the IRB has determined that your study is Exempt from committee review (Category 2) on 04/12/2022.

Please keep in mind that the IRB Committee must be contacted if there are any changes to your research protocol. The number assigned to your protocol is 22-223. Feel free to contact the IRB Office by using the “Messages” option in the electronic Mentor IRB system if you have any questions about this protocol.

Please note that your Consent form bears an official IRB authorization stamp and is attached to this email. Copies of this form with the IRB stamp must be used for your research work. Further, all research recruitment materials must include the study’s IRB approved protocol number.

As the PI of record for this protocol, you are required to:
- Use current, up-to-date IRB approved documents
- Ensure all study staff and their CITI certifications are on record with the IRB
- Notify the IRB of any changes or modifications to your study procedures
- Alert the IRB of any adverse events

You are also required to respond if the IRB communicates with you directly about any aspect of your protocol. Failure to adhere to your responsibilities as a study PI can result in action by the IRB up to and including suspension of your approval and cessation of your research.

You can retrieve a PDF copy of this approval letter from Mentor IRB.

Best wishes for your research work.

Sincerely,
Kaikee Kodama Muacente
Administrative Coordinator
irbreview@tc.columbia.edu
Appendix B:

The Study Email

**ASIANS AND ASIAN AMERICANS WHO LIVED IN THE UNITED STATES DURING THE COVID-19 PANDEMIC (2020-2021) ARE INVITED TO VOLUNTEER 10-15 MINUTES ANSWERING SURVEY QUESTIONS**

About Any Experiences of Hate, Hate Crimes, Microaggressions, Discrimination

**FOR A 3 IN 250 CHANCE TO WIN 1 OF 3 $100 AMAZON GIFT CARDS**

**IRB Protocol Number 22-228**

The Research Group on Disparities in Health (RGDH) within the Department of Health and Behavior Studies at Teachers College, Columbia University, in New York, New York is conducting a study. The study seeks volunteer participants who: 1) identify as Asian or Asian American; 2) are at least age 18 or older; 3) have lived (minimum of 6 months) within the United States during the years 2020 to 2021 of the COVID-19 pandemic; and, 4) feel able to answer online survey questions in English about any experiences of hate, hate crimes, violent attacks, microaggressions/ discrimination and the impact upon them. This includes experiences that happened to someone personally, or to someone one knows or did not know—as in seeing a video online. The study seeks to identify the extent to which Asian and Asian American adults living in the U.S. during the pandemic years of 2020 to 2021 had experiences of hate, hate crimes, microaggressions/ discrimination. We also seek to identify factors related to having had such experiences. Our goal is to be able to use our findings to recommend interventions and policy changes to address the needs of those who have had such experiences, and to prevent these kinds of experiences from happening.

- Participation in this survey is limited to the first 250 volunteers
- Completing the online survey takes about 10-15 minutes
- Those who complete the survey will have a 3 in 250 chance of winning 1 of 3 $100 Amazon gift cards
- Please click on the link in the message below to view the informed consent, learn about your rights as a participant and proceed to the survey.
- We also invite you to forward this email to others who may be willing to volunteer, or send them a text message, or tweet using the message, below:

ALL diverse Asians Living in the US During the COVID-19 Pandemic Invited to Take a 10-15 Minute Online Survey at [https://tinyurl.com/HATE-Toward-Asians](https://tinyurl.com/HATE-Toward-Asians) for chance to enter in a raffle for 1 of 3 $100 Amazon gift cards

THANK YOU FOR YOUR PARTICIPATION!

