BLACK, LATINX, AND ASIAN COLLEGE STUDENTS’ EXPERIENCES OF HATE, MICROAGGRESSIONS, STRESS, PERCEIVED RACISM AND OPPRESSION, AND COPING STRATEGIES: IDENTIFYING PREDICTORS OF A HIGH PREVALENCE OF MICROAGGRESSIONS

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ABSTRACT

BLACK, LATINX, AND ASIAN COLLEGE STUDENTS’ EXPERIENCES OF HATE, MICROAGGRESSIONS, STRESS, PERCEIVED RACISM AND OPPRESSION, AND COPING STRATEGIES: IDENTIFYING PREDICTORS OF A HIGH PREVALENCE OF MICROAGGRESSIONS

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Exposure to hate, racism, discrimination, and microaggressions is prevalent on college campuses, and such exposure also occurs beyond the context of the college campus, whether involving police violence against Blacks, in particular, as well as Hispanics. Also, the COVID-19 pandemic year of 2020 saw a rise in hate and violence toward Asians. The present study aimed to identify the significant predictors of a high prevalence of experiences of microaggressions for Black, Latinx, and Asian students enrolled in college during the pandemic whether at the undergraduate or graduate level in the United States (U.S.). A total of 341 participants (mean age=26.62, female=40.6%, Black/Latinx=54.5%, Asian=45.5%, U.S. born=66.9%, ever attended Historically Black Colleges or Universities/Hispanic Serving Institutions (HBCU/HSI)=52.2%) participated online, having been recruited via a social media campaign and asked to complete the I EXPERIENCED HATE Survey.

Independent t-tests indicated that U.S. born respondents experienced significantly more microaggressions (mean=1.91, SD=.843) than non-U.S. born (mean=1.62, SD=1.016; t=-2.595, df=190.5, p=0.01), and those who ever attended an HBCU/HSI experienced significantly more microaggressions (mean=1.97, SD=0.705) compared to those who never attended HBCU/HSI (mean=1.65, SD=1.073; t=-3.247, df=275.8, p=0.001). Pearson’s correlations showed that a
higher level of experiencing microaggressions was significantly correlated with lower rating of college climate \( (r=\ -0.185, \ p=\ .001)\), higher stage of change for coping and responding to racism and oppression \( (r=\ 0.182, \ p=\ .001)\), higher or more frequent experiences of hate \( (r=\ 0.397, \ p=\ .000)\), and higher stressful and traumatic impact of hate \( (r=\ 0.325, \ p=\ .000)\). Backwards stepwise regression analysis indicated that the significant predictors for a high prevalence of experiences of microaggressions were ever attending an HBCU/HSI \( (b=\ 0.447, \ SE=\ 0.109, \ p=\ .000)\), more experiences of hate \( (b=\ 0.360, \ SE=\ 0.059, \ p=\ .000)\), and more stressful and traumatic impact from hate \( (b=\ 0.131, \ SE=\ 0.052, \ p=\ .013)\). However, the final model explained 26.3% of the variance (adjusted \( R^2=.263\)). This suggests that future studies should identify additional independent variables for inclusion.

The present study findings supported the initial anticipated findings that Black, Latinx, and Asian students who had more frequent hate experiences and had more and higher negative stressful/traumatic impact from hate experiences would significantly predict the high prevalence of experiences of microaggressions. Implications of findings are discussed.
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HL
Chapter I

INTRODUCTION

The year 2020 was historic for a number of reasons, including the COVID-19 pandemic (Xu et al., 2021), the well-publicized police violence and murder of George Floyd with calls to defund the police (Gaynor et al., 2021), and a rise in discrimination and physical attacks against Asians (Li & Nicholson, 2021). Meanwhile, there are long-standing issues of African American, Latinx and Asians experiencing racial hostility, discrimination, and microaggressions in the United States—as well-documented among college populations (Lui, 2020).

The Theory of Racism and Microaggressions Guiding the Present Study

The concept of micro-aggressions arises from the pioneering work of Pierce (1970; 1974). Early on, Pierce (1970) discussed the “feelings of superiority” that allows one group of people to “brutalize, degrade, abuse, and humiliate another group of individuals” (p. 265); and, there are roots in the delusional, false belief in the “innate inferiority of any person with dark skin color” (p. 266). And, because “everyone is involved in this delusion, then by definition it is a public health problem” (p. 266). The resultant racism in the United States is a “public health and mental health illness,” as per Pierce (1970, p. 266). Racism is “a contagious disease,” a “perceptual illness,” as well as a “lethal disease” (p. 267). Further, black-white relations are characterized by “subtle blows” that “are delivered incessantly” while the “cumulative effect” is of “an unimaginable magnitude”—as these “offensive mechanisms” are “usually a micro-aggression” (p. 266). Micro-aggressions, as offensive mechanisms, “assure that the person in the inferior status is ignored, tyrannized, and minimized” (p. 267). The summation of “collective micro-offenses by the majority” also serves the function of permitting “police department after
police department to tyrannize black communities” (p. 268). The results of these micro-offenses or micro-aggressions include Blacks seeing themselves as “useless, unlovable, unable”—while also leading to their “statistical early demise,” as well as “incomparably higher morbidity and mortality rates,” which may be viewed as “perpetrated, calculated murders by the white offender” (p. 268).

Of note, racism and the false belief in the “innate inferiority of any person with dark skin color”—as per Pierce (1970, p. 266) can readily be extended to many members of the Latinx population.

Pierce (1974) provided further explanation of micro-aggressions within a discussion of the “assaults to black dignity and black hope” that are “incessant and cumulative” (p. 515). These “offenses are micro-aggressions,” which are done “in this sort of gratuitous, never-ending way”—as the “major vehicle for racism in this country” (p. 515). Pierce (1974) elaborated by explaining that almost “all black-white racial interactions are characterized” by micro-aggressions involving White people engaging in “put-downs, done in an automatic, preconscious, or unconscious” manner (Pierce, 1974, p. 515). Emphasizing the impact of these assaults and offenses, Pierce (1974) explained how these “mini-disasters accumulate” in such a manner that “the sum total of multiple micro-aggressions by whites to blacks” has a “pervasive effect” that even impacts the “stability and peace of this world” (p. 515).

Pierce et al. (1977) concretized the prior pioneering discussion of superior and inferior dynamics, as well as what were then referred to as “microaggressions” (p. 66) within a “Theory of Racism” (p. 65). Therein, Pierce et al. (1977) succinctly defined microaggressions as the “chief vehicle for proracist behaviors” which are “subtle, stunning, often automatic, and non-verbal exchanges which are “put downs” of blacks by offenders” (p. 66). Further, television was
described as “but one of a plethora of sources which spew out microaggressions,” while they are “daily occurrences in newspapers, radio programs, films, billboards, subway posters, textbooks, statues, and so on” (p. 67). Pierce et al. (1977) advanced the original Theory of Racism which also described how, through television and other media, all societal members are socialized into the core belief that Whites are superior and Blacks are inferior. Results may include the internalization of racism, as well as the proliferation of experiences of microaggressions (Pierce et al., 1977).

Hence, it is for good reason that the Theory of Racism and focus on microaggressions (Pierce, 1970; 1974; Pierce et al., 1977) provides the framework and foundation for the present investigation. Meanwhile, the work of Sue et al. (2007) provides support for extending the concept of microaggressions beyond Black-White interpersonal interactions so as to be inclusive of the three populations of focus in the present study: i.e., the Black, Latinx, and Asian populations, as represented by college students recruited for study participation.

A Contemporary Approach to Racial Microaggressions for People of Color

Sue et al. (2007) found “the term ‘racial microaggressions’ to best describe” what are “subtle and contemporary forms of racism” (p. 272). Taking a broad approach encompassing many racial and ethnic groups, microaggressions were viewed as a form of “covert racism” that has a “dramatic and detrimental impact on people of color” (p. 279). Microaggressions “send denigrating messages to people of color” in everyday interactions and conversations; and, they are expressed as gestures, attitudes, subtle snubs, or disdainful looks (p. 273).

Further, Sue et al. (2007) identified three forms of microaggressions as follows: microassault, as “an explicit racial derogation characterized primarily by a verbal or nonverbal attack meant to hurt the intended victim through name-calling, avoidant behavior, or purposeful
discriminatory action” (p. 274); a microinsult, as “communications that convey rudeness and insensitivity and demean a person’s racial heritage or identity” (p. 274); and, a microinvalidation as “communications that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of a person of color” (p. 274). Further, microaggressions hold inherent power “which lies in their invisibility to the perpetrator, and, oftentimes, the recipient” (p. 275). In addition, there are environmental microaggressions on the macro-level, which involve racial “assaults, insults, and invalidations which are manifested on system and environmental levels” (p. 278); for example, the exclusion of literature “that represents various racial groups” (Sue et al., 2007, p. 274).

**Historic Dynamics in the United States—And the Year 2020 as Historic**

Historically, in the United States, there is not only the core societal-wide dynamic of placing Whites into the position of being superior and Blacks into the position of the inferior, as per the pioneering work of Pierce et al. (1977); as, there is also the Western tradition of constructing the West as “a superior civilization in opposition to” Orientals, as “the racialization of Asians” occurs (Li & Nicholson, 2021, p. 3). As a result, “immigrants from Oriental countries—no matter how long they reside in the United States—are cast as inferior” and “threatening foreigners” (Li & Nicholson, 2021, p. 3).

Also, at various times in the United States, Asians have been cast as “foreign foes” (Li & Nicholson, 2021, p. 2). This view is attached to the “long-standing ‘yellow peril’ stereotype”—such that “Asians’ improved status alone does not bring them into the US mainstream” (p. 2). Instead, “being proclaimed as ‘model minority,’ Asian Americans' economic mobility often engenders less social acceptance and intensifies racism towards them” (Li & Nicholson, 2021, p. 2).
Historically, the term model minority was first developed by Peterson (1966) during the Civil Rights era to indicate “the image of Asian immigrants as those who had prevailed despite racial prejudice and won success in the U.S. based on personal determination” (Thompson et al., 2016, p. 109). A more recent version of the model minority stereotype describes Asian Americans as highly motivated workaholics (Thompson et al., 2016). The model minority concept attributes “Asians' high achievements in SES” to their culture, and this myth works as an instrument to marginalize and racialize Asians (Li & Nicholson, 2021, p. 3–4).

The year 2020 was also historic with regard to unique events, including the COVID-19 pandemic. The year 2020 of the COVID-19 pandemic included a dramatic rise in overt violent attacks against Asians (e.g., Xu et al., 2021). The media focus on the police violence and murder of George Floyd with calls to defund the police (Gaynor et al., 2021) also mobilized a new level of social activism and protest. Meanwhile, the historic dynamics of racism in the United States commonly directed against Blacks have also been documented as impacting Hispanics; for example, higher rates of fatal police interactions and police stops have been documented as occurring for Hispanics as well as Blacks, in comparison to Whites (Njoku et al., 2021). Further, impacting the Latinx population, are statistics showing that those who are immigrants or non-citizens face a greater likelihood of being victimized in hate crimes (McCann & Boateng, 2021).

**Media, Social Media, and Microaggressions**

As most recent and disturbing history, Former President Trump was at the center of both the COVID-19 pandemic and the rise in Asian hate in the year 2020. Meanwhile, his anti-immigrant and anti-Mexican rhetoric was detrimental, going back to his campaign for election, while inclusive of remarks he made during his administration.
In this regard, Li and Nicholson (2021) discussed the role of politicians and the media in “activating or exacerbating Asian hatred” (p. 1). With the COVID-19 pandemic, “across the United States, many Asian ethnics have suffered various forms of discrimination, from physical attacks to verbal harassment to vandalism” (p. 2). Indeed, “sinophobia and hostility against Asians also surged in social media, including Twitter” (p. 5).

More specifically, politicians and “the media played an important role in the racialization of the pandemic” (Li & Nicholson, 2021, p. 7). This occurred despite “the World Health Organization specifically naming the disease COVID-19 to avoid regional or ethnic stigma” (p. 7). Yet, “political leaders, administrative officials, and media commentators have frequently referred to the ailment the ‘Chinese virus’ or ‘Wuhan virus’”—while the former “President Donald Trump” was known for “repeatedly and deliberately” referring to “the ‘Chinese virus’ or ‘kung flu’” (Li & Nicholson, 2021, p. 7).

While former President Trump’s media presence and use of twitter have been noted for their impact on key events in the historic year 2020, others have acknowledged key dynamics involving twitter, in general.

As per Nguyen et al. (2021), any contemporary approach to the experience of racial and ethnic minorities in the United States may need to recognize the role of online activity involving Twitter tweets and their potential link to hate crimes. It was found that those individuals “living in states with higher levels of negative racial sentiment assessed from Twitter expressed greater racial bias” (Nguyen et al., 2021, p. 5).

It is also important to recall how the early work of Pierce et al. (1977) was not only highlighting the theory of racism—with the core construct of White superiority and Black inferiority; but also highlighting research analyzing television commercials from the year 1972.
Research findings showed that the representations of Whites and Blacks disseminated via commercials reinforced notions of Whites exerting authority with displays of superior knowledge, in contrast to the negative depictions of Blacks.

Going beyond just television, it was also the larger media that was described by Pierce et al. (1977). Indeed, it was the larger media that perpetrated microaggressions “as the critical means for training people” to accept racist behavior (p. 65). These microaggressions were described as daily occurrences in a variety of media (e.g., newspapers, films, billboards).

In contemporary times, other newer forms of social media serve to perpetrate microaggressions. This has followed the rise in the use of various social media platforms.

Rowan-Kenyon et al. (2020) described how acts of racial hostility directed toward students of color via social media has intensified their susceptibility to racism. This reality is now an essential part of campus culture. Online racism is “perceived as a domain of interpersonal victimization,” while negatively affecting the mental health of college students of color (p. 1). Identifying students of colors’ experience of racist aggressions on campus and via social media could help college counselors understand students’ mental health problems, thereby mitigating students’ stress levels. Furthermore, investigating experiences of online racism informed the perceptions of the campus environment on the part of students of color. Strategies were recommended investigating racial hostility toward minority students on college campuses in order to begin to dismantle “oppressive structures that exist on social media or in other environments” that negatively affect minority college students’ experiences (Rowan-Kenyon et al., 2020, p. 10).

Eschmann (2020) found an increase in overt online racist messages toward students of color on campus, as controversial online content. Students of color were exposed to a higher risk
of overt racism, stereotyping, and microaggressions from online content. However, students of color could also access more immediate support from allies, while using social media and technology “to independently assess, critique, and sanction racial microaggressions” in the absence of institutional action against microaggressions (p. 11). By recognizing and criticizing “the racist ideologies that support practices like microaggressions,” students of color were empowered to refuse to accept the microaggressions as normal or suitable practices (Eschmann, 2020, p. 12).

Microaggressions, College Campus Racial Climates, and Health Impacts

The racial climate of college campuses has garnered a great deal of attention in research. There has been a specific focus on students of color and their experiences of racial microaggressions.

According to Leath and Chavous (2018), campus racial climate, reflecting students’ perception of “their campus institutional norms related to race” is a critical factor influencing racially diverse college students’ academic motivation and satisfaction (p. 130). Also, having more racially stigmatizing experiences on campus was negatively associated with Black women students’ academic motivation, which plays a vital role “in their future academic and professional decisions” as well as in their persistence in college (Leath & Chavous, 2018, p. 136).

Nguyen et al. (2021) discussed findings showing that “racial climates that are less welcoming to minorities are associated with higher racial bias at the individual level” (p. 5). Regarding the impact, it was also found that area-level “negative racial sentiment was positively associated with hate crimes targeting racial and ethnic minorities” (p. 5). The focus on the importance of racial climates and experiences of racial bias emerges as important, given how
both individual-level and community-level experiences of racial bias “have been associated with adverse health outcomes” (Nguyen et al., 2021, p. 5).

According to Linley (2018), racism has evolved from an overt and conscious form to a more covert and subtle form, so that microaggressions are difficult to identify as racism (p. 24). Specifically, in the college context, experiencing microaggressions during the class, whether from peers or instructors, may make students of color question their value, ultimately causing identity-related stress. Classroom microaggressions “are elements of the behavioral component of campus climate” and create an unfavorable college climate for racially minoritized students (Linley, 2018, p. 29).

While microaggressions are prevalent in higher education, and institutional microaggressions have a disproportionate effect “on the lives and careers of minority students,” microaggression are most prevalent among African American students, (Ogunyemi et al., 2020, p. 107). As the diversity of student populations has increased in higher education, minority students have reported encountering subtle bias more than overt bias from peers and faculty in the classroom and have also perceived a hostile campus climate associated with negative stereotypes. Microaggressions, which are “associated with” an “ongoing major negative impact on the learning environment,” have contributed to significant psychological distress in students of color (Ogunyemi et al., 2020, p. 97).

Other reported that the vast majority of African American college students (95.2%) at a large public University reported having experienced racial discrimination and “at least two forms of racism multiple times” during their first year at college (Lee et al., 2020, p. 5). African American students also had “a higher likelihood and greater frequency of experiencing” microaggressions at the campus, academic, and peer levels (Lee et al., 2020, p. 9).
More broadly, Lee et al. (2020) discussed the manner in which underrepresented minority students experienced microaggressions at the campus, academic, and peer levels, and the negative racial climate on campus and microaggressions significantly contributed to “the low rates of students of color” at a large public university (p. 2). At the campus level, students of color, regardless of race, reported that they were ignored both on- and off-campus, were excluded from many social activities, and perceived the campus climate as being a hostile one. Suggestive of a negative mental health impact, at the academic level, students of color also reported experiences of microaggressions in the form of humiliation when faculty members, teaching assistants, and advising personnel stereotyped Black and Latinx students as not being suited to STEM pursuits, or stereotyped Asian students as understanding math better than members of other racial groups. Furthermore, students of color experienced “harassment and exclusion around campus, especially in the classroom” (p. 11). Peers stated assumptions that Black and Latinx students were admitted into STEM majors “only because of their race, not based on intelligence” (p. 12). Thus, experiences of not being valued and unsupported contributed to students of color deciding to leave their STEM major “as a consequence of feeling marginalized and pushed out” (Lee et al., 2020, p. 12).

According to Hernández and Villodas (2020), encountering more racial microaggressions in college was correlated with students of color evidencing poorer mental health. In addition, exposure to microaggression was associated with the use of more problem-focused coping styles.

Regarding potential negative impacts on physical health status, Homandberg and Fuller-Rowell (2020) discovered a 3-year “longitudinal association between experiences of discrimination and urinary catecholamines” among racially diverse college students (p. 843). Experiencing discrimination on campus was significantly associated with college students’
increased levels of norepinephrine and epinephrine for 3 years, even after controlling for their depression, negative affect, and rejection sensitivity. Racial discrimination as a stressor was associated with increased cardiometabolic risk among racial and ethnic minority students via “chronic overactivation of the sympathetic nervous system” (p. 848). Findings showed that, while African American students reported significantly more discrimination experiences than Asian, Hispanic, and European Americans, the different racial groups exhibited no significant differences with regard to health effects. Similar health outcomes across race indicated that, even though racial discrimination on campus might be experienced differently by minority students, “the effects of the perceived racism are similar across race” in terms of the health impacts found in this particular study (Homandberg & Fuller-Rowell, 2020, p. 848).

Of note, the large of body of research that acknowledges perceived racism has roots in the pioneering work of Clark et al. (1999). Perceived racism describes individuals’ subjective experiences under racial discrimination or prejudice (Clark et al., 1999). Perceived racism is beyond experiences “that may ‘objectively’ be viewed as representing racism,” and it can cause physiological and psychological stress responses (Clark et al., 1999, p. 808).

Taking a different approach involving self-ratings of health, others found that Asian American students regularly faced racial microaggressions which negatively impacted health. Racial microaggressions, specifically the model minority stereotype (i.e. Asian students are naturally talented at science or math)—and “the perceived foreignness of Asians in American society”—both negatively affected Asians and Asian Americans’ self-rated overall health (Nicholson & Mei, 2020, p. 215). Experiencing a microinvalidation (e.g., people behaving as if Asian Americans did not speak English) “was associated with higher odds of poorer perceived health” in Asian American college students (Nicholson & Mei, 2020, p. 213). Experiencing a
microinsult (indicating people’s belief that Asian Americans do not think creatively), and also a microassault (referring to receiving poorer services at a public place than individuals of other race groups) significantly correlated with worse self-rated health (Nicholson & Mei, 2020).

Wong-Padoongpatt et al. (2020) reported the negative impact of microaggressions on Asian American college students’ levels of stress. When Asian American students experienced microaggressions about their ability to speak English from both White perpetrator (cross-race) and Asian perpetrator (same-race), cross-raced microaggressions from White perpetrators “caused more stress compared with same-race microaggressions” (p. 130). Also, compared with Asian American women, Asian American men “who were more sensitive to being rejected” reported significantly higher stress when experiencing cross-race microaggressions than same-race microaggressions (Wong-Padoongpatt et al., 2020, p. 132).

Lui (2020) discovered distinct patterns across racial and ethnic minority college students’ experiences of overt discrimination and microaggressions. Findings showed that African American students, compared with Latinx and Asian students, reported the highest intensity level of overt discrimination and microaggressions. Psychological distress was directly associated with African American college students’ drinking problems, alcohol consumption, and negative affect; however, experiencing “microaggression and overt discrimination did not consistently predict psychological adjustment” (p. 551). A weak association between racism experiences and psychological adjustment suggested that African American college students “have come to expect both subtle and overt forms of racism” in everyday situations (Lui, 2020, p. 572).

Latinx American students experienced the same level of overt racism and microaggressions as Asian Americans, but, in contrast, for Latinx American students’ overt discrimination was a more “important predictor of psychological distress and negative affect”
(Lui, 2020, p. 571). Also, according to Solis and Durán (2020), Latinx students at public research-intensive university experienced several cases where professors made racist remarks or instances where professors made them feel inferior in class. The Latinx community college students, who were in the transition to a 4 year public university, reported encountering racism, feelings of inferiority, and discrimination in curricula, “which students perceived as negatively affecting their academic experiences” (Solis & Durán, 2020, p. 6).

According to Johnson (2020), African American college students experienced moderate levels of internalized shame, low self-esteem, and “moderate levels of racism in the past year and over the lifetime” (p. 6). The frequency of experiencing racism within the past year significantly predicted higher scores of internalized shame among African American students. Self-esteem also had a negative association with internalized shame. Specifically, lower self-esteem that was “coupled with frequent experiences of racist events” significantly contributed to African American college students’ internalized shame (p. 8). Internalized shame thought to be the result of experiencing threats to self-esteem was associated with poorer physical and psychological health. African American students “may be vulnerable to shame experiences as racism threatens self-esteem” (Johnson, 2020, p. 1).

Volpe et al. (2020) discussed the role of John Henryism as a coping strategy that “entails prolonged, effortful exertion of energy in response to stress” among Black college students attending a large, predominantly White institution (p. 246). When African American college students adopted moderate and high levels of John Henryism, more frequent experiences of racial discrimination were “significantly associated with higher diastolic blood pressure” (p. 247). Moreover, for African American college students who experienced recurrent discrimination, “high-effort active coping may be associated with health risk” (p. 249). Diastolic
blood pressure, an index of physiological functioning related to nervous system influence, was a particularly crucial outcome for African American college students coping with racial discrimination (Volpe et al., 2020).

Solis and Durán (2020) also reported that experiencing hostile social interactions on campus and suffering from limited peer interactions in classes negatively affected the Latinx students’ academic performance. Moreover, having a racist colleague “who constantly made remarks about undocumented people” caused the Latinx students to develop a high level of anxiety that made it difficult for them to focus on studying (Solis & Durán, 2020, p. 11).

According to Torres-Harding et al. (2020), racial microaggressions are not monolithic experiences that could be measured by the sum of scale scores but are qualitatively different experiences, which were “associated with health indicators through diverse pathways” eliciting varied emotional and intellectual responses (p. 132). Different types of microaggressions were identifying as including the following: foreigner (respondents are treated as a foreigner); low-achieving (different racial culture is treated as dysfunctional); sexualization (the specific race is sexually stereotyped), criminality (respondents’ behaviors are treated as criminal); invisibility (respondents are overlooked); and environmental (respondents felt themselves as the only one in their environments). Racially diverse college students’ “somatic symptoms were strongly correlated with all racial microaggressions types” (p. 130). Moreover, all types of racial microaggressions—except for the environmental type—had significantly positive associations with depression, while only invisibility, criminality, and low-achieving types were correlated with perceived stress. Findings suggested that individuals who experienced depressive symptoms, such as feeling guilty, self-blame, and sadness, were “particularly vulnerable to also
experiencing more physical symptoms”—suggesting a negative impact on health (Torres-Harding et al., 2020, p. 132).

Rice (2020) described how the spokesperson phenomenon, as seen when a student of color is “asked to speak for their entire race or culture,” is detrimental and an inappropriate microaggression (p. 4). When students are expected to have a particular cultural background based on their appearance and are asked to constantly take the role of spokesperson for a specific culture, “othering” microaggressions may deliver the message that they are everlasting foreigners in the United States and not real Americans. The spokesperson phenomenon also refers to a microinvalidation, not only because it denies an individual’s actual experiences, but also because it “positions them as something they may simply not be” (p. 4). Through repeated experiences of being “othered” by being allocated as a spokesperson for their culture, South Asian students felt embarrassment over their identity and had difficulty building close relationships with their peers and teachers, which could eventually cause race-based trauma: i.e., meaning “the cumulative negative effects of racism on” individuals’ psychological and/or physical well-being (Rice, 2020, p. 12).

Experiencing microaggressions was found to be significantly associated with poorer mental health, including a greater level of stress and depressive symptoms, among non-White college students (Farber et al., 2020). Hernández and Villodas (2020) also reported that experiencing more microaggressions in college contributed to reduced psychological well-being for racial minority students. Furthermore, overt discrimination and microaggressions can evoke psychological distress, which can predict different adjustment outcomes, and may “precipitate psychological maladjustment through factors other than perceived distress” (Lui, 2020, p. 570).

**Institution-Level Recommendations for Colleges to Improve Racial Climates**
Farber et al. (2020) asserted that, given “the negative mental health effects of experiencing microaggressions” among students of color on college campuses, institutions should create a racially inclusive policy (p. 252). Such policy might help minority students access materials or support to cope with their daily experience of microaggressions (Farber et al., 2020, p. 252).

Similarly, Cheng et al. (2020) argued that addressing discrimination and tackling racism at the institutional level can help decrease academic distress in minority college students. Furthermore, by providing a statement of diversity and publicly condemning racism, institutions can convey their “dedication to an inclusive and just campus climate” to minority students (Cheng et al., 2020, p. 407).

