CALIFORNIA BAPTIST UNIVERSITY

THE RELATIONSHIP BETWEEN MICROAGGRESSIONS, RACE-BASED TRAUMATIC STRESS, AND POSTTRAUMATIC GROWTH: ASSESSING THE MODERATING ROLE OF CHRISTIAN GRATITUDE FOR AFRICAN AMERICAN CHRISTIANS

by

Stephanie Gregorius Zivanovic

A dissertation submitted to the
College of Behavioral and Social Sciences
in partial fulfillment of the requirements
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DEDICATION

My dissertation is dedicated to Dr. Taylor, as well as my other friends and family, who have inspired, supported, and advised me during this journey. Your continued presence in my life is something that I genuinely cherish and appreciate.

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ABSTRACT

In the current study, the author sought to understand the relationships between Christian gratitude (CG) and posttraumatic growth (PTG) following racial and ethnic microaggressions (REM) and race-based traumatic stress (RBTS) in a sample of self-identified Black American Christians living in the United States ($N = 157$). More specifically, using a moderated mediation analysis, the researcher explored the mediating role of RBTS in explaining the link between REM and PTG, using CG as a moderator between RBTS and PTG. The findings showed a positive association between REM and PTG (a medium effect). Further, a positive association appeared between REM and RBTS and RBTS and PTG (both medium effects). Finally, inconsistent with the proposed hypothesis, the index of moderated mediation was not significant. In other words, CG did not moderate the relationship between RBTS and PTG. Post-hoc mediation-only analysis revealed that RBTS was a significant mediator of the association between REM and PTG. The author examines the therapeutic implications of the findings as well as potential directions for future research.

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CHAPTER 1

INTRODUCTION

Problem Background

According to the 2021 United States census, self-identified African Americans or Blacks comprise 13.6 percent of U.S. inhabitants (U.S. Census Bureau, 2021). Unfortunately, they are among those across the globe impacted by ongoing mental health inequities (Berger & Sarnyai, 2015). Research has shown that they have higher rates of psychological distress than Whites (Williams, 2018). Also, they, like members of other ethnic and racial groups, are underrepresented in traditional counseling settings and face inequities in both access to care and the quality of treatment received (Avent Harris et al., 2021; Sue et al., 2009). For reasons such as expense, stigma, historical distrust, and low levels of clinical cultural competence, both adequate mental health support and culturally competent interventions are often unavailable to African Americans (Novacek et al., 2020). Likewise, Forrest-Bank and Jensen (2015) shared that African Americans experience more racism than other racial/ethnic groups. In fact, Lee et al. (2019) found that 69% of African Americans reported higher rates of racism than those of any other group.

Racism's far-reaching effects on the African American community's psychological well-being and coping are deeply woven into the fabric of North American history and society (Smith et al., 2008). According to Carter (2007), racism negatively impacts the health status of African Americans at every developmental stage. Further, it can impact familial bonds and compromise the wellness of African American families (Trent et al., 2019; Washington et al., 2017). Evidence shows African Americans

experience greater amounts of distress from historical, institutional, sociocultural, and individual racism in comparison with other racial groups (Carter et al., 2020a; Torres-Harding & Turner, 2015; Williams, 2020a). African Americans often experience microaggressions which include subtle, negative race-based interactions or statements that reflect aggressive, insulting, or mocking attitudes against them (Sue et al., 2007). Furthermore, racial discrimination toward a member of a racial in-group witnessed by another member of the same group may cause a negative stress response known as vicarious race-based trauma (Shell et al., 2021). In fact, subjection to racial microaggressions, historical racial injustices, and ongoing vicarious trauma can cause African Americans to experience significant distress (Carter, 2007a). Those who endure distress from racism may retain cumulative racial trauma, also known as race-based-traumatic stress (RBTS; Comas-Díaz et al., 2019).

Carter (2007) defined RBTS as the phenomenon in which individuals of color who have been subjected to racial discrimination respond to racism in a traumatic way that profoundly and negatively affects their psychological and physiological well-being. These traumatic responses to negative racial encounters are similar to the symptoms of posttraumatic stress disorder (PTSD) but also have unique expressions. Symptoms of RBTS may include changes in alertness and reactivity, as well as cognitive and emotional changes but may manifest not only in avoidance but also in poor self-esteem (Polanco-Roman et al., 2016). The differences between PTSD and RBTS are further outlined by Carter (2007) and others (Bryant-Davis et al., 2017; Bryant-Davis & Ocampo, 2006; Carter et al., 2020a; Comas-Díaz et al., 2019), and these authors make a case that RBTS does not fit the diagnostic criteria for PTSD. More specifically, the PTSD criteria limit

the inclusion of RBTS by describing trauma as related to life-threatening experiences, not the cumulative day-to-day stress of racism that results in potentially life-threatening distress.

As described earlier, African Americans experience racism in multiple ways; one form is through exposure to microaggressions. Sue et al. (2007) detailed microaggressions as everyday, repetitive, and persistent interactions in which dominant people communicate discreetly demeaning cues to marginalized others. According to Sue et al. (2019), microaggressions accumulate and are associated with lifelong enduring stress. Traumatic reactions to these stressful race-based events, RBTS, often negatively affect the mental health and functional capacity of African American individuals (Carter et al., 2020a).

For this reason, understanding RBTS in the context of racial microaggressions is essential to addressing the clinical needs of African American individuals seeking mental health treatment (Sue et al., 2007). Furthermore, psychologists are not immune to the system of racism and sometimes engage in racial microaggressions, unaware of the impact on already traumatized patients (Taylor & Kuo, 2019; Yeo & Torres-Harding, 2021). Yet, there is no diagnostic category for RBTS, and clinicians may not recognize the problem or may misdiagnose a patient (Carter, 2007b). Either way, they may be unable to ethically or appropriately deliver relevant therapeutic interventions if a greater understanding of microaggressions and their connection with RBTS is not developed.

Furthermore, a review of the literature shows a lack of resources focused on approaches to posttraumatic healing for religious African Americans, specifically African American Christians, who experience RBTS in the context of microaggressions (Avent

Harris et al., 2021; Carter et al., 2017; Carter & Muchow, 2017a). According to Pew Research Center (2014), 79% of Black Americans self-identify as Christian. Therefore, mental health professionals and academics need to address the difficulties faced by African American communities disproportionately impacted by racism. Religious coping strategies, racial awareness, and cultural humility can be paramount to effective psychotherapy and may help diminish the mental health gap.

Problem Statement

Culturally sensitive and patient-centered mental health interventions are necessary within the field of psychology for vulnerable populations who endure racial trauma (Avent Harris et al., 2021; Sue et al., 2009). Moreover, African American Christians comprise a unique cultural group and share some unique problems in coping with racial trauma (Carter et al., 2017). Specifically, Christianity has a distinct connection with RBTS (Avent Harris et al., 2021).

Mosley et al. (2021) addressed the avoidance of Christianity by some African Americans, indicating that African Americans may identify as spiritual as opposed to being Christian. The authors speculated that this may be related to violence against African American Christians throughout history and the tendency for Christians to persuade African Americans to remain passive in the face of their oppression as a Christian virtue rather than taking action against it (Mosley et al., 2021). Further, religious coping may play a role in the experience of African Americans as they respond to discrimination, as one study showed that negative religious coping following adverse racial encounters may heighten the frequency of a target's negative emotion, which can lead to psychological distress (McCleary-Gaddy & Miller, 2019).

Overall, evidence supports the benefits of religion and religious coping for African American Christians (Avent Harris et al., 2021; Lehmann & Steele, 2020). Studies focused on trauma, in general, show that positive and negative religious coping may have a strong positive relationship with posttraumatic growth (Mesidor & Sly, 2019). Furthermore, the literature shows that African Americans use a number of other coping strategies to respond to racism and microaggressions (Holder et al., 2015). For example, general gratitude as a coping mechanism is a protective factor against risky behaviors in African American youth who experience RBTS (Ma et al., 2013). Although general gratitude demonstrates empirical support as a potential coping response, it is unknown if exercising a Christian-specific form of gratitude, Christian gratitude in the context of RBTS may be related to posttraumatic growth (Ellison et al., 2008; Rosmarin et al., 2011). As a supported principle in the literature, traumatic stress may foster and sustain PTG (Dekel et al., 2012) and this may include racial trauma for some African American individuals (Manove et al., 2019; Mesidor & Sly, 2019; Mosley et al., 2021).

Study Purpose

African American Christians in the U.S. have survived racial trauma throughout the centuries (Lee et al., 2020). Those who are religious, for example, may find resilience through spiritual influences that may contribute to PTG (Lee et al., 2020). Some evidence exists demonstrating relationships between religious coping, RBTS, and PTG (Alsubaie et al., 2021; RBS). However, understanding these relationships and the interventions helpful for African American Christian experiencing RBTS are scarce in the literature. African Americans have a substantial history of finding means of coping with racism (Drolet & Lucas, 2020). The current study highlights constructs derived from what is

already known about African Americans' use of religious problem solving and coping (Lewis-Coles & Constantine, 2006). Specifically, the current study explores relationships between PTG, RBTS, and Christian gratitude as a religious coping strategy when microaggressions are experienced. It is possible that spiritual practices and coping strategies, such as Christian gratitude, may help explain the relationship between RBTS and PTG in the context of microaggressions. Factors associated with African American Christian culture and spirituality may help to explain their resilience, human development, and healing from RBTS (Al'Uqdah & Adomako, 2018; Avent Harris et al., 2021; Barber, 2021; Drolet & Lucas, 2020; Henderson et al., 2021)

Research Questions

Some models that address trauma not specific to race-related stress focus on understanding the mechanisms of religious coping and psychospiritual flexibility in response to trauma (Lehmann & Steele, 2020; Lewis-Coles & Constantine, 2006; McCleary-Gaddy & Miller, 2019; Schultz et al., 2010). In the aftermath of a traumatic event, religion and spirituality may provide coping mechanisms that are linked to posttraumatic stress and posttraumatic growth outcomes (Lehmann & Steele, 2020). With this in mind, the current study seeks to explore the potential links between microaggressions, RBTS, and PTG, assessing the moderating role of Christian gratitude in these relationships.

Study Hypotheses

According to Splevins et al. (2010), PTG involves processing trauma to decrease traumatic stress symptoms and overall distress. In this study, the research will examine microaggressions conceptualized as a source of racial trauma. In the relationship between

microaggressions and posttraumatic growth, the study will assess the mediating role of RBTS and the moderating role of Christian gratitude for African American Christians, given that general gratitude appears to be related to posttraumatic growth after trauma in a general population (Rosmarin et al., 2011). Still, little is known about the relationships between Christian gratitude, RBTS, and PTG for Christians who experience microaggressions. The study hypotheses for a community sample of self-identified African American Christians are as follows:

1. Microaggressions will be positively associated with PTG.
2. Microaggressions will be positively associated with RBTS.
3. RBTS will be positively associated with PTG.
4. The association between microaggressions and PTG will be mediated by RBTS, and this association will be moderated by Christian gratitude in that African American Christians with higher Christian gratitude will report more PTG (see Figure 1 for the hypothesized moderated mediation model).

Theoretical Framework

The framework for the current study hypotheses is drawn from the literature on RBTS, microaggressions, PTG, and religious coping.

Microaggressions and Race-Based Traumatic Stress

As previously described, racism is expressed in many ways, but one type of racism that is often underestimated as to its lasting negative impact is the manifestation of microaggressions (Sue et al., 2007). According to Williams (2020), they are "deniable acts of racism that reinforce pathological stereotypes and inequitable social norms" (p. 4). Research suggests that the accumulation of day-to-day microaggressions can cause

symptoms that, in some ways, mimic PTSD and can continue to aggravate negative stress symptoms (Abdullah et al., 2021). Some symptoms include hypervigilance, low self-esteem, intrusive memories, nightmares, experiential avoidance, irritability, and somatic complaints such as headaches, rapid heart rate, and nausea (Carter et al., 2020a; Lau et al., 2015). Individual racism causes significant stress from cumulative day-to-day racial encounters, which manifests as anxiety-based symptoms known as RBTS (Carter, 2007a; Carter et al., 2017; Williams et al., 2018). RBTS' distinctiveness warrants an exploration of how to support recovery from this sort of trauma.

Posttraumatic Growth

One way of understanding trauma resiliency is by looking at how a person may undergo positive change such as PTG (Lotfi-Kashani et al., 2014). Dekel et al. (2012) found in their longitudinal study that the presence of PTSD promotes and sustains PTG rather than hinders it. Rather than growth based on a traumatic event, PTG views trauma as a circumstance that may trigger transformative outcomes by challenging underlying beliefs, which may lead to a deeper sense of connection with people, a sense of self-confidence, fresh perspectives, a greater appreciation for the beauty of life, and even a shift in one's spiritual and existential views (Tedeschi & Moore, 2021). Despite the fact that the frequency with which individuals experience PTG is unknown, these cognitive processes seem to be an important part of recovery from trauma (Zoellner & Maercker, 2006). There are several ways in which PTG is beneficial, including a refreshed sense of understanding, fortitude, and a stronger appreciation for personal relationships (Tedeschi & Moore, 2021; Wu et al., 2015).

Religious Coping and Christian Gratitude

PTG in the context of RBTS may be facilitated in different ways. One theory is that various coping strategies, which may encompass religious coping (RC), may facilitate PTG. According to Beutler and Moos (2003), coping is a quality in which cognitive and behavioral capacities are activated when environmental circumstances change in some manner. Coping strategies are used in order to manage and reduce unpleasant feelings and conflict (Beutler & Moos, 2003). There are two major categories of RC, including positive and negative coping mechanisms (Pargament et al., 2011).

Positive religious coping techniques may include praying, meditating, and expressing gratitude to God (Pargament, 2007). Worry, uncertainty, guilt, and feelings of disillusionment with an all-powerful God are a few ways negative religious coping manifests (Pargament, 2007). To manage negative emotions, those who use negative religious coping mechanisms may use the following methods: internal coping (e.g., negative presumptuous religious cognitions), interpersonal coping (e.g., fellowship avoidance), inter-theological coping (e.g., negative religious reappraisals that conflict with scripture), or inter-spiritual coping (e.g., spiritual dysphoria) (Bjorck & Thurman, 2007; Hebert et al., 2009).

The ability of African Americans to cope with RBTS may depend on the type of race-related coping strategies they use (Lewis-Coles & Constantine (2006a). Viewing microaggressions through the lens of racial trauma and PTG allows for further study of the potential religious factors that may moderate this relationship. Christian gratitude is a type of religious coping, and "cultivating resilience and enhancing gratitude" are factors that relate to PTG (Subandi et al., 2014; Vieselmeyer et al., 2017, p. 62).

Study Significance

RBTS from the accumulation of microaggressions may be underestimated. The specific clinical needs of African Americans may be better addressed if RBTS is understood in the context of racial microaggressions. Many models address traumas unrelated to race, and some of these models indicate that individuals attempt to resolve stress through religious coping mechanisms (Alsubaie et al., 2021; Avent Harris et al., 2021; Kim et al., 2015). Exploring the relationship between these differing constructs with this particular population may help establish the groundwork for new intervention strategies and approaches to psychotherapeutic care for this population.

Furthermore, there is very little data on the relationship between African American Christian gratitude, RBTS, and PTG. The current study will help give a better understanding of how African American Christians use Christian gratitude for coping. It may clarify if this coping activity in the context of RBTS is associated with higher PTG. Closer investigation of this population may help clinical psychologists find new culturally competent intervention strategies and contribute to the conversation on healing RBTS.

Research Design

For the purpose of this study, 157 African American Christians were recruited to participate in the survey. Four scales were used to measure the study variables. Microaggressions, the independent variable, was measured using the Racial and Ethnic Microaggression Scale (Nadal, 2011). PTG, the dependent variable, was measured using the Posttraumatic Growth Inventory (Ramos et al., 2018). Christian gratitude was measured using the Christian Gratitude Scale (Knabb et al., 2021). RBTS was measured using the Race-Based Traumatic Stress Symptoms Scale (Carter et al., 2013).

Associations between all variables were analyzed. The primary focus was a moderated mediation analysis to assess whether Christian gratitude moderates the mediating role of RBTS in the association between microaggressions and PTG.

Definitions

For the current study, the following definitions of terms will be used. Uncommon terms are further elaborated on throughout this document.

African American and Black

For the purpose of this study, the terms African American and Black will be used for people who identify as "Black." According to the American Psychological Association, several considerations guide the use of words while writing about persons who identify as descent of the African diaspora (American Psychological Association, 2019). A person's cultural background, genetics, and personal preference or exposure might vary greatly among people of African origin. Although "African American" is the preferred word for certain persons of African heritage in the United States, "Black" is also often used. These terms are used interchangeably throughout this document.

Afro-centric Worldview

According to Williams et al. (2012), the Afro-centric worldview is flexible and present-oriented. The worldview of people of African ancestry is further defined by Neblett et al. (2010) as the principles, perceptions, and practices of persons who identify as being of African descent. Some examples of these are cognitive and emotional reprocessing with compensatory responses to perceived environmental threats, spiritual-centered coping based on a cosmic relationship with the Creator, collective

coping with group-centered actions, and ritual-centered coping like candle and incense burning (Utsey et al., 2000).

Historical Racism

Historical racism includes traumas of the transatlantic passage, slavery, torture, murder, and Jim Crow segregation of African Americans over the past 400 or so years (Jarvis, 2007; Taylor, 2020). This includes psychological and emotional harm passed down from one generation to the next due to large-scale and individual encounters of racism that result in psychological trauma (Taylor, 2020; Williams-Washington & Mills, 2018).

Internalized Racism

According to David et al. (2019), internalized racism refers to an overly negative view of oneself, the racial group of which one is a part, and the view that others, such as White individuals, are superior and other races are inferior. One's upbringing and experiences shape one's perspective and the internalization of racism.