If you have any questions or would like to have additional information about the study, please contact:

**Vanna Som, M.S.** Doctoral Candidate, Department of Health and Behavior Studies, Teachers College, Columbia University, Box 114, 525 W. 120th Street, New York, NY 10027; vs2583@tc.columbia.edu--or

**BARBARA C. WALLACE, Ph.D.,** Director, Research Group on Disparities in Health, Professor of Health Education, Clinical Psychologist, Department of Health and Behavior Studies, Teachers College, Columbia University, Box 114, 525 W. 120th Street, New York, NY 10027; bcw3@tc.columbia.edu; Study Contact Number: 267-269-7411
Appendix: C

The Study Text/Tweet

ALL diverse Asians Living in the US During the COVID-19 Pandemic Invited to Take a 10-15 Minute Online Survey at https://tinyurl.com/HATE-Toward-Asians for chance to enter in a raffle for 1 of 3 $100 Amazon gift cards
Appendix D:
Informed Consent and Participants’ Rights Forms

Teachers College, Columbia University
525 West 120th Street
New York NY 10027
212 678 3000

INFORMED CONSENT

IRB Protocol Number 22-228

Protocol Title:
Online Investigation with Diverse Asians Living in the United States During the COVID-19 Pandemic on Experiences of Hate, Hate Crimes, and Microaggressions: Identifying Predictors of Microaggressions

Principal Researcher: Vanna Som, MS
Teachers College, Columbia University
vs2583@tc.columbia.edu

INTRODUCTION
You are invited to participate in this research study called the “Online investigation with diverse Asians living in the United States during the COVID-19 Pandemic on experiences of hate, hate crimes, and microaggressions: identifying predictors of microaggressions”. You may qualify to take part in this research study if you: 1) identify as Asian or Asian American; 2) are at least age 18 or older; 3) have lived (minimum of 6 months) within the United States during the years 2020 to 2021 of the COVID-19 Pandemic; and, 4) feel able to answer survey questions in English about your experiences of hate that had a stressful or traumatic impact on you—whether it happened to you personally, or to someone you know or did not know. Approximately 250 people will participate in this study and it will take about 10-15 minutes of your time to complete.

WHY IS THIS STUDY BEING DONE? This study is being done to learn about factors related to the rise in hate crimes and violent hate attacks against Asians during the COVID-19 pandemic; and, to identify the predictors of microaggressions towards Asians along with the racism, oppression, anxiety and trauma experienced among Asian American communities in the U.S. during the COVID-19 pandemic.

WHAT WILL I BE ASKED TO DO IF I AGREE TO TAKE PART IN THIS STUDY? If you decide to participate in the study, you will answer a series of questions in an online survey. The questions will cover the following: your personal background, ratings of your health status before and during the pandemic, your social support, trauma symptoms and perceived stressed during the pandemic. Other questions include your perception and experiences of hate, microaggressions, racism and oppression. Moreover, there will be questions focused on depression, anxiety, well-being, satisfaction with life and coping strategies. Finally, you are
asked to freely share your views on any experiences of hate, how it impacted you and its effect on your overall health, your anticipated future needs and your recommendations for innovations to combat the rise in hate crimes.

**WHAT POSSIBLE RISKS OR DISCOMFORTS CAN I EXPECT FROM TAKING PART IN THIS STUDY?** The risks of study participation include the possibility that you may feel some discomfort from taking the survey or some stress due to some of the questions. However, your participation in this study is completely voluntary, and you can stop at any time.

**WHAT POSSIBLE BENEFITS CAN I EXPECT FROM TAKING PART IN THIS STUDY?** There is no direct benefit to you for participating in this study.

**WILL I BE PAID FOR BEING IN THIS STUDY?** You will not be paid to participate. However, when you complete the survey you will be invited to enter your email address and to hit a “submit” button—so that you are officially entered into a drawing for a chance to receive a prize (i.e., 1 of 3 bar coded Amazon gift certificates for $100). You do not have to enter the lottery drawing to complete the survey. Once you submit your email address, then it will automatically be entered into a private and secure data base that even the principal investigator cannot access. Once 250 people have completed the entire survey, you will have a 3 in 250 chance of winning 1 of 3 bar coded Amazon gift certificates for $100. The www.Amazon.com gift certificates will be sent to three randomly chosen e-mail accounts using a secure online program. This occurs without in any way linking your identity to the survey results. The principal investigator is not able to view any of the e-mail addresses to which the gift certificates are sent. Only the 3 winners will be contacted.

**WHEN IS THE STUDY OVER? CAN I LEAVE THE STUDY BEFORE IT ENDS?** The study is over when you have completed the online survey. However, you can leave the study at any time even if you have not finished.