Others recommended strategies to improving campus climates include colleges taking action to increase the number of diverse faculty and staff (Guthrie & Fruith, 2020). In this manner, Guthrie and Fruith (2020) focused on “the importance of students having faculty and staff” who share their racial background (p. 537). Research showed the strongest predictor of students’ perceived ability and academic hope was faculty support. However, there was an on-campus support gap between White and underrepresented minority students. Specifically, compared with White and multiracial students, significantly more Latinx students and African American students reported a lack of on-campus support, and they were also “significantly less likely to identify having support from teachers” (p. 535). Because students pointed to faculty and staff of color as positive and important influences in their college experience, constructing a racially and ethnically diverse body of faculty and academic staff members was deemed critically important. To help all students have supportive relationships with caring adults on campus, thereby fostering their academic success, institutions’ intentional efforts to build more
diverse faculty and staff may “contribute to closing the support gap on a college campus” (Guthrie & Fruhiht, 2020, p. 536).

Mushonga (2020) also focused on the importance of the college campus climate, citing it as a critical factor affecting Black students’ ability to adjust to college. Perceiving the campus climate as racially tense contributed to Black students’ poor psychological health outcomes, including feelings of a lack of social support, alienation, and isolation. Evidence of the importance of this issue was found in Black college students having the lowest graduation rates in comparison to White and Asian students. Thus, it was viewed as essential to establish “campus settings that are conducive” to Black college students’ “academic success and overall well-being” (p. 9). Accordingly, institutions seeking to increase retention and graduation rates should provide programs in which Black students can identify the challenges they face and discuss “coping strategies and resources that could be utilized on campus” (p. 9). Here, too, a focus was placed on providing additional supports from faculty to help Black college students have a sense of belonging (Mushonga, 2020, p. 9).

Volpe et al. (2020) indicated that Black college students’ worst experiences of racism occurred at the institutional level, showing the systemic nature of racism, with students reporting that their opportunities and access were “restricted by a White authority figure in power” (Volpe et al., 2020, p. 5). Hence, efforts to reduce experiences of racism at the individual level are unlikely to be successful—such as via strategies to enhance individual-level coping ability. Pursuing “a direct role in creating interventions and policies” at the institutional- and national-levels would be required to decrease exposures to multi-level racism among Black college students on campus (Volpe et al., 2020, p. 13).
Institutional efforts to “raise awareness and minimize the occurrence of racial microaggressions” are crucially important (Ogunyemi et al., 2020, p. 114). To address racial microaggressions that create adverse learning environments and create a positive racial climate in college, the following is required: “a critical mass of minority students, faculty and administrators;” programs for recruiting and retaining minority students; an innovative mission “that reinforces commitment to pluralism and diversity;” and, curriculums that integrate minority students’ historical and contemporary experiences (Ogunyemi et al., 2020, p. 114).

Others cited specific negative health impacts for African American students, while using their data to argue for targeted interventions and policy implemented on the institutional level (Volpe et al., 2020). Considering the risks to cardiovascular health for African American students in hostile college contexts, targeted policies and interventions are needed to “help disrupt the risk of developmental sequelae for” cardiovascular disease (Volpe et al., 2020, p. 249).

The Impact of Racism, Hate Crimes, Police Violence, and Microaggressions Beyond College Campuses—And Other Factors

Beyond the college climate, there are also risks for exposure to racism, hate crimes, and police violence. There are also other factors operating that are worthy of consideration, even via just a brief selective overview in this section.

One study had relevant findings of what may occur beyond the college campus. These considerations are especially important in the year of the COVID-19 pandemic when many students were studying online, at home, and within their own community, given the transition to online learning and students leaving college campuses. For example, one study found that frequently encountering mistreatment in public settings due to exposure to “anti-Asian sentiment
and racist attitudes toward them” critically contributed to worse health outcomes for Asians (Nicholson & Mei, 2020, p. 215).

Further, consider how there are potential risks for Asians and Asian American college students both on and off their college campuses, as well as for their family and community members. Consider the most recent rise in Asian hate crimes and violence in the United States.

Providing clarity, Schweppe (2021) defined hate crimes as a phenomenon involving “hostilities that are manifested towards minority communities,” including microaggressions, discrimination, hate speech, or criminal acts (Schweppe, 2021, p. 1). Hate crimes may involve attacks caused by prejudice and hostility based on people’s race, sexual orientation, gender identity, or religion (Xu et al., 2021).

Xu et al., (2021) acknowledged how the COVID-19 pandemic contributed to the global spread of stigmatization to “groups in the Chinese language–speaking world” (p. 52). This included the year 2020 spread of stigmatization and hate incidents in the United States, as “hate crimes” were “widely reported” from March of 2020 onwards during the pandemic (p. 61). Incidents of violent attacks against Asian Americans of all ages were reported across the United States, spanning from Los Angeles County to New York City (Xu et al., 2021).

The impact of the hate crimes of which Xu et al. (2021) speak, above, is most noteworthy. Schweppe (2021) stated that hate crimes are understood as message crimes as victims are interchangeable and the perpetrator sends “a message, not only to the direct victim, but also to the community to which they belong” when committing the crime (p. 4). A qualitative difference exists between the impact of hate crimes versus overall crimes. The victims of hate crime were more likely to report that they were emotionally affected, suffered “a loss of confidence or feelings of vulnerability after the incident” as well as having experienced a panic
attack, sleep problem, and fear compared to victims of non-hate crimes (p. 5). Moreover, by targeting the victim “on the basis of their membership of a particular community,” hate crimes can make all members of the same community feel that they do not belong to this society (Schweppe, 2021, p. 6).

Others acknowledge the rise in hate crimes in the United States, well before the COVID-19 pandemic, as well as their negative impact. Daftary et al. (2020) discussed the mental health outcomes of female college students of color caused by racial discrimination experiences, considering the rise “in racially motivated hate crime since the 2016 United States presidential election” (p. 765). Compared with White women, women of color reported a significant increase in racial discrimination experiences in college, which was associated with greater levels of anxiety and depression along with decreased levels of resilience. Findings revealed that exposure to racial discrimination depleted the ability of women of color to exhibit resilience in the face of stressful experiences, giving “way to more feelings of depression and anxiety” (p. 773). For the women of color, having a weaker sense of being resilient was not associated with previous lifetime traumatic events, but was solely depleted by discrimination experiences since 2016. Hence, resilience could not function as a stress buffer for women of color in contemporary circumstances. To combat hate crimes and decrease discrimination in college, increased and intentional efforts to create activities “that address micro-, mezzo-, and macro-level factors” are necessary (Daftary et al., 2020, p. 774).

Also, for Blacks, beyond the college campus there are risks for facing police brutality and even death. For, “police brutality may increase the death rates among” members of the “Black community”—while there are also risks of physical injury (Njoku et al., 2020, p. 263). Indeed, “the global COVID-19 pandemic has unveiled the extent of police disparity toward Blacks in the
United States and has brought racial disparities to the forefront,” while also “revealing the worsening effects of racial differences on health” (p. 264).

As for those who are Latinx, the experience of global or non-academic context perceived discrimination significantly impacted Latinx college students’ academic distress even a year later, while controlling for depressive symptoms (Cheng et al., 2020). The impact of racial discrimination, which occurred outside academic contexts was “likely to carry into individuals’ academic concerns” causing severe distress (Cheng et al., 2020, p. 406).

Others have focused on links between microaggressions and the role of social support. Salami et al. (2020) found that when students had a lower level of perceived social support, experiencing racial microaggressions at college significantly increased Black college students’ worry about future employment regardless of academic achievement level.

Choi et al. (2020) explored ethnic and racial identity and whether it can buffer “the detrimental impact of perceived racial discrimination” on psychological distress among Asian immigrant populations (p. 142). High ethnic and racial identity was, theoretically, supposed to work as a coping strategy that protects individuals from discrimination by providing a sense of pride or belonging. However, findings showed that ethnic and racial identity intensified psychological distress, instead of buffering the harmful impact of discrimination, Asian immigrants with higher ethnic and racial identity were more likely to “experience higher psychological distress when they faced discrimination” (p. 146). Asian immigrants were perceived as a model minority, promoting the unrealistic image that they experience less discrimination compared to other racial groups; and, so were not at risk of a negative impact on mental health. This model minority myth caused “a lack of attention to Asian immigrants and their experiences of racial discrimination” (p. 151). Health practitioners should consider various
factors, such as sociocultural contexts, racial orientation, and attitudes, along with details of racial discrimination, in order to provide more sensitive treatment for Asian immigrants’ psychological well-being (Choi et al., 2020, p. 151).

Regarding the relationship between students and faculty, caring student–faculty interactions could significantly predict “both academic and social engagement” of Black undergraduates at a large Southwestern predominantly White institution (Beasley, 2020, p. 8). Black students perceived that caring faculty were proactive and responsive when interacting with students, and caring faculty also showed a deeper commitment to students’ performances in academic life. Compared with respectful interactions between students and faculty relationships, caring attitudes in student–faculty interactions play a “particularly important role in the engagement of Black students” (Beasley, 2020, p. 9).

Lewis et al. (2020) explored a relationship between “racial identity attitudes and coping with racism-related stress” among Black, Latinx, and Asian college students (p. 108). Black and Latinx college students showed lower internalization and higher conformity and dissonance racial identity attitudes, which were associated with less active antisocial and greater active coping strategies. In contrast, Asian college students showed “higher conformity, dissonance, and immersion-emersion racial identity attitudes” and tended to use active antisocial and more avoidant coping strategies (p. 115). Specifically, Asian students who were ambivalent and confused between an idealization of White culture and their own culture were more likely to adopt greater avoidant coping strategies. Considering the role of racial identity, which affects racially diverse minority students’ different types of coping strategies, college counselors should assess individual students’ racial identity development to help them build “culturally congruent coping strategies to combat the stress associated with racism” (Lewis et al., 2020, p. 117).
Statement of the Problem

The problem that this study addresses is the experience of stress associated with experiences of exposure to hate, racism, discrimination and microaggressions on college campuses within a hostile climate, as well as more broadly within the context of the United States—with potential associated negative impacts on physical and mental health for Black, Latinx, and Asian students. Meanwhile, such exposure has also occurred beyond the context of the college campus, whether involving police violence against Blacks, in particular, as well as Hispanics; or, the COVID-19 pandemic year of 2020 rise in hate and violence toward Asians, given racist references to the virus (kung flu) by the former President. Indeed, college students may possess a level of English-speaking skills for exposing the exposure to hate and violence that may be currently under-reported in Asian communities, due to English as a second language for victims, or an inability to speak English, especially among older adults. Similarly, Black and Latinx college students may be especially well-equipped to disclose through a mixed methods study such as the present one the extent of exposure to racism, hate, and violence experienced by members of their own respective communities. This assessment of exposure to experiences of racism, discrimination, hate and microaggressions via quantitative and qualitative research is important, whether the targeted college students are undergraduate students, graduate students—or studying online, on campus, or while living with their families in their communities, during the COVID-19 pandemic.

A focus on the above stated problem is justified by multiple theories. Of note, in addition to the Theory of Racism with a focus on microaggressions (i.e., Pierce, 1970; 1974; Pierce et al., 1977), as elaborated upon in this introductory chapter, other theories are relevant. Specifically, in Chapter II, Review of Literature, there will be brief review of additional theories that also
provide a framework for the present study: i.e., Theory on the Biopsychosocial Effects of Perceived Racism (Clark et al., 1999), Social Support Theory (Harrell, 2000), and Stages of Change from the Transtheoretical Model (Prochaska & DiClemente, 1983).

**Purpose of the Study**

The purpose of the present study is to identify the significant predictors of a high prevalence of experiences of microaggressions for Black, Latinx, and Asian students enrolled in college at this time—whether at the undergraduate or graduate level.

While controlling for social desirability, the regression model utilized for predicting the study outcome variable of a high prevalence of experiences of microaggressions for Black, Latinx, and Asian college students will be chosen from among the following independent variables:

- **Demographics** [gender, race, age, skin color, U.S. Born (yes/no), year in undergraduate or graduate school, household income, ever attended a minority serving college (yes/no)]
- **Personal Health Background** [ratings of health status and mental/emotional status; Body Mass Index (BMI)]
- **Learning Setting** [in-person, online, hybrid]
- **Rating of College Climate** [0 to 10]
- **Perceived Social Support** [0 to 6 or more people providing it]
- **Perceived Stress** [past 30 days]
- **Perceptions of Racism and Oppression** [level of ability]
- **Coping and Responding to Racism and Oppression** [stage of change for this behavior]
- **Experiences of Hate** [prevalence of experiences and rating of stressful and traumatic impact]
Research Questions and Survey Parts

Given a sample of adults (N=341) who responded to a social media campaign inviting Black, Latinx, and Asian undergraduate or graduate college students to complete a survey (i.e., Black, Latinx, Asian & Minority U.S. undergraduate or graduate college students click link https://tinyurl.com/I-EXPERIENCED-HATE to take 10-15 MINUTE SURVEY on experiences of hate, stress, racism, microaggressions & violence for a chance to win 1 of 3 $100 Amazon gift cards), the study will answer the following research questions:

1-What did the college students report as their demographic characteristics (i.e., gender, age, race/ethnicity, skin color, birthplace (US born yes/no), annual household income, year in undergraduate or graduate school, history of attending either Historically Black College or University, or Hispanic Serving Institution)?
   Part I: Basic Demographics (BD-8)

2-What was their personal health background (i.e., rating for overall physical health status, rating for overall mental/emotional health status, Body Mass Index)?
   Part II: Personal Health Background (M-PHB-5)

3-To what extent were they at risk for providing socially desirable answers?
   Part III: Single Item Rating of Risk of Providing Socially Desirable Responses (SIR-RPSDR-1)

4-For the past year, during the COVID-19 pandemic, in what kind of college setting did they report learning (i.e., in-person, online, hybrid)?
   Part IV: In-Person, Online, or Hybrid Learning (IOHL-1)

5-How did they rate their college’s climate for how well their university has supported, engaged, valued, fairly disciplined, affirmed, reflected empathy for, and served as a safe space for students from diverse cultural backgrounds?
   Part V: Rating the College Climate (RCC-1)

6-To what extent did they experience social support?
   Part VI: Perceived Social Support Scale (PSSS-1)

7-What did they report as their past month experience of perceived stress?
   Part VII: Perceived Stress Scale (PSS-4)
8-To what extent had they experienced microaggressions—whether in the campus/college setting, work settings, shopping in stores, or during online/social media interactions?
   Part VIII: Ratings of Experiences of Microaggressions (REM-6)

9-What was their level of ability for perceiving racism and oppression?
   Part IX: Perceptions of Racism and Oppression Scale (PROS-10)

10-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 X: Coping and Responding to Racism and Oppression Staging Scale (CRROSS-7)

11-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 XI: Experiences of Hate (EOH-12)

12-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?

13-What were the significant predictors of the study outcome variable of a higher prevalence of the experience of microaggressions in the United States—when controlling for social desirability?

The Anticipated Findings

It is anticipated that significant predictors of the study outcome variable of a higher prevalence of experiences of microaggressions—when controlling for social desirability—in the United States will be the following: darker skin color; U.S. born; lower ratings of physical health status; lower ratings of mental/emotional status; higher Body Mass Index (BMI); learning in an in-person setting; lower rating of college climate; having less social support; higher stress in the past 30 days; higher level of ability to perceive racism and oppression; higher stage of change for coping and responding to racism and oppression; higher prevalence of experiences of hate; and higher rating of stressful and traumatic impact from hate.
Delimitations

Regarding delimitations, the present study was delimited to those who: identified as Black, Latinx, or Asian; reported being age 18 or above; lived in the U.S.; and, were attending college as an undergraduate or graduate student.

Limitations

As an online study conducted during the COVID-19 pandemic, the study limitations included this being an online study, necessitating access to a computer, tablet or smart phone with Internet connection. There was also the use of a sample of convenience who were exposed to the online study opportunity via online recruitment (i.e., Twitter, Facebook, LinkedIn, emails, texts, etc…). Most important was the need to reduce the burden of time by making the survey as short as possible (i.e., 10 to 15 minutes), given the pandemic. Yet, the stress of the pandemic may have negatively impacted study participation, and/or survey completion.

Conclusion

This chapter introduced the dissertation topic, which focuses on experiences of hate, microaggressions, stress, perceived racism, and oppression among Black, Latinx, and Asian college students in the United States. It also presented the statement of the problem, the study purpose, research questions, anticipated findings, as well as the study delimitations and limitations.

The following Chapter II will provide a review of literature relevant to the dissertation topic. Chapter III will describe the methods and procedures followed in the study. Thereafter, Chapter IV will provide the results of data analysis. Finally, Chapter V will provide a summary
of the dissertation, discussion, implications, recommendations for future research, and the conclusion.
Chapter II

REVIEW OF THE LITERATURE

This chapter will provide a review of the literature on the following topics: 1-racism, perceived racism, microaggressions, and perceived discrimination; 2-microaggressions and racism in higher education and on college campuses; 3-discrimination, stress, and adverse health outcomes; 4-institutional change for social justice; and 5-theoretical framework.

Racism, Perceived Racism, Microaggressions, and Perceived Discrimination

Racism can be used as an umbrella term describing “all forms of racially and ethnically fueled experiences,” including microaggressions and perceived discrimination (Cheng et al., 2020, p. 402). This section will avoid repeating vital information discussed in the Chapter I, Introduction, while providing a review of additional literature of value.

Racism

As per Braveman et al. (2011), racism not only includes intentional and overt discriminatory actions but also is deeply rooted in societal structures that “systematically constrain some individuals’ opportunities and resources” based on their race or ethnicity, even without the intent to discriminate (p. 387). It is important to understand “the pathways through which social factors shape health” (Braveman et al., 2011, p. 385). Upstream social factors that influence health include neighborhood conditions, the working environment, education, and income. Race and ethnicity are also significant social factors influencing health, mainly through racism. Furthermore, racism directly affects health through chronic stress responses caused by experiences of overt discrimination and subtle forms of racial or ethnic bias. The chronic stress
caused by experiences of racism “may contribute to racial/ethnic disparities in health,” regardless of education, income, or neighborhood factors (Braveman et al., 2011, p. 388).

Bonilla-Silva (1997) proposed a more general notion of racialized social systems. In racialized social systems, a hierarchy “produces definite social relations between the races,” while generating a disparate allocation of resources, power, and status to the race that is deemed inferior (Bonilla-Silva, 1997, p. 496).

Harrell (2000) focused on those systems in which racism is deeply rooted, viewing racism as a system that exercises “dominance, power, and privilege based on racial group designations” (p. 43). In such a system, members of the dominant group use their societal privilege to preserve their ideology and structures but members of non-dominant groups do not have equal power or access to the same resources. Racism, which is embedded in “a historical continuity of injustice and disparity,” systematically affects a large number of people’s experiences in contemporary conditions (Harrell, 2000, p. 43).

Although racism is frequently believed to signify interpersonal discrimination, with well-documented negative health effects, inequities associated with health-related issues can be worsened by structural racism (Kristen et al., 2019). Structural racism is “a manifestation of historical and contemporary ‘structural violence’” (p. 1,491). Social structures prevent certain racial groups from having their basic needs met. With the establishment of a resultant structural racism, racial inequities are created by social, economic, and political systems. A status quo continues through structures that cause systemic discrepancies in opportunity based on people’s race/ethnicity. Structural racism is not explicitly recognized as race-based. Further, structural racism persists “in the implicit assumptions that guide everyday institutional practices” (p. 1,491). These institutional practices generate the unequal distribution of resources. Hence,
structural racism is a root cause of health inequities between different racial groups in the United States (Kristen et al., 2019, p. 1,491).

Wallace (2003) explained that racism can be manifested as institutionalized oppression or violence. Institutionalized violence and oppression involve “patterns of behavior, ways of thinking, and emotional responses” in organizations that negatively impact a variety of “diverse and different others” (p. 3). In this view, the presence of racism, White privilege, and White domination in organizations function so that diverse and different others “feel unwelcome, unaccepted, and disrespected within the institution” (p. 3). The impact from exposure to institutionalized violence and oppression can include poor health, mental illness, stress responses, and cognitive distress (Wallace, 2003, p. 3).

Hill et al. (2007) observed that institutional racism affects people of color’s health in diverse ways. Further, perceived racism reflects the personal experience of racism, while a salient social stressor that plays an important role in the health of people of color (p. 405).

The term perceived racism was developed to refer to individuals’ personal perceptions of discrimination when there is no way to verify “the actions or behaviors that precipitated the perception” (Heads et al. 2020, p. 2,198). As pioneers in this area, for Clark et al. (1999), perceived racism refers to people’s subjective experiences under racial discrimination or prejudice. Hence, perceived racism goes beyond experiences “that may ‘objectively’ be viewed as representing racism” (p. 808). Perceived racism may lead to individual stress responses that occur both physiologically and psychologically (Clark et al., 1999, p. 808).
Microaggressions

Beyond the discussion provided in the Chapter I Introduction, which focused on the work of Pierce (1970; 1974; Pierce et al., 1977) and Sue et al. (2007), others have contributed to the literature on microaggressions, as well.

Applebaum (2018) explained that microaggressions often do not involve an obvious intention to harm and “can even appear in the form of a compliment,” so that their detrimental effects are not easily recognized (p. 134). For example, although a person of color may be described as “a credit to his race” with the intent of giving a compliment, such a statement still relies on stereotyping that may be harmful to people of color. A single microaggression may be viewed as insignificant, but because microaggressions are “events that are connected to larger structures of injustice,” their collective effects on people of color are significant (Applebaum, 2018, p. 134).

According to Rosa-Dávila et al. (2020), microaggressions, which are manifested as micro-assaults, microinsults, or microinvalidations, are particularly harmful “because their subtle character makes them socially legitimized” and their frequency negatively affect their targets’ psychological well-being (p. 4). Micro-assaults, the most explicit type of microaggression, convey overt, covert, or deliberate biases, attitudes, or behaviors toward people of color; and, they “harm the person’s group identity” or function to effectively attack or injure the victim” (p. 4). This occurs through intentional discrimination, insults, or avoidance actions (p. 4). Microinvalidations are the most harmful type of microaggression, because they directly exclude and reject the feelings or psychological thoughts of people of color through communications or environmental signals. Microinsults, by contrast, include insensitivity and rude behaviors or stereotypes that degrade people’s racial or cultural heritage identities. Some microinsults
“represent subtle slights, often outside the perpetrator’s consciousness,” but others often involve hidden insulting messages that demean a marginalized group of people (Rosa-Dávila et al., 2020, p. 4).

According to Williams (2020), microaggressions can be “conceptualized as manifestations of everyday racism and discrimination” (p. 7). Everyday racism refers to unrecognized racism that is “integrated into common situations through cognitive and behavioral practices;” and, thus can initiate differential power structures between races (p. 7). As a part of the structural racism that strengthens racial hierarchy, everyday racism negatively and cumulatively affects people of color. Despite claims that microaggressions are often unintended and their harms often minor, microaggressions are actually aggression and violence; and, they are a type of racism, which “leads to negative mental- and physical-health outcomes” (p. 9). Moreover, “othering” microaggressions, which “interrogate targets about where they are from,” show that people of color are not Americans nor important social members of the United States (p. 15). Because they can make people of color feel alienated and excluded, microaggressions are psychologically detrimental, especially for children, who are still developing their identity. Cross-racial social connections can help reduce microaggressions by fostering the development of multicultural sensitivity and cultural humility; and, by decreasing pathological stereotypes (i.e., false myths about people of color that justify disparities), which “flourish in the absence of social connection across race” (Williams, 2020, p. 21).

**Perceived Discrimination**

Everyday discrimination, or racially motivated daily obstacles, overlaps with microaggressions, whereas everyday discrimination focuses more on obvious prejudice or distinct discriminatory experiences (Williams, 2020). Everyday racism and everyday
discrimination, like microaggressions, feature subtle prejudice and “are rooted in power differentials between groups” (Williams, 2020, p. 7).

According to Heads et al. (2020), racial and ethnic discrimination comprises “actions or behaviors based on negative race-based” perceptions, judgment, and actions that cause unfair treatment of certain racial or ethnic groups (p. 2,198). The term perceived discrimination describes the personal experience of discrimination without verification, while it does not mean that perceived discrimination is not real. Because discrimination is unpredictable and uncontrollable, perceived discrimination “is a stressor that can negatively impact health” through adverse physiological and psychological health outcomes (Heads et al., 2020, p. 2,198).

**Microaggressions and Racism in Higher Education and on College Campuses**

Although institutions of higher education have promoted equity and diversity by trying to create a “welcoming environment where people feel that they belong,” minority students experience microaggressions, a hostile campus climate, and racial discrimination on a daily basis (Rosa-Dávila et al., 2020, p. 5). These microaggressions, which are associated with poorer mental health and lower self-esteem, exist at every level in the academic environment; and, microaggression are kept alive for future generations to perpetuate through the socialization process. One way of deconstructing current social reality and creating a microaggressions-free society “is through the social institution of higher education” (p. 6). To create an environment in which people are treated with dignity regardless of their race or ethnicity, the administrations of institutions of higher education should clearly state what is and what is not permitted, noting that “how the message is expressed will reflect campus ideology” (Rosa-Dávila et al., 2020, p. 6).

According to Hassouneh et al. (2013), faculty of color (FOC) at predominantly Euro-American schools of nursing could play a critical role in the success of students through
“processes of connecting, guiding and supporting, and challenging racism” in college (p. 156). Much of the work done and activities engaged in by FOC in higher education went beyond the traditional role of mentors for students. First, the connection between FOC and individuals of color helped the survival of students of color in “academic environments that were often isolating and alienating” (p. 157). In addition, when students of color encountered crises related to racism, FOC provided guidance that was instrumental in helping them navigate racism, stay in academia, and ultimately graduate. FOC’s expert knowledge also helped students of color challenge “racism at both individual and group levels” (p. 159). FOC in higher education have substantially helped students of color “overcome barriers to success—barriers often rooted in racism” (Hassouneh et al., 2013, p. 160).

Blake-Beard et al. (2011) investigated the effects of having faculty/mentors of one’s own race on academic experiences among undergraduate, graduate, and postdoctoral students in the STEM (science, technology, engineering and math) field, as well as “the extent to which they have adopted the idea that matching by race” matters (p. 629). Their study population comprised White, Asian American, Black, Native American, Hispanic, Hawaiian or Pacific Islander, and bi- or multiracial students. A total of 1,013 racially diverse students answered 38 questions about sources and amounts of mentoring support, desired and actual mentoring experiences, and academic outcomes. Findings showed that students “who had a mentor of their own race” reported receiving more psychological and instrumental support (p. 635). Having mentors matched by race was more significant for minorities than for White students; and, more significant for women than men (p. 635). Moreover, students who had race-matched mentors also reported experiencing a greater impact from role modeling, than those who did not experience race-matched mentoring. Seeing American society as stratified by race, racially
diverse college students believed that “same-race mentor-protégé pairs will be most satisfying and will produce the best results” (Blake-Beard et al., 2011, p. 637).