Microaggressions

The term microaggression was defined by Sue et al. (2007) to characterize everyday rude deportment or spoken expressions that reflect violent, belittling, or sarcastic attitudes toward stigmatized or culturally oppressed groups, whether they are deliberate or not.

Peripheral Trauma

In the context of racial or ethnic group trauma, "peripheral trauma" refers to the negative effect on the health of members of the same group who have not been directly

affected by the traumatic occurrence of other members of the same group (Alsan et al., 2020).

Posttraumatic Stress Disorder (PTSD)

PTSD is a mental disorder that results from exposure to traumatic, life-threatening experiences. This exposure results in problematic and maladaptive responses, including hyperarousal, intrusive thoughts, and avoidance (American Psychiatric Association, 2022; Lotfi-Kashani et al., 2014; Rosenberg et al., 2000;)

Posttraumatic Growth

PTG is psychological and spiritual growth that occurs following a traumatic experience (Kurian et al., 2016; Lotfi-Kashani et al., 2014). PTG includes positive changes such as a sense of strength and wisdom, enhanced value for close relationships, spiritual growth, and a renewed appreciation for each new day (Tedeschi & Calhoun, 1996; Wu et al., 2015).

Racism

Racism is discrimination of many kinds against people of a different race (historical, institutional, cultural, and individual) based on the premise that race determines human attributes and abilities (Ellison et al., 2008; Boynton, 2020).

Race-Based Traumatic Stress

Traumatic stress caused by racial discrimination or racial violence is called RBTS or racial trauma (Carter, 2007b). Individual acts of discrimination and institutional racism, as well as historical, sociocultural, and community racism, are all examples of cumulative stressors that may cause individuals to suffer from RBTS. (Williams et al., 2021).

Religious Coping

According to Pargament et al. (2011), religious coping may be divided into two major divisions of positive and negative coping. Religious cognitive and behavioral strategies are used to lessen and manage unpleasant sensations and conflicts when the environment changes (Beutler & Moos, 2003). Praying, meditating, and being grateful to God are all examples of positive religious coping mechanisms (Pargament et al., 1998). Negative religious coping strategies involve coping with negative emotions to resolve tensions (Bjorck & Thurman, 2007; McCleary-Gaddy & Miller, 2019). Some examples of negative religious coping strategies include disagreements with religious peers, doubt, shame, and a sense of separation from or disillusionment with an all-powerful deity (Pargament, 2007).

Target

The term "target" is used to distinguish the intended receiver of a microaggression who may or may not be negatively impacted by the racial encounter (Williams, 2020).

Assumptions, Limitations, and Delimitations

There are limitations and delineations to consider with this research study. Assumptions are made that all survey takers will answer all questions accurately and completely. It is also assumed that the survey questionnaires are reliable. Reliability and validity are assumed based on the use of surveys that have strong empirical research backing showing internal consistency and validity.

Limitations could arise from the use of MTurk, an online research platform that matches the researcher with criteria-specific participants. It is difficult to verify participants ʾidentities if researchers do not have direct contact with them, which can

result in a sample error. It is critical that the study's eligibility criteria be as specific as possible. Existing implicit bias may also cause a selection error when respondents choose to participate based on their interests (Pannucci & Wilkins, 2010). With this understanding, a larger sample that allows for the removal of participant data for inaccurate reporting may improve the reliability and validity of the test results (Barends & deVries, 2019).

Measurement errors can also occur from the use of the online research platform. Bots can take surveys, or people may participate without reading the questions. Attention check questions in the survey design may help to exclude completed surveys that do not meet inclusion criteria for adequate attention (Barends & deVries, 2019). Despite the use of attention check questions, random errors are to be expected when using this method of data collection. Further, sample bias can occur as the participants may have demographic differences between MTurk and the overall population, as seen in previous research studies; thus, the data results may not be generalizable (Burnham et al., 2018).

The research design included a sample of 157 African Americans of the Christian faith who currently reside in the U.S. In order to take part in the study, participants must have been at least 18 years old and self-identify as African American Christians. This study's shortcoming is that it can only be generalized to samples like the one it utilizes. The findings will not be applicable to other people of color's circumstances.

CHAPTER 2

LITERATURE REVIEW

Introduction

There is a long history of negative race-based experiences affecting the mental health of African American Christians (Lewis-Coles & Constantine, 2006). Psychologists may play an important role in the healing process of African Americans who have been traumatized by racial discrimination. African American Christians are a distinct group of people who may use religion to cope with racial trauma. The purpose of this review, therefore, is to provide a theoretical foundation for understanding the relationships between the constructs of microaggressions, RBTS, PTG, and Christian gratitude. This review of the literature provides a foundation for the current study.

Racism

Trauma may be experienced as a response to stressful life events and has negative consequences for psychological well-being and functioning (McFarlane, 2010). Mental health professionals often interpret trauma through the lens of posttraumatic stress disorder (PTSD) with the *Diagnostic and Statistical Manual of Mental Disorders-5-TR* (DSM-5-TR) criteria (American Psychiatric Association, 2013). The DSM-5-TR explains PTSD as resulting from exposure to a life-threatening experience and a disturbance of clinically significant distress that lingers for more than one month. Although these interpretations of trauma work well for those who can pinpoint a traumatic life event that triggers a traumatic response, they fail to explain other stressful experiences and their subsequent symptoms. There are no DSM-5-TR criteria that acknowledge how the stress of racism and the corresponding traumatic responses interfere with psychological stability

and normative functioning (Carter et al., 2020a). Despite this, the literature differentiates between types of racism that can lead to racial trauma, such as sociocultural and historical, institutional, and individual (i.e., behavioral, mental, and emotional; Carter et al., 2020).

Historical and Sociocultural Racism

According to Sotero (2006), the oppression of a population by a dominating group is a major form of historical or sociocultural trauma. These authors asserted that to effectively dominate a population, at least four conditions must be met. These include extreme physical and psychological violence, segregation or forced migration, financial oppression, and cultural alienation (Sotero, 2006). Sotero (2006) also noted that dominant racial groups have historically inflicted widespread trauma on non-group individuals in these ways, causing societal, economic, and cultural consequences. As such, the target group's response to this trauma is seen in reports of higher negative psychological, social, and physiological experiences (Wilson & Gentzler, 2021). This marginalization negatively impacts each future generation (Laveaga, 2018).

Historical trauma in these forms has adversely impacted the mental health of African American communities for centuries (Henderson et al., 2021). Furthermore, repercussions of historical racism and injustices in the United States presently impact not only individuals but also the current racial climate within the African American population (Liu et al., 2019). Indeed, the past 400-plus years of the unresolved impact of slavery, torture, segregation, and racism have shaped United States ’culture (Zinn, 1990). Consequently, historical trauma has afflicted many individuals through transgenerational

and epigenetic factors that lend themselves to the continuation of illness and compromised well-being (Henderson et al., 2021; Sotero, 2006).

Alsan et al. (2020) explored the psychological impact of historical racial trauma and racial discrimination by assessing the peripheral trauma of the Tuskegee Syphilis experiments. Peripheral trauma is a term used to describe how negative events that involve a particular racial or ethnic group might negatively impact the health of members of the same group that have not directly experienced the negative event (Aslan et al., 2020). This study found that peripheral trauma may occur when African American men become aware of historical events that they did not experience firsthand (Alsan et al., 2020). Men who had knowledge of the Tuskegee Syphilis experiments limited their use of the health care system. The study also showed that the men's proximity to the tragedy was significantly related to peripheral trauma and higher mortality rates (Aslan et al., 2020). As such, it is possible that racially targeted historical events may have negative mental and physical health consequences for members of the group who are not directly implicated (Boynton, 2020).

Institutional Racism

Henkel et al. (2006) define institutional racism as the deliberate or unintentional manipulation or tolerance of institutional practices (e.g., voting, fees, college entrance criteria) that disproportionately limits the prospects of particular groups of individuals. Institutional racism is not the result of a private individual's prejudice but rather the result of legislation, norms, and policies enforced at every level of the economy and government (Bailey et al., 2021).

Many of the psychological difficulties African Americans experience may also be related to these institutional factors (Jones et al., 2020; Vontress et al., 2007) and systemic oppression that pervades many aspects of African Americans' lives (David et al., 2019). As an example, segregated neighborhoods have a negative impact on African Americans in many ways, including their social lives, access to education and economic opportunities and associations, physical and mental wellness, prosperity, and the fair administration of the law (Banaji et al., 2021). In addition, African Americans in underserved communities often face a number of issues, including disenfranchisement and a lack of access to health care (Jackson et al., 2016; Shavers‐Hornaday et al., 1997). Furthermore, the challenges African Americans face are commonly related to socioeconomic status and the related institutional policies that influence it (Range et al., 2018).

According to Sue et al. (2011), institutional policies and behaviors may either promote or diminish the status of people of color. An example of institutional racism that appears to have negatively impacted the mental health system in the United States involves the underrepresentation of African Americans as medical professionals (Key, 2020). Institutions like the American Medical Association (AMA) and the American Association of Psychiatry (AAP) excluded African American medical doctors from full membership until 1968 as "White only" organizations (deShazo et al., 2014). There is speculation that, with a little over 50 years of admittance into full membership of these institutions, there remains inadequate representation advocacy for African American mental health (Holliday, 2009). Furthermore, these institutional systems may be predisposed to encouraging microaggressions (Shavers‐Hornaday et al., 1997;

Williams, 2020a). This may impact the population's trust, access to care, and appropriate diagnosis, creating health disparities (Jackson et al., 2016; Jarvis, 2007; Shavers - Hornaday et al., 1997; Sue et al., 2009; Williams et al., 2018). Carter (2007) echoed the idea in their article on race-based stress that the existing diagnostic system does not assist patients or mental health practitioners in recognizing the mental health impacts of racism. Institutional, systemic, and racial inequalities such as these can create ongoing difficulties for African Americans.

Individual Racism

There is a multidimensional aspect to individual racism, also known as interpersonal racism or personally mediated racism, that is historically defined as some form of disparate treatment of people of a particular race (Boynton, 2020). According to Greenwald and Krieger (2006), personal and racial beliefs may influence how people behave in cross-racial encounters, resulting in this type of prejudice, including implicit bias. Implicit bias is characterized by subconscious attitudes or assumptions and may generate behaviors that diverge from a person's stated beliefs or principles (Greenwald & Krieger, 2006). In many cases, they consist of small, personal insults or slights directed at an individual. A White correction officer, for example, might regularly monitor the conduct of African American individuals because they believe African Americans are more prone to crime than their White peers (David et al., 2019), or a White woman might ignore her African American female coworker's work-related ideas on days when her coworker wears her hair as a natural afro (Johnson et al., 2017).

Individual racism may also include explicit bias. Explicit bias refers to deliberate and conscious negative attitudes, beliefs, and actions against a particular racial group,

such as a White person telling racial jokes, using racial slurs, or using the "N-word," believing it is okay (Trent et al., 2019). The distinctions between individual racism and sociocultural, historical, and institutional racism are marked by the direct individual focus and the internal process and perceptions of a person who experiences racism (Brown & Segrist, 2016).

According to Trent et al. (2019), race-based prejudices may be internalized as a repercussion of the impacts of both systemic and interpersonal racism. Internalized racism is a particularly pernicious kind of divisive racism, characterized as the internalization of prejudice and oppression against one's own group (Hwang, 2021). More specifically, Jones (2000) agreed that internalized racism is the internalization of negative messages about one's own capabilities and inherent value by members of stigmatized races. Theorists surmised discrimination is less likely to have a negative impact on people who have a strong sense of their own racial identity (Trent et al., 2019). For those who may be more susceptible, the process involves internalizing self-defeating attitudes, beliefs, and acts. For example, in a review of the literature, David et al. (2019) suggested that internalized racism has a negative impact on the professional ambitions of marginalized populations. More specifically, Brown & Segrist (2016), in their mediation study of 315 African American adults, found that individuals who saw Africultural traditions and an African worldview as less significant may have lower professional goals.

The targets of racism who have internalized this negative self-schema may also feel self-blame and responsibility associated with racism (Speight, 2007). Internalized racism can create considerable psychological harm, which may be due to shame

associated with Africanness as a result of slavery and racism, as well as the humiliation of being shamed (David et al., 2019; Williams & Williams-Morris, 2000). According to Speight (2007), feeling shame about one's culture can be experienced as a form of psychological enslavement. The normalization of one's own self-negativity from internalized negative stereotypes may likewise be linked to feelings of shame (Keum & Choi, 2021). Mouzon and McLean (2017) studied whether these negative stereotypes are associated with mental health among African Americans and Caribbean Blacks. They found that serious psychological distress increased with higher internalized racism. The study showed that internalized racism was highest among African Americans born in the United States (Mouzon & McLean, 2017).

What is more, although individual racism's complex impact on people of color throughout their lives is poorly understood, research indicates that it may be linked to a number of health disparities (Alsan et al., 2020; Harnett, 2020; Jones et al., 2020) and can also impact early childhood development (Balbernie, 2001; Doidge et al., 2017; Harnett, 2020). According to Brown and Segrist (2016), evidence of this is seen in links between racism and low birth weight, premature birth, and fetal growth restriction in relation to the mother's individual and systemic experiences of race-related stress (Carter, 2007a; Mustillo et al., 2004).

The negative effects of racism may also be observed in victims of other forms of racial injustice. Individual racism is not only recognized by internal processes associated with it, but also by external manifestations of racism. As a form of racism, microaggressions may be commonly found to be harmful to individuals who encounter them on a daily basis (Sue et al., 2007). Microaggressions may be formed by pathological

stereotypes that influence how the perpetrator thinks about and judges the qualities and actions of a person of color (Williams, 2020b). As such, these problematic beliefs and opinions may lead to harmful behaviors that have a lasting psychological impact on an individual target (Lui & Quezada, 2019; Williams, 2020b).

Microaggressions. Ong and Burrow (2017) indicated that the term microaggression was first mentioned in the 1970s by Pierce as "subtle, stunning, often automatic and nonverbal exchanges which are 'put-downs' of Blacks by offenders" (p. 173). A more recent interpretation by Sue et al. (2007) used the term "microaggression" to describe everyday insulting deportment or spoken expressions, whether intentional or unintentional, that show hostile, demeaning, or sardonic beliefs toward groups that have been stigmatized or are culturally oppressed. Sue et al. (2019) stated that microaggressions are different from "everyday rudeness" in four ways (p. 130). Specifically, Sue et al. (2019) claimed that microaggressions are constant and recurring, cumulative, in that they are life-long and unchanging, and they trigger poor social standing and a reminder of historical trauma.

In a broader sense, microaggressions are acts of oppression that may perpetuate pathological preconceptions and social norms that are inequitable (Williams, 2020a, 2020b). A microaggressor's stereotypical beliefs can be held by individuals or collectively by whole groups of people or cultures (Williams, 2020b). Collective structures of power, bias, and a multiplicity of prejudice can create an environment that not only excuses microaggressions, but facilitates their legitimacy (Williams, 2020a). Microaggressions often include behaviors that cause embarrassment or erode another's

self-esteem (Nadal et al., 2014). They might be done on purpose or without intention; either way, they communicate negative views of the victim (Sue et al., 2007).

Sue et al. (2007) produced an ethno-racial microaggression categorization, further differentiating nine types of microaggressions: (a) the belief that a person of color is not a true American; (b) the assumption that a person of color has inferior intelligence; (c) making remarks implying colorblindness or denying the significance of race; (d) a presumption that an individual of color is more likely to engage in unlawful or harmful behavior; (e) being in a state of denial of racism on a personal level; (f) encouraging economically, racially, and ethnically marginalized people to believe that the system is fair and social and economic mobility is always possible; (g) stereotypes that a person has about a racial or ethnic group's communication style and cultural origin; (h) experiencing being mistreated as someone who does not deserve, have, or is not given the same rights as others; and (i) recognizable messages of being unwanted or unvalued within an environment.

Based on these nine types of microaggressions, Sue et al. (2007) found that there are three categories: microinsults, micro-assaults, and microinvalidations. Microinsults, which are usually unintentional, present as behavioral or verbal statements or acts that convey rudeness and insensitivity and demean the target's racial identity or background (Sue et al., 2007). One example, according to Sue et al. (2007), is a person of color being overlooked, such as a White professor addressing only White students in the classroom or an African American employee joining a White supervisor in a discussion about work while the supervisor's body language and avoidant eye contact suggest they are indifferent and uninterested. Micro-assaults, which are usually conscious, are marked by

verbal or nonverbal attacks, such as name-calling, avoidance, or intentional discriminating actions directed at the target as racial derogatory insults (Sue et al., 2007). Examples of this type of traditional racism may include hanging a confederate flag on a car's antenna or a White waitress serving White diners first, despite the fact that African Americans sat down at a table 20 minutes before the other guests arrived. Finally, Sue et al. (2007) emphasized microinvalidations are used to remove the target's racial reality and include mental and emotional consequences. For example, a White person may allege to an African American person, “Color doesn't exist,” “We are equal,” or “I grew up poor too, and I am White.”

The African American population in the United States experiences a disproportionate number of racial microaggressions (Avent Harris et al., 2021; Forrest-Bank & Jenson, 2015). In their study, Forrest-Bank and Jenson (2015) found that African Americans experienced more microaggressions associated with assumptions of inferiority and microinvalidations than other racial groups. The injustices experienced by African American people, such as these, are a daily occurrence (Boynton, 2020). Although certain types of explicit racism, such as lynching, are no longer socially acceptable, racism is a common part of everyday life in the United States (Sue et al., 2007). Subtle modern-day racism takes on some new dimensions and practices, as seen in the various types of microaggressions (Carter, 2007a).