**PROTECTION OF YOUR CONFIDENTIALITY** The study does not involve collecting any of your personal identifying information, such as your name or address, allowing you to remain anonymous. (NOTE: Recall, as per what is above, you can elect to enter your e-mail address to enter the drawing for a chance to receive a prize. However, this occurs without in any way linking your identity to your survey answers, and the principal investigator cannot view any e-mail addresses.) Teachers College, Columbia University has determined that www.Qualtrics.com provides a secure platform for the online survey you will take. The survey data files will also be saved on the primary researcher’s password protected computer. Regulations require that research data be kept for at least three years. For quality assurance, the study team, and/or members of the Teachers College Institutional Review Board (IRB) may review the data collected from you as part of this study. Otherwise, all information obtained from your participation in this study will be held strictly confidential and will be disclosed only with your permission or as required by U.S. or State law.
**HOW WILL THE RESULTS BE USED?** The results of this study will be published in journals and presented at academic conferences. This study is being conducted as part of the doctoral dissertation of the principal investigator.

**WHO CAN ANSWER MY QUESTIONS ABOUT THIS STUDY?**
If you have any questions about taking part in this research study, you should contact the primary researcher, Vanna Som at vs2583@tc.columbia.edu. You can also contact the sponsor/supervisor of this particular research study, Dr. Barbara Wallace, at bcw3@tc.columbia.edu or 267-269-7411.

If you have questions or concerns about your rights as a research subject, you should contact the Institutional Review Board (IRB) (the human research ethics committee) at 212-678-4105 or email IRB@tc.edu. Or you can write to the IRB at Teachers College, Columbia University, 525 W. 120th Street, New York, NY 10027. Box 151. The IRB is the committee that oversees human research protection for Teachers College, Columbia University.

**PARTICIPANT’S RIGHTS**

- I have read the Informed Consent Form and have been offered the opportunity to discuss the form with the researcher.
- I have had ample opportunity to ask questions about the purposes, procedures, risks and benefits regarding this research study.
- I understand that my participation is voluntary. I may refuse to participate or withdraw participation at any time without penalty.
- The researcher may withdraw me from the research at her or his professional discretion. I understand that if I take the survey more than once I will be eliminated from the study.
- If, during the course of the study, significant new information that has been developed becomes available which may relate to my willingness to continue my participation, the researcher will provide this information to me.
- Any information derived from the research study that personally identifies me will not be voluntarily released or disclosed without my separate consent, except as specifically required by law.
- I should receive a copy of the Informed Consent Form document. (I understand that I can download it).

By signing electronically, you agree to be in the study and confirm that you are a frontline nurse who has provided direct care to COVID-19 patients during the U.S. pandemic, are at least age 22 or older, and feel able to answer questions about the COVID-19 Pandemic.

**Provide your electronic signature:**

__________________________________________ Date: _____________
Appendix E:

Screening Survey

Screening Tool for the
ASIAN HATE AND HATE CRIME SURVEY

Teachers College, Columbia University

IRB Protocol # 22-228

During the COVID-19 pandemic in the United States, or for the years 2020 and 2021, there was a rise in violent hate attacks against Asians. This study invites those who identify as Asian who are age 18 and above to answer questions about this rise in hate and violent hate attacks against Asians during the pandemic.

See if you qualify by answering the questions, below:

1- Are you at least 18 years of age or older?
   Yes___No____

2- Have you been or were you living in the United States—for at least 6 months continually without travel outside the country—during the years 2020 and/or 2021, or during the COVID-19 pandemic? Yes No

3- Do you self-identify as Asian?
   Yes___No____

4- Do you feel able to read and answer questions in English (on a 12th grade level)?
   Yes___No____

5. Are you able to devote **10-15 minutes** to this study at this time? Yes No

Of note, those who answer all questions will have a 1 in 250 chance of winning in a lottery 1 of 3 $100 Amazon gift cards.

If they answered YES to all of the above questions, they access survey.

If they answered NO to any of the above questions, they receive this message:

Thank you for your time, but, unfortunately, you are not qualified to participate in this study. Feel free to invite others to participate in this study by forwarding to them the link you used to access this study.
INSTRUCTIONS: Please answer the following questions in this survey.