Alsulami and Sherwood (2020) also noted that faculty diversity can benefit all members of an institution, including students, other faculty members, and administrators, while enacting strategies “to assure all are treated equally, respectfully, and hospitably” (p. 9). Diversity is central to establishing a variety of perspectives in the group and to enhancing innovation. Specifically, culturally diverse groups may encourage each member to respect others’ strategies and to value diversity as a core strength of the group. Moreover, faculty members representing “cultural differences indeed serve as exceptional role models” to students of similar ethnicity or cultural backgrounds and also carry various “research perspectives, pedagogies, and background experiences to their teaching” (p. 2). When faculty members of various races, ethnicity, religions, and experiences “share their interests, and develop their traditions,” the strength of diversity can emerge through constructive conversations among different members of the group (p. 2). Thus, to establish the diversity of different cultural/ethnic backgrounds and to create a fair environment, higher education should amend institutional policies to support minority faculty members. Specifically, the commitment of leaders of higher education plays a key role in creating a positive campus climate that emphasizes diversity. Leaders in higher education should implement innovative strategies to communicate to diverse faculty members that their presence “is a part of the collective group” on campus and to promote a safe, supportive working environment for minority faculty members (Alsulami & Sherwood, 2020, p. 9).
Discrimination, Stress, and Adverse Health Outcomes

All sociodemographic groups of people experience diverse circumstances that may cause stress, but for people of color, specifically, life stress is associated with certain events that “are related to the unique person-environment transactions involving race” (Harrell, 2000, p. 44). The experience of racism is rooted in diverse situations such as sociopolitical, cultural, and interpersonal contexts, and racism can influence people’s physical, psychological, social, functional, and spiritual well-being. Experiencing racism has pathogenic effects on recipients’ physical and psychological well-being, including by causing hypertension, physiological arousal, and cardiovascular reactivity. Psychologically, moreover, racism promotes depression, violence, traumatic symptoms, and eating disorders. Experiencing interpersonal racism may affect individuals’ social well-being, specifically through their capability and willingness to have close relationships with people “within and outside of one’s racial/ethnic group” and to become a member of a social group (p. 48). Because racism plays a key role in functional well-being, it also affects people of color’s functional behaviors, such as performance as a student, a worker, and a parent. Finally, experiencing racism can affect spiritual well-being by threatening “the vitality of one’s spirit and faith” (p. 48). This framework of racism-related stress and well-being can identify the role of the predecessor and “mediating variables in a racism-related stress process” (Harrell, 2000, p. 48).

Experiences of Discrimination and Alcohol Problems

Cheng and Mallinckrodt (2015) investigated the effect of experiences of discrimination. These experiences function as “stressors that contribute to poor health outcomes” by stimulating psychological and physiological stress responses (p. 39). The study explored links between
experiences of discrimination and potential alcohol problem and posttraumatic stress disorder (PTSD) symptoms among Hispanic/Latino college students. A total of 203 Hispanic/Latino college students in the southwest United States (mean age = 24.06±7.36, female = 120) completed a survey at the beginning of the study and after one year. Measures included the General Ethnic Discrimination scale (GED; Cronbach’s alphas ≥ 0.91 at Time 1 and 2), the Posttraumatic Stress Disorder Checklist–Civilian scale (PCL-C; Cronbach’s alpha = 0.94 at Time 2), and the Alcohol Use Disorders Identification Test (AUDIT; Cronbach’s alphas = 0.83 at Times 1 and 2). PCL-C data were available only at Time 2, because analysis was conducted “only after Time 1 data collection had been completed” (Cheng & Mallinckrodt, 2015, p. 41).

Study findings showed that experiences of discrimination were significantly and positively “associated with subsequent alcohol problems and PTSD symptoms” (Cheng & Mallinckrodt, 2015, p. 44). Because the alcohol problem did not significantly affect PTSD symptoms or experiences of discrimination that were measured after one year, the direction of causality was found only from the experience of discrimination to alcohol problems. This result indicated that racial discrimination functions as a source of “distress that may lead to maladaptive coping responses” (p. 44). Moreover, Hispanic/Latino college students who “experienced more discrimination reported higher levels of PTSD symptoms,” suggesting that racial discrimination can be a risk factor for increasing traumatic stress (Cheng & Mallinckrodt, 2015, p. 45).

With regard to implications, because racism and discrimination gave rise daily to stress responses in students of color, the evaluation of Hispanic/Latino students’ “perception of racial/ethnic discrimination as a potential contributing factor” to their drinking was needed to address their alcohol problems (Cheng & Mallinckrodt, 2015, p. 46). It was recommended that
College counselors should help students recognize their behavioral and emotional responses after experiencing discrimination; and, should identify their cognitive attributions of unfair treatment. Discussion of trauma-related symptoms and behavioral responses can help students understand “how discrimination has affected their thoughts and feelings” (p. 46). Furthermore, drawing attention to racial discrimination as a source of PTSD symptoms and maladaptive coping may help students work “through the emotional injuries resulting from discrimination” and prevent them from internalizing racism (Cheng & Mallinckrodt, 2015, p. 46).

Heads et al. (2020) studied the relationship between perceived discrimination and risk behaviors and the “moderating effect of ethnic socialization and emotion regulation” on this association among college students (p. 2,205). As a part of Multi-Site University Study of Identity and Culture (MUSIC) research, 266 Black or African American college students’ (mean age = 20.3±3.37, female=71.8%) data were collected and used for analysis. Study measures included the Alcohol Use Disorders Identification Test (Cronbach’s alpha = 0.86), the perceived discrimination subscale from the scale of ethnic experience (Cronbach’s alpha = 0.76), the ethnic socialization measure (Cronbach’s alpha = 0.93), and the emotion regulation questionnaire (Cronbach’s alpha = 0.83).

Findings showed that students’ personal experience of discrimination “was positively correlated with hazardous alcohol use” (Heads et al., 2020, p. 2,204). Interactions between perceived discrimination and possible moderators, including ethnic socialization and emotional regulation, were not significantly associated with risky alcohol use. However, emotional regulation—suppression and perceived discrimination were both “significant predictors of hazardous alcohol use” (p. 2,205). Because emotional suppression or avoidance may lead to unhealthy behaviors, an intervention program is needed to equip students of color with active
coping strategies that include cognitive reframing of skills at the individual level. Furthermore, at the community level, “prevention of discrimination and interventions with perpetrators of discrimination” are needed to decrease students of color’s exposure to discrimination on campus (Heads et al., 2020, p. 2,206).

Boynton et al. (2014) examined “associations among lifetime discrimination, alcohol use, and alcohol-related problems” in a sample (N = 619) of African American college students (mean age = 20±1.6, female = 53%) (p. 229). Measures included the Schedule of Racist Events (SRE), which has been well validated “with alcohol use, as well as with anger and depression,” the Beck Depression Inventory (BDI; Cronbach’s alpha = 0.73), and the Brief Young Adult Alcohol Consequences Questionnaire (Cronbach’s alpha > 0.75) (Boynton et al., 2014, p. 229).

Findings showed that racial discrimination was “a significant predictor of alcohol-related problems” for African American college students even after controlling for risky family background (Boynton et al., 2014, p. 232). Specifically, men, who experienced higher levels of discrimination, were more likely “to report higher levels of generalized anger” than women (p. 232). Men showed significant relations between discrimination and both alcohol use and alcohol problems via generalized anger. Discrimination also significantly predicted a higher level of depression for both men and women. Both genders showed that depression significantly and indirectly “mediated the association between discrimination and alcohol problems” (p. 232). Racial discrimination may be a more powerful precursor of alcohol-related problems for African American college students, with no significant association identified between risky family background and alcohol problems. Certain African American college students, who experienced greater racial discrimination and could not effectively regulate their emotions, were “especially vulnerable to the negative effects of alcohol” (Boynton et al., 2014, p. 233).
Experiences of Microaggressions and Marijuana Use

Pro et al. (2018) examined “the association between exposure to microaggressions and marijuana use” among 332 racial/ethnic minority college students (mean age = 22.7±5.2, female = 66.87%) at a large Division I university (p. 375). Measures included five subscales of the Racial and Ethnic Microaggressions Scale (REMS; Cronbach’s alpha ≥0.80) and questionnaires asking minority students “how often they use marijuana” (Pro et al., 2018, p. 378).

Findings showed a significant and positive association between “exposure to any racial microaggressions and marijuana use” (Pro et al., 2018, p. 384). Most students reported having experienced at least one episode of microaggression on campus during the preceding 6 months, and a third of students reported regularly using marijuana. Ethnic minority men were more likely than women to “use marijuana regularly when experiencing increased racial microaggressions” (p. 385). Because minority students used marijuana as a coping strategy when encountering microaggressions, “integrating microaggression awareness into substance use prevention efforts” could help racially minority students improve health outcomes (p. 384). Also, university counseling services should provide culturally competent care, understanding “barriers that exist among racial/ethnic minority college students” as well as these students’ experiences of microaggressions with different coping strategies (Pro et al., 2018, p. 384).

Experiences of Discrimination and Sleep Disturbance

Fuller-Rowell et al. (2020) examined “within-person, day-to-day fluctuations in perceived discrimination as a predictor” of sleep disturbance among African American college students, identifying experiences of racial discrimination, or unfair treatment based on race or ethnicity, as a common social stressor (p. 1). A total of 124 African American college students
(mean age = 20.1±1.6, female = 74%) at predominantly White institutions in the northeastern United States participated in the survey for 2 consecutive academic years. Questionnaire measures included the Racism and Life Experiences Scale (RaLES; Cronbach’s alpha = 0.9), the Cross Racial Identity Scale measuring internalized racism (Cronbach’s alpha = 0.84), the Multidimensional Inventory of Black Identity (MIBI; Cronbach’s alpha = 0.89), and the revised Center for Epidemiological Studies Depression Scale (Cronbach’s alpha = 0.75). Moreover, sleep problems were assessed using self-reported daily diary measures, which have established validity and “are known to be effective for handling intraindividual variability” in sleep quality problems (p. 4). Students answered two items: how difficult it was to get to sleep the night before and how well rested participants felt in the morning (Fuller-Rowell et al., 2020, p. 4).

The findings showed that “when participants experienced more discrimination, their sleep problems increased” (Fuller-Rowell et al., 2020, p. 7). Also, the within-person association between perceived discrimination and sleep disturbance was less subject to other confounding effects, such as individuals’ identity and personality or recall bias. The association between discrimination and sleep problems was positively and significantly related to high levels of internalized racism, or degree of “agreement with negative messages about one’s racial/ethnic group” (p. 8). Among those reporting higher levels of internalized racism, the association between discrimination and sleep problems was stronger. Thus, internalized racism was a significant construct “in understanding the deleterious consequences of discrimination” among African American college students (Fuller-Rowell et al., 2020, p. 8).

Implication suggested that reducing discrimination and racism in higher education is thus important “in the movement to eliminate racial health disparities” (Fuller-Rowell et al., 2020, p. 8). Because institutional and structural racism can create an adverse environment for
African American students, a macro approach is required that goes beyond individual-level action. Furthermore, institution-level actions to eliminate discrimination could not only help students’ sleep problems and racial climate but also improve “enrollment, retention, and graduation rates of minority students” (Fuller-Rowell et al., 2020, p. 8).

Experiences of Stress from Racism and Coping Responses

Ingram and Wallace (2018) investigated “the prevalence of experiences of perceived racism and/or oppression” among minority college students and whether students felt stress and/or trauma as a result of experiencing perceived racism using a mixed-methods study (p. 84). The sample included 228 undergraduate and graduate students (female = 178, Black/African American = 151, Hispanic/Latino = 50, White/Caucasian = 19, Asian = 33, Native American = 8, Native Hawaiian = 1, Arab American = 4, other = 10). Study scales included the Minority Student College Stress Survey (MSCSS) and the Mixed Methods Responses on Stress and Coping scale (MMR-SC-4; Cronbach’s alpha = 0.856). Moreover, qualitative prompts were used to explore minority students’ coping responses when facing racism and/or oppression and to seek their recommendations for how colleges can help “students who have experienced racism, stress, and trauma” (Ingram & Wallace, 2018, p. 85).

The results showed that most participants (85.1%) had experienced any racism and/or oppression, indicating that minority students are “living at the nexus of multiple forms of racism,” while many attended predominantly White institutions (Ingram & Wallace, 2018, p. 98). Additionally, 85.2% of students who had experienced racism and/or oppression reported that it had been stressful, and 38.3% indicated that it had been traumatic. About 59% of those who experienced racism were African American students, and most reported that “their experience was both stressful and traumatic” (p. 88). Moreover, qualitative data demonstrated
that experiences of racism fit within the proposed conceptual framework, which was the nexus of multiple forms of racism, including: individual racism, institutional racism, cultural racism, structural racism, police violence, and microaggressions. Among coping responses to perceived racism, adaptive coping was “much more prevalent than maladaptive coping (e.g. smoking marijuana)”\); examples of adaptive coping included cognitive reframing, seeking social support, expressing the experience, relying on God, and engaging in advocacy, education, organizing, or activism (p. 102). Regarding the recommendations for colleges to assist students, participants were calling for not only acknowledging the students’ experience of perceived racism “but also for colleges taking ameliorative action” such as by recognizing that racism happens at college and actively working to combat it (Ingram & Wallace, 2018, p. 103).

Implications suggested that colleges embrace innovative leadership, which values “cultural differences, diversity, and works for organizational change” (Ingram & Wallace, 2018, p. 104). This new type of leadership would include pursuing diverse students, faculty, and staff members as well as providing multicultural competence courses as a core curriculum for all college students. Colleges were also advised to provide culturally appropriate counseling services, increase accessibility of counseling services on campus, and enhance “the hiring of more health professionals/psychologists of color” (p. 104). Furthermore, as a feasible diversity agenda, “colleges would go beyond hiring more faculty of color” and work to have more faculty of color obtain tenure (Ingram & Wallace, 2018, p. 105).

**Racial–Ethnic Microaggressions and Mental Health**

Sanchez et al. (2018) discussed the nature of microaggressions, examining “the direct link between racial-ethnic microaggressions and psychological distress” among Asian American and Latinx American college students (p. 216). A total of 308 college students (Asian
American = 164, Latinx American = 144, male = 54%, mean age = 20.65±1.61) participated and completed a survey at the University of Texas. Measures included the Racial and Ethnic Microaggressions Scale (REMS; Cronbach’s alpha = 0.912), a modified version of Coping Strategies Inventory (CSI; Cronbach’s alphas of engagement and disengagement = 0.79 and 0.71, respectively), and the Mental Health Inventory (MHI-5; Cronbach’s alpha = 0.76) (Sanchez et al., 2018).

Findings showed that racial–ethnic microaggression had a “statistically significant direct effect on psychological distress” among Asian American and Latinx American college students (Sanchez et al., 2018). Those students who more often experienced microaggressions tended to have higher levels of depression and anxiety (Sanchez et al., 2018, p. 220). Also, racial–ethnic microaggressions were significantly associated with increased use of engagement and disengagement coping strategies. Only engagement coping strategies, however, “mediated the link between racial-ethnic microaggressions and mental health” (p. 221). Hence, students who used engagement coping strategies reported less psychological distress from facing microaggressions. Specifically, this demonstrated that proactive coping strategies, such as seeking social support, expressing emotions to family and friends, and practicing cognitive restructuring, may help students of color mitigate psychological stress when experiencing racial–ethnic microaggressions. Conversely, disengagement coping strategies, such as social withdrawal, avoidance, and wishful thinking, “were not significantly linked to mental health” in Asian American and Latinx American college students (Sanchez et al., 2018, p. 222).

Regarding study implications, because racial–ethnic microaggressions “were predictive of both engagement and disengagement coping strategies,” health professionals should understand the varied ways that students of color may use them to cope with microaggressions.
(Sanchez et al., 2018, p. 222). Further, because the engagement coping strategy was found to help students of color reduce their depression and anxiety levels, health professionals should help students adopt more proactive engagement coping strategies. Further, it would be important for counselors and health professionals to evaluate their own “racial biases, stereotypes, and perceptions of other groups” so that they also can avoid committing microaggressions when meeting with students of color in counseling sessions (Sanchez et al., 2018, p. 223).

Jochman et al. (2019) examined the association between “mental health and interpersonal discrimination-related social events” among 149 racial minority students (mean age = 20.3±1.87, female = 62%) at a predominantly White institution (p. 1). The data were collected using a daily diary protocol, which investigated college students of color’s experiences of discrimination and their detailed feelings over the day for two weeks in fall and for a week in spring. The instruments included five scales from the Center for Epidemiologic Studies. A Depression Scale (CES-D) and the National Institutes of Health (NIH) toolbox were used to measure mental health outcomes. The Racism and Life Experiences Scale (RaLES) was also used to measure respondents’ daily interpersonal discrimination experiences and to discover whether they attributed the event to racism; and, also “how bothered the respondent was by the event” (Jochman et al., 2019, p. 4).

Findings showed that distress from interpersonal discrimination negatively affected mental health by increasing “feelings of anger, anxiety, loneliness, and depressive symptoms” among racially diverse college students (Jochman et al., 2019, p. 8). Day to day exposure to vicarious racism via social media also adversely affected minority students’ anxiety symptoms. Frustrating social encounters experienced through interpersonal discrimination and vicarious racism elevated the day-to-day mental health burden and “the stress of social life for racial-
Thus, racism functioned as “a systematic denial of positive social interactions,” not only because it contributed to racial minority college students’ exclusion from social interactions, whether directly or vicariously, but also because it heightened the chance of social encounters’ being “less rewarding and more frustrating,” causing detrimental mental health outcomes (Jochman et al., 2019, p. 9).

Hollingsworth et al. (2017) examined whether experiencing racial microaggressions (RMs) was associated with any increased suicide ideation among African American college students ($N = 135$, mean age = 19.45, female = 56.3%) at predominantly White institutions. Measures included the Interpersonal Needs Questionnaire–15 (INQ-15; Cronbach’s alpha = 0.93) to assess thwarted belongingness (TB) and perceived burdensomeness (PB), the Racial Microaggressions Scale (RMAS), which demonstrated “good reliability, construct validity and convergent validity in an ethnically diverse sample,” and the Hopelessness Depressions Symptom Questionnaire–Suicidality Subscale (HDSQ-SS; Cronbach’s alpha = 0.87) (Hollingsworth et al., 2017, p. 106).

Findings showed that African American college students experienced different types of microaggressions, including verbal, behavioral, and environmental racial insults every day, which was associated with “increased perceptions of being a burden on others” (Hollingsworth et al., 2017, p. 107). This increased perceived burden was also associated with suicidal ideation. Specifically, racial insults, including statements that made African Americans feel incompetent or as if “other African Americans are not equally represented in society,” were associated with higher levels of suicidal thoughts among African American college students (p. 107). Because racially marginalized college students suffered from a subtle form of racism, it is critically “important to disseminate knowledge about what constitutes RMs” – or racial microaggressions.
Institutional-level efforts to conduct interventions, such as support groups and workshops, will also be necessary to address inequality and enhance the value of diversity in college. To reduce African American college students’ increased suicide risk, administrators should develop a campus policy that can “potentially lessen the effects of RMs, specifically PB [perceived burdensomeness] on minority students,” and promote an inclusive campus climate (Hollingsworth et al., 2017, p. 110).

**Institutional Change for Social Justice**

Discrimination can occur within “a multilevel framework that includes institutional policies and practices” (Stevens et al., 2018, p. 671). Thus, efforts to decrease discrimination should focus not only on individual interaction, but also on changing institutional structures—which can contribute to racial/ethnic minority students’ discriminatory experiences (Stevens et al., 2018).

Anderson (2012) reported that correcting epistemic injustices for those who face enormous structural inequality is important. And, reconfiguring “institutions so as to prevent epistemic injustice from arising” would be effective (p. 171). This is because structural remedies for a large-scale social system can eliminate structural inequalities (p. 171). Particularly, group integration can function as a structural remedy. When equal resources can be shared by all different social members, they thus “have access to the same (legitimate) markers of credibility” (p. 171). If people “engage in inquiry together on terms of equality” they can produce a shared reality that can eventually overcome injustice (Anderson, 2012, p. 171).

Wallace (2000) called for a change in multicultural training in graduate schools of education, and there are some fundamentals. First, deans of higher education institutions may show leadership by “recruiting, retaining, and promoting minorities and women” in their
institutions (p. 1,105). Professors can teach mandatory multicultural core courses or integrate diversity into the curriculum by addressing topics that may bring difficult conversations into the classroom. Moreover, organizations can pursue institutional programs, practices, or policies to evaluate “whether the organization is appropriately pursuing multicultural organizational development” (p. 1,106). Furthermore, institutions can emphasize “the importance of professional development for university faculty” regarding multiculturalism (Wallace, 2000, p. 1,106).

**Theoretical Framework**

There is a theoretical framework that guided the study. This included guiding the selection of research measures. These theories are briefly reviewed in this section.

**Stress Response-Racism: The Biopsychosocial Model**

Clark et al.’s (1999) biopsychosocial model postulated the “role of racism as a perceived stressor” and the effects of perceived racism, as subjective experiences under racial discrimination or prejudice—that also impact health outcomes (p. 812). The biopsychosocial model presents three essential principles. First, perceiving the experience of racism as stressful may have harmful “biopsychosocial sequelae that might help explain intergroup differences in health outcomes” (p. 806). Second, “differential exposure to and coping responses following perceptions of racism” may explain any large variation in health outcomes within a group (p. 806). Third, if exposure to racism is among the factors causing negative health outcomes, “specific interventions and prevention strategies could be developed and implemented” to minimize the adverse impact (p. 806). These three principles can aid “efforts aimed at reducing health disparities in American society” (Clark et al., 1999, p. 806).
The foremost tenet of the biopsychosocial model is that “the perception of an environmental stimulus as racist” may cause inflated physiological and psychological stress responses, which “are influenced by constitutional factors, sociodemographic factors, psychological and behavioral factors, and coping responses” (Clark et al., 1999, p. 806). These environmental stimuli may be sources that exert a negative influence on health outcomes over time. On a historical basis, minority ethnic groups, particularly African Americans, have been excessively exposed to environmental stimuli that may cause chronic and acute stress. Moreover, the combination of chronic and acute stress effects possesses “the potential to contribute to psychological and physiological sequelae” detrimental to African Americans (p. 807). Numerous psychological stress responses, such as anger, anxiety, hopelessness, resentment, and frustration, may follow perceptions of racism. Following psychosocial responses, physiological responses also “most notably involve immune, neuroendocrine, and cardiovascular functioning” (p. 811).

Markedly, perceived racism can affect health in many ways, even when racism is not perceived as a stressor. For example, institutional racism, which reduces African Americans’ access to services and opportunities in health care, may cause dire health outcomes for African Americans “even when no individual racism may be perceived” (Clark et al., 1999, p. 812).

Social Support

According to Harrell (2000), satisfactory social support, which plays a vital role in mediating stress, can buffer the impact of stress on physical and psychological health. Specifically, external mediators indicate “the array of interpersonal, structural, and community support resources” available for individuals (p. 51). Three types of support systems that function as external mediators include intragroup, intergroup, and environmental and institutional support. First, intragroup support means that members and organizations from the same racial/ethnic
group can provide modeling, mentoring, and understanding to help individuals deal with experiences of racism. At the community level, support includes “the more global sense of a psychological community,” whereby people acknowledge that other members from the same racial group have also experienced racism and survived it (p. 52). Individuals from within one’s racial group are also aware that support is available in the community, and they have “a feeling of connectedness and not being alone” in facing racism-related experiences (p. 52). Second, the term intergroup support describes having allies from both the dominant and other historically oppressed racial/ethnic groups. The affirmation “of racism experiences by outgroup members” not only decreases alienation but also delivers hope and a sense of safety (p. 52). Lastly, environmental and institutional support ensures that politics and systems, such as “a fair and open process for complaints within” an institution, are available to assist individuals facing racism-related experiences (Harrell, 2000, p. 52).

**Stages of Change from the Transtheoretical Model**

DiClemente (2005) proposed that the Transtheoretical Model can help in understanding the behavior change process that an individual experiences in modifying existing behavior, stopping problematic behavior, or initiating new behaviors. The Transtheoretical Model explains that the process of behavior change is a distinguished pathway that individuals go across, and it includes a distinct series of tasks that individuals are required to accomplish to change or stop their problematic behaviors (DiClemente, 2005). Those different steps and required tasks in the process of change are represented by Stages of Change, which have five stages: precontemplation, contemplation, preparation, action, and maintenance stage (DiClemente & Velasquez, 2002). People in precontemplation are “unaware of problem behavior or are unwilling or discouraged,” showing resistance to change their behaviors (p. 204). In the
contemplation stage, people recognize that they have a problem and start thinking about how to solve it seriously; however, they are “far from actually making a commitment to action” (p. 208). People in the preparation stage are ready to make “a serious attempt at changing” in the “near future” and commit to following the action they choose (p. 210). During the action stage that is up to 6 months, people start taking action and “implement the plan for which they have been preparing” (p. 212). Finally, in the maintenance stage, people work to “consolidate the gains attained during the action stage,” and also try to prevent relapse (p. 212). The maintenance stage is longer “than 6 months to as long as a lifetime” (DiClemente & Velasquez, 2002, p. 212). The stages of change incorporated both the cognitive and motivational aspects of change, which are important to health beliefs and decision making; and it emphasized that all individuals are in different places in the process of change (DiClemente, 2005).

**Structural Racism and Health Disparities**

According to Yearby (2020), the United States has attempted to address health disparities since 2010 using the social determinants of health (SDOH) framework, which asserts that “social factors, outside an individual’s control, cause these disparities” (p. 518). The SDOH framework recognizes five key factors related to racial health disparities: education, social and community context, economic stability, health care, and the built environment. Disparities persist due to structural racism, which is the root cause of racial health disparities. Structural racism denotes the way systems—such as health care, housing, public health, employment, and education—are “structured to advantage the majority and disadvantage racial and ethnic minorities” (p. 518).

This form of racism, which creates different conditions between the majority and racial minorities, eventually causes racial health disparities. Moreover, the main tool that produces such different conditions is the law, which never questions the structures that “limit racial and
ethnic minorities’ equal access” to employment, education, housing, and healthcare (p. 521).

Hence, the law legitimizes the existing structures, and racial health disparities continually persist within the social structures of American systems, such as employment and public health care. An aggressive effort by the government to eliminate structural racism and restore all of the systems would be needed to achieve health equity. This effort would ensure that racial and ethnic minorities would receive “material support they need to overcome the harms they have already suffered” as well as to have equal treatment in these systems (p. 524). This framework can guide public health officials and governments to make the association between “structural discrimination, law, systems, and racial health disparities,” which would be the beginning to achieving the well-being of racial minorities and racial health equity (Yearby, 2020, p. 524).