Microaggressions and Psychological Symptoms. Williams et al. (2020a) indicated that the term "microaggressions" does not do justice to the severity of psychological damage they cause. As subtle manifestations of covert racism, they frequently occur without the aggressor's awareness (Williams et al., 2020a). However,

microaggressions are frequently met by the target with questions about one's reality, memory, or perceptions, which can work as an additional micro-aggressive insult, compounding their effects (Carter et al., 2017; Sue et al., 2019). The very nature of their delivery (potentially outside of a perpetrator's awareness) and the experience of the associated stigma may escalate the victim's stress with each assault (Sue et al., 2007). According to Williams (2020a), a common reaction of the offender, when confronted with the perpetration of a microaggression, is denial, with the inferred or outright declaration that the victim is mistaken. Williams (2020a) also noted that the victim is frequently held to blame, and in denial, the perpetrator pushes for the authority of the event's interpretation, leaving the victim feeling powerless.

According to Ong et al. (2017), there is a well-documented link between racial discrimination (i.e., microaggressions) and psychological distress. Lui (2020) studied different types of racial microaggressions and their relationship to negative emotions. The researchers controlled for overt discrimination and narcissism while they assessed the role of microaggressions and their link to psychological distress outcomes. They asserted, in general, that the existence of microaggressions may elevate the target's degree of negative emotions (e.g., depressed mood, stress, shame). The findings may be due to a target's inability to process unexpected and covert negative racial encounters (Carter, 2007b; Sue et al., 2019; Wilson & Gentzler, 2021). It is important to note that negative emotional reactivity from microaggressions may also be linked to somatic symptoms (Huynh, 2012). Robinson-Wood et al. (2015), in their qualitative study, explored the presence and nature of microaggressions among master and doctoral level female students who were of African descent. They found negative somatic symptoms, such as

headaches and tension, may be linked to the frequency, length, and gravity of microaggressions.

Negative emotionality from racial microaggressions may also lead to depressive symptoms (Huynh, 2012). Torres et al. (2010), in their multiphase study, sought to understand the role of microaggressions and their impact on mental health among African American doctoral students. They discovered that microaggressions led to some participants having poorer perceptions of their own abilities, which were linked to higher levels of stress. As a result, higher levels of depressive symptoms were seen in these individuals one year later (Torres et al., 2010). Further, Robinson-Perez et al. (2020) explored the link between psychological suffering and racial microaggressions among college students. They found racially-motivated microaggressions were more psychologically distressing for students who lived outside of the university community than those who resided on campus. These authors concluded that healing and empowerment may be experienced through affirmation of racial identity and validation of microaggressions (Robinson-Perez et al., 2020).

In addition to community factors increasing psychological suffering from racial-motivated microaggressions, there may also be additional perceptual influences. Hollingsworth et al. (2017) examined the relationship between racial microaggressions (the predictor variable) and suicidal ideation (the outcome variable) while measuring the mediating role of self-perception, such as seeing self as a liability and having a thwarted sense of belonging. They found that African American young adults may be vulnerable to specific types of microaggressions, particularly others' beliefs of low achievement and undesirable culture, environmental invalidations, and invisibility. The study's results

showed that a higher self-perceived burden on others (i.e., self as liability) was related to increased suicidal ideation for individuals with these experiences of microaggressions. In light of these findings, it is important to note that racial microaggressions can harm mental health in a variety of ways.

Race-Based Traumatic Stress

The psychological damage and emotional distress produced by experiencing racial discrimination and racial violence are also known as race-based traumatic stress (RBTS; Carter, 2007b). RBTS is racial trauma characterized as the cumulative damaging effect of racism on a racialized individual, which may encompass both individual acts of racial discrimination and systemic racism, as well as historical and sociocultural racism (Williams et al., 2021). Carter and Muchow (2017b) found that symptoms of RBTS included depression, physical symptoms, anger, hypervigilance, intrusion, avoidance, and low self-esteem. According to Carter and Muchow (2017), RBTS is a "complex race-related stress reaction" (p. 694).

Although the original conceptualization of racism in the RBTS literature was historically divided into two forms of discrimination and harassment, there are additional types of racism that impact RBTS (Carter, 2007b; Speight, 2007). In studying reactions to discrimination and harassment, Carter and Forsyth (2010) looked at cognitive and affective reactions to racial encounters and measured how participants solicited support for dealing with racial circumstances. The authors identified race-based discrimination as covert acts of racial injustice, such as judicial rulings, lawsuits, deadly force by police officers, and unjust, harsh treatment due to marginal income and education. Fright, stress, anxiety, depressed mood, sorrow, resolve to address related issues, solidarity, and use of

the negative encounter to gain strength are all examples of emotional reactions to discriminated-based racism (Carter, 2007b; Carter et al., 2013). Racial harassment can encompass bodily, interactional, or spoken assaults, as well as racial stereotypes of being sluggish, unintelligible, criminal, or dangerous (Carter & Forsyth, 2010). Wrath, hostility, helplessness, humiliation, regret, paralysis, negative self-concept or continuous self-uncertainty, mistrust, and skepticism are some of the emotional reactions to harassment-based racism (Carter & Forsyth, 2010; Speight, 2007). According to Carter and Forsyth's (2010) study, harassment-based racism was associated with more negative emotional reactions that may be more impactful than discrimination types of racism.

In a confirmatory analysis, Carter and Muchow (2017b) investigated whether RBTS stress responses and racial identity status attitudes were linked to psychological functioning in people of color. A lower sense of racial identity was linked to greater levels of RBTS, according to the findings. On the other hand, Pieterse et al. (2012), in their meta-analysis, investigated the link between racism and mental health among African Americans. In particular, they sought to investigate whether perceived racism is associated with negative psychological and physiological consequences. Their results supported the conceptualization that a target's experience of negative race-based encounters (racism) may be perceived as deeply troubling, resulting in feelings of helplessness, anxiety, and depression. Thus, targets who encounter negative race-based events may have a lower sense of psychological wellness, may experience anger that can trigger a fight or flight response, and may have higher negative emotional reactivity (Carter & Forsyth, 2010; Carter & Muchow, 2017b; Pieterse et al., 2012).

Discrepancy Between PTSD and RBTS

Although racism in its many forms (including microaggressions) may cause African Americans to show symptoms of clinical distress, current techniques used to diagnose PTSD may not benefit the patient or mental health provider in understanding RBTS (Bryant-Davis et al., 2017; Bryant-Davis & Ocampo, 2006; Carter, 2007a, Carter et al., 2013; Carter et al., 2020a; Comas-Díaz et al., 2019). Carter et al. (2017) and others provide mounting evidence of a discrepancy between symptoms of PTSD among Whites and those of minority racial groups. Traumatic reactions to racial discrimination may be one possible cause of this gap. The findings support Carter's (2007) RBTS model. The model theorizes that responses to racism can be conceptualized as a form of trauma. With a distinct pattern of symptomology, RBTS may resemble symptoms of general trauma. Traditional PTSD measures, however, do not adequately assess for distinctive characteristics of race-based trauma, such as poor self-confidence and vehemence, and may not be appropriate in capturing the complete experience of race-based stress (Roberson & Carter, 2021).

Likewise, in their canonical correlation analyses, Carter et al. (2020b) looked at the link between general trauma symptoms and RBTS to see whether and how responses to negative race-based experiences are comparable or unique to other trauma symptoms. The study confirmed adverse racial experiences may be related to PTSD-like reactions and impairments, such as avoidance, intrusion, and anger. However, Carter et al. (2020b) surmised that different racial-ethnic groups, Black and others, may experience unique negative racial or ethnic encounters and their traumatic reactions may trigger the distinct symptoms of RBTS. In RBTS, for example, hypervigilance may be absent among symptoms for some individuals, and poor self-esteem may be a symptom of RBTS

(Roberson & Carter, 2021). Moreover, distress connected to repeated racial encounters (e.g., interpersonal trauma) may be more likely to elicit greater extreme emotional reactions than major disasters or single life-threatening events (Carter et al., 2020b; Courtois, 2004, 2008).

Accordingly, Roberson and Carter (2021) indicated that the use of DSM-5-TR criteria to assess for racial trauma may be discriminatory, since symptoms of RBTS do not match those of PTSD, as RBTS is not considered a form of PTSD. Further, they showed the criteria for RBTS included emotional pain associated with *reactions* to racism (both immediate and accumulated), not "experienced or vicarious physical threats" (Robertson & Carter, 2021, p. 3). Avoidance, bodily symptoms, intrusion, anger, poor self-esteem, depression, and hypervigilance are examples of these reactions (Carter & Muchow, 2017). RBTS symptoms do not present exactly the same as PTSD but may overlap with PTSD symptoms. Also, the symptoms of racial trauma may differ from patient to patient. Furthermore, the DSM-5-TR's diagnostic category for PTSD is not related to race or racism, but the DSM-5-TR may benefit from its inclusion in the current criteria (Carter & Johnson, 2019).

Racism, Microaggressions, and Coping in the African American Community

Researchers have addressed the mechanisms and processes that may help targets cope with the accumulation of racism and racial microaggressions (Spanierman et al., 2021). When environmental conditions change, coping activates cognitive and behavioral processes and is used to reduce negative affect and tension (Beutler & Moos, 2003). Throughout U.S. history, African Americans have responded to and coped with racism in a variety of ways. Certain cultural strengths that existed before and after enslavement,

such as spirituality, have often figured prominently in helping them to cope with racism (Henderson et al., 2021; Lewis-Coles & Constantine, 2006a). Some African-centered ways of coping may focus on people's benevolence, relationships, and community movements, as well as their internal and external connections with the supernatural (Bent-Goodley et al., 2017).

Henderson et al. (2021) looked at historical evidence of healing among enslaved persons of African origin on plantations in the Southern United States. These researchers paid particular attention to cultural methods of healing since different cultures have different methods for dealing with trauma. More precisely, as a historical reaction to trauma and injustice, African Americans who were slaves developed and accessed unique healing techniques (Henderson et al., 2021). The researchers used a thematic analysis of historical texts from African American historiography to explore these intergenerational healing mechanisms. They reported finding evidence of intergenerational healing mechanisms that may have come from the transmission of spirituality, including sharing morals and ideals that were passed down individually, via the family, or through the community.

In a qualitative study, Ortega-Williams (2021) studied the relevance of self-care for African American youth organizers by using an interpretative phenomenological technique, in line with the values of critical qualitative analysis, to evaluate conversational and observational data. Considering the historical ways African American youth have coped by organizing under oppressive political and socioeconomic climates, the researcher found these individuals used collective self-care strategies for individual well-being and group action for healing. Exercise, rest, and music, as well as

mental and emotional preparation for organizing, were all included, as were social action, rituals, collective wellness practices, and fundamental group solidarity. Research such as this may provide evidence of African American resilience in the face of race-related stress by coping through socially adaptive healing strategies (Boyd-Franklin, 2003; Lewis-Coles & Constantine, 2006). Further, Carter and Forsyth (2010) found that targets have other distinct coping and help-seeking strategies and behaviors in response to negative racial encounters. For example, they found African American adolescents were more likely to seek support from family members than professional mental health care workers when dealing with stressful race-based experiences. African American intergenerational coping may include seeking advice and support for negative racial encounters from relatives (Henderson et al., 2021).

McNeil Smith et al. (2019) used structural equation modeling to test the social support degradation model to determine if lower levels of family social support explained the relationship between racial prejudice and psychological distress. They found that adolescents who experienced high levels of prejudice reported high levels of distress, no matter the level of family support. On the other hand, low levels of family social support mediated the relationship between racial discrimination and adolescent psychological distress for adolescents reporting low racial prejudice. That is to say, they found support for the social support degradation model in that adolescents infrequently encountering or fearing racial discrimination reported decreased family social support, which was related to higher psychological distress. It may be that adolescents who experience less exposure to racial bias may find it harder to recognize mental health problems and seek help when they encounter discrimination (McNeil Smith et al., 2019).

Conversely, in their hierarchical regression analyses, Gaylord-Harden and Cunningham (2009) explored the influence of racial discrimination on stress-reduction methods and internalizing symptoms among a sample of early adolescent African Americans. Adolescents self-reported their levels of negative race-related distress, ways that they coped with that stress, and internalizing outcomes. The researchers found that higher levels of discrimination were related to higher internalizing symptoms and more culturally relevant coping such as communal and spiritual coping. While increased use of communal coping strategies was associated with higher anxiety overall, they reported that other culturally distinctive methods of coping may help lower depression and anxiety related to racism. Culturally relevant strategies such as responsive coping, solution finding, and flexibility in dealing with prejudice may be associated with less psychological distress following discriminatory encounters (Gaylord-Harden & Cunningham, 2009; Szymanski & Lewis, 2016).

Religious Coping

Thurman (1949) gave insight into how faith and religious coping are mechanisms to overcome fear for the oppressed. Others have examined patterns of oppression and the connected negative emotions and methods used to resolve internal, interpersonal, and inter-theological tensions, which may have both negative and positive outcomes (Lehmann & Steele, 2020). Faith-focused coping may be avoided by some African American Christians (Rivers, 2019). On the other hand, for other African Americans, religious coping strategies may play a central role in their traditions and identity, which may help mitigate the impact of racism on a target's overall well-being in a way that

enables them to better deal with the stress of discrimination (Chapman & Steger, 2010; Park et al., 2018).

Negative and Positive Religious Coping. In most research, positive and negative forms of religious coping are studied (Pargament et al., 1998, 2011). According to Bjorck and Thurman (2007), negative religious coping is characterized by a strained connection with God, a pessimistic perspective of reality, and an inability to grasp the larger purpose of life. Further, they described spiritual discontent, religious presumption, and interpersonal religious dysphoria as types of negative religious coping. Hebert et al. (2009) used linear regression to examine the relationship between religious coping (positive and negative) and well-being in women with malignant breast cancer. Their findings suggested that negative religious coping strategies may be associated with lower mental well-being and less overall satisfaction (Hebert et al., 2009).

In their longitudinal study, Burke et al. (2011) found individuals who used negative religious coping strategies following trauma reported more psychological problems six months after the traumatic encounter. In another study, Szymanski and Obiri (2011) conducted a mediation study with African American participants. They found that negative religious coping partially mediated the positive associations between racist occurrences, internalized racism, and the outcome of psychological distress. In other words, they discovered a positive relationship between negative religious coping and psychological distress for individuals who experienced negative racial encounters and internalized racism. These studies suggest there may be a direct association between distress after trauma and negative religious coping. However, Kim et al. (2015) demonstrated that, in a group of Christian Asian American college students, negative

religious coping moderated the relationship between racism and mental health. They found negative religious coping may buffer the negative effects of racism on mental health (Kim et al., 2015).

Positive religious coping (PRC) is also linked to an improved degree of psychological well-being when used to cope with certain stressors (Pargament et al., 1998). Pargament et al. (1998) defined positive religious coping as an expression of spirituality, a solid connection with God, the perception that life has value, and faith in an interrelated spiritual community. Forgiveness sought via collaborative cooperation with God, seeking control through a supportive relationship with God, and reframing pressures through religion may be other forms of PRC useful for improving and sustaining psychological health (Szymanski and Obiri, 2011).

Further, Ahrens et al. (2010) analyzed the factors that were linked to Christian sexual assault survivors 'positive and negative religious coping. They discovered in their study sample that African Americans utilized both positive and negative religious coping more often than other races. The results corroborated other findings that show religious coping is particularly high among church members, African Americans, and those who are in a state of extreme stress (Ahrens et al., 2010; Pargament et al., 1998, 2001). Further, Campbell and Long (2014) found among African American communities that participants commonly reported religion and prayer as feasible methods of obtaining help. This literature further supports the notion that religion may be an essential aspect of stress management among African Americans.

Yet, little is known about religious coping and its relationship to RBTS, in particular (Park et al., 2018). For example, Lewis-Coles and Constantine (2006) studied

the relationship between individual, institutional, and cultural race-based stress and specific Africultural coping strategies. Cognitive and affective debriefing, spiritual-focused, communal, and ritual-focused coping, and religious problem-solving approaches were all Africultural coping components (Lewis-Coles & Constantine, 2006). The results showed individual racism-related stress was not significantly associated with any type of religious coping methods, despite the fact that institutional and cultural racism were positively associated with greater use of the religious coping strategies studied. The findings reveal a need to better understand religious coping in the face of racism, race-based stress, and microaggressions. The results may also indicate that culturally sensitive coping techniques, such as exploring the use of Christian gratitude for buffering psychological distress in African American Christians with RBTS, are still needed.

General Gratitude and Christian Gratitude. General gratitude is seen in the literature as essential to an individual's well-being throughout their lifetime (Fincham & May, 2021; Upenieks & Ford-Robertson, 2022). As a positive social and moral emotion, general gratitude emphasizes the need to notice and make the most of one's existing circumstances (Crouch et al., 2020). There are several psychological, behavioral, and social benefits to being grateful, such as positive affect and ego, contentment, prosocial and charitable behaviors, and improved relationships (Rosmarin et al., 2011).

Further, a substantial body of findings demonstrates that gratitude protects against the symptoms of mental illness (Van Dusen et al., 2015). Researchers discovered that gratitude is associated with higher social support and shields individuals from stress and chronic negative emotional states, as found in two longitudinal studies (Wood et al., 2008). Gratitude as a psychological concept has been identified as an attitude, affect,

behavior, moral virtue, or coping reaction (Upenieks & Ford-Robertson, 2022). Being grateful may be defined as both an affective state and a quality characterized by appreciating and acknowledging the good things in life (Emmons & McCullough, 2003). Findings support the psychological benefits of using gratitude as a coping mechanism and set the precedence for gratitude to God and Christian gratitude as an important component of religious coping (Fincham & May, 2021; Rosmarin et al., 2011; Upenieks & Ford-Robertson, 2022; Van Dusen et al., 2015; Wood et al., 2008).