-----------------------------------------------------------------------------------------------------------------------------
Part I: Basic Demographics (BD-10)

1-I am: ___Female ___ Male ___Transgender

2-My age is: _________ [DROP DOWN MENU 24 – 80]

3-My race/ethnicity is as follows: (Please mark all that apply)
___Asian (Asian Indian, Cambodian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian)

If they select Asian, then they are asked:
Please further specify your Asian identify, or how you identify, or your Asian descent: (please select all that apply)
___Bangladeshi
___Bhutanese
___Burmese
___Cambodian
___Chinese
___Indian
___Indonesian
___Filipino
___Japanese
___Korean
___Lao
___Malaysian
___Maldivians
___Mongolian
___Myanmarese (Burmese)
___Nepal
___Pakistani
___Polynesian
___Singaporean
Thank you for responding to this eligibility survey. Unfortunately, you are not eligible for our research study. We thank you for your time.
4. Associate degree or technical degree/training (e.g.: AA, AS, Certificate, etc.)
5. Bachelor’s degree (e.g. BA, BS)
6. Master’s degree (e.g. MA, MS, MEd)
7. Doctorate or Professional degree (e.g. PhD, EdD, DrPH, MD, DDS, DMD, PharmD)

[NOTE: create a continuous scale from low=1 to high=7 education]

9. I am currently (check all that apply):
   __Employed for wages
   __Self-employed
   __Unemployed
   __A homemaker
   __Military
   __Retired
   __Disabled/Unable to work
   __A student [IF SELECT STUDENT → # 9]

10. As a STUDENT, I am
   __In High School, GED program, etc.
   __College Freshman
   __College Sophomore
   __College Junior
   __College Senior
   __1st year in graduate school
   __2nd year in graduate school
   __3rd year in graduate school
   __4th year in graduate school
   __5th year in graduate school
   __6th year in graduate school
   __7th year in graduate school or higher

Part II: Personal Health Background—Current and Before Pandemic (PHB-CABP-9)

1. Please check, below, what best describes you:
   __I have now, or had COVID-19 at some point in the past two years __Yes __No __Not Sure
   __I currently have, or had long-COVID-19 __Yes __No __Not Sure
   __I think COVID-19 is a hoax; it does not exist. So, I cannot answer questions about COVID-19. __Yes __No __Not Sure NOTE: If select YES → exclude from study

2. My current height (feet) [DROP DOWN BOX, 4-9]

3. My current height (inches) [DROP DOWN BOX, 0-11]

4. My current weight (in pounds) [DROP DOWN BOX, 70-400]

[2,3,4 for calculation of BMI]

5. For the years 2020-2021, during the COVID-19 pandemic (please check all that apply)
—My weight stayed about the same —I gained weight —I lost weight

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For BEFORE the COVID-19 pandemic:
6-I rate my overall physical health status as 
    —1-Very poor —2-Poor —3-Fair —4-Good —5-Very Good —6-Excellent

For NOW, DURING the COVID-19 pandemic:
7-I rate my overall physical health status as 
    —1-Very poor —2-Poor —3-Fair —4-Good —5-Very Good —6-Excellent

---------[paired t-test with 7 and 8]-----

For BEFORE the COVID-19 pandemic:
8-I rate my overall mental/emotional health status as 
    —1-Very poor —2-Poor —3-Fair —4-Good —5-Very Good —6-Excellent

For NOW, DURING the COVID-19 pandemic:
9-I rate my overall mental/emotional health status as 
    —1-Very poor —2-Poor —3-Fair —4-Good —5-Very Good —6-Excellent

---------[paired t-test with 9 and 10]-----

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Part III: Single Item Rating of Risk of Providing Socially Desirable Responses (SIR-RPSDR-1)

1-I sometimes say things that I think will please people, or what I think they want to hear— versus the honest truth, which might be difficult or painful for other people to hear and accept, or might lead them to judge me harshly…

I rate myself on a scale of 0 to 10, as follows:

0  1  2  3  4  5  6  7  8  9  10
0-I am not like this at all
10-I am like this all the time