**Conclusion**

This chapter provided a review of the literature pertinent to the dissertation topic, as follows: 1-racism, perceived racism, microaggressions, and perceived discrimination; 2-microaggressions and racism in higher education and on college campuses; 3-discrimination, stress, and adverse health outcomes; 4-institutional change for social justice; and 5-theoretical framework. The next chapter, III, will present the methods followed in the research study.
Chapter III

METHODS

This chapter will present the methods and procedures used in this study, including an overview of the study design and procedures, a description of the study participants, and a description of the research instrumentation. The treatment of data and the data analysis plan are also described.

Overview of The Study Design and Procedures

This study was a cross-sectional design that used an online survey (Qualtrics). The survey was administered to a convenience sample of Black, Latinx, and Asian undergraduate and graduate college students in the United States who were age 18 and above. This section presents an overview of all study procedures.

IRB Approval

On March 26, 2021, the present study received IRB approval under the category exempt from the Teachers College, Columbia University Institutional Review Board (IRB) as Protocol #21-247 (see Appendix A for IRB Approval Letter). Data collection of this study was initiated after receiving IRB approval.

Recruitment of Study Participants

Participants for this study were recruited online via a social media campaign (i.e., Facebook, Instagram, websites, emails). The social media campaign entailed messages asking for participation in the survey of the study and describing the prize money associated with participation. Participants were sent a key recruitment message that stated:
“Black, Latinx, Asian & Minority U.S. undergraduate or graduate college students click link [https://tinyurl.com/I-EXPERIENCED-HATE](https://tinyurl.com/I-EXPERIENCED-HATE) to take 10-15 MINUTE SURVEY on experiences of hate, stress, racism, microaggressions & violence for a chance to win 1 of 3 $100 Amazon gift cards”.

Furthermore, to ensure an adequate response from Asian students, some platforms commonly used by Chinese and other Asians were also sent a more tailored message, as follows:

“ASIAN undergraduate or graduate college students click link [https://tinyurl.com/I-EXPERIENCED-HATE](https://tinyurl.com/I-EXPERIENCED-HATE) to take 10-15 MINUTE SURVEY on experiences of HATE (against you or your community), stress, racism, microaggressions & violence for a chance to win 1 of 3 $100 Amazon gift cards”

**Other Study Procedures**

This section presents additional study procedures followed in the recruitment of participants.

**Informed Consent, Participants’ Rights, and Agreement to Participate**

Participants first read the study Informed Consent and Participants Rights Forms (See Appendix D) before they were directed to the full survey. To indicate that the participants had read and understood the Informed Consent and Participants’ Rights forms, they had to check the “I agree” box to show that they agreed to participate in the study.

**Study Inclusion Criteria: Screening Tool**

After participants checked the “I agree” box on the informed consent, participants proceeded to a brief screening tool that embodied the inclusion criteria for study participation, as follows:

The year 2020 and COVID-19 pandemic included an increased focus on violent police attacks against Black and Latinx adults, as well as on violent hate attacks against Asians. This study invites Black, Latinx, and Asian undergraduate and graduate college students
in the United States who are age 18 and above to answer questions about experiences of HATE, stress, racism, microaggressions, and violence.

See if you qualify by answering the questions, below:

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

2- Are you a college student in the United States—whether a freshman, sophomore, junior, senior or graduate student?
   Yes___ No____

3- Do you self-identify as a Black, Latinx, Asian or other person of color? Do you fall within the group of Black, Indigenous or People of Color?
   Yes___ No____

4- Are you able to devote 10-15 minutes to this study at this time—for a chance to win one of three $100 Amazon gift cards?
   Yes___ No____

If they answered YES to all of the above questions → they accessed survey.

Participants who met the inclusion criteria were directed to the full survey questionnaire in this study (See Appendix F). Participants who did not meet the inclusion criteria were thanked for their interest and time in the study and informed that they did not qualify for study participation. Finally, they were asked to feel free to invite others to participate in this study by forwarding them the link they used to access this study.

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

When participants completed the survey, they were invited to submit their e-mail address—so that they were officially entered into a drawing for a chance to receive a prize (i.e., 3 in 250 chance to win 1 of 3 $100 barcoded Amazon gift certificates). As part of the research protocol of Professor Barbara Wallace’s Research Group on Disparities in Health (RGDH) involving study incentive for participation upon completion of the study, the RGDH webmaster
(i.e., Dr. Rupananda Misra) created a secure online program that automatically sent out three barcoded gift certificates to three randomly chosen e-mail accounts; this program generated, specifically, in this case, three Amazon.com gift certificates (barcoded) in the denomination of $100. This occurred without in any way linking their identity to the survey results. The principal investigator was blinded to the e-mail addresses to which the gift certificates were sent. Only the 3 winners were contacted.

**Description of The Study Participants**

A total of 341 Black, Latinx, and Asian undergraduate and graduate college students were a convenience sample, who voluntarily completed the study survey. Originally, a total of 654 records were collected; however, 147 out of 654 respondents were excluded due to duplicate responses (i.e., duplicate computer IP addresses—22.5%). Qualified participants who met inclusion criteria after answering the screening tool for the I EXPERIENCED HATE Survey (see the Study Screening Survey, Appendix E) were 411 individuals. Among 411 students who could access the full survey, 341 participants completed the entire survey.

Compared to participants who completed the survey and had the primary outcome variable (N=341), non-completers (N=70) who did not complete the survey (e.g., lacked the primary outcome data) did not show any significant differences.

See Table 1.
Table 1. Comparing Survey Completers (N=341) to Non-Completers (N=70) Via Independent T-Tests

<table>
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<th>Has Primary Outcome Variable?</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>T</th>
<th>df</th>
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<th>SD</th>
<th>T</th>
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</table>

*p<.05, **p<.01, ***p<.001 Bonferroni Adjustment Significance (.05/4 p=.013)

Note: All p values above .013 are considered non-significant, and only those below .013 are considered statistically significant.

Description of Research Instrumentation

A diverse array of tools made up the survey for this study, including those developed by Professor of Health Education, Dr. Barbara Wallace, who is a director of the Research Group on Disparities in Health (RGDH), and also Director of the Programs in Health Education and Community Health Education, Teachers College, Columbia University. The research instrument also included new survey tools developed by the Principal Investigator and her dissertation sponsor, Professor Barbara Wallace specifically for use in the study. Also, several surveys, which have been previously used and validated by fellow researchers of the RGDH, were adopted for use in this study. This section will describe each of the survey parts in detail (See Appendix F for the full survey).
Part I: Basic Demographics (BD-8)

The Basic Demographics (BD-8) scale followed a common tool used by the Research Group on Disparities in Health (RGDH). The BD-15, which was developed by Dr. Wallace, was shortened to 8 questions in the present study. Questions were also revised for the study population, and some of the college-related questions were taken from previous fellows in the RGDH (e.g., Ingram, 2017). This part of the survey contained 8 questions, as follows: gender, age, race/ethnicity, skin color, U.S. Born (yes/no), year in undergraduate or graduate school, household income, ever attended a minority-serving college (yes/no).

Part II: Personal Health Background (M-PHB-5)

The Personal Health Background (PHB-9) was a tool created by Professor Barbara Wallace for use by the Research Group on Disparities in Health (RGDH). Given the pandemic stress, the survey was shortened to 5 questions, including: rating of their overall physical health status; rating of their overall mental/emotional health status, reporting of their height (feet), height (inches), and their weight (pounds)—for determining Body Mass Index (BMI). Questions on physical and mental/emotional health status used a Likert scale (1=very poor, 2=poor, 3=fair, 4=good, 5=very good, 6=excellent).

This study will determine a mean for overall physical health status, mental/emotional health status, and Body Mass Index (BMI)—with standard deviation, minimum and maximum scores.
Part III: Single Item Rating of Risk of Providing Socially Desirable Responses (SIR-RPSDR-1)

The Single Item Rating of Risk of Providing Socially Desirable Responses (SIR-RPSDR-1) was a relatively new single item scale created for first-time use by Dr. Barbara Wallace in studies in 2018 conducted by the Research Group on Disparities in Health (RGDH), and for ongoing use by the RGDH (Torez, 2019; Laryea, 2019).

Meyer and Santos (2020) stated that many empirical studies depend on the participants’ honest response to the survey questions; however, there has been concern that individuals may provide socially desirable responses “through the over-reporting of positive behaviors or under-reporting of negative ones” (p. 1). Thus, a measure of social desirability is required as an additional control to remove any bias, which may be caused by socially desirable responses when the research depends on self-reported data (Meyer & Santos, 2020).

Laryea (2019) demonstrated that the new one-item measure of social desirability was one of two significant predictors of nurses’ higher personal skill/ability rating for managing patients’ pressure ulcers. This was noteworthy, as the well-known 13-item measure of social desirability similarly was found to be the sole significant predictor of nurses’ ratings for a higher personal skill/ability for managing patients’ pressure ulcers (Crowne & Marlowe, 1960).

Therefore, there was value in reducing the burden of time on study participants and using the new one-item measure of social desirability (scale from 0=low to 10=high), especially, given the stress of the pandemic. This single item scale 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:
Part IV: In-Person, Online, or Hybrid Learning (IOHL-1)

In-Person, Online, or Hybrid Learning (IOHL-1) was a new short one-item tool created by the Principal Investigator, Hyorim Lee, and her dissertation sponsor, Dr. Barbara Wallace, for first time use in this study, and for ongoing use by the Research Group on Disparities in Health (RGDH). It is ideal for pandemic era research, reducing response burden. This single item was a dichotomous variable—in-person versus online or hybrid:

1-During the COVID-19 pandemic, or in the past year, I have participated in my college or university in the following ways:

__in-person on campus learning or living
__online learning
__hybrid model: combination of in-person on campus learning or living, AND online learning

This IOHL-1 will permit describing the participants’ learning settings in their college or university during the COVID-10 pandemic.

Part V: Rating the College Climate (RCC-1)

Rating the College Climate (RCC-1) was based on the work of Aiyedun (2019), while being modified and reduced to a one-item tool for the purpose of this study, and given pandemic era stress. In the RCC-1, participants were asked to rate the climate of their colleges on a scale from 0 (lowest level) to 10 (highest level). This single item scale provided an introduction:

The scale permits determining the sample’s mean social desirability, as well as minimum and maximum scores. Of note, the regression analysis will control for social desirability.
Please think about your college’s or university’s CLIMATE, or the way the overall environment or institutional culture feels to YOU. The CLIMATE may be perceived and felt whether you are a student in-person, on campus, or online—including via the emails sent out by institutional representatives or postings on the website.

The tool then asked:

Now, think about how well your college or university has supported, engaged, valued, fairly disciplined, affirmed, reflected empathy for, and served as a safe space for students from diverse cultural backgrounds—such as YOU.

1- With these thoughts in mind, please rate that CLIMATE: 0-10

\[
\begin{align*}
\text{I rate the CLIMATE:} & \\
0 & 1 & 2 & 3 & 4 & 5 & 6 & 7 & 8 & 9 & 10 \\
0 = \text{Lowest level} & & & & & & & & & & 10 = \text{Highest level}
\end{align*}
\]

The RCC-1 scale in this study will produce a mean, standard deviation, minimum and maximum score.

**Part VI: Perceived Social Support Scale (PSSS-1)**

Perceived Social Support Scale (PSSS-1) was a common tool used by the Research Group on Disparities in Health (RGDH), having been used by Lian (2017). 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 core of the original 5 questions into one description of what having social support “means.” Participants then indicated the number of people they had in their life, using the 5-option scale:

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 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, “not at all” means having no one for social support, “low” means having at least 1 person, “moderate” means having at least 2 people, “high” means having 3-5 people, and “very high” means having 6 or more people for social support.

In the study of Lian (2017), the original 5-item version showed a Cronbach’s Alpha of .901 or excellent internal consistency. The PSSS-1 scale in this study will not produce a Cronbach’s Alpha, but will determine a mean for perceived social support with standard deviation, minimum and maximum score.

**Part VII: Perceived Stress Scale (PSS-4)**

Perceived Stress Scale (PSS-4) was a short version of the PSS-10 that was created by Cohen et al. (1983). The shorter PSS-4 version utilized in this study was also used by Karam et al. (2012). The questions in this scale asked participants about their feelings and thoughts during the last month, and in each item, participants responded how often they felt or thought on a 5-point scale of 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) on 4 items:

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

In the PSS-4 tool, questions 2 and 3 were positively stated items, thus, PSS-4 scores were obtained by reverse coding the positive items, e.g., 0=4, 1=3, 2=2, etc.; and, summing across all 4 items. Scores could range from 0 to 16—with higher scores indicating higher perceived stress.

The PSS-4 tool was demonstrated by Karam et al. (2012) to be a valid and useful tool in a study with pregnant women while examining stress, depression, and quality of life (Cronbach's alpha coefficient = .79). It also showed a Pearson correlation coefficient of .63 ($p < .001$) with the 10-item PSS tool (Karam et al., 2012).

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 VIII: Ratings of Experiences of Microaggressions (REM-6)**

Ratings of Experiences of Microaggressions (REM-6) was a scale previously used in Lian (2017) and created for use by the Research Group on Disparities in Health (RGDH) by Dr. Barbara Wallace. It has been used in numerous studies conducted by the RGDH, with instructions tailored for different demographic groups—as in this study (i.e., for Black, or Latinx, or Asian, or an Indigenous, or Person of Color). The tool has roots in the work of Sue et al. (2007) on microaggressions, as an elaboration of the original work of Pierce et al. (1977). Due to the pandemic and social distancing, an addition was made to the scale, adding that an experience could occur in-person or online. A final question (Question 6) was added to capture the original work of Pierce et al. (1977) on microaggressions.
In the REM-6, participants were asked to score six items for the frequency of having the experience of microaggressions in the United States, using a Likert scale (0=never/not at all, 1=at least once, 2=more than once, 3=a few times, 4=many times), after reading an introduction/instructions. The introduction/instructions and sample REM-6 items are as follows:

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 Black, or Latinx, or Asian, or an Indigenous, or Person of Color:

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

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

Lian (2017) investigated experiences of microaggressions among Chinese international students in the U.S. showing a Cronbach’s Alpha of .851 for good internal consistency. For Chinese international students ‘experiences of microaggressions, specifically at their college or university, a Cronbach’s Alpha was .855 for good internal consistency. 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 IX: Perceptions of Racism and Oppression Scale (PROS-10)**

Perceptions 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). Sample PROS-10 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 (Asian, Black, Latinx, etc.). For oppression, injury is suffered due to one’s characteristics (female, poor, gay/lesbian/transgender, illegal immigrant, immigrant status, race, religion, ethnicity, etc.…). Racism/oppression may include: prejudice, discrimination, harassment, violence, exclusion, disadvantage, or lack of access to opportunity—whether while driving, eating out, walking around, shopping, voting, hailing down a taxi, interacting with police, searching for employment, seeking health care, applying for a bank loan/mortgage, searching for housing, negotiating the criminal justice system, working, traveling, vacationing, or seeking out literally any opportunity, etc.

**Please answer the following questions.**

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

1-I am not sure it 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.

66
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
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

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.

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

Coping and Responding to Racism and Oppression Staging Scale (CRROSS-7) was previously used in many studies (Ingram, 2017), as it was created by Professor Barbara Wallace for use by the Research Group on Disparities in Health (RGDH). Dr. Wallace based the CRROSS on Prochaska and DiClemente (1983)’s Stages of Change theory to evaluate participant’s 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. 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. Sample CRROSS-7 items were as follows:

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
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 1=precontemplation 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 2=contemplation 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 3=preparation 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)

According to Ellington-Murray (2005), the first study to use this tool, self-reported ability for coping with and responding to racism and/or oppression showed a high level of test-retest correlation (r=.947, p=.000). The CRROSS-7 in the present study will provide a mean, standard deviation, minimum and maximum score.

Part XI: Experiences of Hate (EOH-12)

Experiences of Hate (EOH-12) was a new scale created by the Principal Investigator, Hyorim Lee, and her dissertation sponsor, Dr. Barbara Wallace, for first time use in this study, and for use by the Research Group on Disparities in Health (RGDH). This new tool had two scales. First, the Experiences of Hate Scale was composed of 6-items, i.e., the odd-numbered items 1, 3, 5, 7, 9, 11, where participants were scored from 0 (never) to 5 (great number of times) or 6 (Not Applicable). Second, for the Stressful or Traumatic Impact from Hate Scale composed of 6-items, i.e., the even-numbered items 2, 4, 6, 8, 10, 12, participants were scored from 0 (no
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, police killings of Black and Latinx people can be thought of as involving police feeling and acting on their feelings of HATE. 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 experience since the beginning of the COVID-19 pandemic, or in the past year. 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

This study will determine the internal consistency of the EOH-12, using Cronbach’s Alpha, as well as provide a mean, standard deviation, minimum and maximum score.
The Data Treatment Plan

This 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 27 to proceed with the data analysis.

Data Analysis Plan

The data analysis plan for the present study addressed the research questions. The specific data analysis plan (see bold) was described, as follows, below each research question.

1-What did the college students report as their demographic characteristics (i.e., gender, age, race/ethnicity, skin color, birthplace (US born yes/no), annual household income, year in undergraduate or graduate school, history of attending either Historically Black College or University, or Hispanic Serving Institution)?

Part I: Basic Demographics (BD-8) reported descriptive statistics, including means, standard deviations, frequencies, and percentages.

2-What was their personal health background (i.e., rating for overall physical health status, rating for overall mental/emotional health status, Body Mass Index)?

Part II: Personal Health Background (M-PHB-5) reported descriptive statistics, including means, standard deviations, frequencies, and percentages.

3-To what extent were they at risk for providing socially desirable answers?

Part III: Single Item Rating of Risk of Providing Socially Desirable Responses (SIR-RPSDR-1) reported descriptive statistics, including means, standard deviations, frequencies, and percentages. This variable was controlled for in the regression analysis.

4-For the past year, during the COVID-19 pandemic, in what kind of college setting did they report learning (i.e., in-person, online, hybrid)?

Part IV: In-Person, Online, or Hybrid Learning (IOHL-1) reported descriptive statistics, including means, standard deviations, frequencies, and percentages.
5-How did they rate their college’s climate for how well their university has supported, engaged, valued, fairly disciplined, affirmed, reflected empathy for, and served as a safe space for students from diverse cultural backgrounds?

Part V: Rating the College Climate (RCC-1) reported descriptive statistics, including means, standard deviations, frequencies, and percentages.

6-To what extent did they experience social support?

Part VI: Perceived Social Support Scale (PSSS-1) reported descriptive statistics, including means, standard deviations, frequencies, and percentages.

7-What did they report as their past month experience of perceived stress?

Part VII: Perceived Stress Scale (PSS-4) reported descriptive statistics, including means, standard deviations, frequencies, and percentages.

8-To what extent had they experienced microaggressions—whether in the campus/college setting, work settings, shopping in stores, or during online/social media interactions?

Part VIII: Ratings of Experiences of Microaggressions (REM-6) reported descriptive statistics, including means, standard deviations, frequencies, and percentages. This was the study outcome variable.

9-What was their level of ability for perceiving racism and oppression?

Part IX: Perceptions of Racism and Oppression Scale (PROS-10) reported descriptive statistics, including means, standard deviations, frequencies, and percentages.

10-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 X: Coping and Responding to Racism and Oppression Staging Scale (CRROSS-7) reported descriptive statistics, including means, standard deviations, frequencies, and percentages.

11-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 XI: Experiences of Hate (EOH-12) reported descriptive statistics, including means, standard deviations, frequencies, and percentages.

12-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?

For this research question, independent t-tests and Pearson correlations were conducted and reported.

13-What were the significant predictors of the study outcome variable of a higher prevalence of the experience of microaggressions in the United States—when controlling for social desirability?
Backward stepwise regression analysis was conducted and regression coefficients were reported. Social desirability was adjusted for in the analysis.

Conclusion

This chapter described the methods used in the present study. The methods included an overview of the study design, study procedures, recruitment of participants, and description of research instrumentation. Additionally, the data management and data analysis plan were described in detail. Chapter IV will describe the results of data analysis.
Chapter IV

RESULTS

This chapter will present the results of data analysis for each research question. The findings will be shown in tables.

Data Analysis Results by Study Question

Results for Research Question #1 - What did the college students report as their demographic characteristics (i.e., gender, age, race/ethnicity, skin color, birthplace (US born yes/no), annual household income, year in undergraduate or graduate school, history of attending either Historically Black College or University, or Hispanic Serving Institution)? (BD-8)

Part I: Basic Demographics (BD-8). While a total of 654 records were collected, 147 were excluded as duplicate responses (i.e., duplicate computer IP addresses—22.5%), leaving 411 participants who consented to participate in the study. However, only included in the study were those who had data for the primary outcome variable, i.e., experiences of microaggression, resulting in 341 study participants. Comparing those who were included (n=341) and those who were excluded (i.e., those who lacked the primary outcome variable; n=70) from further analysis, there were no statistically significant differences—as discussed in Chapter III.

Among those who were included (n=341), 40.6% was female (n=138) and 59.2% were male (n=202). Self-reported age of the participants ranged from 18 to 59 with a mean age of 26.61 years (SD=6.752).

The sample participants (N=341) were composed of diverse races/ethnicities: 43.7% of Black/African American (n=149), 9.4% of Latinx/Hispanic/Latino (n=32) (including Puerto Rican, Mexican, Mexican American, Chicano, Cuban, other Spanish), 44.9% of Asian (n=153) (including Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian), and 2.1% of other groups (n=7). Specifically, for the other group(s) category, participants specified
their ethnicity as follows: Afro Latinx (n=1), Afro-Cuban and Arab American/Middle Eastern (n=1), American Indian/Black/Mexican/White (n=1), Black/Caribbean American (n=1), Black and Latina (n=1), and Asian/White (n=2).

Mean skin color was 4.48 (min=1, max=7, SD=1.327), or was between medium to light and medium to dark, such that participants who reported medium to light skin color accounted for 27.3% (n=93) of the total sample. Most participants (66.9%) reported that they were born in the United States (n=228). Among participants who reported they were not born in the United States, most were from China (n=31, 9.1%), followed by India (n=26, 7.6%), South Korea (n=13, 3.8%), Jamaica (n=5, 1.5%), and Japan (n=5, 1.5%).

Mean annual household income level was category 5.54 (min=2, max=11, SD=2.091), or between the $50,000 - $99,990 category and the $100,000 to $199,999 category. For example, 27.6% reported their annual household income level was between $100,000 to $199,999 (n=94). With regard to education level, mean years in college was category 4.71 (min=1, max=11, SD=2.354). Most commonly reported year was Sophomore (n=59, 17.3%) followed by 2nd year in graduate school (n=57, 16.7%), and 1st year in graduate school(n=56, 16.4%). Also, about half of the participants (52.2%) reported that they attended Historically Black Colleges and Universities or Hispanic Serving Institutions (HBCU/HSI; n=178).

See Table 2.

<table>
<thead>
<tr>
<th>Table 2. Basic Demographics (BD-8) (N=341)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (N=341)</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age (N=341)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
</tr>
</tbody>
</table>
### Race/Ethnicity (N=341)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Black/African American</td>
<td>149</td>
<td>43.7</td>
</tr>
<tr>
<td>2-Latinx/Hispanic/Latino</td>
<td>32</td>
<td>9.4</td>
</tr>
<tr>
<td>3-Asian</td>
<td>153</td>
<td>44.9</td>
</tr>
<tr>
<td>4-Other Groups</td>
<td>7</td>
<td>2.1</td>
</tr>
</tbody>
</table>

### Skin color (N=341)

<table>
<thead>
<tr>
<th>Skin Color</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-White</td>
<td>4</td>
<td>1.2</td>
</tr>
<tr>
<td>2-Very Light</td>
<td>19</td>
<td>5.6</td>
</tr>
<tr>
<td>3-Light</td>
<td>58</td>
<td>17.0</td>
</tr>
<tr>
<td>4-Medium to Light</td>
<td>93</td>
<td>27.3</td>
</tr>
<tr>
<td>5-Medium to Dark</td>
<td>77</td>
<td>22.6</td>
</tr>
<tr>
<td>6-Dark</td>
<td>76</td>
<td>22.3</td>
</tr>
<tr>
<td>7-Very Dark</td>
<td>14</td>
<td>4.1</td>
</tr>
</tbody>
</table>

### Born in the US (N=341)

<table>
<thead>
<tr>
<th>Status</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>228</td>
<td>66.9</td>
</tr>
<tr>
<td>No</td>
<td>113</td>
<td>33.1</td>
</tr>
</tbody>
</table>

### Country of Origin (N=341)

<table>
<thead>
<tr>
<th>Country</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albania</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Andorra</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Antigua and Barbuda</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Argentina</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Australia</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Austria</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>3</td>
<td>.9</td>
</tr>
<tr>
<td>Belgium</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Burma</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Canada</td>
<td>2</td>
<td>.6</td>
</tr>
<tr>
<td>China</td>
<td>31</td>
<td>9.1</td>
</tr>
<tr>
<td>Colombia</td>
<td>3</td>
<td>.9</td>
</tr>
<tr>
<td>Guyana</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Haiti</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Country</td>
<td>N</td>
<td>Average</td>
</tr>
<tr>
<td>--------------</td>
<td>---</td>
<td>---------</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>3</td>
<td>.9</td>
</tr>
<tr>
<td>India</td>
<td>26</td>
<td>7.6</td>
</tr>
<tr>
<td>Indonesia</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Jamaica</td>
<td>5</td>
<td>1.5</td>
</tr>
<tr>
<td>Japan</td>
<td>5</td>
<td>1.5</td>
</tr>
<tr>
<td>Korea, North</td>
<td>2</td>
<td>.6</td>
</tr>
<tr>
<td>Korea, South</td>
<td>13</td>
<td>3.8</td>
</tr>
<tr>
<td>Nepal</td>
<td>2</td>
<td>.6</td>
</tr>
<tr>
<td>Nigeria</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Pakistan</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>Peru</td>
<td>3</td>
<td>.9</td>
</tr>
<tr>
<td>Thailand</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>United States</td>
<td>228</td>
<td>66.9</td>
</tr>
</tbody>
</table>

### Annual Household Income (N=341)

<table>
<thead>
<tr>
<th>Income Range</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1- $0 to $9,999</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>2- $10,000 to $19,999</td>
<td>24</td>
<td>7.0</td>
</tr>
<tr>
<td>3- $20,000 to $39,999</td>
<td>33</td>
<td>9.7</td>
</tr>
<tr>
<td>4- $40,000 to $49,999</td>
<td>35</td>
<td>10.3</td>
</tr>
<tr>
<td>5- $50,000 to $99,999</td>
<td>80</td>
<td>23.5</td>
</tr>
<tr>
<td>6- $100,000 to $199,999</td>
<td>94</td>
<td>27.6</td>
</tr>
<tr>
<td>7- $200,000 to $299,999</td>
<td>30</td>
<td>8.8</td>
</tr>
<tr>
<td>8- $300,000 to $399,999</td>
<td>16</td>
<td>4.7</td>
</tr>
<tr>
<td>9- $400,000 to $499,999</td>
<td>5</td>
<td>1.5</td>
</tr>
<tr>
<td>10- $500,000 to $799,999</td>
<td>9</td>
<td>2.6</td>
</tr>
<tr>
<td>11- $800,000 or More</td>
<td>15</td>
<td>4.4</td>
</tr>
</tbody>
</table>

**Mean income (5.54), SD (2.091)**

*min (2), max (11)*

### Education Level (N=341)

<table>
<thead>
<tr>
<th>Level</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Freshmen</td>
<td>23</td>
<td>6.7</td>
</tr>
<tr>
<td>2-Sophomore</td>
<td>59</td>
<td>17.3</td>
</tr>
<tr>
<td>3-Junior</td>
<td>40</td>
<td>11.7</td>
</tr>
<tr>
<td>4-Senior</td>
<td>32</td>
<td>9.4</td>
</tr>
<tr>
<td>5-1st year in graduate school</td>
<td>56</td>
<td>16.4</td>
</tr>
<tr>
<td>6-2nd year in graduate school</td>
<td>57</td>
<td>16.7</td>
</tr>
<tr>
<td>7-3rd year in graduate school</td>
<td>24</td>
<td>7.0</td>
</tr>
<tr>
<td>8-4th year in graduate school</td>
<td>30</td>
<td>8.8</td>
</tr>
<tr>
<td>9-5th year in graduate school</td>
<td>15</td>
<td>4.4</td>
</tr>
<tr>
<td>10-6th year in graduate school</td>
<td>2</td>
<td>.6</td>
</tr>
<tr>
<td>11-7th year in graduate school or higher</td>
<td>3</td>
<td>.9</td>
</tr>
</tbody>
</table>

**Mean years in school (4.71), SD (2.354)**

*min (1), max (11)*

### Type of Institution (N=341)
Yes- HBCU/HSI (Attend or Previously attended)  178  52.2  
No- Did Not Attend HBCU/HSI  163  47.8  

Abbreviations:
HBCU – Historically Black Colleges and Universities
HSI – Hispanic Serving Institutions

**Results for Research Question #2- What was their personal health background (i.e., rating for overall physical health status, rating for overall mental/emotional health status, Body Mass Index)? (M-PHB-5)**

**Part II: Personal Health Background (M-PHB-5).** The mean rating for physical health status was category 4.11 (min=1, max=6, SD=1.098) for closest to ‘good’. For example, 37.8% (n=129) reported a ‘good’ overall physical health status. For mental/emotional health status, the mean category was 3.80 (min=1, max=6, SD=1.091) for closest to ‘good’. There were 111 participants (32.6%) who reported ‘good’ mental/emotional health status. The mean body mass index (BMI) was 23.14 (min=7.86, max=58.99, SD=7.653) for normal or healthy weight.