Christian gratitude, like general gratitude, when exercised, may also heighten an individual's positive affect (Froh et al., 2009). According to Emmons and Kneezel (2005), the Christian faith is rooted in the spirit of gratitude. Knabb et al. (2021) defined Christian gratitude as a spiritual action, which includes psychological variables such as thoughts and emotions of genuine appreciation, as well as the reflections and physical manifestations of each. These authors further describe Christian gratitude as motivated by an individual's response to the unearned bounties of the creator, and, as seen in the biblical text of Hebrews 4:15, recognizing God's loving presence as a generous giver of existence, no matter the earthly perception (Knabb et al., 2021). As such, the exercise of Christian gratitude demonstrates an individual's indebtedness and oneness with God, and it fosters a believer's deeply shared interconnectedness with fellow Christians (Emmons & Kneezel, 2005).

In their mediation and hierarchical regression study, Rosmarin et al. (2011) analyzed religious and general gratitude, religious commitment, and mental and physical health. In the mediation, they studied religious commitment (the independent variable) and general gratitude (the dependent variable) and assessed the mediating role of

religious gratitude. They found that religious gratitude mediated the positive association between religious commitment and general gratitude. The results of their hierarchical regression suggested that individuals who were religiously committed and engaged in religious gratitude experienced more well-being than those who only practiced general gratitude. These findings may give empirical support to the benefits of practicing Christian gratitude for African American Christians who may already utilize strategies of religious coping in response to traumatic stress symptoms. Studies such as these may also provide a foundation for understanding the relationships between Christian gratitude, symptoms of RBTS, and PTG.

Posttraumatic Growth

PTG is a positive psychological shift for an individual coping with trauma (Lotfi-Kashani et al., 2014; Ortega-Williams et al., 2021). PTG may occur as a consequence of a natural desire to grow from the affective processes of intrusion and avoidance following a traumatic event (Joseph & Linley, 2005). PTG theories see trauma in the context of circumstances that may trigger transformative outcomes by challenging underlying beliefs, leading to a deeper sense of connection with people, self-confidence, fresh perspectives, and a strong respect for life's splendor (Tedeschi & Calhoun, 1996). It can even change the spiritual and existential views of a survivor (Tedeschi & Moore, 2021).

Empirical findings show that PTG may trigger a survivor to acquire renewed wisdom and strength, as well as a greater appreciation for intimate connections and a deeper value for existence as a result of PTG (Tedeschi & Calhoun, 1996; Wu et al., 2015). Self-discerned transformation; relational alteration; enhanced transcendence or a

shift in metaphysical reality; a deeper recognition of past existence; and a heightened appreciation for life are PTG (Lotfi-Kashani et al., 2014). Likewise, PTG may be seen in the form of a fresh perspective on life that might result from a shift in one's own worldview (Yasdiman et al., 2022).

Various cognitive factors have been linked to PTG, which seem to play a significant role in the healing process following a traumatic event (Zoellner & Maercker, 2006). In their study, Lotfi-Kashani et al. (2014) sought to determine whether self-efficacy and perceived social support served as mediators of the relationship between trauma and PTG outcomes. They discovered that self-efficacy and perceived social support were significant mediators, explaining the relationships between trauma and PTG. In particular, participants experienced PTG, which included new positive schemes, ideologies, and viewpoints. They concluded their mediation study by noting that these psychological characteristics might be used to develop interventions that promote PTG (Lotfi-Kashani et al., 2014).

Furthermore, looking at what facilitates PTG may help identify therapeutic factors that may contribute to healing trauma. For example, after the Wenchuan earthquake, Wu et al. (2015) examined the role of intrusive and deliberate rumination in PTSD and PTG among adolescents. Their results indicated that intrusive rumination shortly following the earthquake was related to more recent intrusive rumination, which had a significant impact on PTSD but not PTG. On the other hand, the relationship between deliberate rumination after the earthquake and PTG was mediated by recent deliberate rumination but this was not the case with PTSD. In summary, PTG among

adolescents may be related to deliberate rumination at the time of a traumatic event as well as deliberate rumination at a later time.

Manove et al. (2019) looked at additional mitigating factors that facilitated PTG in their qualitative analysis. Hurricane Katrina damaged or destroyed the houses of low-income African American mothers in New Orleans; thus, the researchers examined this sample for PTG experiences. The qualitative interviews revealed general themes of related factors that may have contributed to the women's PTG, including greater racial diversity, better neighborhoods, and new educational and economic possibilities in the survivors' post-disaster communities. According to the frequency that these themes appeared in the research data, opportunities such as these after trauma may contribute to PTG (Manove et al., 2019).

Likewise, after the shooting at Seattle Pacific University, Vieselmeyer et al. (2017) conducted a moderated mediation study to examine the relationship between trauma exposure and PTG mediated through posttraumatic stress (PTS). Using resilience and gratitude as moderators in the model, they found a significant conditional indirect effect of exposure to trauma on PTG. Their results suggested that post-trauma interventions emphasizing gratitude and resilience may lower PTS while heightening PTG. Karanci et al. (2012) also examined possible correlates of PTG by conducting a survey among a sample of 969 adult Turkish individuals. The survey assessed personality characteristics, PTG and PTSD. They discovered that conscientiousness, agreeableness, and openness to experiences may be strong predictors of overall PTG for the majority of PTG domains (Karanci et al., 2012).

Individuals will use a variety of coping strategies when confronted with traumatic circumstances, and these may be understood as an individual's cognitive and behavioral responses to internal and external experiences of stressful encounters (Folkman & Moskowitz, 2004). Two types of general coping found in the literature include emotional and problem focused coping. Tuncay and Musabak (2015) sought to see how PTG, sociodemographic, amputee-related factors, and coping strategies were linked in a sample of Turkish military veterans. They discovered that problem-focused coping, such as religion, acceptance, planning, and active coping, was positively linked to PTG, but emotion-focused coping, such as denial and behavioral disengagement, was negatively related with PTG. These findings indicate that general coping strategies such as these are associated with PTG. Further, Mesidor and Sly (2019) studied survivors of the 2010 Haiti earthquake. Among a sample of 256 participants, the researchers looked at the links between resiliency, perceived social support, coping mechanisms, PTSD, and PTG. In terms of correlates of PTG, they found that positive religious coping was the strongest correlate, followed by active coping, a sense of social support, resiliency, PTSD, and, lastly, negative religious coping.

PTG, Microaggressions, Race-Based Stress, and Religious Coping

As described above, PTG may come about through the healing of complex preexisting traumatic responses to stress (Courtois, 2004). Microaggressions experienced as traumatic incidents may influence the development of posttraumatic stress responses, various trauma symptoms, and PTG (Carter et al., 2020). Hence, a better understanding of the relationships between PTG, negative racial events, and religious coping strategies is needed to inform work with African American Christian patients in mental health

treatment (Alsubaie et al., 2021; Jernigan & Daniel, 2011). Survivors of race-based trauma may have trouble healing; thus, a framework is required for bringing about necessary therapeutic transformation (Carter et al., 2020b; Courtois, 2004). The therapeutic framework that is required must be specifically suited to the needs of the African American clinical population (Chino & DeBruyn, 2006; Sotero, 2006).

Ortega-Williams et al. (2021) developed a framework for understanding racial trauma and PTG. They described collective domains that are included in PTG's processes of growth and change after racial trauma. Collective strength, spiritual transformation, and linking to ancestors and culture are all examples of African American indigenous coping methods rooted in Africultural ontology and epistemology (Ortega-Williams et al., 2021; Pierotti & Wildcat, 2000; Sheridan & Longboat, 2006). African Americans may use these as resources to help them cope after racial trauma (Ortega-Williams et al., 2021). With this in mind, African American targets who are unable to apply appropriate coping methods after individual racism (i.e., microaggressions) may be at risk of developing RBTS (Carter et al., 2017; Polanco-Roman et al., 2016; Williams, 2020b; Williams et al., 2021). Therefore, coping strategies for individual racism, which may take the form of microaggressions, need further study. It may be that these negative racial encounters, which tend to evoke negative self-, other-, and safety-related perceptions, may be linked to poorer mental health outcomes compared to other forms of racism (Carter et al., 2017).

Despite the fact that survivors of racial trauma may have a hard time recovering, Africultural coping and religious problem-solving strategies are resources commonly used by African Americans to deal with various forms of racism-related stress, including

individual direct racism (Courtois, 2008; Lewis-Coles & Constantine, 2006). The scientific literature on coping shows that religious coping strategies are functionally distinct from nonreligious coping (Aflakseir & Mahdiyar, 2016). Religious coping practices may influence psychosocial wellness in ways that nonreligious coping cannot (Pargament et al., 1998).

The ability of African Americans to cope with RBTS through religious coping is well documented (Lewis-Coles & Constantine, 2006a; Thurman, 1949). One culturally sensitive intervention may be the practice of Christian gratitude (CG). CG is a type of positive religious coping that may have positive outcomes for African American Christians who experience individual racism, the accumulation of microaggressions, and traumatic race-related stress responses. However, there is a scarcity of literature supporting Africultural religious practices and their relationship to PTG (Johnson & Carter, 2020; Krägeloh et al., 2012; Lewis-Coles & Constantine, 2006). Theoretically, there may be benefits of CG in reducing general stress and traumatic stress and increasing overall psychological well-being (Bock et al., 2018; Kim & Bae, 2019; Krause, 2006; Uhder et al., 2017). Gratitude has been shown to be associated with fewer posttraumatic stress symptoms after trauma and is linked to PTG. There may also be an association between RBTS and PTG (Johnson & Carter, 2020; Lewis-Coles & Constantine, 2006; Subandi et al., 2014). Therefore, the hypotheses for the current study are described next.

Hypotheses

The study hypotheses among a community sample of self-identified African American Christians are as follows:

1. Microaggressions will be positively associated with PTG. According to the findings of previous research, persons who had responded negatively to traumatic experiences with posttraumatic symptoms showed greater levels of PTG over time than those who did not suffer from PTSD (Dekel et al., 2012).

2. Microaggressions will be positively associated with RBTS. According to the literature, the accumulation of microaggressions may provoke a chain of compounded negative racial occurrences that cause an individual to respond with trauma symptoms (Carter, 2007).

3. RBTS will be positively associated with PTG. Endorsement of posttraumatic symptoms has been linked to posttraumatic growth (Dekel et al., 2012).

4. The association between microaggressions and PTG will be mediated by RBTS, and this association will be moderated by Christian gratitude in that Christians with higher Christian gratitude will demonstrate more PTG. The literature indicates that Christian gratitude, a type of religious coping, may be positively associated with racial stress and growth (Emmons & Kneezel, 2005; Kim et al., 2015; Knabb et al., 2021; Upenieks & Ford-Robertson, 2022).

CHAPTER 3

METHODOLOGY

The present research looked at the relationships between microaggressions, PTG, RBTS, and Christian gratitude. This section discusses the research design and variables, participants, procedures, measurements, and data analysis strategy.

Research Design and Rationale

The present study design is a moderated mediation analysis. The researcher explored potential links between microaggressions as an independent variable, RBTS as a mediating variable, and PTG as a dependent variable, assessing the moderating role of Christian gratitude in these relationships. Some models that address trauma not specific to race-related stress focus on understanding the mechanisms of religious coping and psychospiritual flexibility in response to trauma (Lehmann & Steele, 2020; Lewis-Coles & Constantine, 2006a; McCleary-Gaddy & Miller, 2019; Schultz et al., 2010). The current study explored how religion and spirituality provide coping mechanisms that were linked to posttraumatic stress (RBTS) and PTG outcomes (Lehmann & Steele, 2020).

Participants and Procedure

MTurk and Demographics

The study solicited participants using a research market platform called Mechanical Turk, also known as MTurk (Burnham et al., 2018). Run by Amazon, MTurk connects researchers with online participants based on the parameters set by the study for the researcher's desired tasks. A final sample of 157 individuals was recruited for the study. An estimated sample size was calculated using a priori power analysis through

G*Power (Faul et al., 2007). For a medium effect with significant results ($p < .05$) and 80% power for multiple linear regression, fixed model, and R^2 deviation from zero, approximately 77 participants were required. For a mediation analysis, Fritz and MacKinnon (2007) recommended a total of 71 participants. These findings were extrapolated for the current study due to limited empirical findings for estimating sample size for a moderated mediation analysis.

MTurk's statistical validity is equivalent to that of a typical, traditional community sample (Rouse, 2020). The researcher took an additional step to verify reliability by including six different attention check questions (ACQ; Aguinis et al., 2021; Barends & de Vries, 2019). An example of an ACQ is, "To monitor quality, please respond with a '2' rating to this item." If the participants failed just one of these questions, they were removed from the sample. With the potential of disqualifying individuals based on failing the ACQs and upon data cleaning, the researcher found 11 individuals who missed at least one of the six ACQs. Two multivariate outliers were also removed. The total sample size prior to removing these individuals was 170; exclusions of these 13 participants resulted in the current study sample of 157 participants. Qualifying individuals self-identified as African American and Christian and lived within the continental United States. Participants were required to have performed at least 500 or more previous MTurk tasks. They were also required to have been approved for payment with at least 95% of those tasks (Peer et al., 2014). Qualifying participants were paid $2 each to complete the research surveys.

The majority of the sample were female (64.3%) and affiliated with the Protestant faith (70.7%). The average age of the participants was 40.4 years old ($SD = 11.7$). Most

participants had a college or higher education (69.4%). See Table 1 for a summary of all participant demographics.

CloudResearch, IRB, and Other Procedures

The study used CloudResearch, an online survey platform, to access MTurk participants. Qualtrics was used to post the survey and collect the resulting data. Prior to the start of the study, the researcher submitted the study proposal for review and approval by a university Institutional Review Board (IRB). The IRB approval is attached in Appendix B, with the name of the institution and approval number. Study participants remained anonymous and were only identified by their MTurk delegated worker code. The code verified the worker's identity for payment of $2 per participant after reading and agreeing to the informed consent (see Appendix A) and completing the study surveys.

Measures

Christian Gratitude Scale

The Christian Gratitude Scale (CGS) is a six-item self-report measure (Knabb et al., 2021). The scale measures participants' Christian gratitude from a Christian worldview. The measure uses a 6-point Likert scale (1 = *strongly disagree* to 6 = *strongly agree*). The scale asks questions related to the participant's relationship with God such as, "I should thank God daily for His forgiveness" and "I often meditate on God's goodness." It has strong internal consistency (Cronbach's α was .95) and is correlated with measures of general gratitude and psychological well-being (Knabb et al., 2021). In the current study, α = .96 also showed excellent internal consistency.

Posttraumatic Growth Inventory

The Posttraumatic Growth Inventory (PTGI) is a scale that measures the experience of those who have suffered traumatic events (Tedeschi & Calhoun, 1996). It is a 21-item self-report questionnaire that includes components of potential, relating, personal power, spiritual difference, and life reflection (e.g., "I changed my priorities about what is important in life" and "I established a new path for my life"). The measure uses a 6-point Likert scale (0 = *I did not experience this change as a result of my crisis* to 5 = *I experienced this change to a very great degree as a result of my crisis)*. The scale assesses how well individuals manage their posttrauma identity, as well as comprehend traumatic events. The PGI has shown excellent internal consistency (Cronbach's α was .96; Tedeschi & Calhoun, 1996). In the current study, α = .97 also showed excellent internal consistency.

Race-Based Traumatic Stress Symptom Scale

The Race-Based Traumatic Stress Symptoms Scale (RBTSSS) measures traumatic responses after racism (Carter et al., 2013). The original RBTSS uses a Likert scale. In the current study, using *yes* or *no* responses for 52 items, we assessed symptoms on seven subscales, including Depression, Anger, Physical Reactions, Avoidance, Intrusion, Hypervigilance/Arousal, and Low Self-Esteem. In previous studies, the scale components were strongly correlated with existing measures of race-related stress and trauma models (Carter & Muchow, 2017). In the current study, participants were asked to think about a memorable experience with discrimination (microaggressions as described in the Racial and Ethnic Microaggressions Scale). They then responded to questions related to that event, such as, "I was worried about situations in which I might panic and make a fool of myself" and “I feel I can seldom do anything right.” Carter et al. (2013)

found that Cronbach's α was .96 for the RBTSSS, showing adequate internal consistency. In the current study, α = .81 showed good internal consistency.

Racial and Ethnic Microaggression Scale

The Racial and Ethnic Microaggression Scale (REMS) is a self-report 6-point Likert scale (0 = *I did not experience this event in the past six months* to *5 = I experienced this event five times in the past six months*) measure that includes 45 items (Nadal, 2011). As indicated by the significant correlations between current measures of racism and participant feedback, it has strong construct validity. The scale asks questions related to the participant's experiences of microaggressions. Sample items include, "I was told that I should not complain about racism" and "Someone wanted to date me only because of my race." Inferiority Assumptions; Second-Class Citizen Assumptions; Microinvalidations; Exoticization and Assumptions of Similarity; Environmental Microaggressions; and Workplace and School Microaggressions make up the six-factor model of this scale. Nadal (2011) found a Cronbach's alpha of .91 for the overall model showing excellent internal consistency. In the current study, α = .98 also showed excellent internal consistency.

Data Analysis and PROCESS Macro

The main analysis for this study was a moderated mediation analysis. The study used Hayes 'PROCESS macro (Hayes, 2022). The PROCESS macro is a statistical modification software plugin. The researcher used model 14 for a moderated mediation analysis to determine whether *x* (the independent variable) had an effect on *y* (the dependent variable) through the mediator (*m*), of which the effect was moderated by another variable (*w*). Microaggressions (REMS) served as the independent variable,

RBTS as the mediating variable, PTG as the dependent variable, and CG as the moderator, with religious affiliation as a covariate. Additionally, the study used bootstrapping with 5,000 samples to determine the upper-level and the lower-level confidence intervals for the unstandardized regression coefficients to assess indirect effects, direct effects, and moderation. If the confidence interval results did not include zero, the results were considered significant. The researcher also looked at Pearson correlations across all variables using interpretive guidelines for assessing the strength of the relationships between variables (correlation coefficient descriptors: small/weak = .10; medium/moderate = .30; large/strong = .50; Schober et al., 2018). The researcher also conducted *t*-tests and analysis of variance (ANOVA) to see whether there were any variations between group means by gender or religious affiliation (Sajeevanie, 2020). The researcher controlled for variables for which differences were found (religious affiliation only).