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Part IV: Perceived Social Support Scale (PSSS-1)

Having SOCIAL SUPPORT means having people in your life who provide the following kinds of support and assistance: you can ask them for advice, or receive words of encouragement; get money or get food in an emergency; or have a place to temporarily wait for help, or stay or live in an emergency.
1. Please indicate the extent to which you experience SOCIAL SUPPORT in your life at this time (i.e., right now):
   1. I have no one like this in my life right now
   2. I have at least 1 one person like this in my life right now
   3. I have at least 2 people like this in my life right now
   4. I have 3-5 people like this in my life right now
   5. I have 6 or more people like this in my life right now

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Part V: Retrospective Depression, Anxiety, Trauma and Receipt of Counseling Scale (RDATS-4)

**Depression** is an overwhelming feeling of intense sadness. It can include feeling helpless, hopeless, and worthless. It can sometimes be expressed through angry outbursts, as well as bursting into tears. There can also be loss of appetite, or an increase in appetite. There can also be difficulty sleeping or oversleeping. In addition, there can be a loss of interest in your activities. Such a depression can last for days or weeks. This goes beyond typical feelings of sadness, such as following some disappointment.

1-Do you think you experienced any **depression** in the past year or 12 months?
   0-No
   1-Yes, a very mild level
   2-Yes, a moderate level
   3-Yes, a severe level
   4-Yes, a very severe level

**Anxiety** is an overwhelming and intense feeling of nervousness, fear, tension, powerlessness, and apprehension. It can reach a peak so there are moments of panic where one’s heart may be pounding/beating quickly, or there is rapid breathing/difficulty breathing. A person may also experience sweating and trembling. Sometimes it can be so intense that one has trouble concentrating/thinking, leaving the house, or trouble being around other people. The fear can be very intense, and one can feel like there is some impending danger. This goes beyond typical feelings of nervousness, such as when anticipating a new situation, or something unexpected, or unknown.

2-Do you think you experienced any **anxiety** in the past year or 12 months?
   0-No
   1-Yes, a very mild level
   2-Yes, a moderate level
   3-Yes, a severe level
   4-Yes, a very severe level

**Trauma** is the most shocking and horrible thing to ever happen to a person (unless prior trauma)—such as: serious accident or fire; seeing someone seriously injured or die; war;
earthquake/flood; physical/sexual abuse; or, a loved one’s homicide, suicide, or other tragedy. Trauma symptoms may include: anxiety; nightmares; feeling numb, unable to love, and detached with no interest in spending time with others; guilt about surviving if others did not; flashbacks from trauma as images that unexpectedly “pop up” in the mind; avoiding reminders of trauma; and problems concentrating.

3-Do you think you experienced any trauma or trauma symptoms in the past year or 12 months?
0-No 1-Yes, a very mild level 2-Yes, a moderate level 3-Yes, a severe level 4-Yes, a very severe level

Receipt of Counseling
4-In the past year, did you seek out any kind of counseling or advice for any depression, anxiety, or trauma—such as from a mental health professional or other helper?
   ___Yes ___No  ___Not Applicable/ No experience of depression/anxiety/trauma

Part VI: Perceived Stress Scale (PSS-4)

Instructions: The questions in this scale ask you about your feelings and thoughts during the last month. In each case, please indicate with a check how often you felt or thought a certain way.

1. In the last month, how often have you felt that you were unable to control the important things in your life?
   ___0=never ___1=almost never ___2=sometimes ___3=fairly often ___4=very often

2. In the last month, how often have you felt confident about your ability to handle your personal problems?
   ___0=never ___1=almost never ___2=sometimes ___3=fairly often ___4=very often

3. In the last month, how often have you felt that things were going your way?
   ___0=never ___1=almost never ___2=sometimes ___3=fairly often ___4=very often

4. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?
   ___0=never ___1=almost never ___2=sometimes ___3=fairly often ___4=very often

[PSS-4 scores are obtained by reverse coding the positive items, e.g., 0=4, 1=3, 2=2, etc. and then summing across all 4 items. Items 2 and 3 are the positively stated items.]