See Table 3.

<table>
<thead>
<tr>
<th>Overall Physical Health Status: (N=341)</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Very poor</td>
<td>5</td>
<td>1.5</td>
</tr>
<tr>
<td>2-Poor</td>
<td>21</td>
<td>6.2</td>
</tr>
<tr>
<td>3-Fair</td>
<td>62</td>
<td>18.2</td>
</tr>
<tr>
<td>4-Good</td>
<td>129</td>
<td>37.8</td>
</tr>
<tr>
<td>5-Very good</td>
<td>91</td>
<td>26.7</td>
</tr>
<tr>
<td>6-Excellent</td>
<td>33</td>
<td>9.7</td>
</tr>
</tbody>
</table>

*Mean physical health status (4.11), SD (1.098), min (1), max (6)*

Overall Mental/Emotional Health status: (N=341)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Very poor</td>
<td>7</td>
<td>2.1</td>
</tr>
<tr>
<td>2-Poor</td>
<td>30</td>
<td>8.8</td>
</tr>
<tr>
<td>3-Fair</td>
<td>97</td>
<td>28.4</td>
</tr>
</tbody>
</table>
4-Good  111  32.6
5-Very good  82  24.0
6-Excellent  14  4.1

Mean mental health status (3.80), SD (1.091), min (1), max (6)

Body Mass Index (BMI): (N=265)
1-Underweight (Below 18.5)  44  16.6
2-Normal (18.5–24.9)  134  50.6
3-Overweight (25–29.9)  55  20.8
4-Obese (30.0 and Above)  32  12.1

Mean=23.14, ***Min=7.86, Max=58.99, SD=7.653
NOTE: 18.5 ≤ BMI <25 = Normal or Healthy Weight

***NOTE: Participants who reported their height as greater than or equal to 7 feet were excluded from the analysis sample. Further, there were 11 participants who reported their weight between 70 –80 lbs, and these participants were not excluded from the sample. Thus, it is possible to have a BMI of 7.86 if a participant weighed between 70-80 lbs and was taller than 6 feet—suggesting ongoing issues with the BMI variable. This should be kept in mind when interpreting results of data analysis.

Results for Research Question #3- To what extent were they at risk for providing socially desirable answers? (SIR-RPSDR-1)

Part III: Single Item Rating of Risk of Providing Socially Desirable Responses (SIR-RPSDR-1). The mean social desirability rating was 6.39 (min=1, max=10, SD=1.818), which indicated a moderately high level of social desirability. The results of research question #13, which is the regression analysis, will control for social desirability.

See Table 4.

<table>
<thead>
<tr>
<th>Risk of Providing Socially Desirable Responses: (N=341)</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - I am not like this at all</td>
<td>4</td>
<td>1.2</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>.6</td>
</tr>
</tbody>
</table>
Results for Research Question #4- For the past year, during the COVID-19 pandemic, in what kind of college setting did they report learning (i.e., in-person, online, hybrid)? (IOHL-1)

Part IV: In-Person, Online, or Hybrid Learning (IOHL-1). Among the 341 participants, 73.3% reported online or a hybrid learning (n=250), while 26.7% reported in person learning (n=91).

See Table 5.

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-Online/ Hybrid</td>
<td>250</td>
<td>73.3</td>
</tr>
<tr>
<td>1-In person</td>
<td>91</td>
<td>26.7</td>
</tr>
</tbody>
</table>

Results for Research Question #5- How did they rate their college’s climate for how well their university has supported, engaged, valued, fairly disciplined, affirmed, reflected empathy for, and served as a safe space for students from diverse cultural backgrounds? (RCC-1)

Part V: Rating the College Climate (RCC-1). For how well their university has supported, engaged, valued, fairly disciplined, affirmed, reflected empathy for, and served as a safe space for students from diverse cultural backgrounds, the mean of 6.49 (min=0, max=10, SD=1.752) suggested this was done to a moderately high extent.
See Table 6.

Table 6. Rating the College Climate (RCC-1) (N=341)

<table>
<thead>
<tr>
<th>Rating the College Climate: (N=341)</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – Lowest level</td>
<td>2</td>
<td>.6</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>.9</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>1.5</td>
</tr>
<tr>
<td>3</td>
<td>8</td>
<td>2.3</td>
</tr>
<tr>
<td>4</td>
<td>22</td>
<td>6.5</td>
</tr>
<tr>
<td>5</td>
<td>46</td>
<td>13.5</td>
</tr>
<tr>
<td>6</td>
<td>59</td>
<td>17.3</td>
</tr>
<tr>
<td>7</td>
<td>103</td>
<td>30.2</td>
</tr>
<tr>
<td>8</td>
<td>65</td>
<td>19.1</td>
</tr>
<tr>
<td>9</td>
<td>17</td>
<td>5.0</td>
</tr>
<tr>
<td>10 – Highest level</td>
<td>11</td>
<td>3.2</td>
</tr>
</tbody>
</table>

Mean Rating the College Climate (6.49), SD (1.752)
min (0), max (10)

Results for Research Question #6- To what extent did they experience social support? (PSSS-1)

Part VI: Perceived Social Support Scale (PSSS-1). The perceived social support mean category was 3.21 (min=1, max=5, SD=1.193) for closest to moderate level of social support, or having at least two people in their lives now providing such social support. There were 24.9% of participants who reported that they had at least two people in their life right now for social support (n=85).

See Table 7.
Table 7. Perceived Social Support Scale (PSSS-1) (N=341)

<table>
<thead>
<tr>
<th>Social Support in Life at Present (N=341)</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-I have no one like that in my life right now</td>
<td>17</td>
<td>5.0</td>
</tr>
<tr>
<td>2-I have at least one person like that in my life right now</td>
<td>99</td>
<td>29.0</td>
</tr>
<tr>
<td>3-I have at least two people like that in my life right now</td>
<td>85</td>
<td>24.9</td>
</tr>
<tr>
<td>4-I have at least 3-5 people like that in my life right now</td>
<td>76</td>
<td>22.3</td>
</tr>
<tr>
<td>5-I have 6 or more like that in my life right now</td>
<td>64</td>
<td>18.8</td>
</tr>
</tbody>
</table>

*Mean Social Support in Life at Present (3.21), SD (1.193)*
*min (1), max (5)*

Results for Research Question #7- What did they report as their past month experience of perceived stress? (PSS-4)

Part VII: Perceived Stress Scale (PSS-4). The Perceived Stress Scale using 4 items had a low internal constancy (i.e., Cronbach’s Alpha of 0.509). The mean experience of perceived stress in the past month was 1.99 (min=0.5, max=3.75, SD=0.557) for closest to moderate stress in the past month, or participants ‘sometimes’ felt they were perceiving stress in their lives. For example, 52.8% of the study participants responded with ‘sometimes’ to the question, “in the last month, how often have you felt that you were unable to control the important things in your life?” (n=180).

See Table 8.

<table>
<thead>
<tr>
<th>Table 8. Perceived Stress Scale (PSS-4) (N=341)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</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=341)</td>
</tr>
<tr>
<td>0 = Never</td>
</tr>
<tr>
<td>1 = Almost Never</td>
</tr>
</tbody>
</table>
2 = Sometimes 180 52.8
3 = Fairly Often 83 24.3
4 = Very Often 21 6.2

* 2. In the last month, how often have you felt confident about your ability to handle your personal problems?* (N=341)

<table>
<thead>
<tr>
<th>Rating</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = Very Often</td>
<td>28</td>
<td>8.2</td>
</tr>
<tr>
<td>1 = Fairly Often</td>
<td>95</td>
<td>27.9</td>
</tr>
<tr>
<td>2 = Sometimes</td>
<td>137</td>
<td>40.2</td>
</tr>
<tr>
<td>3 = Almost Never</td>
<td>75</td>
<td>22.0</td>
</tr>
<tr>
<td>4 = Never</td>
<td>6</td>
<td>1.8</td>
</tr>
</tbody>
</table>

* 3. In the last month, how often have you felt that things were going your way?* (N=341)

<table>
<thead>
<tr>
<th>Rating</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = Very Often</td>
<td>26</td>
<td>7.6</td>
</tr>
<tr>
<td>1 = Fairly Often</td>
<td>109</td>
<td>32.0</td>
</tr>
<tr>
<td>2 = Sometimes</td>
<td>148</td>
<td>43.4</td>
</tr>
<tr>
<td>3 = Almost Never</td>
<td>55</td>
<td>16.1</td>
</tr>
<tr>
<td>4 = Never</td>
<td>3</td>
<td>.9</td>
</tr>
</tbody>
</table>

4. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them? (N=341)

<table>
<thead>
<tr>
<th>Rating</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = Never</td>
<td>19</td>
<td>5.6</td>
</tr>
<tr>
<td>1 = Almost Never</td>
<td>47</td>
<td>13.8</td>
</tr>
<tr>
<td>2 = Sometimes</td>
<td>159</td>
<td>46.6</td>
</tr>
<tr>
<td>3 = Fairly Often</td>
<td>98</td>
<td>28.7</td>
</tr>
<tr>
<td>4 = Very Often</td>
<td>18</td>
<td>5.3</td>
</tr>
</tbody>
</table>

Mean Perceived Stress (1.99), SD (.557)
min (.5), max (3.75)
Cronbach's Alpha (.509)

Note: * indicates a reverse scored item – for reverse scoring of positively stated items

Results for Research Question #8- To what extent had they experienced microaggressions—whether in the campus/college setting, work settings, shopping in stores, or during online/social media interactions? (REM-6)

Part VIII: Ratings of Experiences of Microaggressions (REM-6). The ratings of experiences of microaggressions scale (REM-6) produced a good internal consistency (Cronbach’s alpha = 0.847). The mean of experiences of microaggression was 1.82 (min=0, max=4, SD=0.913) for closest to experiencing them “more than once.” When examining the
experience of the microaggression of “Brief exchanges or brief interactions (in-persons or online) where you felt you were receiving messages that were a put down, denigrating, or conveyed something negative,” 65.7% (n=224) had experienced it more than once, a few times, or many times. For the experience of the microaggression of “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,” 48.7% (n=166) reported having experienced it more than once, a few times, or many times. When examining the experience of the microaggression 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,” 54.9% (n=187) answered that they had experienced it more than once, a few times, or many times. For the experience of the microaggression of “A communication that was insulting, or conveyed rudeness and insensitivity, put downs or demeaning language,” 56.6% (n=193) reported having experienced it more than once, a few times, or many times. When examining the experience of the microaggression of “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,” 57.7% (n=197) had experienced it more than once, a few times, or many times. In addition, a final item included in this study to convey the concept of microaggressions emphasized by Pierce et al., (1977) attempted to capture the frequency of the following experience: “media messages on television, in commercials, on billboards, in magazines, and other online platforms as putting people down like you – denigrating them, spreading negative stereotypes, or conveying something negative about people like you.” For this item, 67.7% (n=231) had experienced it more than once, a few
times, or many times; and, it was for this item (compared to the prior 5 items) where there were
the highest percentages reporting the experience as occurring ‘many times’ (24.5%, n=84).

See Table 9.

<table>
<thead>
<tr>
<th>Table 9. Ratings of Experiences of Microaggressions (REM-6) (N=341)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td><strong>1. Brief exchanges or brief interactions (in-persons or online)</strong></td>
</tr>
<tr>
<td>where you felt you were receiving messages that were a put down,</td>
</tr>
<tr>
<td>denigrating, or conveyed something negative: (N=341)</td>
</tr>
<tr>
<td>0 - Never/Not at all</td>
</tr>
<tr>
<td>1 - At least once</td>
</tr>
<tr>
<td>2 - More than once</td>
</tr>
<tr>
<td>3 - A few times</td>
</tr>
<tr>
<td>4 - Many times</td>
</tr>
<tr>
<td><strong>2. A verbal attack that was hurtful and caused mental or emotional</strong></td>
</tr>
<tr>
<td>pain, whether this involved name-calling, or some act of</td>
</tr>
<tr>
<td>discrimination performed on purpose: (N=341)</td>
</tr>
<tr>
<td>0 - Never/Not at all</td>
</tr>
<tr>
<td>1 - At least once</td>
</tr>
<tr>
<td>2 - More than once</td>
</tr>
<tr>
<td>3 - A few times</td>
</tr>
<tr>
<td>4 - Many times</td>
</tr>
<tr>
<td><strong>3. A nonverbal attack, or some behavior that was hurtful and</strong></td>
</tr>
<tr>
<td>caused mental or emotional pain, whether this involved someone</td>
</tr>
<tr>
<td>avoiding contact and interaction, or avoiding communication, or</td>
</tr>
<tr>
<td>some act of discrimination performed on purpose: (N=341)</td>
</tr>
<tr>
<td>0 - Never/Not at all</td>
</tr>
<tr>
<td>1 - At least once</td>
</tr>
<tr>
<td>2 - More than once</td>
</tr>
<tr>
<td>3 - A few times</td>
</tr>
<tr>
<td>4 - Many times</td>
</tr>
<tr>
<td><strong>4. A communication that was insulting, or conveyed rudeness and</strong></td>
</tr>
<tr>
<td>insensitivity, put downs or demeaning language: (N=341)</td>
</tr>
<tr>
<td>0 - Never/Not at all</td>
</tr>
<tr>
<td>1 - At least once</td>
</tr>
<tr>
<td>2 - More than once</td>
</tr>
<tr>
<td>3 - A few times</td>
</tr>
<tr>
<td>4 - Many times</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=340)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - Never/Not at all</td>
<td>57</td>
<td>16.7</td>
</tr>
<tr>
<td>1 - At least once</td>
<td>86</td>
<td>25.2</td>
</tr>
<tr>
<td>2 - More than once</td>
<td>107</td>
<td>31.4</td>
</tr>
<tr>
<td>3 - A few times</td>
<td>67</td>
<td>19.6</td>
</tr>
<tr>
<td>4 - Many times</td>
<td>23</td>
<td>6.7</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=340)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - Never/Not at all</td>
<td>38</td>
<td>11.1</td>
</tr>
<tr>
<td>1 - At least once</td>
<td>71</td>
<td>20.8</td>
</tr>
<tr>
<td>2 - More than once</td>
<td>67</td>
<td>19.6</td>
</tr>
<tr>
<td>3 - A few times</td>
<td>80</td>
<td>23.5</td>
</tr>
<tr>
<td>4 - Many times</td>
<td>84</td>
<td>24.6</td>
</tr>
</tbody>
</table>

*Mean experienced microaggressions (1.82), SD (.913)*
*min (0), max (4)*
*Cronbach’s Alpha (.847)*

Results for Research Question #9- *What was their level of ability for perceiving racism and oppression?* (PROS-10)

Part IX: Perceptions of Racism and Oppression Scale (PROS-10). The PROS-10 scale displayed a good internal consistency with a Cronbach’s Alpha of 0.874. The mean value of perception to racism and oppression was 3.67 (min=2.5, max=5, SD=0.739) for between a moderate to high level of ability for perceiving racism and oppression (3=moderate ability, 4=high ability). For example, 38.7% (N=132) strongly disagreed with the statement that they are not sure it really exists or happens to people, while they also agreed with the statement that they can usually see or sense when it is happening to themselves (39.3%, n=134), or others (42.5%, n=145).

See Table 10.
Table 10. Perceptions of Racism and Oppression Scale (PROS-10) (N=340)

<table>
<thead>
<tr>
<th>1-I am not sure it really exists or happens to people. (N=340)</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Strongly agree</td>
<td>13</td>
<td>3.8</td>
</tr>
<tr>
<td>2 – Agree</td>
<td>38</td>
<td>11.1</td>
</tr>
<tr>
<td>3 – Undecided</td>
<td>85</td>
<td>24.9</td>
</tr>
<tr>
<td>4 – Disagree</td>
<td>72</td>
<td>21.1</td>
</tr>
<tr>
<td>5 – Strongly disagree</td>
<td>132</td>
<td>38.7</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=340)</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Strongly agree</td>
<td>11</td>
<td>3.2</td>
</tr>
<tr>
<td>2 – Agree</td>
<td>69</td>
<td>20.2</td>
</tr>
<tr>
<td>3 – Undecided</td>
<td>64</td>
<td>18.8</td>
</tr>
<tr>
<td>4 – Disagree</td>
<td>96</td>
<td>28.2</td>
</tr>
<tr>
<td>5 – Strongly disagree</td>
<td>100</td>
<td>29.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3-I think it never happens to me. (N=340)</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Strongly agree</td>
<td>12</td>
<td>3.5</td>
</tr>
<tr>
<td>2 – Agree</td>
<td>48</td>
<td>14.1</td>
</tr>
<tr>
<td>3 – Undecided</td>
<td>77</td>
<td>22.6</td>
</tr>
<tr>
<td>4 – Disagree</td>
<td>118</td>
<td>34.6</td>
</tr>
<tr>
<td>5 – Strongly disagree</td>
<td>85</td>
<td>24.9</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=340)</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Strongly agree</td>
<td>6</td>
<td>1.8</td>
</tr>
<tr>
<td>2 – Agree</td>
<td>95</td>
<td>27.9</td>
</tr>
<tr>
<td>3 – Undecided</td>
<td>84</td>
<td>24.6</td>
</tr>
<tr>
<td>4 – Disagree</td>
<td>98</td>
<td>28.7</td>
</tr>
<tr>
<td>5 – Strongly disagree</td>
<td>57</td>
<td>16.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5-I think it never happens to others. (N=340)</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Strongly agree</td>
<td>4</td>
<td>1.2</td>
</tr>
<tr>
<td>2 – Agree</td>
<td>31</td>
<td>9.1</td>
</tr>
<tr>
<td>3 – Undecided</td>
<td>80</td>
<td>23.5</td>
</tr>
<tr>
<td>4 – Disagree</td>
<td>84</td>
<td>24.6</td>
</tr>
<tr>
<td>5 – Strongly disagree</td>
<td>141</td>
<td>41.3</td>
</tr>
</tbody>
</table>

86
6-There are times when I “don’t get it,” or I can’t really tell when it is happening to others. (N=340)

<table>
<thead>
<tr>
<th>Level</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Strongly agree</td>
<td>7</td>
<td>2.1</td>
</tr>
<tr>
<td>2 – Agree</td>
<td>81</td>
<td>23.8</td>
</tr>
<tr>
<td>3 – Undecided</td>
<td>79</td>
<td>23.2</td>
</tr>
<tr>
<td>4 – Disagree</td>
<td>85</td>
<td>24.9</td>
</tr>
<tr>
<td>5 – Strongly disagree</td>
<td>88</td>
<td>25.8</td>
</tr>
</tbody>
</table>

7-I can usually see or sense when it is happening to me. (N=340)*

<table>
<thead>
<tr>
<th>Level</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Strongly agree</td>
<td>65</td>
<td>19.1</td>
</tr>
<tr>
<td>2 – Agree</td>
<td>134</td>
<td>39.3</td>
</tr>
<tr>
<td>3 – Undecided</td>
<td>89</td>
<td>26.1</td>
</tr>
<tr>
<td>4 – Disagree</td>
<td>49</td>
<td>14.4</td>
</tr>
<tr>
<td>5 – Strongly disagree</td>
<td>3</td>
<td>.9</td>
</tr>
</tbody>
</table>

8-I can usually see or sense when it is happening to others. (N=340)*

<table>
<thead>
<tr>
<th>Level</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Strongly agree</td>
<td>66</td>
<td>19.4</td>
</tr>
<tr>
<td>2 – Agree</td>
<td>145</td>
<td>42.5</td>
</tr>
<tr>
<td>3 – Undecided</td>
<td>82</td>
<td>24.0</td>
</tr>
<tr>
<td>4 – Disagree</td>
<td>43</td>
<td>12.6</td>
</tr>
<tr>
<td>5 – Strongly disagree</td>
<td>4</td>
<td>1.2</td>
</tr>
</tbody>
</table>

9-When incidents are talked about, I think “That could happen to me or someone I love.” (N=340)*

<table>
<thead>
<tr>
<th>Level</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Strongly agree</td>
<td>122</td>
<td>35.8</td>
</tr>
<tr>
<td>2 – Agree</td>
<td>94</td>
<td>27.6</td>
</tr>
<tr>
<td>3 – Undecided</td>
<td>72</td>
<td>21.1</td>
</tr>
<tr>
<td>4 – Disagree</td>
<td>48</td>
<td>14.1</td>
</tr>
<tr>
<td>5 – Strongly disagree</td>
<td>4</td>
<td>1.2</td>
</tr>
</tbody>
</table>

10-When incidents are talked about, I can identify with and understand the experience. (N=340)*

<table>
<thead>
<tr>
<th>Level</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Strongly agree</td>
<td>81</td>
<td>23.8</td>
</tr>
<tr>
<td>2 – Agree</td>
<td>151</td>
<td>44.3</td>
</tr>
<tr>
<td>3 – Undecided</td>
<td>79</td>
<td>23.2</td>
</tr>
<tr>
<td>4 – Disagree</td>
<td>28</td>
<td>8.2</td>
</tr>
<tr>
<td>5 – Strongly disagree</td>
<td>1</td>
<td>.3</td>
</tr>
</tbody>
</table>

Mean level of ability for perceiving racism/oppression (3.67), SD (.739) min (2.5), max (5)
Cronbach’s Alpha (.874)
*Note: In scoring the PROS-10, items 7-10 are reverse scored, allowing a high score to mean a higher level of ability for perceiving racism/oppression. One then sums the scores for all 10 items to arrive at the total score, permitting arriving at a sample mean, minimum 1=very low ability, maximum 5= very high ability and SD. Also, for the interpretation of the mean score for level of ability to perceive racism/oppression: 1=very low ability, 2=low ability, 3=moderate ability, 4=high ability, 5=very high ability

**Results for Research Question #10** - 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 X: Coping and Responding to Racism and Oppression Staging Scale**

(CRROSS-7). The participants’ mean stage of change for coping and responding to racism and oppression was 4.29 (SD=1.159, min=1 or precontemplation stage, max=5, maintenance stage) for closest to the action stage. With respect to the amount of time the participants have spent to learn how to cope with and respond to racism and oppression, some 71.8% (n=243) reported having done this for greater than 5 months.

See Table 11.