CHAPTER 4

RESULTS

The following results include a review of mean score comparisons for all study variables, Pearson correlations, and the primary study analysis moderated mediation.

Mean Score Comparisons and Pearson Correlations

Independent samples *t*-tests and ANOVAs were conducted to evaluate mean score differences by religious affiliation and gender for all variables. For gender, there were no Statistically significant differences found between males and females on any of the study variables. Specifically, the REM levels among men ($M = 58.5$, $SD = 51.7$) and women ($M = 52.1$, $SD = 42.0$) presented no significant statistical differences, $t(155) = .83$, $p = .20$). In terms of gender, with RBTS levels of male participants, there was no statistically significant difference ($M = 12.4$, $SD = 12.7$) compared to their female counterparts ($M = 11.6$, $SD = 12.3$), $t(155) = .39$, $p = .35$. For gender, CG levels for male participants were also not found to have statistically significant differences ($M = 30.8$, $SD = 5.44$) compared to females ($M = 31.9$, $SD = 4.21$), $t(155) = -1.44$, $p = .08$. Finally, *t*-tests for gender and PTG revealed no significant differences between males ($M = 48.6$, $SD = 28.6$) and females ($M = 44.4$, $SD = 31.8$), $t(155) = .83$, $p = .20$.

A one-way ANOVA was conducted to compare the three faith affiliations (Protestant, Catholic, and other) on REM, RBTS, CG, and PTG. The ANOVA revealed significant differences between the three faith groups on REM, $F(2, 154) = 18.27$, $p < .001$, $\eta 2 = .19$. Post hoc comparisons using the Tukey HSD test revealed that Catholics reported significantly more REM ($M = 91.6$, $SD = 53.0$) than Protestants ($M = 43.5$, $SD = 36.8$) and other Christians ($M = 46.2$, $SD = 43.2$). Statistically significant differences

emerged between the three faith groups on RBTS, $F(2, 154) = 5.82$, $p < .01$, $\eta 2 = .07$. Post hoc comparisons using the Tukey HSD test revealed that Catholics reported significantly more RBTS ($M = 17.8$, $SD = 14.5$) than Protestants ($M = 10.5$, $SD = 11.6$) and other Christians ($M = 7.10$, $SD = 7.60$). There were statistically significant differences found between the three faith groups on PTG, $F(2, 154) = 11.7$, $p < .001$, $\eta 2 = .13$. Post hoc comparison showed that Catholics ($M = 66.6$, $SD = 27.1$) reported greater PTG than Protestants ($M = 40.2$, $SD = 29.1$), and others ($M = 37.4$, $SD = 29.9$). There were no statistically significant differences found between the three faith groups on CG, $F(2, 154) = 1.62$, $p = .20$, $\eta 2 = .02$; Catholics, $M = 30.5$, $SD = 5.28$; Protestants, $M = 31.9$, $SD = 4.46$; and others, $M = 30.2$, $SD = 4.70$.

Pearson correlation analyses were used to investigate the relationships between all study variables (REM, RBTS, CGS, and PTG; see Table 2). Statistically significant relationships were discovered between several variables, ranging from a weak to a strong degree of association. Specifically, the findings indicated that REM and RBTS were positively related ($r = .48$; a medium to large effect). A significant positive association emerged between RBTS and PTG ($r = .40$; a medium effect). Further, REM and PTG were significantly positively correlated ($r = .54$; a large effect). Likewise, a significant positive relationship was found between CG and PTG ($r = .18$; a small effect). CG was not significantly associated with REM or RBTS.

Moderated Mediation

The researchers conducted a moderated mediation analysis with REM (independent variable), RBTS (mediator), CG (moderator), PTG (dependent variable), and religious faith as a covariate using Hayes' PROCESS Macro Model 14 through SPSS

statistical software (Hayes, 2022). REM emerged as significantly and positively associated with RBTS, as shown in path *a* ($b = .12$, $p < .001$) (see Figure 2). RBTS emerged as significantly and positively associated with PTG, shown in path b_1 ($b = .38$, $p < .032$). CG emerged as significantly and positively associated with PTG, as indicated in path b_2 ($b = 1.42$, $p < .001$). There was a positive and significant direct effect of REM on PTG in path *c'* ($b = .29$, $p < .001$). CG was shown to be a non-significant moderator of the association between RBTS and PTG in path b_3 ($b = .02$, $p = .60$). However, a closer look at the data revealed that moderated mediation was supported at average ($b = .05$, 95% LLCI = .01, UCLI = .09) and high ($b = .05$, 95% LLCI = .01, ULCI = .11) levels of the moderator.

In other words, the moderated mediation was not significant at low levels of the moderator (Christian gratitude). As seen in the bootstrap analysis for both the lower-level confidence interval (LLCI = .00) and the upper-level confidence interval (ULCI = .09), at low levels of the moderator, the findings included zero. Moreover, the index of moderated mediation was .00 (95% LLCI = .00; ULCI = .01). The studied variables (REM, RBTS, CG) accounted for 38% of the variance in PTG, $F(5, 151) = 18.9$, $p < .001$, $R^2 = .38$). See Table 3 for a summary of the moderated mediation results.

Following a post-hoc mediation-only analysis, it was discovered that significant relationships existed between REM, RBTS, and PTG, using religious affiliation as a covariate. REM emerged as significantly and positively associated with RBTS ($b = .12$, p < .001). RBTS emerged as significantly and positively associated with PTG ($b = .39$, $p < .05$). There was a positive and significant direct effect of REM on PTG ($b = .28$, $p < .001$). The results also revealed a significant indirect effect of REM on PTG through

RBTS (*b* = .05, 95% CI [.01, .10]). Thus, RBTS was shown to significantly mediate the association between REM and PTG.

CHAPTER 5

DISCUSSION

The purpose of this research was to investigate the connections between racial and ethnic microaggressions, race-based traumatic stress, posttraumatic growth, and Christian gratitude in a population of adult Christian Black Americans. The researcher used an online survey to collect data on REM, RBTS, PTG, and CG for a moderated mediation analysis using Hayes ’(2022) PROCESS macro. Initially, comparisons were conducted for all variables to determine if differences existed by gender or religious affiliation. There were no significant differences between genders (male and female) for any of the research variables, which may suggest that adverse racial interactions are experienced in a manner that is similar for both Black Christian men and women. Significant score differences emerged between faith traditions with Catholics showing greater REM, RBTS, and PTG than Protestants and other Christians. The reasons for these differences are unclear. However, this may indicate that people of differing faiths may experience and respond to racism in a manner connected with their religious beliefs and experiences.

Additionally, the results showed that CG was not significantly associated with REM or RBTS but showed a significant positive association with PTG (a small effect). However, all of the other variables (REM, RBTS, and PTG) had significant medium to large positive associations that were expected based on the current literature (Abdullah et al., 2021; Barber, 2021; Carter, 2007b; Carter et al., 2020; Dekel et al., 2012; Jernigan & Daniel, 2011; Johnson & Carter, 2020; Noel & Johnson, 2005; Ortega-Williams et al., 2021; Utsey et al., 2000). For example, in their longitudinal study, Dekel et al. (2012) found that posttraumatic stress symptoms had a strong positive association with PTG.

Further, Carter (2007b) provided a theoretical backing for RBTS' relationship with REM. The theoretical basis of RBTS supported microaggressions as having a continual or enduring effect on individuals who experience them, potentially resulting in RBTS. Abdullah et al. (2021) found in their linear regression analysis that REM had a positive association with PTSD symptoms, including those of RBTS. Furthermore, consistent with these findings, participants in this study reported experiencing microaggressions, and there was a positive correlation between these negative racial experiences and race-based traumatic stress. In sum, the findings of the current study indicate that REM was associated with RBTS for Black Christians, adding to these previous studies that also reported similar findings (Abdullah et al., 2021; Carter, 2007a; Carter et al., 2017, 2020; Sue et al., 2019; Williams, 2020a).

Furthermore, the hypothesized moderated mediation was not supported by the overall model. However, the conditional indirect effect of RBTS on PTG at average and high levels of Christian gratitude was significant. Despite this, given that the index of moderation was not significant, further research is needed to determine whether the conditional indirect effect at average and high levels can be supported. Effect sizes at average and high levels of CG were small; therefore, power may have been a factor, and replication of the study with a larger sample may produce a larger effect.

In addition, in a post-hoc mediation-only model, RBTS mediated the association between REM and PTG. Thus, the hypotheses of the research were partially supported. Based on these results, RBTS appears to explain the relationship between REM and PTG. Zhou et al. (2022), in their mediation analysis on secondary posttraumatic growth among adult children of former prisoners of war (POW), found similar results. In adult offspring

of POW fathers, there was a strong positive association between overall stress exposure and stress symptoms as well as between stress symptoms and secondary posttraumatic growth factors.

These current findings add legitimacy to the conclusions drawn from earlier studies involving African American participants and the relationships between microaggressions, RBTS, and PTG but may call into question the theoretical assumption of the current study about the types of religious coping strategies that are most effective for promoting positive psychological outcomes in African Americans who experience RBTS (Dekel et al., 2012). Although gratitude in the Christian faith may be a form of spiritual coping, it exists among many other coping strategies. Some of these include using Negro spirituals and religious music, rituals, meditation, collective assembly, collaborative movements, trust and humor, and other spiritual traditions (Barber, 2021; Johnson & Carter, 2020; Noel & Johnson, 2005; Utsey et al., 2000). Therefore, further research is necessary to better understand whether other religious coping strategies may moderate the relationships studied herein.

Clinical Implications

The associations between REM, RBTS, CG, and PTG have important clinical implications that should be considered. First, the positive correlation between negative racial encounters (REM) and racial trauma (RBTS) helps support the need for clinical psychologists to recognize that racial incidents, no matter how serious or mild, everyday racial injustices, and REM are related to psychological symptoms given the repeated nature of these negative racial exposures (Carter, 2007b). This is relevant to clinical diagnosis, given that symptoms of RBTS may often be misdiagnosed, and this can

happen if the patient does not provide a history of major racist events or traumatic experiences but, instead, reports the accumulation of REM encounters (Carter, 2007b). Correct diagnosis of African Americans requires an understanding of RBTS within the context of racial microaggressions (Sue et al., 2007). Clinicians have an ethical duty to help their patients in need; thus, they should acquire knowledge and understanding of racial microaggressions as linked to RBTS in order to provide culturally relevant diagnosis and therapeutic care. In acknowledging and attaining a history of negative racial experiences (including minor racial slights) of individuals who self-identify as Black Christians, a clinician can assess their cumulative impact, which may help identify the presence of the unique symptoms of RBTS.

An accurate assessment and evaluation of RBTS will also inform clinical treatment for individuals who suffer from this sort of traumatic stress. For this reason, it is essential for clinicians to engage in early assessment of RBTS symptoms and REM experiences to inform case conceptualization and intervention. This is particularly relevant for practitioners who identify as belonging to a different racial and ethnic group. For example, in their content analysis, Yeo and Torres-Harding (2021) found that negative racial encounters in therapy (including microaggressions) significantly affected the client–therapist interaction and active approaches to mending these ruptures improved therapeutic bonds for patients of color. Further, clinicians may unconsciously deliver racial microaggressive insults to their already-vulnerable patients without specialized training (Taylor & Kuo, 2019). Therefore, clinicians who are more aware of microaggressions and include assessment and intervention strategies in treatment may be less likely to experience these ruptures.

Clinicians will also need to develop a comprehensive understanding of the values and beliefs that influence culturally distinctive coping for those who identify as African American, which may include Christian gratitude. Culturally based religious coping is an important historical aspect of Black resilience and may have clinical relevance for healing racial trauma (Lewis-Coles & Constantine, 2006; McCleary-Gaddy & Miller, 2019; Range et al., 2018; Vazquez et al., 2021). Despite Christian gratitude not having a moderating role between RBTS and PTG in the current study, it was still shown to be positively associated with PTG. According to Wood et al. (2010), there is neglect and a lack of appreciation for the significance of promoting gratitude through psychotherapeutic treatment. Vieselmeyer et al. (2017) discovered that posttraumatic therapies aimed at increasing gratitude enabled trauma-exposed individuals to develop more psychologically flexible perceptions of their trauma narrative, which, in turn, led to posttraumatic growth. Christian gratitude may be a culturally sensitive focus of this form of treatment for Black Christians.

According to a number of studies, a general attitude of thankfulness might influence perceptions by acting as an affirmation of the goodness present in the individual's life and an acknowledgment that the origins of goodness are external (Fincham & May, 2021; Rosmarin et al., 2011). Although the results of the current study found that CG may not buffer the relationship between RBTS and PTG, it still maintained a weak association with PTG. While acknowledging that there may be other spiritual coping methods that better address race-based psychological suffering for African Americans, PTG may also emerge as CG is facilitated within a culturally humble therapeutic alliance. As clinicians emphasize cultural humility by working within the

worldview of the client, they can develop a more productive working alliance. Sensitivity for what works and what does not work helps clinicians remain aware of the need for individual and cultural adaptations, such as the use of some religious coping interventions (Wang et al., 2013; Yeo & Torres-Harding, 2021).

Black Christians who exhibit clinical symptoms from RBTS may also need support for making meaning to move toward healing, change, and PTG (Carter, 2007a, 2007b; Carter et al., 2017). Due to the multiple ways in which racism is experienced, including microaggressions, fostering PTG may include directly addressing RBTS. This may include tools that expose the trauma, address reactivity, and challenge negative schemas (Bryant-Davis et al., 2017; Bryant-Davis & Ocampo, 2006; Carter, 2007b; Carter et al., 2013, 2020; Comas-Díaz et al., 2019). Focusing on the current findings, the traditional PTSD measures do not adequately assess for distinctive characteristics of RBTS (Roberson & Carter, 2021), which includes a lack of assessment related to REM. Therapeutic approaches and interventions that address the uniqueness of symptoms while also considering historical, institutional, sociocultural, and individual racism (REM) are important for clinicians to develop while addressing the psychological healing of Black Americans who have RBTS.

Limitations

The current study had several limitations. The study is limited in that causation cannot be determined with the use of a mediation or moderated mediation model. In spite of that fact, mediation models are useful in situations in which the statistical model is backed by a robust theoretical model, such as in this investigation. However, it is impossible to draw causal inferences (Agler & De Boeck, 2017). Furthermore, the use of

MTurk is not without risk; for example, researchers cannot verify participants' identities without interacting with them directly, increasing the possibility of sampling error. Also, when respondents opt to engage based on their interests, an implicit bias may potentially lead to a selection error (Pannucci & Wilkins, 2010). Keeping this in mind, it is possible that the reliability and validity of the test findings may have increased with a bigger sample that allowed for the exclusion of additional participant data for erroneous reporting (Barends & de Vries, 2019).

As noted, online research platforms have the potential to introduce measurement errors. Surveys may be taken by bots, and humans can participate without reading the questions. The ACQs in the survey design helped to exclude completed surveys that did not meet the inclusion criteria for adequate attention (Barends & de Vries, 2019). Although, there is still a chance for inaccuracy in this kind of data gathering, even with the inclusion of ACQs. Also, as demonstrated in prior research, sample bias might emerge due to possible demographic variations between MTurk and the broader population, meaning that the findings may not be generalizable (Burnham et al., 2018).

The study is also limited in that it is unknown where the participants who took the study lived. Geographical location may have played a role in the study's results. According to Kim et al. (2016), the interplay of geography, namely the sociocultural environment, with reported experiences of racial prejudice may be a significant factor for targets of racism. They found that Blacks in the Western United States were shown to be more affected by their perception of racial discrimination than Blacks in the Southern United States, and this effect persisted in negatively impacting the participant's psychological well-being. Their results suggested that there may be a connection between

perceived racial discrimination and poor mental health among older Blacks; this may vary depending on their location of residence. (Kim et al., 2016).

Thus, geographical location may have impacted the participants' perceptions of negative racial encounters in this study resulting in more or less reported negative experiences and traumatic responses to microaggressive encounters. The lack of this variable's inclusion may also have limited the results and may account for some variability. Further, knowing the general geographical location of participants may have elucidated the complex nature of the constructs and underscored the complex nature of this population. It might also be one reason that it was difficult to pinpoint the role of CG in PTG and RBTS.

Future Directions

Reasons including cost, stigma, historical mistrust, and a lack of professional cultural competency all contribute to African Americans' lack of access to effective mental health treatment and culturally competent therapies (Novacek et al., 2020). More research is required to assist clinical psychologists in discovering novel treatment strategies for cultivating PTG in persons with RBTS. Previous research supports the notion that traumatic stress may both influence and sustain posttraumatic growth (Dekel et al., 2012). It would be beneficial to conduct more research to better understand the mechanisms by which RBTS might help sustain and enable PTG. For example, the African American community may find comfort through the use of various religious coping mechanisms and has a long history of using church support to cope (Barber, 2021; Chatters et al., 2008; Johnson & Carter, 2020; Noel & Johnson, 2005; Park et al., 2018; Taylor et al., 2021; Utsey et al., 2000).

In subsequent research, it may be possible to investigate the extent to which Christian gratitude for Christian African Americans is moderated by the support provided through their Black congregations. PTG may increase after RBTS as a result of the Black church community providing an insular experience free from racial microaggressions while allowing the space for healing, which may include Christian gratitude. Church support may play a role in the development of a deeper and more pervasive sense of Christian gratitude among Black Christians not found in outside sources (Krause & Cairney, 2009).