Part VII: Ratings of Experiences of Microaggressions (REM-6)
For the following questions, please indicate to what extent you experienced any of the following in the United States (e.g. campus/college setting, work settings, shopping in stores, online/social media interactions, etc...) and **it seemed related to your being Asian:**

1-Brief exchanges or brief interactions (in-person or online) where you felt you were receiving messages that were a put down, denigrating, or conveyed something negative:

   __0__-Never/Not At All __1__-At Least Once __2__-More Than Once __3__-A Few Times __4__-Many Times

2-A verbal attack that was hurtful and caused mental or emotional pain, whether this involved name-calling, or some act of discrimination performed on purpose:

   __0__-Never/Not At All __1__-At Least Once __2__-More Than Once __3__-A Few Times __4__-Many Times

3-A nonverbal attack, or some behavior that was hurtful and caused mental or emotional pain, whether this involved someone avoiding contact and interaction, or avoiding communication, or some act of discrimination performed on purpose:

   __0__-Never/Not At All __1__-At Least Once __2__-More Than Once __3__-A Few Times __4__-Many Times

4-A communication that was insulting, or conveyed rudeness and insensitivity, put downs or demeaning language:

   __0__-Never/Not At All __1__-At Least Once __2__-More Than Once __3__-A Few Times __4__-Many Times

5-A communication that excluded you, cancelled out your existence, made you invisible, or ignored the reality of your thoughts, feelings, and existence as a diverse person:

   __0__-Never/Not At All __1__-At Least Once __2__-More Than Once __3__-A Few Times __4__-Many Times

6-How often have you experienced various media messages on television, in commercials, on billboards, in magazines, and other online platforms as putting down people like YOU--denigrating them, spreading negative stereotypes, or conveying something negative about people like YOU?

   __0__-Never/Not At All __1__-At Least Once __2__-More Than Once __3__-A Few Times __4__-Many Times

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**Part VIII: Perceptions of Racism and Oppression Scale (PROS-10)**

**Directions:** We are interested in learning about your perceptions of racism and oppression.

**For Your Information:** Racism and oppression are potentially stressful, negative, harmful experiences where the injured party is sent the message they are “less than,” “unequal,” or “inferior.” For racism, injury is suffered due to one’s race or ethnicity (e.g., Asian.). For oppression, injury is suffered due to one’s characteristics (e.g. skin color, immigrant status, race, religion, etc…). Racism/oppression may include: prejudice, discrimination, harassment, violence, exclusion, disadvantage, or lack of access to opportunity (e.g. housing, employment), etc.

**Please answer the following questions.**

**In terms of experiences of RACISM AND OPPRESSION....**

1-I am not sure it is really exists or happens to people.

   __1__-Strongly Agree __2__-Agree __3__-Undecided __4__-Disagree __5__-Strongly Disagree

2-When incidents are talked about, I am not sure what makes something racist or oppressive.

   __1__-Strongly Agree __2__-Agree __3__-Undecided __4__-Disagree __5__-Strongly Disagree

3-I think it never happens to me.

   __1__-Strongly Agree __2__-Agree __3__-Undecided __4__-Disagree __5__-Strongly Disagree

4-There are times when I “don’t get it,” or I can’t really tell when it is happening to me.
1. ___Strongly Agree  2. ___Agree   3. ___Undecided  4. ___Disagree  5. ___Strongly Disagree
5-I think it never happens to others.
1. ___Strongly Agree  2. ___Agree   3. ___Undecided  4. ___Disagree  5. ___Strongly Disagree
6-There are times when I “don’t get it,” or I can’t really tell when it is happening to others.
1. ___Strongly Agree  2. ___Agree   3. ___Undecided  4. ___Disagree  5. ___Strongly Disagree
7-I can usually see or sense when it is happening to me.
1. ___Strongly Agree  2. ___Agree   3. ___Undecided  4. ___Disagree  5. ___Strongly Disagree
8-I can usually see or sense when it is happening to others.
1. ___Strongly Agree  2. ___Agree   3. ___Undecided  4. ___Disagree  5. ___Strongly Disagree
9-When incidents are talked about, I think “That could happen to me or someone I love.”
1. ___Strongly Agree  2. ___Agree   3. ___Undecided  4. ___Disagree  5. ___Strongly Disagree
10-When incidents are talked about, I can identify with and understand the experience.
1. ___Strongly Agree  2. ___Agree   3. ___Undecided  4. ___Disagree  5. ___Strongly Disagree
ITEMS # 7-10 ARE REVERSE SCORED