<table>
<thead>
<tr>
<th>The Sample's Stages of Change for Coping and Responding to Racism and Oppression (N=339)</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1- Precontemplation</td>
<td>13</td>
<td>3.8</td>
</tr>
<tr>
<td>2- Contemplation</td>
<td>30</td>
<td>8.8</td>
</tr>
<tr>
<td>3- Preparation</td>
<td>24</td>
<td>7.0</td>
</tr>
<tr>
<td>4- Action</td>
<td>50</td>
<td>14.7</td>
</tr>
<tr>
<td>5- Maintenance</td>
<td>222</td>
<td>65.1</td>
</tr>
</tbody>
</table>

*Mean stage of change (4.29), SD (1.159)*

*min (1), max (5)*

The Sample's CRROSS-7 Individual Item Responses (N=341)

1. I don’t think they exist, so there is nothing to learn how to cope with and respond to. (N=339)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10</td>
<td>2.9</td>
</tr>
<tr>
<td>Option</td>
<td>Count</td>
<td>Percentage</td>
</tr>
<tr>
<td>--------</td>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>1 - Strongly agree</td>
<td>10</td>
<td>2.9</td>
</tr>
<tr>
<td>2 – Agree</td>
<td>76</td>
<td>22.3</td>
</tr>
<tr>
<td>3 – Undecided</td>
<td>60</td>
<td>17.6</td>
</tr>
<tr>
<td>4 – Disagree</td>
<td>127</td>
<td>37.2</td>
</tr>
<tr>
<td>5 - Strongly disagree</td>
<td>66</td>
<td>19.4</td>
</tr>
</tbody>
</table>

2. I never thought about how to cope with or respond to it. (N=339)

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Strongly agree</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>2 – Agree</td>
<td>3</td>
<td>0.9</td>
</tr>
<tr>
<td>3 – Undecided</td>
<td>3</td>
<td>0.9</td>
</tr>
<tr>
<td>4 – Disagree</td>
<td>2</td>
<td>0.6</td>
</tr>
<tr>
<td>5 - Strongly disagree</td>
<td>2</td>
<td>0.6</td>
</tr>
</tbody>
</table>

3. I have thought about how to cope with and respond to it. (N=339)

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Strongly agree</td>
<td>10</td>
<td>2.9</td>
</tr>
<tr>
<td>2 – Agree</td>
<td>131</td>
<td>38.4</td>
</tr>
<tr>
<td>3 – Undecided</td>
<td>68</td>
<td>19.9</td>
</tr>
<tr>
<td>4 – Disagree</td>
<td>61</td>
<td>17.9</td>
</tr>
<tr>
<td>5 - Strongly disagree</td>
<td>7</td>
<td>2.1</td>
</tr>
</tbody>
</table>

4. I never took steps to learn more about how to cope with and respond to it. (N=339)

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Strongly agree</td>
<td>3</td>
<td>0.9</td>
</tr>
<tr>
<td>2 – Agree</td>
<td>82</td>
<td>24.0</td>
</tr>
<tr>
<td>3 – Undecided</td>
<td>129</td>
<td>37.8</td>
</tr>
<tr>
<td>4 – Disagree</td>
<td>39</td>
<td>11.4</td>
</tr>
<tr>
<td>5 - Strongly disagree</td>
<td>7</td>
<td>2.1</td>
</tr>
</tbody>
</table>

5. I am planning to take steps to learn more about how to cope with and respond to it (N=338)

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Strongly agree</td>
<td>58</td>
<td>17.0</td>
</tr>
<tr>
<td>2 – Agree</td>
<td>133</td>
<td>39.0</td>
</tr>
<tr>
<td>3 – Undecided</td>
<td>74</td>
<td>21.7</td>
</tr>
<tr>
<td>4 – Disagree</td>
<td>68</td>
<td>19.9</td>
</tr>
<tr>
<td>5 - Strongly disagree</td>
<td>5</td>
<td>1.5</td>
</tr>
</tbody>
</table>

6. I have been actively learning how to cope with and respond to it (N=338)

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Strongly agree</td>
<td>58</td>
<td>17.0</td>
</tr>
<tr>
<td>2 – Agree</td>
<td>133</td>
<td>39.0</td>
</tr>
<tr>
<td>3 – Undecided</td>
<td>74</td>
<td>21.7</td>
</tr>
<tr>
<td>4 – Disagree</td>
<td>68</td>
<td>19.9</td>
</tr>
<tr>
<td>5 - Strongly disagree</td>
<td>5</td>
<td>1.5</td>
</tr>
</tbody>
</table>

7. Learning how to cope with and respond to it is something that I have been actively working on: (N=338)

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0- never in my life</td>
<td>23</td>
<td>6.7</td>
</tr>
<tr>
<td>1- &lt; 1 month</td>
<td>29</td>
<td>8.5</td>
</tr>
<tr>
<td>2- &lt; 6 months</td>
<td>41</td>
<td>12.0</td>
</tr>
</tbody>
</table>
Results for Research Question #11: 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 XI: Experiences of Hate (EOH-12). EOH-12 had two scales; the Experiences of Hate Scale composed of 6-items and the Stressful or Traumatic Impact from Hate Scale composed of 6-items.

First, the Cronbach’s Alpha for the Experiences of Hate Scale was .774 indicating good internal consistency. The mean experience of hate was 2.34 or closest to experiencing hate twice, since the beginning of the COVID-19 pandemic (min=0, max=5, SD=1.032).

Of note, the frequency of having Experiences of Hate was examined by combining the responses for twice, a few times, many times, and a great number of times—in order to better capture exposure to hate. Findings are below:

- 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;
- 66.8% of the participants (n=228) responded that they personally witnessed hate against someone else (live, in-person or online) twice to great number of times;
- 53.4% of the students (n=182) reported that people they were close to (e.g., family members or friends) experienced hate (live, in-person, or online) twice to great number of times;
- 51.7% (n=176) reported that they knew people in their neighborhood or in the area where they live who experienced hate (live, in-person or online) twice to great number of times.
• 73.6% of the participants (n=251) responded that a person that they considered to be a part of their racial/ethnic community experienced hate (live, in-person, or online) twice to great number of times; and,
• 76.8% of the students (n=262) answered that they saw someone who they did not know being a victim of hate twice to great number of times from a video, including television, YouTube, or social media.

Second, the Cronbach’s Alpha for the **Stressful or Traumatic Impact from Hate Scale** was .864 for good internal consistency. The mean impact of hate was 3.02 for having a moderate impact (min=0, max=5, SD=1.142).

Also, the degree to which they experienced any **Stressful or Traumatic Impact from Hate** was examined by combining the responses for moderate impact, high impact and very high impact—in order to better capture that impact. Findings are below:

• 51% of the participants (n=174) reported a moderate, high or very high impact from personally experienced hate;
• 63.6% of the students (n=217) reported a moderate, high or very high impact from witnessing hate against someone else
• 60.4% of the participants (n=206) reported a moderate, high or very high impact from a person close to them experiencing hate
• 51.6% of them (n=176) reported a moderate, high or very high impact from knowing a person in their neighborhood or living area who experienced hate
• 69.3% of the participants (n=236) reported a moderate, high or very high impact from a person who was considered to be a part of their racial/ethnic community experiencing hate
• 70.4% of the participants (n=240) reported a moderate, high or very high impact from watching a video of someone who they did not know being a victim of hate

See Table 12.

<table>
<thead>
<tr>
<th>Table 12. Experiences of Hate (EOH-12) (N=337)</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A--I personally experienced HATE (Live, in-person—or while online). (N=337)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 – Never</td>
<td>77</td>
<td>22.6</td>
</tr>
<tr>
<td>1 – Once</td>
<td>69</td>
<td>20.2</td>
</tr>
<tr>
<td>2 – Twice</td>
<td>3 – Few Times</td>
<td>4 – Many Times</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------</td>
<td>---------------</td>
</tr>
<tr>
<td>74</td>
<td>21.7</td>
<td>72</td>
</tr>
<tr>
<td>32</td>
<td>9.4</td>
<td></td>
</tr>
</tbody>
</table>

**1B--I rate the impact on me, given how stressful or traumatic it was for me. (N=337)**

<table>
<thead>
<tr>
<th>0 – No impact</th>
<th>1 – Very low impact</th>
<th>2 – Low impact</th>
<th>3 – Moderate impact</th>
<th>4 – High impact</th>
<th>5 – Very high impact</th>
<th>6 – Not Applicable/Did not experience this</th>
</tr>
</thead>
<tbody>
<tr>
<td>38</td>
<td>11.1</td>
<td>38</td>
<td>11.1</td>
<td>44</td>
<td>12.9</td>
<td>96</td>
</tr>
<tr>
<td>44</td>
<td>12.9</td>
<td>52</td>
<td>15.2</td>
<td>26</td>
<td>7.6</td>
<td>26</td>
</tr>
<tr>
<td>52</td>
<td>15.2</td>
<td>97</td>
<td>28.4</td>
<td>49</td>
<td>14.4</td>
<td>30</td>
</tr>
<tr>
<td>96</td>
<td>28.4</td>
<td>52</td>
<td>15.2</td>
<td>26</td>
<td>7.6</td>
<td>7</td>
</tr>
<tr>
<td>7</td>
<td>2.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**2A--I personally witnessed HATE against someone else (live, in-person—or while online). (N=337)**

<table>
<thead>
<tr>
<th>0 – Never</th>
<th>1 – Once</th>
<th>2 – Twice</th>
<th>3 – Few Times</th>
<th>4 – Many Times</th>
<th>5 – Great Number of Times</th>
<th>6 – Not Applicable/Did not experience this</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>14.7</td>
<td>52</td>
<td>15.2</td>
<td>44</td>
<td>12.9</td>
<td>30</td>
</tr>
<tr>
<td>52</td>
<td>15.2</td>
<td>97</td>
<td>28.4</td>
<td>49</td>
<td>14.4</td>
<td>30</td>
</tr>
<tr>
<td>52</td>
<td>15.2</td>
<td>49</td>
<td>14.4</td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**2B--I rate the impact on me, given how stressful or traumatic it was for me. (N=337)**

<table>
<thead>
<tr>
<th>0 – No impact</th>
<th>1 – Very low impact</th>
<th>2 – Low impact</th>
<th>3 – Moderate impact</th>
<th>4 – High impact</th>
<th>5 – Very high impact</th>
<th>6 – Not Applicable/Did not experience this</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>5.9</td>
<td>30</td>
<td>8.8</td>
<td>44</td>
<td>12.9</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td></td>
<td>108</td>
<td>31.7</td>
<td>70</td>
<td>20.5</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>11.4</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**3A--A person CLOSE to me (e.g. family member, friend, etc.) experienced HATE (live, in-person—or while online). (N=337)**

<table>
<thead>
<tr>
<th>0 – Never</th>
<th>1 – Once</th>
<th>2 – Twice</th>
<th>3 – Few Times</th>
<th>4 – Many Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>72</td>
<td>21.1</td>
<td>74</td>
<td>21.7</td>
<td>62</td>
</tr>
<tr>
<td>62</td>
<td>18.2</td>
<td>80</td>
<td>23.5</td>
<td>31</td>
</tr>
<tr>
<td>31</td>
<td>9.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Great Number of Times</td>
<td>9</td>
<td>2.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>---</td>
<td>-----</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Applicable/Did not experience this</td>
<td>9</td>
<td>2.6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**3B--I rate the impact on me, given how stressful or traumatic it was for Me. (N=337)**

<table>
<thead>
<tr>
<th>Impact Level</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – No impact</td>
<td>33</td>
<td>9.7</td>
</tr>
<tr>
<td>1 – Very low impact</td>
<td>24</td>
<td>7.0</td>
</tr>
<tr>
<td>2 – Low impact</td>
<td>38</td>
<td>11.1</td>
</tr>
<tr>
<td>3 – Moderate impact</td>
<td>85</td>
<td>24.9</td>
</tr>
<tr>
<td>4 – High impact</td>
<td>77</td>
<td>22.6</td>
</tr>
<tr>
<td>5 – Very high impact</td>
<td>44</td>
<td>12.9</td>
</tr>
<tr>
<td>6 – Not Applicable/Did not experience this</td>
<td>36</td>
<td>10.6</td>
</tr>
</tbody>
</table>

**4A--A person in my neighborhood or in the area where I live experienced HATE (live, in-person—or while online). (N=337)**

<table>
<thead>
<tr>
<th>Impact Level</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – Never</td>
<td>72</td>
<td>21.1</td>
</tr>
<tr>
<td>1 – Once</td>
<td>66</td>
<td>19.4</td>
</tr>
<tr>
<td>2 – Twice</td>
<td>51</td>
<td>15.0</td>
</tr>
<tr>
<td>3 – Few Times</td>
<td>74</td>
<td>21.7</td>
</tr>
<tr>
<td>4 – Many Times</td>
<td>35</td>
<td>10.3</td>
</tr>
<tr>
<td>5 – Great Number of Times</td>
<td>16</td>
<td>4.7</td>
</tr>
<tr>
<td>6 – Not Applicable/Did not experience this</td>
<td>23</td>
<td>6.7</td>
</tr>
</tbody>
</table>

**4B--I rate the impact on me, given how stressful or traumatic it was for me. (N=337)**

<table>
<thead>
<tr>
<th>Impact Level</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – No impact</td>
<td>44</td>
<td>12.9</td>
</tr>
<tr>
<td>1 – Very low impact</td>
<td>22</td>
<td>6.5</td>
</tr>
<tr>
<td>2 – Low impact</td>
<td>49</td>
<td>14.4</td>
</tr>
<tr>
<td>3 – Moderate impact</td>
<td>76</td>
<td>22.3</td>
</tr>
<tr>
<td>4 – High impact</td>
<td>60</td>
<td>17.6</td>
</tr>
<tr>
<td>5 – Very high impact</td>
<td>40</td>
<td>11.7</td>
</tr>
<tr>
<td>6 – Not Applicable/Did not experience this</td>
<td>46</td>
<td>13.5</td>
</tr>
</tbody>
</table>

**5A--A person I consider to be a part of my racial/ethnic community experienced HATE (live, in-person—or while online). (N=337)**

<table>
<thead>
<tr>
<th>Impact Level</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – Never</td>
<td>25</td>
<td>7.3</td>
</tr>
<tr>
<td>1 – Once</td>
<td>56</td>
<td>16.4</td>
</tr>
<tr>
<td>2 – Twice</td>
<td>50</td>
<td>14.7</td>
</tr>
<tr>
<td>3 – Few Times</td>
<td>82</td>
<td>24.0</td>
</tr>
<tr>
<td>4 – Many Times</td>
<td>59</td>
<td>17.3</td>
</tr>
<tr>
<td>5 – Great Number of Times</td>
<td>60</td>
<td>17.6</td>
</tr>
<tr>
<td>6 – Not Applicable/Did not experience this</td>
<td>5</td>
<td>1.5</td>
</tr>
</tbody>
</table>
5B--I rate the impact on me, given how stressful or traumatic it was for me. (N=337)
0 – No impact 21  6.2
1 – Very low impact 27  7.9
2 – Low impact 43  12.6
3 – Moderate impact 92  27.0
4 – High impact 79  23.2
5 – Very high impact 65  19.1
6 – Not Applicable/Did not experience this 10  2.9

6A--I saw a VIDEO (e.g. television, YouTube, on social media) of someone I did not know being a victim of HATE. (N=337)
0 – Never 20  5.9
1 – Once 51  15.0
2 – Twice 42  12.3
3 – Few Times 67  19.6
4 – Many Times 60  17.6
5 – Great Number of Times 93  27.3
6 – Not Applicable/Did not experience this 4  1.2

6B--I rate the impact on me, given how stressful or traumatic it was for me. (N=337)
0 – No impact 10  2.9
1 – Very low impact 23  6.7
2 – Low impact 51  15.0
3 – Moderate impact 72  21.1
4 – High impact 79  23.2
5 – Very high impact 89  26.1
6 – Not Applicable/Did not experience this 13  3.8

Mean Experience of hate (2.34), SD (1.032), min (0), max (5); Cronbach's Alpha (.774)
Mean Impact of hate (3.02), SD (1.142), min (0), max (5); Cronbach's Alpha (.864)

Results for Research Question #12- 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?
Relationships between selected independent variables and a higher prevalence of the experience of microaggressions were examined using both independent t-tests and Pearson Correlations. Results for each are presented, below.

**Independent T-tests Comparing Groups with The Study Outcome Variable – a higher prevalence of the experience of microaggressions.** First, five dichotomous groups (e.g., gender, race, etc.) were compared on the outcome variable, a higher prevalence of the experience of microaggressions. The Bonferroni adjustment significance level was (p= 0.05/5= 0.01). The results showed that two groups had a significant relationship with the outcome variable, as follows:

- comparing respondents who were born in the United States (mean=1.91, SD=.843) to those who were not born in the United States (mean=1.62, SD=1.016), there was a significant difference \( t=-2.595, df=190.5, p=0.01 \) where **U.S. born respondents experienced significantly more microaggression.**
- comparing respondents who never attended HBCU/HSI (mean=1.65, SD=1.073) with those who ever attended HBCU/HSI (mean=1.97, SD=0.705), there was a significant difference \( t=-3.247, df=275.8, p=0.001 \) where **those who ever attended HBCU/HSI had significantly more experiences of microaggressions** \( (p=.001) \).

See Table 13.

**Table 13. Independent Group T-Test for a High Prevalence of the Experience of Microaggressions**

<table>
<thead>
<tr>
<th></th>
<th>High Prevalence of the Experience of Microaggressions</th>
<th>t-test</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>138</td>
<td>1.82</td>
<td>.877</td>
</tr>
<tr>
<td>Male</td>
<td>202</td>
<td>1.80</td>
<td>.938</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black/Latinx</td>
<td>186</td>
<td>1.88</td>
<td>.815</td>
</tr>
<tr>
<td>Asian</td>
<td>155</td>
<td>1.74</td>
<td>1.015</td>
</tr>
<tr>
<td><strong>Born in US</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>113</td>
<td>1.62</td>
<td>1.016</td>
</tr>
<tr>
<td>Yes</td>
<td>228</td>
<td>1.91</td>
<td>.843</td>
</tr>
</tbody>
</table>
Pearson’s Correlations. Correlation coefficients were measured between 15 independent variables and the primary outcome variable. The Bonferroni adjustment significance (0.05/15) was 0.003. Significant correlations were observed, such that the higher the level of experiencing microaggressions, then the:

- lower the Rating of College Climate ($r=-.185$, $p=.001$)
- higher the Stage of Change for Coping with and Responding to Racism/Oppression ($r=.182$, $p=.001$)
- higher the Experiences of Hate ($r=.397$, $p=.000$)
- higher the (stressful and traumatic) Impact of Hate ($r=.325$, $p=.000$)

As non-significant trends, not meeting significance (i.e., Bonferroni adjustment, 0.05/15 = 0.003), showed that the higher the level of experiencing microaggressions, then the:

- higher the Age ($r=.144$, $p=.008$)
- higher the Year in undergraduate or graduate school ($r=.148$, $p=.006$)
- higher the Perceived Stress in past month ($r=.149$, $p=.006$)

See Table 14.
Table 14. Correlations Between Selected Variables and a High Prevalence of the Experience of Microaggressions

<table>
<thead>
<tr>
<th></th>
<th>High Prevalence of the Experience of Microaggressions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pearson's R</td>
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<td>Social Desirability</td>
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<td>Perceived Stress past month</td>
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<td>Stage of Change for Coping &amp; Responding to Racism/Oppression</td>
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<td>Frequency of Experiences of Hate</td>
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<tr>
<td>Stressful and Traumatic Impact from Hate</td>
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</table>

*p<.05, **p<.01, ***p<.001 Bonferroni Adjustment Significance (.05/15, p=.003).

Note: All p values above .003 are considered non-significant; and, only those below .003 are considered statistically significant.

Results for Research Question #13- What were the significant predictors of the study outcome variable of a higher prevalence of the experience of microaggressions in the United States—when controlling for social desirability?

Backward Stepwise Regression—Independent Variables, Rationale for Use,

Findings. This study aimed to identify the significant predictors of the outcome variable, a high prevalence of experiences of microaggressions for Black, Latinx, and Asian college/university students, while controlling for social desirability using Backward Stepwise Regression.

Backward Stepwise Regression model used the following 20 independent variable:

1- Gender (female/male); 2- Race (Black and Latinx/Asian); 3- U.S. born (yes/no); 4- Ever attended a minority serving college (yes/no); 5- Learning Setting (Online or Hybrid/In-person); 6- Age (continuous); 7 Skin Color (continuous); 8- Annual Household Income (categories as continuous); 9- Year in undergraduate or graduate school
To predict study outcome variables, backward stepwise regression was used. Backward stepwise regression “starts with all possible explanatory variables and then discards the least statistically significant variables, one by one,” until each remaining variable in the equation is statistically significant (Smith, 2018, p. 2). Mantel (1970) explained that the discarding process provides the consecutive suitableness of fit, and “any decision about final variables to be retained can be made after the process is completed” (p. 622). It is important to note that the backward stepwise procedure “discards only variables which one can afford to discard” without seriously “impairing the goodness of fit” (Mantel, 1970, p. 622).

Guyon and Elisseeff (2003) explained that “greedy search strategies seem to be particularly computationally advantageous and robust against overfitting,” and the backward elimination method is one of the strategies (p. 1,167). The advantage of using backward stepwise regression is that “it drops regressor variables, or sets of regressor variables, only when it can afford to drop them—where a set of regressor variables should be kept in its entirety it is kept, though the step-up procedure could have failed to pick up the set” (Mantel, 1970, p. 624).

In this study, the analysis started with all 20 independent variables and removed the variable which showed the weakest association with a high prevalence of experiences of microaggressions—doing so one at a time. This process was completed when the remaining
variables in the model were statistically significant. Because social desirability acted as a control variable, it was also included (forced) into each step, regardless of its significance.

**Findings.** The results of the backwards stepwise regression analysis for this study showed that 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 \( (b=.360, \ SE=.059, \ p=.000) \)
- **More** Stressful and Traumatic Impact from Hate \( (b=.131, \ SE=.052, \ p=.013) \)

According to this model, the \( R^2 \) was .274, and the adjusted \( R^2 \) was .263, indicating that 26.3% of variance was explained by this model.

See Table 15.

<table>
<thead>
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<th>SE of B</th>
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<td><strong>More Frequent</strong> Experiences of Hate***</td>
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<td>.059</td>
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<tr>
<td><strong>More</strong> Stressful and Traumatic Impact of Hate*</td>
<td>.131</td>
<td>.052</td>
<td>.013</td>
</tr>
</tbody>
</table>

*\( p<.05, \ **p<.01, \ ***p<.001; \ R^2 \text{ (0.274), Adjusted } R^2 \text{ (0.263) – meaning 26.3\% of variance was explained by this model; } F= 24.081, \ p=.000 \)

HBCU – Historically Black Colleges and Universities; HSI – Hispanic Serving Institutions

**Conclusion**

This chapter described the results of the data analysis for each research question. Results were summarized in tables for each research question. Chapter V will provide the discussion of results, implications of the findings, recommendations, limitations, and a conclusion.
Chapter V

DISCUSSION, IMPLICATIONS, RECOMMENDATIONS, AND CONCLUSION

This chapter will present a discussion of findings, implications of the findings, and recommendations for future research. The limitations of this study and the final conclusion will also be described.

Discussion of Results

Discussion of Demographic Findings

The study findings on demographics may be compared to those of Ingram (2017)—who used similar measures and had a similarly diverse college sample. In the present study, there were a total of 341 participants with 40.6% female (n=138) and 59.2% male (n=202), while having a mean age of 26.6 years (SD=6.752, min 18, max 59). The sample participants (N=341) were composed of diverse races/ethnicities: 43.7% of Black/African American (n=149), 9.4% of Latinx/Hispanic/Latino (n=32, 44.9% of Asian (n=153), and 2.1% of other groups (n=7).

Notably, compared to Ingram (2017) which had 78.1% of female respondents, the present study had a larger percentage of males (59.2%, n=202) than female respondents (40.6%, n=138). The larger number of male participants might be explained by the events of the murder of George Floyd, incessant police violence toward innocent Black Americans, and the surge in Asian hate crimes during the COVID-19 pandemic in the United States. Meanwhile, two recruitment messages in the present study were distributed via social media to recruit first, the general population including Black, Latinx, and Asians, and second, only the Asian population. The survey links were provided clearly showing the name of the survey with a brief explanation:

“https://tinyurl.com/I-EXPERIENCED-HATE to take 10-15 MINUTE SURVEY on experiences of
hate, stress, racism, microaggressions & violence for a chance.” Thus, the tailored recruitment messages, explicitly stating “I experienced hate” during the pandemic may have contributed to a large number of male college students potentially identifying with that experience, potentially motivating them to participate in the study survey.

In the present study, most participants (66.9%) were born in the United States (n=228). Among participants who reported they were not born in the United States, most were from China (n=31, 9.1%), followed by India (n=26, 7.6%), South Korea (n=13, 3.8%), Jamaica (n=5, 1.5%), and Japan (n=5, 1.5%). Ingram (2017), in examining the prevalence of undergraduate and graduate minority college students’ perceived experiences of racism and/or oppression, used a largely female sample (N=228, female=78.1%) with a similar mean age of 25.6 (SD=7.946, min=18, max=60). Yet, Ingram’s (2017) sample had a larger proportion of Black participants (i.e., 66.2% Black/African American, 21.9% Hispanic/Latino, and 14.5% Asian college students)—with 82% of participants being born in the U.S.

In the present study, the mean annual household income level was category 5.54 (min=2, max=11, SD=2.091), or between the $50,000 to $99,999 category and the $100,000 to $199,999 category. For example, 27.6% reported their annual household income level was between $100,000 to $199,999 (n=94). Ingram (2017) reported, in comparison, a lower mean annual income that was closest to the $40,000-$49,000 category (mean=2.82, SD=1.640, min=1 or $10,000–$19,000, max=10 or $800,000 and more).

This study found with regard to education level that the sample had a mean number of years in college of 4.71 (min=1, max=11, SD=2.354) for closest to first year in graduate school. Most commonly reported was being a Sophomore in college (n=59, 17.3%), followed by being in the 2nd year in graduate school (n=57, 16.7%), and then being in the 1st year in graduate school
(n=56, 16.4%). Also, about half of the participants (52.2%) reported that they attended Historically Black Colleges and Universities or Hispanic Serving Institutions (HBCU/HSI; n=178). In comparison, Ingram (2017) reported a mean education level that was similar, being closest to the 1st year in graduate school (mean=4.83, SD=2.514, min=1 or freshman, max=11 or 7th year in graduate school). Further, Ingram (2017) found a lower percentage had a history of attending a Historically Black College or University (HBCU) or Hispanic Serving Institution (HSI), while 62.3% had never attended an HBCU or HSI.

**Discussions of Findings on Health Status**

The present study sample (N=341) had closest to ‘Good’ physical health status (mean=4.11, min=1, max=6, SD=1.098); and, between ‘Fair’ and ‘Good’ mental/emotional health status (mean=3.80, min=1, max=6, SD=1.091). The mean Body Mass Index (BMI) was 23.14 (min=7.86, max=58.99, SD=7.653) for normal or healthy weight. Of note, the Centers for Disease Control and Prevention (CDC, 2020) 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, 2020).

There were similarities to the Ingram (2017) sample. The overall health of the Ingram (2017) sample was similarly a ‘Good’ status (mean=4.24, min=1 or very poor, max=6 or excellent, SD=1.03).

In contrast to this study’s diverse sample having a normal or healthy weight, as per their Body Mass Index (BMI), Ingram (2017) had sample that was overweight (mean=26.119, min=10.85 or underweight, max=47.29 or obese, SD=6.235).

Tirhi (2019), examining life stress, islamophobic discrimination, and microaggressions among adult Muslim Americans, found an overall health status between ‘Good’ and ‘Very good’
(mean=4.52, SD=.962, min=1 or very poor, max=6 or excellent)—which was better than for this study’s diverse sample. Tirhi (2019) found a BMI mean corresponding to overweight (mean=26.780, min=18.24, max=46.68, SD = 5.23), whereas the present study found a normal or healthy weight.