The significant difference seen in the current study between Catholics, Protestants, and others, with Catholics showing greater REM, RBTS, and PTG, may also provide future direction for research in these areas. The reasons for these differences are unclear. However, this may indicate that people of differing faiths may experience and respond to racism in a manner connected with their religious beliefs, experiences, and ways of understanding suffering. For instance, Catholics may subscribe to a unique worldview that calls them to endure suffering as a means to participate in world redemption (McTavish, 2016; Perkins, 2021). It may be that racism, negative racial encounters, and the subsequent traumatic response may be seen as a part of the intrinsic and extrinsic metaphysical value of suffering for the sake of the church (Considine, 2017; Krause, 2010a, 2010b), which, ultimately, may promote posttraumatic growth (McTavish, 2016).

Also, alternate types of religious coping have the potential to act as a moderator between RBTS and PTG. Further research on mitigating strategies for RBTS, such as the use of other religious coping methods, may help to underscore culturally relevant

therapies for clinical practice with Christian African Americans who are in need of posttraumatic healing.

Moreover, Christian gratitude has different origins than general expressions of gratitude, as general gratitude is often motivated by self-love (Dunnington, 2022). Christian gratitude, however, is a response to God's goodness (Knabb et al., 2021) demonstrated in such things as Christ's saving work on the cross (see Matt. 27) and God's expressed unconditional love (see John 3:16). Noel and Johnson **(**2005) observed that through Negro spirituals the narrative of Christ's crucifixion and its symbolism served as a coping mechanism for maintaining the psychological well-being of African Americans over centuries of racial oppression. These sacred songs focused on Christ's crucifixion may have served as a support for those enduring continual race-based suffering. Therefore, it may be that focusing on Christ's atonement (reparation made for the sins of the world) may create a heart appreciation (CG) for what Christ accomplished on the cross. With this in mind, future studies might focus on Christian meditation and its role for Christian African Americans who experience RBTS. Christian meditation focused on Christ's redeeming act of self-sacrificing love may influence the relationship between RBTS and PTG and may present more subtle elements of Christian gratitude.

Conclusion

Christian gratitude did not moderate the indirect effect of racial microaggressions on posttraumatic growth through race-based traumatic stress, but it did show a positive association with PTG. Although the practice of Christian gratitude is one religious coping mechanism among others, future research should seek to understand the relationship between CG and PTG. CG and alternative methods of religious coping may prove to be

useful for African American Christians who experience REM. More research is required to determine the role that religious coping techniques may have in promoting psychological well-being and posttraumatic growth in the context of REM and RBTS.

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APPENDIX A

INFORMED CONSENT

CONSENT TO ACT AS HUMAN RESEARCH SUBJECT/PARTICIPANT

INVESTIGATOR(S): Stephanie Gregorius Zivanovic, Psychology Doctoral Student, California Baptist University**.**

TITLE: Christians African Americans and Race-based Traumatic Stress

PURPOSE: To examine gratitude to God among Christian African Americans and its relationship to psychological functioning.

VOLUNTARY STATUS: You are being invited to participate in a research study conducted by the individual listed above. Your participation is voluntary, which means you can choose whether or not you want to participate. You may withdraw at any time without penalty, although you will not be compensated if you do not fill out the measures in full. Before you can make your decision, you will need to know what the study is about, the possible risks and benefits of being in this study, and what you will have to do in this study. The below section offers a brief overview of this information. You may also decide to discuss it with your family or friends before agreeing to participate. You may find some of the language difficult to understand. If this is the case, please ask the lead researcher about this form. If you decide to participate, you will be asked to electronically sign this form—in Qualtrics—by clicking on the "I agree" option on this page to continue.

PROCEDURES: To participate in this study, you must (a) be at least 18 years old, and (b) self-identify as a Christian African American. You will fill out questions related to your relationship with God, psychological functioning (e.g., thoughts, feelings, behaviors), and stressful/traumatic rase-based encounters. The entire survey will be completed in Qualtrics, an online survey platform, and take approximately 20 minutes.

RISKS: It is expected that participation in this study may lead to some discomfort and/or distress, given you will be asked to answer questions about your relationship with God, daily psychological functioning (i.e., your thoughts, feelings, and behaviors), and stressful/traumatic racial encounters. We are aware that answering questions about stressful/traumatic racial encounters could lead to an increase in the frequency and intensity of trauma-related thoughts and symptoms. If you feel uncomfortable or distressed, you can choose to stop the study at any time by not answering the remaining questions. If needed, you can also access the links below to seek help from a mental health provider in your area at your own expense.

American Association of Christian Counselors
(https://connect.aacc.net/?search_type=distance)

Christian Association for Psychological Studies (https://www.caps.net/online-directory/)

Psychology Today (https://www.psychologytoday.com/us/therapists)

Also, if at any time you believe that you are in a crisis situation, you are encouraged to call 988 suicide hotline, 911 emergency hotline or go to a local emergency room. Additional foreseeable risks in this study include an accidental disclosure of your private information due to the online nature of the surveys. Finally, keep in mind, the lead researcher can choose to discontinue this study at any time.

BENEFITS: By participating in this study, you will help the researchers better understand gratitude to God, psychological functioning, and experiences of stressful/traumatic life events.

COMPENSATION (if any): $2 for completing all of the surveys in Qualtrics, totaling about 20 minutes in duration and arranged through MTurk. You will be asked for your MTurk Worker ID in order to verify that you have completed the surveys in their entirety prior to receiving payment. If you choose to discontinue the survey prior to completion, no compensation will be provided.

CONFIDENTIALITY: This research does not ask for identifying information, other than your MTurk Worker ID to verify you have completed the surveys and facilitate payment and basic demographic information (e.g., age, marital status, gender, ethnicity).

If you have any questions related to this study or need to report an adverse experience, please contact the primary researcher (information listed below). Also, if you have questions related to your rights as a research participant, please contact CBU's Institutional Review Board (irb@calbaptist.edu).

By clicking the "I agree" button below, you are indicating that you have read and understand the information provided above, that you willingly agree to participate, that you may withdraw your consent at any time and discontinue participation without penalty, that you have saved a copy of this form as desired, and that you are not waiving any legal rights or future claims.

Primary Researcher Information:
Stephanie Gregorius Zivanovic, M.A.
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APPENDIX B

IRB APPROVAL

IRB Approval

RE: IRB Review
IRB No.: 016-2223 Full

Project: The relationship between microaggressions, race-based traumatic stress, and posttraumatic growth: Assessing the moderating role of Christian gratitude for African American Christians

Date Complete Application Received: 9/30/2022
Date Final Revision Received: 10/4/2022

Principle Investigator: Ms. Stephanie Gregorius Zivanovic
Co-PI: N/A
Faculty Advisor: Dr. Veola Vazquez

College/Department: CBSS

IRB Determination: Full Application **Approved** – Faculty research using anonymous survey questionnaires; no minor participants; risk appropriately mitigated; no deception utilized; acceptable consent procedures and documentation; acceptable data protection procedures. Data collection may begin, in accordance with the final submitted documents and approved protocol.

Future Correspondence: All future correspondence about this project must include all PIs, Co-PIs, and Faculty Advisors (as relevant) and reference the assigned IRB number.

Approval Information: (Expiration: Full Review Only) Approval is granted for one year from date below. If you would like to continue research activities beyond that date, you are responsible for submitting a Research Renewal Request with enough time for that request to be reviewed and approved prior to the expiration of the project. In the case of an unforeseen risk/adverse experience, please report this to the IRB immediately using the appropriate forms. Requests for a change to protocol must be submitted for IRB review and approved prior to implementation. At the completion of the project, you are to submit a Research Closure Form.

Researcher Responsibilities: The researcher is responsible for ensuring that the research is conducted in the manner outlined in the IRB application and that all reporting requirements are met. Please refer to this approval and to the IRB handbook for more information.

Date: 10/07/2022

The IRB has reviewed your amendment application for 016-2223-FULL to increase participant compensation (and adjust the informed consent accordingly. This request has been approved.

Please refer to the original approval notice for guidelines and expiration date (if applicable).

On behalf of the IRB,
Date: 11/18/22

APPENDIX C

TABLES

Table 1

Demographics of the Participants and Study Variables (N = 157)

Variables	*N*	*%*	*M*	*SD*
Hours per month				
Bible reading	-	-	18.2	42.2
Prayer	-	-	32.7	72.9
Church attendance	-	-	8.74	16.2
Age	-	-	40.4	11.7
Gender				
Male	56	35.7		
Female	101	64.3		
Marital Status				
Married	64	40.8		
Single	73	46.5		
Divorced	0	0		
Widowed	16	10.2		
Separated	1	.6		
Other	6	1.9		
Education				
Some high school	1	.6		
High school graduate	8	5.1		
Some college	32	20.4		
Trade/technical/vocational	7	4.5		
College graduate	79	50.3		
Some postgraduate work	12	7.6		
Postgraduate work	18	11.5		
Religious Faith				
Catholic	35	22.3		
Protestant	111	70.7		
Other	11	7.0		

Note. All participants self-identified as Black or African American.

Table 2

Bivariate Correlations Among the Study Variables

Variables	1	2	3	4	*M*	*SD*	α
1. REM	-				54.4	45.7	.98
2. RBTS	.48**	-			11.9	12.4	.81
3. CG	-.08	-.01	-		31.5	4.7	.96
4. PTG	.54**	.40**	.18*	-	45.9	30.6	.97

Note. $N = 157$. *$p < .05$. **$p < .01$.

Table 3

Moderated Mediation Analyses with PTG

	b	*SE*	*t*	LLCI	ULCI
Outcome: PTG					
Predictor: REM	.29**	.05	5.73	.19	.40
RBTS	.38*	.18	2.07	.02	.73
CG		.43	3.32	.57	2.26
	1.42**				
RBTS x CG	.02	.03	.53	-.04	.07

Conditional Indirect Effect	*b*	*SE*	LLCI	ULCI
-1 *SD* (low) CI	.04	.02	.00	.09
Mean (average) CI	.05	.02	.01	.09
+1 *SD* (high) CI	.05	.03	.01	.11

Note. LLCI = bootstrapped lower-level confidence interval; ULCI = bootstrapped upper-level confidence interval. All values are unstandardized regression coefficients. * $p < .05$. ** $p < .001$.

APPENDIX D

FIGURES

Figure 1

Hypothesized Moderated Mediation Model

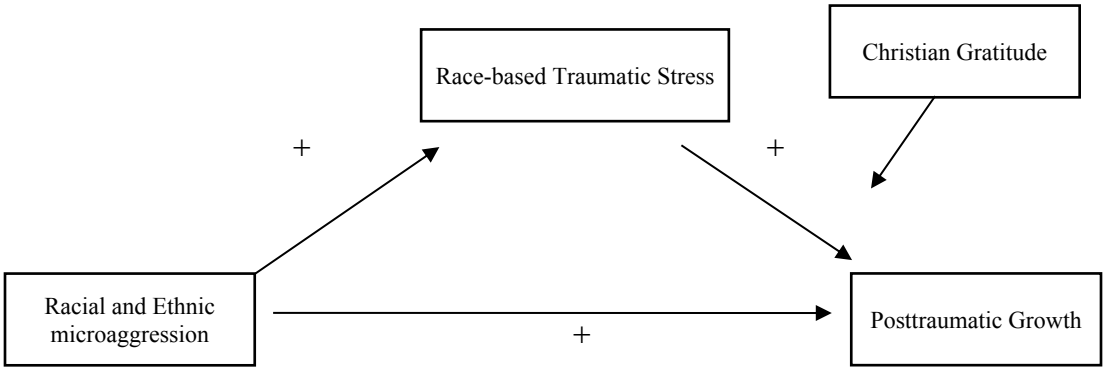
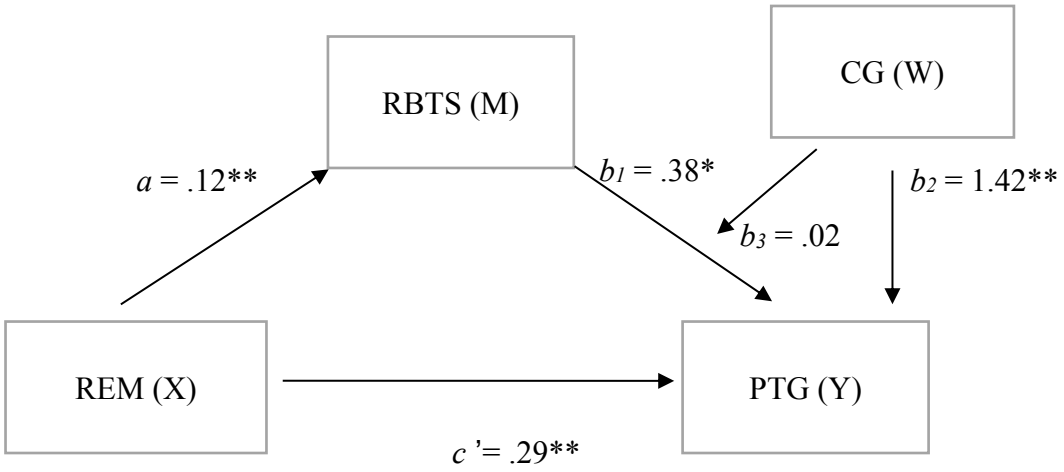


Figure 2

Moderated Mediation PROCESS Model 14



Note. All values are unstandardized regression coefficients. *c*' = direct effect of REM on PTG. * $p < .05$. ** $p < .001$.

APPENDIX E

MANUSCRIPT

The Relationship Between Microaggressions, Race-Based Traumatic Stress, and Posttraumatic Growth: Assessing the Moderating Role of Christian Gratitude for African American Christians

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Abstract

In the current study, the authors sought to understand the relationships between Christian gratitude (CG) and posttraumatic growth (PTG) following racial and ethnic microaggressions (REM) and race-based traumatic stress (RBTS) in a sample of self-identified Black American Christians living in the United States ($N = 157$). More specifically, using a moderated mediation analysis, the researchers explored the mediating role of RBTS in the link between REM and PTG, using CG as a moderator between RBTS and PTG. The findings showed a positive association between REM and PTG (a medium effect). Further, a positive association appeared between REM and RBTS and RBTS and PTG (both medium effects). Finally, inconsistent with the proposed hypothesis, the index of moderated mediation was not significant. In other words, CG showed no significant interactive relationship with RBTS for moderation between RBTS and PTG. The authors examine the therapeutic implications of the findings as well as potential directions for future research.

Keywords: microaggressions, race-based stress, posttraumatic growth, Christian gratitude

The Relationship Between Microaggressions, Race-Based Traumatic Stress, and Posttraumatic Growth: Assessing the Moderating Role of Christian Gratitude for African American Christians

Introduction

Americans who self-identify as Black or African American make up 13.6% of the total population (U.S. Census Bureau, 2021). These individuals report experiencing more microaggressions than any other racial group (Forrest-Bank & Jenson, 2015; Lee et al., 2019). According to Ong et al. (2017), the link between racial discrimination (e.g., microaggressions) and psychological distress is well-documented. Blacks endure more psychological distress than Whites (Williams, 2018), and racism-related mental health treatment inequities universally affect these individuals (Berger & Sarnyai, 2015). Racism's impact on Black Americans' psychological well-being and coping is part of North American history and culture (Smith et al., 2008). Racism negatively affects the health status of Black Americans at every stage of development (Carter, 2007). Factors of historical, institutional, sociocultural, and individual racism cause Black Americans more psychological distress and adverse health conditions than other races (Carter et al., 2017, 2020; Torres-Harding & Turner, 2015; Williams, 2020b).

As one of many responses, Blacks in the United States have turned to religious coping throughout the history of racism (Henderson et al., 2021; Kim et al., 2015; Lewis-Coles & Constantine, 2006). According to the Pew Research Center (2014), 79% of Black Americans self-identify as Christian. The evidence confirms that religious coping may benefit Black American Christians (Avent Harris et al., 2021; Lehmann & Steele, 2020) and play a helpful role in response to discrimination (Hughes et al., 2014;

McCleary-Gaddy & Miller, 2019). The particular ways in which Christian gratitude, a form of religious coping, may be associated with the negative impact of microaggressions, race-based traumatic stress (RBTS), and posttraumatic growth (PTG) have not been investigated. Therefore, the current study sought to understand these relationships among Christian Black individuals.

Microaggressions

Black Americans commonly experience microaggressions as subtle negative racial encounters, unintentionally or intentionally demeaning verbalized race-based hostility, insults, or ridicule (Sue et al., 2007). Microaggressions that are constant, recurring, and cumulative may foster life-long negative consequences, trigger poor social standing and serve as a reminder of historical trauma (Sue et al., 2019). Williams (2020a) noted that the term "microaggressions" does not do justice to the severity of psychological damage they cause.

As subtle manifestations of covert racism, microaggressions may occur without the aggressor's awareness (Williams, 2020a). However, they are frequently met by the recipient with questions about reality and their memory or perception of the experience, which can add insult to injury, compounding the effect (Carter et al., 2017; Sue et al., 2019). By the very nature of the microaggressive delivery and associated stigma, the victim's stress may escalate with each assault (Sue et al., 2007). A common reaction of the offender when confronted is denial and claim that the recipient is mistaken (Williams, 2020a). The recipient is frequently blamed, and the perpetrator insists on their own authority and interpretation, leaving the target feeling powerless (Williams, 2020a). In

light of these findings, it is important to note that racial microaggressions can harm mental health in a variety of ways.

Race-Based Traumatic Stress

The psychological damage and emotional distress produced by racial discrimination are also known as RBTS (Carter, 2007). RBTS is racial trauma characterized as the cumulative damaging effect of racism on a racialized individual, which may encompass both individual acts of racial discrimination and systemic racism, as well as historical and sociocultural racism (Williams et al., 2021). Carter and Muchow (2017) found that symptoms of RBTS included depression, physical symptoms, anger, hypervigilance, intrusion, avoidance, and low self-esteem. According to Carter and Muchow (2017), RBTS is a "complex race-related stress reaction" (p. 694). Therefore, it is not uncommon for those who experience RBTS to seek means of coping with this experience. Religious coping strategies are one common response.