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Part IX: Coping and Responding to Racism and Oppression Staging Scale (CRROSS-7)

Now, for the next set of questions, think about how you cope or respond to any experiences of racism and/or oppression:

1. I don’t think they exist, so there is nothing to learn how to cope with or respond to.
1. ___Strongly Agree  2. ___Agree   3. ___Undecided  4. ___Disagree  5. ___Strongly Disagree
2. I never thought about how to cope with or respond to it.  [score of 1 or 2 as 1=precontemplation stage]
1. ___Strongly Agree  2. ___Agree   3. ___Undecided  4. ___Disagree  5. ___Strongly Disagree
3. I have thought about how to cope with and respond to it.  [score of 1 or 2 as 2=contemplation stage]
1. ___Strongly Agree  2. ___Agree   3. ___Undecided  4. ___Disagree  5. ___Strongly Disagree
4. I never took steps to learn more about how to cope with and respond to it.  [score of 1 or 2 as 2=contemplation stage]
1. ___Strongly Agree  2. ___Agree   3. ___Undecided  4. ___Disagree  5. ___Strongly Disagree
5. I am planning to take steps to learn more about how to cope with and respond to it.
1. ___Strongly Agree  2. ___Agree   3. ___Undecided  4. ___Disagree  5. ___Strongly Disagree  [score of 1 or 2 as 3=preparation stage]
6. I have been actively learning how to cope with and respond to it.  [score of 1 or 2 as 4=action stage]
1. ___Strongly Agree  2. ___Agree   3. ___Undecided  4. ___Disagree  5. ___Strongly Disagree
7-Learning how to cope with and respond to it is something that I have been actively working on:
__never in my life  __< 1 month  __< 6 months  __> 6 months  __1-3 years
__4-6 years  __7-9 years  __10-20 years  __21-30 years  __>31 years
__unsure
 [score > 6 months as = 5 - maintenance stage]
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Part X: Experiences of Hate (EOH-12)

The experience of HATE involves someone reacting to another human being with extreme dislike, revulsion, disgust, aversion, or loathing. HATE often leads to HATE CRIMES, or to violent attacks, or verbal abuse, or attempted and actual murders.

For example, attacks on Asians can be thought of as involving other people feeling and acting on their feelings of HATE.
Please indicate all that you have experienced since the beginning of the COVID-19 pandemic, or in the past 2 years. And, then rate the impact on you.

1-1 **personally experienced** HATE (live, in-person—or while online)

| 0-Never | 1-Once | 2-Twice | 3-Few Times | 4-Many Times | 5-Great Number of Times | 6-Not Applicable/Did not experience this |

2-1 **rate the impact on me**, given how **stressful or traumatic** it was for me:

| 0-No impact | 1-Very low impact | 2-Low impact | 3-Moderate impact | 4-High impact | 5-Very high impact | 6-Not Applicable/Did not experience this |

3-1 **personally witnessed** HATE against **someone else** (live, in-person—or while online)

| 0-Never | 1-Once | 2-Twice | 3-Few Times | 4-Many Times | 5-Great Number of Times | 6-Not Applicable/Did not experience this |

4-1 **rate the impact on me**, given how **stressful or traumatic** it was for me:

| 0-No impact | 1-Very low impact | 2-Low impact | 3-Moderate impact | 4-High impact | 5-Very high impact | 6-Not Applicable/Did not experience this |

5-1 **A person CLOSE to me** (e.g. family member, friend, etc.) **experienced** HATE (live, in-person—or while online)

| 0-Never | 1-Once | 2-Twice | 3-Few Times | 4-Many Times | 5-Great Number of Times | 6-Not Applicable/Did not experience this |