Discussion of Findings on Social Desirability

The present sample’s mean social desirability was 6.39 (min=1, max=10, SD=1.818) indicating a moderately high level of social desirability. Using the same tool, LeeHim (2021) found with a sample of teachers that the social desirability mean was 4.73 (min=0, max=10, SD=2.430) for a moderate risk of social desirability. Harry (2021) used the same tool with a sample of nurses and found a low-moderate risk of providing socially desirable responses with a mean of 4.41 (SD=0.600, min=0, max=10). With participants being Muslim American adults, the Tirhi (2019) sample’s social desirability mean was 8.76 (min=1, max=13, SD=2.822) for a moderately high level. Moreover, using the same tool for the first time, as the pioneer, Laryea (2019) obtained a mean social desirability score of 6.61 among nurses, suggesting a moderately high level of social desirability (min=0 or I am not like this at all, max=10 or I am like this all the time, SD=3.07)—which was closest to the present study’s finding.

Discussion of Findings on Learning Modality and Ratings of College Campus Climate

Findings in this study for learning modality and ratings of climate were similar to previous studies conducted during the same COVID-19 pandemic era.

In the present study, among the 341 participants, 73.3% (n=250) reported learning online or hybrid, while 26.7% (n=91) reported learning in person during the pandemic. With data collected from K-12 teachers during the exact same period that data was collected for this study,
D’Mello (2021) found that 74.8% (N=119) reported they taught online, and 66.7% (N=106) reported they taught in a hybrid model.

The study findings on college campus climate may be compared to the findings of LeeHim (2021) who used a similar rating measure for school climate. In the present study, for how well their university has supported, engaged, valued, fairly disciplined, affirmed, reflected empathy for, and served as a safe space for students from diverse cultural backgrounds, participants responded that this was done to a moderately high extent (mean=6.49, min=0, max=10, SD=1.752). With a very similar rating, the study by LeeHim (2021) found that their pre-pandemic school climate was 6.65 (min=2, max=10, SD=2.076) for closest to a climate that “moderately supported, engaged, valued, fairly disciplined, affirmed, reflected empathy for, and served as a safe space for students from varied cultural backgrounds” (LeeHim, 2021, p. 88).

**Discussion of Findings on Social Support**

The findings of social support can be compared to the findings of Harry (2021) who used the same Perceived Social Support Scale (PSSS-1). The present study showed that participants had a moderate level of social support, or had at least two people in their lives who provided social support (mean = 3.21, min=1, max=5, SD=1.193). Specifically, 24.9% of participants (n=85) indicated that they had at least two people who provided social support in their lives. This finding is similar to the study by Harry (2021), which examined the social support level in nurses (N =249, mean age = 32.17) who have had direct contact with COVID-19 patients in a healthcare setting in the United States. Harry’s (2021) results showed that the participants had a mean social support score of 2.45 (min = 0, max = 4, SD = 1.132), which was a lower level than in the present study. Of note, for further comparison, the D’Mello’s (2021) study with K-12 teachers who taught during the pandemic found a mean score of 3.21 (min=1, max=5, SD=.930)
for moderate social support (at least 2 people)—which was identical to the present study’s mean of 3.21 for at least 2 people.

**Discussions of Findings for Perceived Stress**

The findings for past-month perceived stress can be compared to the findings of Harry (2021), given use of the same 4-item version of the Perceived Stress Scale (PSS-4) during the exact same period of the COVID-19 pandemic in the United States (i.e., early 2021 data collection. Harry (2021) found an acceptable internal consistency for the PSS-4 (i.e., Cronbach’s Alpha of 0.633), whereas this study found low internal consistency (i.e., Cronbach’s Alpha of 0.509).

In the present COVID-19 era study, the mean experience of perceived stress in the past month was 1.99 (min=0.5, max=3.75, SD=0.557) for closest to moderate stress in the past month, or participants ‘sometimes’ felt they were perceiving stress in their lives. Similarly, as a COVID-19 era study, Harry (2021) found that the perceived stress in the past month among nurses (N=249, mean age=32.17) who had direct contact with COVID-19 patients in a healthcare setting in the United States was also a moderate level (mean=1.874, min=0.00, max=3.75, SD=0.596). D’Mello (2021) found with a sample of K-12 teachers [(N=159), 89.9% female (N=143), 10.1% (N=16) male; mean age of 39.53 years (min=23, max=70, SD=1.138)] who taught during the pandemic in the United States that the Perceived Stress Scale (PSSS-4) had good internal consistency (Cronbach’s Alpha of 0.756).

Again, reflecting similarity, for the question of “In the last month, how often have you felt that you were unable to control the important things in your life,” 52.8% of the present study participants (n=180) responded with “sometimes,” while Harry (2021) found 51.8% of the
participants (n=129) reported “sometimes” to the same question. In the D’Mello (2021) study, 44% of the respondents (N=70) reported ‘sometimes.’

Pre-pandemic, other researchers have used the 10-item version of the Perceived Stress Scale (PSS-10), while pandemic era studies called for the use of the shorter PSS-4. However, pre-pandemic, using the PSS-10, Ingram (2017) found that racially diverse college students’ mean PSS-10 score was 18.918, suggesting a moderate level of stress during the preceding month (min=1, max=38, SD=7.629). Tirhi (2019) investigated diverse adult Muslim Americans’ life stress, islamophobic discrimination, and microaggressions and the study sample’s mean perceived stress during the preceding 30 days was 18.025, suggesting a moderate level (min=2, max=40, SD=7.17947).

Pittman and Kaur (2018) also used the 10 item PSS-10 to investigate stressful life situations among Black female college students (age=20.34±2.12) in the United States, obtaining a mean general life stress score of 18.67 (SD=7.18) that indicated moderate stress. Moreover, scores did not differ significantly between Black female college students attending Historically Black College or Universities (HBCUs) and those attending predominantly White institutions (Pittman & Kaur, 2018).

Discussion of Findings for the Prevalence of Microaggressions

The mean of experiences of microaggression of the present diverse college sample was 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. The ratings of experiences of microaggressions scale produced a good internal consistency (Cronbach’s alpha=0.847), using 6 items.

This study’s findings for experiences of microaggressions may be compared to those of LeeHim (2021) who used the same measure—yet, LeeHim (2021) adapted the tool for
teachers of diverse K-12 students who reflected on in-person school experiences before the COVID-19 pandemic (N=55, mean age=38.02, p. 90). For personally experienced microaggressions in school settings before the pandemic, LeeHim (2021) found that participants had at least one exposure to microaggressions (mean=1.25, min=.00, max=4, SD=1.17751). However, when the categories of “at least once, more than once, a few times, and many times” were combined, more than half of the participants experienced microaggressions.

On the other hand, the present study examined diverse college students’ experiences of microaggressions during the pandemic in early 2021, and the study results showed that the college students had a slightly higher mean than found by LeeHim (2021). In this study, the diverse college students also experienced microaggressions “more than once” (mean=1.82, min=0, max=4, SD=0.913). However, when the categories for “more than once, a few times, and many times” were combined, about half the participants reported that they experienced microaggressions for all 6 items (i.e., 1. Brief exchanges or brief interactions (in-persons or online) where you felt you were receiving messages that were a put down, denigrating, or conveyed something negative; 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; 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; 4. A communication that was insulting, or conveyed rudeness and insensitivity, put downs or demeaning language; 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; 6. Media messages on television, in commercials, on billboards, in magazines, and other online platforms as putting
people down like you – denigrating them, spreading negative stereotypes, or conveying something negative about people like you). Of note, for the last item, which conveyed the concept of microaggressions emphasized by Pierce et al. (1977) as an innovation introduced in this tool by adding this item to the scale for this study, 67.7% (n=231) had experienced it more than once, a few times, or many times; and, it was for this item (compared to the prior 5 items) where there were the highest percentages reporting the experience as occurring ‘many times’ (24.5%, n=84). This underscores the importance of any investigation of microaggressions remaining true to the original work of Pierce et al. (1977) and including this item in a survey on experiences of microaggressions: i.e., Media messages on television, in commercials, on billboards, in magazines, and other online platforms as putting people down like you – denigrating them, spreading negative stereotypes, or conveying something negative about people like you.

Discussion of Findings for the Perception of Racism and Oppression

Ingram (2017) found with racially diverse college students that the Perception of Racism and Oppression (PROS-10) scale had a mean of 4.336 (min=2.30 or moderately low ability, max=5 or very high ability, SD=.576) suggesting that the sample had between a high and a very high level of ability for perceiving racism and oppression. The PROS-10 also displayed good internal consistency (Cronbach’s alpha=.848) in the Ingram (2017) study.

In comparison, the present study sample of diverse college students—with a larger percentage of Asians than did the Ingram (2017) sample—had a lower mean level of ability for perceiving racism and oppression of 3.67 (min=2.5, max=5, SD=0.739) for between a moderate to high level of ability. Also, in the present study, the PROS-10 scale displayed a good internal consistency with a Cronbach’s Alpha of 0.874 that was in line with that of Ingram (2017).
Tirhi (2019) also used the same PROS-10 tool to measure adult Muslim Americans’ perceptions of racism and oppression—specifically, inclusive of Islamophobia and/or Islamophobic discrimination, and obtained a mean score of 4.076, suggesting a high level of ability for perceiving racism and oppression (min=2 or low ability, max=5 or very high ability, SD= .571). This level of ability was similar to what Ingram (2017) found, while the present study found a somewhat lower level of ability for perceiving racism and oppression for the sample of diverse college students.

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

The present sample’s mean stage of change for coping and responding to racism and oppression (CRROSS) was 4.29 (min=1 or precontemplation stage, max=5, maintenance stage, SD=1.159) for closest to the action stage. Some 14.7% (n=50) were in an action stage and 65.1% (n=222) were in a maintenance stage for this behavior of actively coping and responding to racism and oppression. According to Wallace (2005), those with mean CRROSS scores of approximately 4 are in the action stage, being “engaged in actively learning and practicing adaptive coping responses to racism and oppression;” and, those with mean scores of approximately 5 are in the maintenance stage and are “generalizing, refining adaptive coping responses to racism and oppressions for > 6 months” (p. 108).

As a very similar mean score on the CRROSS, Ingram (2017) reported that the diverse college sample’s mean on the CRROSS scale of 4.33—for closest to the action stage (min=1 or precontemplation stage, max=5 or maintenance stage, SD=1.021). In contrast, with an adult Muslim sample, while using the same CRROSS tool adapted to focus on coping with and responding to Islamophobia and/or Islamophobic discrimination, Tirhi (2019) found that the sample mean was 3.44, or closest to the preparation stage (min=1 or precontemplation stage,
max=5 or maintenance stage, SD=1.33)—or just preparing to learn how to cope and respond to racism and oppression.

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

First, the Cronbach’s Alpha for the *Experiences of Hate Scale* was .774 indicating good internal consistency. The mean experience of hate was 2.34 or closest to experiencing hate twice, since the beginning of the COVID 19 pandemic (min=0, max=5, SD=1.032).

The study findings may be compared to the Stop AAPI Hate National Report (2021), where it was reported that 21.2% of Asian Americans and 20.0% of Pacific Islanders had hate experiences in 2020 when the COVID-19 pandemic started. Among those who experienced hate incidents since 2020, 8.3% of Asian Americans and 9.4% of Pacific Islanders reported that “they have experienced multiple hate incidents” (p. 3). Hate incidents included verbal harassment (62.9%), avoidance (16.3%), physical assault (16.1%), and online harassment (8.6%). Moreover, the report showed that the most frequent sites where the hate incidents occurred included public streets (32.4%), online (10.1%), school (5.7%), and University or College (2.9%).

Similarly, the present study found – when combining the responses for twice, a few times, many times, and a great number of times (and whether live, in-person or online)—that: 53.1% of the participants (n=181) reported that they personally experienced hate; 66.8% (n=228) personally witnessed hate against someone else; 53.4% (n=182) had people they were close to (e.g., family members or friends) experienced hate; 51.7% (n=176) knew people in their neighborhood or in the area where they live who experienced hate; 73.6% (n=251) had a person that they considered to be a part of their racial/ethnic community that experienced hate; and, 76.8% (n=262) saw someone who they did not know being a victim of hate (e.g. video).
Witnessing hate against someone else is akin to vicarious racism. Thus, the study findings on experiences of hate can be compared to the findings from Chae et al. (2021). Chae et al. (2021) studied vicarious racism, which is “hearing about or seeing other people of the same racial group experiencing racism” during the COVID-19 pandemic, and its psychological impact on Black (n=844) and Asian (n=604) American adults (p. 510). The results showed that 98.1% of Black and 91.9% of Asian Americans reported that they had experienced any type of vicarious racism, and 61.6% of Black and 50.0% of Asian participants responded that “experiences of vicarious racism during the COVID-19 pandemic were ‘more than usual’” (Chae et al., 2021, p. 511).

Second, the Cronbach’s Alpha for the Stressful or Traumatic Impact from Hate Scale was .864 for good internal consistency. The stressful or traumatic impact of hate scale mean score was 3.02 for having a moderate impact (min=0, max=5, SD=1.142).

Related to the stressful or traumatic impact of hate scale findings in this study, Chae et al. (2021) also found that 87.2% of Black and 72.8% of Asian adults reported that they “sometimes” thought about their experiences of vicarious racism; and 91.2% of Black and 89.6% of Asian participants responded that “they were ‘somewhat’ distressed” by these experiences (p. 512). Further, 85.2% of Black and 68.7% of Asian participants reported that “they were concerned about these experiences ‘somewhat’ or more” (Chae et al., 2021, p. 512). Similarly, in the present study, when combining ratings for moderate, high and very high impact, findings showed: 51% (n=174) reported an impact from personally experienced hate; 63.6% (n=217) reported an impact from witnessing hate against someone else; 60.4% (n=206) reported an impact from a person close to them experiencing hate; 51.6% (n=176) reported an impact from knowing a person in their neighborhood or living area who experienced hate; 69.3% (n=236)
reported an impact from a person who was considered to be a part of their racial/ethnic community experiencing hate; and, 70.4% (n=240) reported an impact from watching a video of someone who they did not know being a victim of hate—underscoring how this scale captures vicarious exposure to hate.

The findings in this study with the new tools of the Experiences of Hate Scale and the Stressful or Traumatic Impact from Hate Scale emerge as important for capturing the personal experiences of Black, Latinx, and Asian college students—and their vicarious experiences of hate, making an important contribution to COVID-19 pandemic era research (and post-pandemic). The work of others suggests the importance of this contribution to research, given the need to document both exposure to hate and the impact of hate, during this current era.

For example, Pan et al. (2021) examined how experiences of personal racial discrimination, including on social media, was related to mental distress among Asian adults (N=209, mean age=33.69, female=54.07%, Chinese=64.59%, majority educational level=had a bachelor’s degree) in the United States during the COVID-19 pandemic. Study results found that personally experiencing racial discrimination and racism-related social media use experiences—such as reading about racism, posting/reposting news or any information related to racism, and discussing racism—both had positive and significant associations with depressive symptoms.

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

**Independent T-Tests:** Using the Bonferroni adjustment significance level (p= 0.05/5= 0.01), independent t-tests comparing groups with the study outcome variable of a higher prevalence of the experience of microaggressions showed: U.S. born respondents (mean=1.91, SD=.843) experienced significantly more microaggressions than non-U.S. born (mean=1.62, SD=1.016; t=-2.595, df=190.5, p=0.01); and, those who ever attended an
HBCU/HSI (mean=1.97, SD=0.705), comparing respondents who never attended HBCU/HSI (mean=1.65, SD=1.073) experienced significantly more microaggressions than with who had not (mean=1.65, SD=1.073; \( t=-3.247, \) df=275.8, \( p=0.001 \)). Those born in the U.S. were more likely to experience microaggressions, as a finding that was not surprising in this study, given the likelihood of greater lifetime exposure to any instance of a microaggression for those living in the U.S. This follows from how there are long-standing issues of African American, Latinx and Asians experiencing racial hostility, discrimination, and microaggressions in the U.S.—as well-documented among college populations (Lui, 2020). It would also follow that there are more African American, Latinx and Asian students attending an HBCU/HSI, helping to explain greater exposure to microaggressions compared to those not attending an HBCU/HSI.

Comparisons to the studies already utilized in the discussion is not possible, here. Specifically, not selecting microaggressions as the study outcome variable, as did this study, Ingram’s (2017) outcome variable(s) included being in a higher stage of change for coping and responding to racism and oppression. Also, Leehim (2021) had a different outcome variable of K-12 school teachers’ rating of school climate. Harry (2021) had a different outcome variable of nurses’ level of burnout. And, Tirhi (2019) also had a different outcome variable of Muslim American’s level of life satisfaction.

**Pearson Correlations:** Also using the Bonferroni adjustment significance (0.05/15; \( p=0.003 \)), significant correlations showed that the higher the level of experiencing microaggressions, then the: lower the rating of college climate (\( r=-.185, p=.001 \)), the higher the stage of change for coping with and responding to racism and oppression (\( r=.182, p=.001 \)), the higher or more frequent the experiences of hate (\( r=.397, p=.000 \)), and, the higher the stressful and traumatic impact of hate (\( r=.325, p=.000 \)).
To interpret these findings, consider the assertion that minority students experience microaggressions, a hostile campus climate, and racial discrimination on a daily basis (Rosa-Dávila et al., 2020). It seems logical that a higher level of experiencing microaggressions as a Black, Latinx or Asian college student is strongly associated with more frequent experiences of hate—as in both instances a student’s demographics and visual appearance may trigger negative treatment in the form of microaggressions or hate. Equally logical is that there would be a strong association between a higher level of experiencing microaggressions and a more stressful and traumatic impact from hate. It also makes sense that the higher the experience of microaggressions, then the higher the likelihood that one has been taking action to cope with and respond to racism and oppression—resulting in being in a higher stage of change (e.g. action or maintenance stage) for that behavior.

Previous research supports the present study finding of an inverse relationship between college climate and higher levels of experiences of microaggression. Pearson’s correlation showed that the lower the rating of the college climate, then the higher the level of experiencing microaggressions. This is consistent with prior research that showed the impact of college climate on students. For example, it has been asserted that in order to create a campus climate or an environment in which people are treated with dignity regardless of their race or ethnicity, the administrations of institutions of higher education should clearly state what is and what is not permitted, noting that “how the message is expressed will reflect campus ideology” (Rosa-Dávila et al., 2020, p. 6).

In this regard, Tausen et al. (2020) found that the academic community leaders’ high levels of support affected Asian students’ perceptions of a more positive racial climate on campus, and campus racial climate predicted Asian students’ affective experiences—even when
the COVID-19 pandemic brought xenophobia and a surge of racism. In sum, academic institutions function, as a whole, “to mitigate the consequences of racism on well-being” (Tausen et al., 2020, p. 377)—and the role of leadership is key.

**Backward Stepwise Regression.** The results of the backwards stepwise regression analysis for this study showed that the significant predictors for the study outcome variable of a high prevalence of experiences of microaggressions were: yes, for ever attended an 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 (b=.131, SE=.052, p=.013)—explaining 26.3% of the variance in the model (R²=.274, adjusted R²=.263). Here, too, it is worth mentioning that prior studies used for comparison had different study outcome variables, not allowing for comparison (i.e., Ingram, 2017; Tirhi, 2019; LeeHim, 2021; Harry, 2021; D’Mello, 2021).

As discussed earlier, with a higher proportion of Black, Latinx and Asian students attending an HBCU/HSI, it makes sense that higher exposure to microaggressions is predicted by HBCU/HSI attendance. Similarly, it seems logical that the higher exposure to microaggressions is associated with more frequent experiences of hate—and a more stressful and traumatic impact from hate. Recall how the experience of microaggressions, a hostile campus climate, and racial discrimination occur for such diverse college students on a daily basis (Rosa-Dávila et al., 2020, p. 5). In previous research, Harwood et al. (2012) reported that students of color experienced feelings of not belonging to predominantly White institutions (PWI) due to racial microaggressions, such as racial comments and jokes from peers.

According to the U.S. Department of Education, HBCUs have experienced concentrated bomb threats in recent years, particularly during Black history month. HBCUs have attempted to
persevere and carry on their mission, but the bomb threats have disrupted the learning environment on campus by destroying students’ “sense of safety and belonging, which are critical to their academic success and wellbeing” (para. 3). Given history, those bomb threats against HBCUs “evoke a painful history of violence against Black Americans in this country that is especially traumatizing to HBCU students, faculty, and staff” (U.S. Department of Education, 2022, para. 3). Against this backdrop, the present study findings are noteworthy; specifically, that those who have ever attended HBCU/HSI experienced significantly more microaggressions, and ever attending HBCU/HSI was a significant predictor for the high prevalence of experiences of microaggressions. This may reflect how Black students have experienced systemic racism and hate at a time of bomb threats against their schools.

The findings are also consistent with the work of others. Tausen et al. (2020) described Asian American Pacific Island (AAPI) students as experiencing xenophobia, anti-Asian racism, and hate crimes, which spread rapidly via social media platforms. Further, there have been COVID-19 related incidents of bias and hate crimes against Asian Americans, reflecting prevalent racial sentiments in American society (Tessler et al., 2020). Gover et al. (2020) indicated that experiences of hate crimes during the pandemic aggravated victims’ long-term period of trauma (p. 660). Hence, it was understandable that for the Black, Latinx and Asian students in this study, having had more hate experiences and having experience a higher negative stressful/traumatic impact from hate would significantly predict the high prevalence of experiences of microaggressions.

Finally, with just 26.3% of the variance accounted for in the backward stepwise regression model, there is a need to identify additional independent variables for inclusion in future research studies.
Implications for Practice and Recommendations for Future Research

The study findings have implications for health educators engaged in practice as well as research, as follows:

- The study findings indicate that there is a need to acknowledge and address the high prevalence of experiences of microaggressions for Black, Latinx and Asian college students, suggesting a role for colleges and universities as settings for the provision of diversity training and resources for administrators, faculty, staff and students, in order to address this issue. This follows from how, when combining the frequencies of more than once, a few times, or many times, this study showed that some 65.7% of college students had received denigrating/put-down messages, 48.7% had a verbal attack, 54.9% had experienced painful nonverbal attacks or behavior, 56.6% had experienced insulting communication, 57.7% had experienced a communication that excluded or cancelled them, and 67.7% experienced a denigrating media message. It is recommended that colleges and universities provide cultural diversity training to administrators, faculty, staff and students—as a way to reduce the incidence of microaggressions and improve college campus climate. Also, it is recommended that college and university counseling services ensure they are able to effectively address the mental health distress that can follow from such experiences, while having the diverse staff for meeting the needs of Black, Latinx, and Asian students.

- Beyond practice, future research should continue to use the tool, Ratings of Experiences of Microaggressions (REM-6), in conducting research on microaggression—and for use as a study outcome variable, as in this study. The ratings of experiences of
microaggressions scale (REM-6) produced a good internal consistency (Cronbach’s alpha = 0.847).

- Future research should follow this study in use of the tool, Ratings of Experiences of Microaggressions (REM-6), and specifically the last question on: “media messages on television, in commercials, on billboards, in magazines, and other online platforms as putting people down like you – denigrating them, spreading negative stereotypes, or conveying something negative about people like you.” For this item, 67.7% (n=231) had experienced it more than once, a few times, or many times; and, it was for this item (compared to the prior 5 items) where there were the highest percentages reporting the experience as occurring ‘many times’ (24.5%, n=84). This item followed the original work of Pierce et al. (1977), suggesting that future research on microaggressions needs to also return to the original work of Pierce, and include attention to media messages. This is vital, as in contemporary times with numerous social media platforms such a focus is justified. Health educators in practice may need to engage in consultation work with advertisers and those in marketing to address the microaggressions that appear to be highly prevalent—providing them with cultural diversity training, as something essential.

- There is also an urgent need for colleges, universities, and health educators (providing leadership in these settings and in the larger community and society) to address the risk of exposure to hate—and the repercussions. This urgent need was supported by data showing over half the sample had experiences of hate twice, a few times, many times, and a great number of times (personally, or witnessed, or to someone they knew, or to someone considered part of their community, or saw a video); and, over half the sample reported a moderate, high or very high stressful and traumatic impact from hate
(personally, or witnessed, or to someone they knew, or to someone considered part of their community, or saw a video). Health educators can collaborate with psychologists in designing interventions that assist college students with coping in the aftermath of exposure to hate, thereby reducing the potential negative impact. Beyond college students, hate has impacted communities, as well. Health educators and psychologists may find that their interventions can also be adapted to other accessible and easily disseminated formats, such as webinars via video, so that training in coping in the aftermath of hate is more widely disseminated, so as to benefit a larger audience. Also, resources must be linguistically appropriate, necessitating translation of training materials into other languages, in order to engage Latinx and diverse Asian community members.

- It is important for health educators and psychologists to design interventions that acknowledge where individuals are with regard to their ability to perceive racism and oppression, as well as cope with it. There is a role for two existing tools in research and practice for this purpose: the PROS-10 for ascertaining participants level of ability for perceiving racism and oppression—and the CRROSS for determining their stage of change for coping and responding to racism and oppression. Both were used in this research study, showing the diverse college students in this study reported a moderate to high level of ability for perceiving racism and oppression; and, their mean stage of change for coping and responding to racism and oppression was closest to the action stage. Hence, the sample was somewhat advanced with regard to perceiving and coping with/responding to racism and oppression. Yet, with experiences of microaggression and the rise in hate during the pandemic, even diverse college students with such characteristics may still benefit from interventions to assist them in emotionally
processing their experiences of microaggressions and hate—and further improve their coping, so as to protect mental health. Of note, in this study, mental/emotional health status was rated as closest to ‘good.’ And, the stressful or traumatic impact of hate was assessed—showing a moderate impact.

- Future research should include additional measures that are indicators of mental health, such as those that assess depression, anxiety, and posttraumatic stress disorder. There would be value in exploring the extent to which microaggressions are predicted by mental distress.

- Also, the fact that the regression model explained 26.3% of the variance when predicting microaggressions, suggests the need to identify additional independent variables. Potential variables include those assessing mental distress, whether depression, anxiety, or posttraumatic stress disorder, while others may arise from the latest literature.

- The new Experiences of Hate (EOH-12) tool had good internal consistency and should also be used in future research. Findings from this tool can be used to determine the level of exposure to experiences of hate (Cronbach’s Alpha .774), as well as the stressful or traumatic impact from hate (Cronbach’s Alpha .864). These two new scales represent an important way to investigate hate at a time of a rise in Anti-Asian hate during the COVID-19 pandemic, as well as increased hate and violence against Black and Latinx adults in the United States—as in the aftermath of the George Floyd verdict. The tools are appropriate for investigating: experiences of hate that may occur in-person or online; that occur personally to one’s self; that are witnessed happening to others that one may know or not know, as in those who may live in one’s neighborhood, or are part of one’s racial/ethnic community, or that one sees experiencing hate via a video.
• This study offered participants a chance to win 1 of 3 $100 Amazon gift cards, and the study prize made some people highly motivated to complete the survey multiple times to get the prize. For example, originally, a total of 654 records were collected; however, 147 out of 654 respondents were excluded due to duplicate responses (i.e., duplicate computer IP addresses—22.5%). It is recommended that any online survey research with a study prize or incentive check for duplicate computer IP addresses and remove invalid responses to improve the quality of the data.