Religious Coping

Culturally relevant strategies such as responsive coping, solution finding, and flexibility in dealing with prejudice may be associated with less psychological distress following discriminatory encounters (Gaylord-Harden & Cunningham, 2009; Szymanski & Lewis, 2016). For some African Americans, religious coping strategies may also play a central role in African American tradition and identity, which may help mitigate the impact of racism on the target's overall well-being in a way that enables them to better deal with the stress of discrimination (Chapman & Steger, 2010; Park et al., 2018).

Most of the research addresses positive and negative forms of religious coping (Pargament et al., 1998; Pargament et al., 2011). Negative religious coping (NRC) is

characterized by a strained connection with God, a pessimistic perspective of reality, and an inability to grasp life's larger purpose (Bjorck & Thurman, 2007). Positive religious coping (PRC) is linked to an improved degree of psychological well-being when used to cope with certain stressors (Pargament et al., 1998). Pargament et al. (1998) defined positive religious coping as an expression of spirituality, a solid connection with God, the perception that life has value, and faith in an interrelated spiritual community. Forgiveness sought via collaborative cooperation with God, seeking control through a supportive relationship with God, and reframing pressures through religion, all may be other forms of PRC useful for improving and sustaining psychological health (Szymanski & Obiri, 2011).

Christian gratitude, when exercised, may also heighten an individual's positive affect (Froh et al., 2009). According to Emmons and Kneezel (2005), the Christian faith is rooted in the spirit of gratitude. Knabb, Vazquez, Wang, et al. (2021) defined Christian gratitude (CG) as a spiritual action that includes psychological variables such as thoughts and emotions of genuine appreciation and the reflections and physical manifestations of each. As such, the exercise of Christian gratitude demonstrates an individual's indebtedness and oneness with God, and it fosters a believer's deeply shared interconnectedness with fellow Christians (Emmons & Kneezel, 2005). The present research investigates the ways in which Christian gratitude, conceptualized as a positive religious coping strategy, may serve as a moderator in a moderated mediation model. Within this model, the authors sought to determine whether the association between REM and PTG is mediated by RBTS, wherein the association between RBTS and PTG may be moderated by CG.

Posttraumatic Growth

Overall, evidence supports the benefits of religious coping for African American Christians (Avent Harris et al., 2021; Lehmann & Steele, 2020). There is a scarcity of literature supporting Africultural religious practices and their relationship to PTG (Johnson & Carter, 2020; Krägeloh et al., 2012; Lewis-Coles & Constantine, 2006). PTG is trauma resiliency seen through positive changes and psychological growth (Lotfi-Kashani et al., 2014). Dekel et al. (2012) found in their longitudinal study that the presence of PTSD promoted and sustained PTG rather than hindering it. Conceptualizations of PTG view trauma as a circumstance triggering transformative outcomes by challenging underlying beliefs, which may lead to a deeper sense of social connection, self-confidence, fresh perspectives, greater appreciation of life, and a shift in spiritual and existential interpretations (Tedeschi & Moore, 2021).

Studies focused on trauma generally show that positive and negative religious coping may have a strong positive relationship with posttraumatic growth (Mesidor & Sly, 2019). Although African Americans use a number of coping strategies to respond to racism and microaggressions (Holder et al., 2015), it is unknown if exercising a Christian-specific form of gratitude, Christian gratitude, in the context of microaggressions and RBTS may be related to PTG (Ellison et al., 2008; Rosmarin et al., 2011). Empirical support shows traumatic stress may foster and sustain PTG; this may include racial trauma for some African American individuals (Manove et al., 2019; Mesidor & Sly, 2019; Mosley et al., 2021). There may be an association between RBTS, CG, and PTG (Johnson & Carter, 2020; Lewis-Coles & Constantine, 2006; Subandi et al., 2014). Therefore, in the current study, the hypotheses were as follows:

1. Microaggressions would be positively associated with PTG.

2. Microaggressions would be positively associated with RBTS.

3. RBTS would be positively associated with PTG.

4. The association between microaggressions and PTG would be mediated by RBTS, and this association would be moderated by Christian gratitude in that African American Christians with higher Christian gratitude would demonstrate more PTG.

Methods

Participants and Procedures

Participants were recruited from Amazon's Mechanical Turk (MTurk), an online research platform, and were required to have performed at least 500 or more previous MTurk tasks. They were also required to have been approved for payment with at least 95% of those tasks (Peer et al., 2014; Rouse, 2020). Further, it was mandatory that they pass all the attention check questions (ACQ) such as, "To monitor attention, please select strongly agree." (Aguinis et al., 2021; Barends & de Vries, 2019). They were removed from the study if they missed just one attention check question (n = 11). In addition, 2 multivariate outliers were also removed. The total sample size prior to removing these individuals was 170 participants. Exclusions of these participants (n = 13) resulted in the current study sample of a total of 157 Black Christians.

The majority of participants were female (64.3%). The average age of the participants was 40 years of age (M = 40.4, SD = 17.7). Three Christian religious affiliations were represented: Protestants (n = 111, 70.7%), Catholics (n = 35, 22.3%), and other (n = 11, 7.0%). Single people made up the largest portion of the sample (n =

73, 46.5%), followed by married individuals (*n* = 64, 40.8%), and then widowed individuals (*n* = 16, 10.2%). See Table 1 for all demographic information.

Measures

Christian Gratitude Scale

The Christian Gratitude Scale (CGS) is a six-item self-report measure (Knabb, Vazquez, Wang, et al., 2021). The scale measures participants' Christian gratitude from a Christian worldview. The measure uses a 6-point Likert scale (*1 = strongly disagree* to *6 = strongly agree*). The scale asks questions related to the participant's relationship with God, such as, "I should thank God daily for His forgiveness" and "I often meditate on God's goodness." It has strong internal consistency and is correlated with measures of general gratitude and psychological well-being (Knabb, Vazquez, Wang, et al., 2021). In the current study, $\alpha = .96$, showing excellent internal consistency.

Posttraumatic Growth Inventory

The Posttraumatic Growth Inventory (PTGI) is a scale that measures the experience of those who have suffered traumatic events (Tedeschi & Calhoun, 1996). It is a 21-item self-report questionnaire that includes components of potential, relating, personal power, spiritual difference, and life reflection (e.g., "I changed my priorities about what is important in life" and "I established a new path for my life"). The measure uses a 6-point Likert scale (*0 = I did not experience this change as a result of my crisis* to *5 = I experienced this change to a very great degree as a result of my crisis)*. The scale assesses how well individuals manage their post-trauma identity, as well as comprehend traumatic events. The PGI has shown excellent internal consistency (Tedeschi & Calhoun, 1996). In the current study, $\alpha = .97$, also showing excellent internal consistency.

Race-Based Traumatic Stress Symptom Scale

The Race-Based Traumatic Stress Symptoms Scale (RBTSSS) measures traumatic responses after racism (Carter et al., 2013). The original RBTSS uses a Likert scale. In the current study, the authors used "*yes" or "no"* responses for 52 items to develop a total score by assessing symptoms from the seven subscales (Depression, Anger, Physical Reactions, Avoidance, Intrusion, Hypervigilance/Arousal, and Low Self-Esteem). In previous studies, the scale components were strongly correlated with existing measures of race-related stress and trauma models (Carter & Muchow, 2017). In the current study, participants were asked to think about a memorable experience with discrimination (microaggressions as described in the Racial and Ethnic Microaggressions Scale). They then responded to questions related to that event, such as, "I was worried about situations in which I might panic and make a fool of myself" and "I feel I can seldom do anything right." Carter et al. (2013) found that the scale has excellent reliability. In the current study, $\alpha = .81$, showing good internal consistency.

Racial and Ethnic Microaggression Scale

The Racial and Ethnic Microaggression Scale (REMS) is a self-report 6-point Likert scale (0 = *I did not experience this event in the past six months* to *5 = I experienced this event five times in the past six months*) measure that includes 45 items (Nadal, 2011). As indicated by the significant correlations between current measures of racism and participant feedback, it has strong construct validity. The scale asks questions related to the participant's experiences of microaggressions. Sample items include, "I was told that I should not complain about racism" and "Someone wanted to date me only because of my race." Inferiority Assumptions; Second-Class Citizen Assumptions;

Microinvalidations; Exoticization and Assumptions of Similarity; Environmental Microaggressions; and Workplace and School Microaggressions make up the six-factor model of this scale. Nadal (2011) found the scale to show excellent internal consistency. In the current study, $\alpha = .98$, also showing excellent internal consistency.

Data Analysis and PROCESS Macro

The main analysis for this study was a moderated mediation analysis using the Hayes 'PROCESS Macro model 14 (Hayes, 2022). The model was used to determine whether microaggressions (the independent variable) had an effect on PTG (the dependent variable) through the RBTS (the mediator), with CG as a moderator of the relationship between RBTS and PTG. Religious affiliation was entered as a covariate. Bootstrapping with 5,000 samples was used to determine the upper-level and the lower-level confidence intervals for the unstandardized regression coefficients to assess the conditional indirect effect. If the confidence interval results did not include zero, the results were considered significant. Pearson correlations across all variables were also assessed using the following interpretive guidelines for assessing the strength of the relationships: small/weak = .10; medium/moderate = .30; large/strong = .50 (Schober et al., 2018). The researchers also conducted *t*-tests and analysis of variance (ANOVA) to determine whether there were any variations between group means by gender or religious affiliation (Sajeevanie, 2020).

Results

Independent samples *t*-tests and ANOVAs were conducted to evaluate mean score differences by religious affiliation and gender for all variables. For gender, there were no differences found between males and females on any of the study variables. Specifically,

the REM levels among men (M = 58.5, SD = 51.7) and women (M = 52.1, SD = 42.0) presented no significant statistical differences ($t(155) = .83$, $p = .20$). In terms of gender, with RBTS levels of male participants, there was no statistically significant difference (M = 12.4, SD = 12.7) compared to their female counterparts (M = 11.6, SD = 12.3, $t(155) = .39$, $p = .35$). For gender, CG levels for male participants were also not found to have statistically significant differences (M = 30.8, SD = 5.44) compared to females (M = 31.9, SD = 4.21, $t(155) = -1.44$, $p = .08$). Finally, t-tests for gender and PTG revealed no significant differences between males (M = 48.6, SD = 28.6) and females (M = 44.4, SD = 31.8, $t(155) = .83$, $p = .20$).

A one-way ANOVA was conducted to compare the three faith affiliations (Protestant, Catholic, and other) on REM, RBTS, CG, and PTG. The ANOVA revealed significant differences between the three faith groups on REM [F (2, 154) = 18.27, $p < .001$, $\eta 2 = .19$]. Post hoc comparisons using the Tukey HSD test revealed that Catholics reported significantly more REM (M = 91.6, SD = 53.0) than Protestants (M = 43.5, SD = 36.8) and other Christians (M = 46.2, SD = 43.2). Statistically significant differences emerged between the three faith groups on RBTS [F (2, 154) = 5.82, $p < .01$, $\eta 2 = .07$]. Post hoc comparisons using the Tukey HSD test revealed that Catholics reported significantly more RBTS (M = 17.8, SD = 14.5) than Protestants (M = 10.5, SD = 11.6) and other Christians (M = 7.10, SD = 7.60). There were statistically significant differences found between the three faith groups on PTG [F (2, 154) = 11.7, $p < .001$, $\eta 2 = .13$]. Post hoc comparison showed that Catholics (M = 66.6, SD = 27.1) reported greater PTG than Protestants (M = 40.2, SD = 29.1), and others (M = 37.4, SD = 29.9). There were no statistically significant differences found between the three faith groups on

CG [F (2, 154) = 1.62, p = .20, η2 = .02; Catholics, M = 30.5, SD = 5.28; Protestants, M = 31.9, SD = 4.46; and others, M = 30.2, SD = 4.70].

Pearson correlation analyses were used to investigate the relationships between all study variables (REM, RBTS, CGS, and PTG; see Table 2). Statistically significant relationships were discovered between several variables, ranging from a weak to a strong degree of association. Specifically, the findings indicated that REM and RBTS were positively related (r = .48; a medium to large effect). A significant positive association emerged between RBTS and PTG (r = .40; a medium effect). Further, REM and PTG were significantly positively correlated (r = .54; a large effect). Likewise, a significant positive relationship was found between CG and PTG (r = .18; a small effect). CG was not significantly associated with REM or RBTS.

Moderated Mediation

The researchers conducted a moderated mediation analysis with REM (independent variable), RBTS (mediator), CG (moderator), PTG (dependent variable), and religious faith as a covariate using Hayes' PROCESS Macro model 14 (Hayes, 2022). REM emerged as significantly and positively associated with RBTS, as shown in path a (b = .12, p < .001) (see Table 3 and Figure 1). RBTS emerged as significantly and positively associated with PTG, shown in path b_1 (b = .38, p = .032). CG emerged as significantly and positively associated with PTG, as indicated in path b_2 (b = 1.42, p < .001). There was a positive and significant direct effect of REM on PTG in path c' (b = .29, p < .001). CG was shown to be a non-significant moderator of the association between RBTS and PTG in path b_3 (b = .02, p = .60). However, a closer look at the data

revealed that moderated mediation was supported at average (b = .05, 95% LLCI = .01, UCLI = .09) and high (b = .05, 95% LLCI = .01, ULCI = .11) levels of the moderator.

In other words, the moderated mediation was not significant at low levels of the moderator (Christian gratitude). As seen in the bootstrap analysis for both the lower-level confidence interval (*LLCI* = .00) and the upper-level confidence interval (*ULCI* = .09), at low levels of the moderator, the findings included zero. Moreover, the index of moderated mediation was .00 (95% *LLCI* = .00; *ULCI* = .01). The studied variables (REM, RBTS, CG) accounted for 38% of the variance in PTG ($F(5, 151)$ = 18.9, p < .001, R^2 = .38)

Discussion

The purpose of this research was to investigate the connections between racial and ethnic microaggressions, race-based traumatic stress, posttraumatic growth, and Christian gratitude in a population of adult Christian Black Americans. The researchers used an online survey to collect data on REM, RBTS, PTG, and CG for a moderated mediation analysis using Hayes (2022) PROCESS macro. Initially, comparisons were conducted for all variables to determine if differences existed by gender or religious affiliation. There were no significant differences between the genders (male and female) for any of the research variables, which may suggest that adverse racial interactions are experienced in a manner that is similar for both Black Christian men and women. Significance emerged between faith traditions, with Catholics showing greater REM, RBTS, and PTG than Protestants and other Christians. The reasons for these differences are unclear. However, this may indicate that people of differing faiths may experience and respond to racism in

a manner connected with their religious beliefs and experiences. Further research to investigate this finding is warranted.

Additionally, the results showed that CG was not significantly associated with REM or RBTS but showed a significant positive association with PTG (a small effect). However, all of the other variables (REM, RBTS, and PTG) had significant medium to large positive associations that were expected based on the current literature (Abdullah et al., 2021; Barber, 2021; Carter, 2007b; Carter et al., 2020; Dekel et al., 2012; Jernigan & Daniel, 2011; Johnson & Carter, 2020; Noel & Johnson, 2005; Ortega-Williams et al., 2021; Utsey et al., 2000). For example, in their longitudinal study, Dekel et al. (2012) found that posttraumatic stress symptoms had a strong positive association with PTG. Further, Carter (2007b) provided a theoretical backing for RBTS' relationship with REM. The theoretical basis of RBTS supported microaggressions as having a continual or enduring effect on individuals who experience them, potentially resulting in RBTS. Abdullah, et al. (2021) found in their linear regression analysis that REM had a positive association with PTSD symptoms, including those of RBTS. Furthermore, consistent with these findings, participants in this study reported experiencing microaggressions, and there was a positive correlation between these negative racial experiences and race-based traumatic stress. In sum, the findings of the current study indicate that REM were associated with RBTS for Black Christians, adding to these previous studies that also reported similar findings (Abdullah et al., 2021; Carter, 2007a; Carter et al., 2017, 2020; Sue et al., 2019; Williams, 2020a). REM, therefore, appear to be a relevant area for research and clinical attention when seeking to understand RBTS.

Furthermore, the hypothesized moderated mediation was not supported by the overall model. However, the conditional indirect effect of RBTS on PTG at average and high levels of Christian gratitude was significant. Despite this, given that the index of moderation was not significant, further research is needed to determine whether the conditional indirect effect at average and high levels can be supported. Effect sizes at average and high levels of CG were very small. Therefore, power may have been a factor, and replication of the study with a larger sample may produce a larger effect.

Overall, these current findings add legitimacy to the conclusions drawn from earlier studies involving African American participants and the relationships between microaggressions, RBTS, and PTG but may call into question the theoretical assumption of the current study about the types of religious coping strategies that are most effective for promoting positive psychological outcomes in African Americans who are confronted with RBTS (Dekel et al., 2012). Although gratitude in the Christian faith may be a form of spiritual coping, it exists among many other coping strategies. Some of these include using negro spirituals and religious music, rituals, meditation, collective assembly, collaborative movements, trust and humor, and other spiritual traditions (Barber, 2021; Johnson & Carter, 2020; Noel & Johnson, 2005; Utsey et al., 2000). Therefore, further research is necessary to better understand whether other religious coping strategies may moderate the relationships studied herein.

Clinical Implications

The associations between REM, RBTS, CG, and PTG have important clinical implications that should be considered. First, the positive correlation between negative racial encounters (REM) and racial trauma (RBTS) helps support the need for mental

health workers to recognize that racial incidents (no matter how serious or mild), everyday racial injustices, and REM are related to psychological symptoms given the repeated nature of these negative racial exposures (Carter, 2007b). This is relevant to clinical diagnosis given that symptoms of RBTS may often be misdiagnosed, and this can happen if the patient does not provide a history of major racist events or traumatic experiences but instead reports the accumulation of REM encounters (Carter, 2007b). Correct diagnosis of African Americans requires an understanding of RBTS within the context of racial microaggressions (Sue et al., 2007). Clinicians have an ethical duty to help their patients in need; thus, they should arm themselves with knowledge and understanding of racial microaggressions as linked to RBTS in order to provide culturally relevant diagnosis and therapeutic care. In acknowledging and seeking a history of negative racial experiences (including minor racial slights) of individuals who self-identify as Black Christians, a clinician can assess their cumulative impact, which may help identify the presence of the unique symptoms of RBTS.