6-1 **rate the impact on me**, given how **stressful or traumatic** it was for me:

| 0-No impact | 1-Very low impact | 2-Low impact | 3-Moderate impact | 4-High impact | 5-Very high impact | 6-Not Applicable/Did not experience this |

7-1 **A person in my neighborhood or in the area where I live experienced** HATE (live, in-person—or while online)

| 0-Never | 1-Once | 2-Twice | 3-Few Times | 4-Many Times | 5-Great Number of Times | 6-Not Applicable/Did not experience this |
6-Not Applicable/Did not experience this
8-I rate the impact on me, given how stressful or traumatic it was for me:
   _0-No impact
   _1-Very low impact
   _2-Low impact
   _3-Moderate impact
   _4-High impact
   _5-Very high impact
   _6-Not Applicable/Did not experience this

9-A person I consider to be a part of my racial/ethnic community experienced HATE (live, in-person—or while online)
   _0-Never _1-Once _2-Twice _3-Few Times _4-Many Times _5-Great Number of Time
   6-Not Applicable/Did not experience this
10-I rate the impact on me, given how stressful or traumatic it was for me:
   _0-No impact
   _1-Very low impact
   _2-Low impact
   _3-Moderate impact
   _4-High impact
   _5-Very high impact
   _6-Not Applicable/Did not experience this

11-I saw a VIDEO (e.g. television, YouTube, on social media) of someone I did not know being a victim of HATE
   _0-Never _1-Once _2-Twice _3-Few Times _4-Many Times _5-Great Number of Time
   6-Not Applicable/Did not experience this
12-I rate the impact on me, given how stressful or traumatic it was for me:
   _0-No impact
   _1-Very low impact
   _2-Low impact
   _3-Moderate impact
   _4-High impact
   _5-Very high impact
   _6-Not Applicable/Did not experience this

-----------------------THE END! THANK YOU!-----------------------

For a 3 in 250 chance of winning one of three $100 Amazon gift cards please enter your email here:_____________________________

COUNSELING RESOURCES
If you need immediate assistance, please refer to the following contact information.
You can download this page with contact information for counseling resources, OR SKIP TO THE LINK, BELOW, FOR ENTERING YOUR EMAIL INTO THE LOTTERY DRAWING FOR A CHANCE TO RECEIVE A PRIZE (i.e., 1 of 3 bar coded Amazon gift certificates for $100).

1-For Free Texting Crisis Help:
   - You text 741741 when in crisis as a service available 24 hours a day, 7 days a week. You will reach a live trained Crisis Counselor who will respond quickly. The Crisis Counselor helps to move you from a hot moment to a cool calm and safe state, using effective active listening and suggested referrals—all using the Crisis Text Live’s secure platform.
   - If you have a phone plan with AT&T, T-Mobile, Sprint, or Verizon, texting to 741741 is free of charge.

2-Contact a Crisis Intervention Hotline for Immediate Help and Referrals:
   [https://www.allaboutcounseling.com/crisis_hotlines.htm](https://www.allaboutcounseling.com/crisis_hotlines.htm)
   Examples of Crisis Intervention Hotlines:
   - If you are in immediate danger, call 911
   - The Lifeline and 988: 988 has been designated as the new three-digit dialing code that will route callers to the National Suicide Prevention Lifeline
   - Grief Recovery Helpline: 800-445-4808

3-Seek Out Top Rated, Low-Cost Online Counseling Services:
   [https://www.e-counseling.com/tp/therapy-1/?imt=1](https://www.e-counseling.com/tp/therapy-1/?imt=1)
   - Please see a list of the top-rated online counseling services—for a “low flat fee”

4-Seek Out Affordable Online Counseling:
   [https://www.betterhelp.com/about/](https://www.betterhelp.com/about/)
   - Access affordable and convenient online counseling with professionals.

5-Seek Help from the Study Sponsor by E-Mail or Phone: 
   [bcw3@tc.columbia.edu](mailto:bcw3@tc.columbia.edu) or 267-269-7411 (i.e. the study contact number)
   - You may contact the study sponsor, Dr. Barbara Wallace, receiving help with referrals. Dr. Wallace is a licensed psychologist with experience working with the study population.