• Due to the COVID-19 pandemic, with data collection occurring in the early part of 2021, there was a need to reduce the burden of time for the study participants. Therefore, this study included short versions of previously used tools, including the 5-item Personal Health Background (M-PHB-5), Single Item Rating of Risk of Providing Socially Desirable Responses (SIR-RPSDR-1), 1-item Rating the College Climate (RCC-1), 1-item Perceived Social Support Scale (PSSS-1), and the 4-item Perceived Stress Scale (PSS-4). The short tools that were used in this study should be adapted for use in future research with Black, Latinx, Asian, and other Indigenous and People of Color groups.

• As previously mentioned, this study included a single item to assess social desirability, i.e., the degree of risk that participants would provide a “socially desirable” response to items in the study. This tool, the Single Item Rating of Risk of Providing Socially Desirable Responses, is a relatively new tool that has now been used in multiple studies conducted by the Research Group on Disparities in Health. Thus, it is recommended that future studies also use this valuable short tool. In this manner, this short one-item tool can be used to replace the longer 13-item of Crowne and Marlowe (1960) long used in research to measure social desirability. The reduction in the burden of time has been
especially significant and important when conducting research during the COVID-19 pandemic.

- Furthermore, the present study showed that when comparing respondents who never attended HBCU/HSI, those who ever attended HBCU/HSI had significantly more experiences of microaggressions. This suggests how health educators and psychologists might collaborate in designing interventions for delivery at HBCUs/HSIs, in order to reach those college students who may have the greatest need for improving their coping with the experience of microaggressions.

- Finally, future research should replicate the study with a larger nationally representative sample of Blacks, Latinx, and Asian college students. This would permit exploration of differences in college students’ experiences by race/ethnicity.

**Limitations of the Study**

This study used a cross-sectional study design, which investigated the significant predictors of a high prevalence of experiences of microaggressions at one point in time. This method has a limitation in assessing the causation between the predictors and the outcome of interest. This study also used a convenience sampling method, which produces several limitations, such as sampling error or selection bias. Since this study used a convenience sample, and did not use random sampling, the sample in this study may not be representative of the general study population. Furthermore, this study recorded self-reported responses from the study participants. Thus, it may be possible that some of the study participants provided socially desirable responses, or the study may be subject to recall bias. Of note, the study did control for level of social desirability.
As a study conducted during the COVID-19 pandemic, the study limitations also include this being an online study, while necessitating access to a computer, tablet, or smartphone with an Internet connection. Most important was the need to reduce the burden of time by making the survey as short as possible (i.e., 10 to 15 minutes), given the pandemic. Yet, the stress of the pandemic may have negatively impacted study participation, and/or survey completion.

Lastly, the study provided participants a chance to win 1 of 3 $100 Amazon gift cards. Generating prizes may have motivated some people, who were interested in getting a gift card for completing the survey. Also, because some participants took the survey more than two times for increasing the chance of a prize, the study necessitated eliminating 22.5% data after detecting duplicate IP computer addresses.

**Conclusion**

The present study addressed the experience of hate, racism, discrimination and microaggressions on college campuses and within the context of the United States for Black, Latinx, and Asian students. The purpose of the present study was to identify the significant predictors of a high prevalence of experiences of microaggressions for Black, Latinx, and Asian students enrolled in college during the COVID-19 pandemic—whether at the undergraduate or graduate level.

The sample (N=341) was 40.6% female, 66.9 % U.S. born, 54.5% Black/Latinx and 45.5% Asian, with a mean age of 26.62 years (min=18, max=59, SD=6.752). Mean skin color was between medium to light and medium to dark (mean=4.48, min=1, max=7, SD=1.327). Mean household income was $50,000 to $59,999 (mean=5.54, min 2=$10,000 to $19,999, max 11=$800,000 or more, SD=2.091), mean education level was closest to 1st year in graduate school (mean=4.71, min=1 or Freshmen, max=11 or 7th year in graduate school or higher,
SD=2.354), and 52.2% of the participants have ever attended HBCU/HSI. The sample had a moderately high level of social desirability (mean=6.39, min=1, max=10, SD=1.818).

In addition, 73.3% of the participants reported online or hybrid learning, while 26.7% reported in person learning, and they reported their mean physical health status was closest to ‘good’ (mean=4.11, min=1, max=6, SD=1.098) and mean mental/emotional health status was also closest to ‘good’ (mean=3.80, min=1, max=6, SD=1.091). The participants’ mean BMI was 23.14 (min=7.86, max=58.99, SD=7.653) indicating normal or healthy weight.

For college climate, i.e., how well the university has supported, engaged, valued, fairly disciplined, affirmed, reflected empathy for, and served as a safe space for students from diverse cultural backgrounds, the participants responded that this was done to a moderately high extent (mean=6.49, min=0, max=10, SD=1.752).

For perceived social support, the sample reported an average of at least two people providing such social support in their lives, or moderated level of social support (mean category=3.21, min=1, max=5, SD=1.193). For the perceived stress level, the sample responded experiencing moderate stress in the past month, or ‘sometimes’ felt they were perceiving stress in their lives (mean=1.99, min=0.5, max=3.75, SD=0.557). The Perceived Stress Scale (PSS-4) showed a low internal constancy (Cronbach’s Alpha of 0.509).

The sample’s mean experiences of microaggression was closest to “more than once” (mean=1.82, min=0, max=4, SD=0.913). When the categories for “more than once, a few times, and many times” were combined, about half the participants reported that they experienced microaggressions among all 6 items producing a good internal consistency (Cronbach’s alpha = 0.847).
For racism and oppression, the participants reported a moderate to high level of ability for perceiving racism and oppression (mean=3.67, min=2.5, max=5, SD=0.739), displaying a good internal consistency (Cronbach’s Alpha of 0.874). Moreover, the participants’ mean stage of change for coping and responding to racism and oppression was closest to the action stage (mean=4.29, SD=1.159, min=1 or precontemplation stage, max=5, maintenance stage).

The mean experience of hate was closest to experiencing hate twice, since the beginning of the COVID 19 pandemic (mean=2.34, min=0, max=5, SD=1.032) producing good internal consistency (Cronbach’s Alpha of .774). When the responses for twice, a few times, many times, and a great number of times were combined, more than half the participants reported that they experienced hate incidents from all 6 items. Further, the mean impact of hate was closest to a moderate impact (mean=3.02, min=0, max=5, SD=1.142), which showed good internal consistency (Cronbach’s Alpha of .864). Similarly, when the responses for moderate impact, high impact and very high impact were combined, more than half the participants reported that they had a moderate, high or very high impact from all 6 items.

Independent t-tests showed that U.S. born respondents (mean=1.91, SD=.843) experienced significantly more microaggressions than non-U.S. born (mean=1.62, SD=1.016; t=-2.595, df=190.5, p=0.01), and those who ever attended an HBCU/HSI (mean=1.97, SD=0.705) compared to those who never attended HBCU/HSI (mean=1.65, SD=1.073) experienced significantly more microaggressions (t=-3.247, df=275.8, p=0.001).

Pearson correlations showed significant correlations between higher level of experiencing microaggressions and lower rating of college climate (r=-.185, p=.001), higher stage of change for coping and responding to racism and oppression (r=.182, p=.001), higher or more frequent
experiences of hate (r=.397, p=.000), and higher stressful and traumatic impact of hate (r=.325, p=.000).

The results of the backwards stepwise regression analysis showed that ever attending an HBCU/HSI (b=.447, SE=.109, p = .000), more experiences of hate (b=.360, SE=.059, p=.000), and more stressful and traumatic impact from hate (b=.131, SE=.052, p=.013) were the significant predictors for a high prevalence of experiences of microaggressions. The final regression model explained 26.3% of the variance; thus, additional independent variables should be included for future research studies.

The last item of the Ratings of Experiences of Microaggressions scale (REM-6) included Pierce et al. (1977)’s concept of microaggressions, and for this item, the highest percentages reported the experience of microaggressions as occurring ‘many times’ compared to the other 5 items. This emphasizes that future studies on experiences of microaggressions should convey the original work of Pierce et al. (1977) by including this item in a survey.

Further, the new tools of the Experiences of Hate (EOH-12) scale captured not only the personal experiences of hate among Black, Latinx, and Asian college students but also their vicarious experiences of hate; thus, EOH-12 is expected to contribute to the research of hate both during the COVID-19 pandemic era as well as post-pandemic.

The times call for attention to the experiences of Black, Latinx, and Asian college and university students, given the rise in hate and microaggressions during this era. Hence, research of this study’s kind is of great import and must continue.
REFERENCES


APPENDICES
Appendix A:

Letter of IRB Approval

Teachers College IRB

Exempt Study Approval

To: Hyorim Lee
From: Kailee Kodama Muscente
Subject: IRB Approval: 21-247 Protocol
Date: 03/26/2021

Thank you for submitting your study entitled, “Black, Latinx, and Asian college students’ experiences of hate, microaggressions, stress, perceived racism and oppression, and coping strategies: Identifying predictors of a high prevalence of microaggressions;” the IRB has determined that your study is Exempt from committee review (Category 2) on 03/26/2021.

Due to COVID-19 quarantine, all in-person study activities with human subjects are suspended. Following guidance from New York State and Teachers College, the Institutional Review Board will announce when in-person research can resume and what steps to take at that time.

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 21-247. 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.

Best wishes,

Kailee Kodama Muscente
Research Compliance Coordinator
Appendix B:

The Study Email

For General Students:

WE ARE INVITING BLACK, LATINX, ASIAN, INDIGENOUS & PEOPLE OF COLOR COLLEGE STUDENTS (Undergraduate or Graduate) TO TAKE A 10-15 MINUTE SURVEY ON WHETHER YOU EXPERIENCED HATE IN THE PAST YEAR—OR ANY RACISM, DISCRIMINATION, MICROAGGRESSIONS FOR A 1 IN 250 CHANCE TO WIN 1 OF 3 $100 AMAZON GIFT CARDS

IRB Protocol Number 21-247

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 year 2020 and COVID-19 pandemic included an increased focus on violent police attacks against Black and Latinx adults, as well as on violent hate attacks against Asians. This study invites Black, Latinx and Asian undergraduate and graduate college students in the United States who are age 18 and above to answer questions about any experiences of hate, discrimination, racism, microaggressions, and violence in the past year. We are seeking to understand factors related to having a greater number of experiences of microaggressions. We also invite anyone who identifies as Indigenous or as a Person of Color to also share their experiences.

- 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 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 out the message, below:

Black, Latinx, Asian & Minority U.S. undergraduate or graduate college students click link https://tinyurl.com/I-EXPERIENCED-HATE to take 10-15 MINUTE SURVEY on experiences
of hate, stress, racism, microaggressions & violence for a chance to win 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:

HYORIM LEE, MPH, MA, Doctoral Candidate, Department of Health and Behavior Studies, Teachers College, Columbia University, Box 114, 525 W. 120th Street, New York, NY 10027; hl3168@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

For Asian Students:

WE ARE INVITING ASIAN STUDENTS, UNDERGRADUATE & GRADUATE COLLEGE STUDENTS, TO TAKE A 10-15 MINUTE SURVEY ON EXPERIENCES OF HATE (against you, your family, or members of your community) IN THE PAST YEAR—OR ANY RACISM, DISCRIMINATION, OR MICROAGGRESSIONS.

*****BLACK, LATINX, INDIGENOUS & PEOPLE OF COLOR COLLEGE STUDENTS ARE ALSO INVITED*****

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

IRB Protocol Number 21-247

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 year 2020 and COVID-19 pandemic included an increased focus on violent police attacks against Black and Latinx adults, as well as on violent hate attacks against Asians. This study invites Black, Latinx and Asian undergraduate and graduate college students in the United States who are age 18 and above to answer questions about any experiences of hate, discrimination, racism, microaggressions, and violence in the past year. We are seeking to understand factors related to having a greater number of experiences of microaggressions. We also invite anyone who identifies as Indigenous or as a Person of Color to also share their experiences.

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• 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 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 out the message, below:

ASIAN undergraduate or graduate college students click link https://tinyurl.com/I-EXPERIENCED-HATE to take 10-15 MINUTE SURVEY on experiences of HATE (against you or your community), stress, racism, microaggressions & violence for a chance to win 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:

HYORIM LEE, MPH, MA, Doctoral Candidate, Department of Health and Behavior Studies, Teachers College, Columbia University, Box 114, 525 W. 120th Street, New York, NY 10027; hl3168@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

For General Students:

Black, Latinx, Asian & Minority U.S. undergraduate or graduate college students click link https://tinyurl.com/I-EXPERIENCED-HATE to take 10-15 MINUTE SURVEY on experiences of hate, stress, racism, microaggressions & violence for a chance to win 1 of 3 $100 Amazon gift cards.

For Asian Students:

ASIAN undergraduate or graduate college students click link https://tinyurl.com/I-EXPERIENCED-HATE to take 10-15 MINUTE SURVEY on experiences of HATE (against you or your community), stress, racism, microaggressions & violence for a chance to win 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 21-247

Protocol Title:
Black, Latinx, and Asian college students’ experiences of hate, microaggressions, stress, perceived racism and oppression, and coping strategies: Identifying predictors of a high prevalence of microaggressions

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INTRODUCTION You are invited to participate in this research study called the “Black, Latinx, and Asian college students’ experiences of hate, microaggressions, stress, perceived racism and oppression, and coping strategies: Identifying predictors of a high prevalence of microaggressions.” You may qualify to take part in this research study if you: 1) self-identify as Black, Latinx, Asian, Indigenous, or a Person of Color; 2) are at least age 18 or older; and, 3) are an undergraduate or graduate student in the United States. 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 whether or not undergraduate and graduate students in the United States have had any experiences of hate, microaggressions, discrimination, racism, oppression and stress in the past year. We also seek to learn about the factors related to having more experiences of microaggressions—and, also about the most effective coping strategies. What we learn through this study will be used to educate others and develop interventions to reduce the risk of members of diverse racial and ethnic groups having such experiences in the United States.

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. This will take about 10-15 minutes of your time. The questions will cover the following: your personal background; ratings of your health status; ratings of your college climate; ratings of your experiences of any social support, stress, racism and oppression, and microaggressions; about your coping with racism and oppression; and, your personal experiences of any hate—as well as for your friends, family and community members. Finally, you are asked to freely share your story of any experience of hate and the impact on you, including whether the experience changed you in any way—and, how you coped, recovered from, or healed from the experience of hate (if you have done so).

**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 $100 bar coded Amazon gift certificates. 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, Hyorim Lee, at 551-226-1422 or at hl3168@tc.columbia.edu. You can also contact the sponsor/supervisor of this 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 his or her 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 checking the “I agree” box, you agree to participate in the study. You also confirm you self-identify as Black, Latinx, Asian, Indigenous (American Indian, Native American), or a Person of Color, are at least age 18 or older, and are an undergraduate or graduate student in the United States.

Provide your response here: □ _I agree. □ _I do not agree. Date_____
Appendix E:

Screening Survey

Teachers College, Columbia University

525 West 120th Street
New York NY 10027
212 678 3000

Screening Tool for the I EXPERIENCED HATE Survey

IRB Protocol Number 21-247

The year 2020 and COVID-19 pandemic included an increased focus on violent police attacks against Black and Latinx adults, as well as on violent hate attacks against Asians. This study invites Black, Latinx and Asian undergraduate and graduate college students in the United States who are age 18 and above to answer questions about experiences of HATE, stress, racism, microaggressions, and violence.

See if you qualify by answering the questions, below:

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

2- Are you a college student in the United States—whether a freshman, sophomore, junior, senior or graduate student?
   Yes___    No____

3- Do you self-identify as a Black, Latinx, Asian or other person of color? Do you fall within the group of Black, Indigenous or People of Color?
   Yes___    No____

4- Are you able to devote 10-15 minutes to this study at this time—for a chance to win one of three $100 Amazon gift cards?
   Yes___    No____

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.
Appendix F:

The Study Survey

Teachers College, Columbia University

525 West 120th Street
New York NY 10027
212 678 3000

IRB Protocol Number 21-247

Study Survey for the I EXPERIENCED HATE

INSTRUCTIONS: Please answer the following questions in this survey.

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Part I: Basic Demographics (BD-8)

[This survey part follows a common tool used by the Research Group on Disparities in Health (RGDH). Questions are tailored for the study population. Some of the ending college-related questions were taken from Ingram (2017). See 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.]

1-I am: ___Female  ___Male  ___Other (meaning___________________)

2-My age is: _______ [DROP DOWN MENU 18 – 80]

3-My race/ethnicity is as follows: (Please mark all that apply)
   ___White / Caucasian / European American
   ___Black/African American
   ___Hispanic / Latino (including Puerto Rican, Mexican, Mexican American, Chicano, Cuban, other Spanish)
   ___Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian)
   ___American Indian / Alaska Native
   ___Native Hawaiian / Pacific Islander
   ___Arab American / Middle Eastern
   ___Other group(s) (Please specify______________________________________)

4-My skin color is
   a. ___Very Dark  b. ___Dark  c. ___Medium to Dark
   d. ___Medium to Light  e. ___Light  f. ___Very Light  g. ___White
5-Were you born in the United States?   ___Yes   ___No
   If answered “No, “Where was you place of birth or your country of origin?
   Country of origin? ________________________

6-My yearly household income is:
   $10,000 to $19,000
   $20,000 to $39,000
   $40,000 to $49,000
   $50,000 to $99,999
   $100,000 to $199,999
   $200,000 to $299,000
   $300,000 to $399,000
   $400,000 to $499,000
   $500,000 to $799,000
   $800,000 or More

7- My year in college or graduate school is
   ___Freshman
   ___Sophomore
   ___Junior
   ___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

8-Indicate all that apply to you
   - I currently attend a college or university that is within the category of Historically Black Colleges and Universities (HBCU)   ____YES   ____NO
   - I previously attended a college or university that is within the category of Historically Black Colleges and Universities (HBCU)   ____YES   ____NO
   - I currently attend a college or university that is within the category of Hispanic Serving Institutions (HSI)   ____YES   ____NO
   - I previously attended a college or university that is within the category of Hispanic Serving Institutions (HSI)   ____YES   ____NO

Part II: Personal Health Background (M-PHB-5)
   [This is a tool created for use by the Research Group on Disparities in Health that is commonly used. It is shortened here, given pandemic stress.]

1-I rate my overall physical health status as

<table>
<thead>
<tr>
<th>1-Very Poor</th>
<th>2-Poor</th>
<th>3-Fair</th>
<th>4-Good</th>
<th>5-Very Good</th>
<th>6-Excellent</th>
</tr>
</thead>
</table>

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2-I rate my overall mental/emotional health status as

<table>
<thead>
<tr>
<th>1-Very Poor</th>
<th>2-Poor</th>
<th>3-Fair</th>
<th>4-Good</th>
<th>5-Very Good</th>
<th>6-Excellent</th>
</tr>
</thead>
</table>

3- My height (feet) [DROP DOWN BOX, 4-9]
4- My height (inches) [DROP DOWN BOX, 0-11]
5- My weight (in pounds) [DROP DOWN BOX, 70-400]
[3, 4, 5 – for calculation of BMI]

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

This is a relatively new single item scale created for first-time use by Dr. Barbara Wallace in studies in 2018 conducted by the Research Group on Disparities in Health [RGDH], and for ongoing use by the RGDH. For example, this tool was used by Torez (2019) and Laryea (2019). See: Torez, M. (2019). An online investigation into Internet Gaming Disorder (IGD), comorbidity, and psychosocial issues: A comparison of American and Chinese gamers—and predictors of meeting criteria for a formal diagnosis of IGD. Doctoral dissertation. Teachers College, Columbia University. See: Laryea, E. (2019). An online mixed-methods study assessing nurses’ attitudes, knowledge, skill/ability, and perceived barriers with regard to adherence to the national pressure ulcer advisory panel’s clinical practice guidelines. Doctoral dissertation. Teachers College, Columbia University. Note: Laryea (2019) found that the new one-item measure of social desirability was one of two significant predictors of nurses’ higher personal skill/ability rating for managing patients’ pressure ulcers. This was noteworthy, as the well-known 13-item measure of social desirability (i.e., Crowne, D., & Marlowe, D. (1960) A new scale of social desirability independent of psychopathology. Journal of Consulting Psychology, 24(4), 349-354.) similarly was found to be the sole significant predictor of nurses’ ratings for a higher personal skill/ability for managing patients’ pressure ulcers. Hence, there is value in reducing the burden of time on study participants and using in this study the new one item measure of social desirability, especially, given the stress of the pandemic.

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

Part IV: In-Person, Online, or Hybrid Learning (IOHL-1)

This is a new short one-item tool created by the Principal Investigator, Hyorim Lee, for first-time use in this study, and for use by the Research Group on Disparities in Health. It is ideal for pandemic era research, reducing response burden.

1-During the COVID-19 pandemic, or in the past year, I have participated in my college or university in the following ways:

__in-person on campus learning or living
__online learning
__hybrid model: combination of in-person on campus learning or living, AND online learning__
Part V: Rating the College Climate (RCC-1)

[This scale has roots in the work of Aiyedun (2019), while being modified and reduced to one item for purposes of this study, and given pandemic era stress. See Aiyedun, F. (2019). A case study of a charter school seeking to transform toward greater cultural competence for working with diverse students: Using Christopher Emdin’s Reality Pedagogy approach as stimulus and guide. Doctoral Dissertation, Teachers College, Columbia University]

Please think about your college’s or university’s CLIMATE, or the way the overall environment or institutional culture feels to YOU. The CLIMATE may be perceived and felt whether you are a student in-person, on campus, or online—including via the emails sent out by institutional representatives or postings on the website.

Now, think about how well your college or university has supported, engaged, valued, fairly disciplined, affirmed, reflected empathy for, and served as a safe space for students from diverse cultural backgrounds—such as YOU.

1-With these thoughts in mind, please rate that CLIMATE:

I rate the CLIMATE:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = Lowest level</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10=Highest level</td>
</tr>
</tbody>
</table>

Part VI: 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). See: Lian, Z. (2017). Predictors of depression/anxiety, mental health service utilization, and help-seeking for Chinese international students: Role of acculturation, microaggressions, social support, coping self-efficacy, stigma, and college staff’s cultural competence and cultural humility. Doctoral Dissertation, Teachers College, Columbia University. Note: 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.]

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

Part VII: Perceived Stress Scale (PSS-4)


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in a study with pregnant women, while examining stress, depression, and quality of life, they found acceptable internal consistency (Cronbach's alpha coefficient = .79), alternate forms stability reliability with the 10-item PSS (Pearson correlation coefficient r = .63; p < .001), concluding it was a valid and useful tool.

**Perceived Stress Scale Scoring:** 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.

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

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**Part VIII: 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. See: Lian, Z. (2017). Predictors of depression/anxiety, mental health service utilization, and help-seeking for Chinese international students: Role of acculturation, microaggressions, social support, coping self-efficacy, stigma, and college staff’s cultural competence and cultural humility. Doctoral Dissertation, Teachers College, Columbia University. 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. See Pierce et al., (1977). An experiment in racism: TV commercials, *Education and Urban Society*, Vol 10, No 1, pp. 61-87.

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 **Black, or Latinx, or Asian, or an Indigenous, or Person of Color**:

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:
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:

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

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:

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?

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

[This is a scale previously used in many studies, as it was created for use by the Research Group on Disparities in Health. See Ingram (2017), for example.]

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 (Asian, Black, Latinx, etc.). For oppression, injury is suffered due to one’s characteristics (female, poor, gay/lesbian/transgender, illegal immigrant, immigrant status, race, religion, ethnicity, etc…). Racism/oppression may include: prejudice, discrimination, harassment, violence, exclusion, disadvantage, or lack of access to opportunity—whether while driving, eating out, walking around, shopping, voting, hailing down a taxi, interacting with police, searching for employment, seeking health care, applying for a bank loan/mortgage, searching for housing, negotiating the criminal justice system, working, traveling, vacationing, or seeking out literally any opportunity, etc.

Please answer the following questions.

In terms of experiences of RACISM AND OPPRESSION….

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

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

3-I think it never happens to me.

4-There are times when I “don’t get it,” or I can’t really tell when it is happening to me.

5-I think it never happens to others.

6-There are times when I “don’t get it,” or I can’t really tell when it is happening to others.
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

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

This is a scale previously used in many studies, as it was created for use by the Research Group on Disparities in Health. See Ingram (2017), for example.

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]

Part XI: Experiences of Hate (EOH-12)

This is a new scale created by the Principal Investigator, Hyorim Lee, and her dissertation sponsor, Dr. Barbara Wallace, for first-time use in this study, and for use by the Research Group on Disparities in Health (RGDH). It is based on a review of the 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. This study will determine the internal consistency of the new tool, using Cronbach’s Alpha.

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, police killings of Black and Latinx people can be thought of as involving police feeling and acting on their feelings of HATE. 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 year. 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-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-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 Time
   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

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Part. XII: Open Self-Expression About a HATE Experience (OSE-HE-3)
[This is a new open-ended question scale created for first-time use in this study by the Principal Investigator, Hyorim Lee, and her dissertation sponsor, Dr. Barbara Wallace—for use by the Research Group on Disparities in Health.]
Please freely share and tell your story, below, in the three 500-word text boxes. Please know that very brief and one-word answers are also acceptable.

1-Please share your story of **any experience 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—including experiences in-person, or online, or on television, or social media, etc..

[500 WORD TEXT BOX]

2-Did the experience of that **HATE change you** in any way? If so, please explain.

[500 WORD TEXT BOX]

3-How did you **cope with that experience of HATE, or recover**, or try to heal from it?

[500 WORD TEXT BOX]

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

**THANK YOU**

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

------------------------END OF SURVEY------------------------

THANK YOU!

SHARE WITH OTHERS THE LINK THAT LED YOU TO THIS STUDY!

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 each)

1-For Free Texting Crisis Help: [https://www.crisistextline.org/](https://www.crisistextline.org/)

- **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
- National Suicide Hotline: 800-SUICIDE (800-784-2433)
- National Suicide Prevention Lifeline: 800-273-TALK (800-273-8255)
- 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
- Please see a list of the top rated online counseling services—with the average weekly cost as low as $60.

4-Seek Out Affordable Online Counseling:
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 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.

Please click here to have a 3 in 200 chance of winning 1 of 3 $100 gift certificates for use on Amazon.com.