An accurate assessment and evaluation of RBTS will also inform clinical treatment for individuals who suffer from this sort of traumatic stress. For this reason, it is essential for clinicians to engage in early assessment of RBTS symptoms and REM experiences to inform case conceptualization and intervention. This is particularly relevant for practitioners who identify as belonging to a different racial and ethnic group. For example, in their content analysis, Yeo and Torres-Harding (2021) found that negative racial encounters in therapy (including microaggressions) significantly affected the client–therapist interaction, and active approaches to mending these ruptures improved therapeutic bonds for patients of color. Further, clinicians may unconsciously

deliver racial microaggressive insults to their already-vulnerable patients without specialized training (Taylor & Kuo, 2019). Therefore, clinicians who are more aware of microaggressions and include assessment and intervention strategies in treatment may be less likely to experience these ruptures.

Clinicians will also need to develop a comprehensive understanding of the values and beliefs that influence culturally distinctive coping for those who identify as African American, which may include Christian gratitude. Culturally based religious coping is an important historical aspect of Black resilience and may have clinical relevance for healing racial trauma (Lewis-Coles & Constantine, 2006; McCleary-Gaddy & Miller, 2019; Range et al., 2018; Vazquez et al., 2021). Despite Christian gratitude not having a moderating role between RBTS and PTG in the current study, it was still shown to be positively associated with PTG. According to Wood et al. (2010), there is neglect and a lack of appreciation for the significance of promoting gratitude through psychotherapeutic treatment. Vieselmeyer et al. (2017) discovered that posttraumatic therapies aimed at increasing gratitude enabled trauma-exposed individuals to develop more psychologically flexible perceptions of their trauma narrative, which in turn led to posttraumatic growth. Christian gratitude may be a culturally sensitive focus of this form of treatment for Black Christians.

According to a number of studies, a general attitude of thankfulness might influence perceptions by acting as an affirmation of the goodness present in the individual's life and an acknowledgment that the origins of goodness are external (Fincham & May, 2021; Rosmarin et al., 2011). Although the results of the current study found that CG may not buffer the relationship between RBTS and PTG, it still

maintained a weak association with PTG. While acknowledging that there may be other spiritual coping methods that better address race-based psychological suffering for African Americans, PTG may also emerge as CG is facilitated within a culturally humble therapeutic alliance. As clinicians emphasize cultural humility by working within the worldview of the client, they can develop a more productive working alliance. Sensitivity for what works and what does not work helps clinicians remain aware of the need for individual and cultural adaptations, such as the use of some religious coping interventions (Wang et al., 2013; Yeo & Torres-Harding, 2021).

Black Christians who exhibit clinical symptoms from RBTS may also need support for making meaning to move toward healing, change, and PTG (Carter, 2007a, 2007b; Carter et al., 2017). Due to the multiple ways in which racism is experienced, including microaggressions, fostering PTG may include directly addressing RBTS. This may include tools that expose the trauma, address reactivity, and challenge negative schemas (Bryant-Davis et al., 2017; Bryant-Davis & Ocampo, 2006; Carter, 2007b; Carter et al., 2013, 2020; Comas-Díaz et al., 2019). Given that traditional PTSD measures do not adequately assess for the distinctive characteristics of RBTS (Roberson & Carter, 2021), the current findings elucidate that this may also include a lack of assessment related to REM. Therapeutic approaches and interventions that address the uniqueness of symptoms while also considering historical, institutional, sociocultural, and individual racism (REM) are important for clinicians to develop while addressing the psychological healing of Black Americans who have RBTS.

Limitations and Future Directions

The current study had several limitations. Importantly, causation cannot be determined with the use of a mediation or moderated mediation model. Furthermore, the use of MTurk is not without risk. For example, researchers cannot verify participants' identities without interacting with them directly, increasing the possibility of sampling error. The study is also limited in that the geographical location and sociocultural environment of the study participants are unknown. According to Kim et al. (2016), the interplay of geography with reported experiences of racial prejudice may be a significant factor for targets of racism. Thus, geographical location may have impacted the participants' perceptions of negative racial encounters in the current study resulting in more or less reported negative experiences and traumatic responses to REM.

Future Research

Previous research supports the notion that traumatic stress may both influence and sustain posttraumatic growth (Dekel et al., 2012). It would be beneficial to further research the mechanisms by which RBTS might help sustain and enable PTG. For example, the African American community finds comfort through the use of various religious coping mechanisms and has a long history of using church support to cope (Barber, 2021; Chatters et al., 2008; Johnson & Carter, 2020; Noel & Johnson, 2005; Park et al., 2018; Taylor et al., 2021; Utsey et al., 2000). In subsequent research, it may also be possible to investigate the extent to which Christian gratitude is moderated by the support provided through Black congregations. Church support may play a role in the development of a deeper and more pervasive sense of Christian gratitude among Black Christians. Moreover, interventions focused on increasing Christian gratitude (i.e.,

Christian meditation; Knabb, Vazquez, Pate, et al. 2021) may be another area of important research in addressing responses to REM.

Finally, the significant difference seen in the current study between faiths, with Catholics showing greater REM, RBTS, and PTG, may also provide future direction for research in these areas. Future studies that focus on the differences within Christian worldviews may help to further explain the differences found herein.

Conclusion

In the current study, Christian gratitude did not moderate the indirect effect of racial microaggressions on posttraumatic growth through race-based traumatic stress, but it did show a positive association with PTG. Although the practice of Christian gratitude is one religious coping mechanism among others, future research should seek to understand the relationship between CG and PTG. CG and alternative methods of religious coping may prove to be useful for African American Christians who experience REM. More research is required to determine the role that religious coping techniques may have in promoting psychological well-being and posttraumatic growth in the context of REM and RBTS.

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Table 1

Demographics of the Participants and Study Variables (N = 157)

Variables	*N*	*%*	*M*	*SD*
Hours per month				
Bible reading	-	-	18.2	42.2
Prayer	-	-	32.7	72.9
Church attendance	-	-	8.74	16.2
Age	-	-	40.4	11.7
Gender				
Male	56	35.7		
Female	101	64.3		
Marital Status				
Married	64	40.8		
Single	73	46.5		
Divorced	0	0		
Widowed	16	10.2		
Separated	1	.6		
Other	6	1.9		
Education				
Some high school	1	.6		
High school graduate	8	5.1		
Some college	32	20.4		
Trade/technical/vocational	7	4.5		
College graduate	79	50.3		
Some postgraduate work	12	7.6		
Postgraduate work	18	11.5		
Religious Faith				
Catholic	35	22.3		
Protestant	111	70.7		
Other	11	7.0		

Note. All participants self-identified as Black or African American.

Table 2

Bivariate Correlations Among the Study Variables

Variables	1	2	3	4	*M*	*SD*	α
1. REM	-				54.4	45.7	.98
2. RBTS	.48**	-			11.9	12.4	.81
3. CG	-.08	-.01	-		31.5	4.7	.96
4. PTG	.54**	.40**	.18*	-	45.9	30.6	.97

Note. $N = 157$. *$p < .05$. **$p < .01$.

Table 3

Moderated Mediation Analyses with PTG

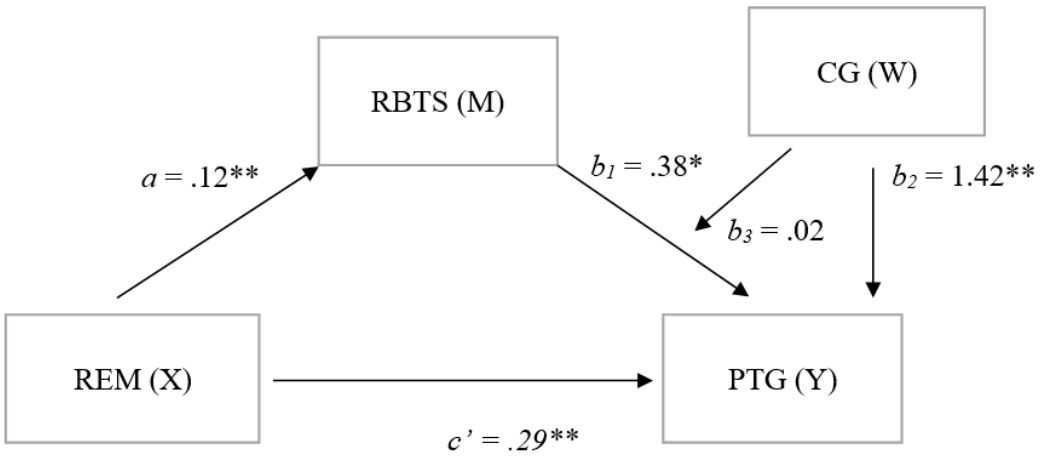
	b	*SE*	*t*	LLCI	ULCI
Outcome: PTG					
Predictor: REM	.29**	.05	5.73	.19	.40
RBTS	.38*	.18	2.07	.02	.73
CG	1.42**	.43	3.32	.57	2.26
RBTS x CG	.02	.03	.53	-.04	.07

Conditional Indirect Effect	*b*	*SE*	LLCI	ULCI
-1 *SD* (low) CI	.04	.02	.00	.09
Mean (average) CI	.05	.02	.01	.09
+1 *SD* (high) CI	.05	.03	.01	.11

Note. LLCI = bootstrapped lower-level confidence interval; ULCI = bootstrapped upper-level confidence interval. All values are unstandardized regression coefficients. * $p < .05$. ** $p < .001$.

Figure 1

Moderated Mediation PROCESS Model 14



Note. All values are unstandardized regression coefficients. *c*' = direct effect of REM on PTG.

* $p < .05$. ** $p < .001$.

APPENDIX F

CURRICULUM VITAE

STEPHANIE GREGORIUS ZIVANOVIC

Stephaniegregorius.zivanovic@calbaptist.edu | College of Behavioral and Social Sciences 8432 Magnolia Avenue Riverside, California 92504

LANGUAGES

Serbian – Conversational

HONORS AND AWARDS

Phi Alpha Honor Society Berrien Springs, MI
Andrews University, Social Work, Epsilon Nu Chapter, 2000

Community Service Award, Lincoln, NE
The Good Neighbor Community Center, 1994

EDUCATION

DOCTORATE IN CLINICAL PSYCHOLOGY, PsyD - ANTICIPATED COMPLETION 2024
California Baptist University, Riverside, CA

MASTERS IN CLINICAL PSYCHOLOGY, MA - 2021
California Baptist University, Riverside, CA

BACHELOR OF SOCIAL WORK - 1999
Andrews University, Berrien Spring, MI

SUPERVISED CLINICAL EXPERIENCES

Brea Olinda Unified School District, Brea CA
Psychological assessment, in-person neuropsychological evaluation for children and adolescents**:** Janira Jacoubs-Beye, PsyD & Evette Yanez, PsyD, 08/2022 – 06/2023

Psychology Student Clinician, Riverside University Health Systems, Women's Health, Riverside, CA
Integrative care, in-person individual and family psychotherapy intervention and brief assessment, supervised: Antonia Ciovica, PhD, 09/2021 – 07/2022

Psychology Student Clinician, Psychological Services of Riverside, Riverside, CA

Individual psychotherapy treatment and psychodiagnostic evaluation, supervised: Timothy Sisemore, PhD & Raymond Kim, PsyD, 09/2020 - 08/2021& Jessie Lowell, PsyD, 01/2022 – 08/2022

WORK EXPERIENCE

Assistant Instructor (Tutor), World Health and Pan American Health Organizations
Training of trainers for Problem Management Plus, program planning and implementation, bridging the mental health gap, 11/2021 – 03/2022

ESL Teacher, Loma Linda, CA
Provided private and group English lessons to Chinese speaking children, 2018 - Present

Adoption Counselor, Department of Children and Families, Jacksonville, FL
Found adoptive families for state-dependent children, monitored children under my care through home visits and transportation, attended court appointments regarding each child, prepared and processed all paperwork for every part of the adoption process, did bio-psychosocial assessments of children and dealt with parental rights, 2001– 2002

Respite worker, Riverwood Community Health Center, Benton Harbor, MI
Provided intermediary relief for parents by caring for their children who were on the autism spectrum, 1997 – 1998

Student Teacher, Saniku SDA Elementary & English School, Hiroshima, Shi, Japan
Taught English as a second language to secondary school children as well as adults. Ages ranged from five to sixty years, 1995 – 1996

Church & Community Outreach & Home Health Educ, Lincoln, NE, Minneapolis, MI
Community Service - Assisted people living in the inner-city by providing for their basic needs, distributed whole health literature, 1993 -1994

INTERNSHIPS

Battle Creek VA Medical Center, Battle Creek, MI
APA Internship, Clincial Psychology Intern, 7/2023 - 6/2024

Madison Center for Children South Bend, IN
Worked with emotionally and socially handicapped children and youth, organized and conducted individual, group, and play therapy with young children ages two through fifteen, learned administrative aspects of this organization through shadowing and active participation with the goal of youth reintegration into the community, 1999

Adventist Development and Relief Agency (ADRA), Negros Occidental, Philippines
Helped with projects in 36 indigenous villages, community development with a focus on physical and mental health, medication compliance, and the relief of tuberculosis and malnutrition, developed a local organization, to help village children, and found local college students to run it, 1998

PROFESSIONAL PRESENTATION

Zivanovic, S. (2021, June 18). *Riding the wave of the pandemic mental health crisis, the hidden truth of teen mental health*. Lecture given at the Psychological Services of Riverside, Riverside, CA.

SCHOLARLY PRESENTATION

Zivanovic, S., Baker, T. (2021, November 1). *Attachment to God and Posttraumatic*
Growth: The Mediating Role of Gratitude to God. Research co-presented at California Baptist University PsyD Research Showcase, Riverside, CA.

POSTER PRESENTATION

Zivanovic, S., Baker, T., Pate, R. (2021, November 1). *Attachment to God and Posttraumatic Growth: The Mediating Role of Gratitude to God*. Poster co-presented at California Baptist University, Riverside, CA.

Zivanovic, S., Baker, T., Pate, R. (2021, August 9-13). *Attachment to God and Posttraumatic Growth: The Mediating Role of Gratitude to God*. Poster co-presented at the American Psychological Annual Convention, Recorded video presentation.

RESEARCH EXPERIENCE

The relationship between microaggressions and posttraumatic growth: assessing the mediating role of Christian gratitude for African American Christians. CBU Doctoral Dissertation, Dissertation Chair: Veola Vazquez, PhD, 2021-Present

Arab Muslim perceptions of American women on Arab Muslim perceptions of Christianity, Andrews University, Qualitative Student Research study under Oystein LaBianca, PhD. 1998

PUBLICATION

Vazquez, V. E., Pate, R. A., MacCallum, J., Matta, M., Zivanovic, S., Chamberlin, S., Baker, T., & Newman, S. (2022). Deliberate rumination and posttraumatic

growth: The mediating role of Christian gratitude and attachment to God. *Mental Health, Religion & Culture*, *25*(8), 755–773. https://doi.org/10.1080/13674676.2022.2102160

PROFESSIONAL MEMBERSHIPS

American Psychological Associations, Graduate Student Affiliate, 2019 - Present

American Psychological Association Division 12, The Society of Clinical Psychology, 2019 - Present

American Psychological Association Division 36, The Society of Religion and Spirituality, 2019 - Present

International OCD Foundation, Graduate Student Affiliate, 2022 – present

Psychology Club, College of Behavioral and Social Sciences, CBU, 2022 – present

International Dyslexia Association, Graduate Student Affiliate, 2023

CERTIFICATES

Accredited Certificate Course TEFL 160 Hours, Loma Linda, CA
Advanced Certificate in Teaching English as a Foreign Language, TEFL, 2018

Accredited Certificate Course TEYL 40 Hours, **Loma Linda, CA**
Advanced Teaching English to Young Learns TEYL, 2018

Accredited Certificate Course TESOL 120 Hours, Loma Linda, CA
Teaching English to Speakers of Other Languages certificate, 2018

Certificate of Outstanding Service-Contributions to Community, Benton Harbor, MI
Riverwood Community Mental Health Center Benton Harbor, Michigan, 2000

Certificate of Social Compassion Ministry, Berrien Springs, MI
Awarded by the Chair & Graduate School Director, Department of Social Work, Andrews University, Berrien Springs, Michigan, 1999

Certificate of Completion, Respite Care, MI
Training program for Respite Care Providers for families of Children and Adolescents with Emotional Disorders, 1997

SERVICE AND LEADERSHIP EXPERIENCE

APA Campus Ambassador, Riverside, CA

Acts as a bridge between APA and CBU peers, 2020 - Present

Health Director, Jacksonville, FL
Jacksonville First SDA Church, Taught seminars, gave workshops on mental & physical health education & organized speakers & topic related events, 2007 - 2008

School of Social Work, Student MSW Public Relations Officer, Berrien Springs, MI
Andrews University, Helped organize activities for social work students, 2000

Co-Organized New Life Seminars, Berrien Springs, MI
Organized group meetings that provided health principles to the community, gave guidance and information on health topics, taught healthy cooking classes, provided support to people seeking a healthier lifestyle, 1999 - 2000

Benton Harbor Ministries Volunteer, PMC, Benton Harbor, MI
Worked with Benton Harbor children and adolescents to promoted personal growth and community development, 1998 - 1999

Community Outreach Volunteer, Weimar, CA
Gave door-to-door surveys addressing holistic health and needs of individuals to connect, helped community members with existing community projects, 1995

Community Service, The Good Neighbor Community Center, Lincoln, NE
Lead community youth project,1994