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Lived Racial/Ethnic Microaggression Experiences and the Impacts on Self-reported Stress and Health among Female African American and Filipino Registered Nurses

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Lived Racial/Ethnic Microaggression Experiences and the Impacts on Self-reported Stress and Health among Female African American and Filipino Registered Nurses

A dissertation submitted in partial satisfaction of the requirements for the degree Doctor of Philosophy in Nursing

by

Tykeysha Thomas

2019

ABSTRACT OF THE DISSERTATION

Lived Racial/Ethnic Microaggression Experiences and the Impacts on Self-reported Stress and Health among Female African American and Filipino Registered Nurses

by

Tykeysha Thomas

Doctor of Philosophy in Nursing

University of California, Los Angeles, 2019

Professor Felicia S Hodge, Chair

Background: Microaggressions are recognized as harm-producing insults and slights associated with increased anxiety, acute stress, and engagement in risky health behaviors (e.g., smoking, alcohol and drug use), however the extent and impacts on chronic stress and health are not fully understood. A mixed methods approach is being utilized to investigate the self-reported health effects related to racial microaggressions and stress among female African American and Filipino registered nurses (RN) using methods designed to elicit information aimed at understanding lived microaggression experiences from respondents' perspectives but focused on impacts that may have long term stress and health implications. Methods: A mixed methods approach to investigate female African American and Filipino RNs' microaggression experiences and the relationship to respondents' self-reported stress and health was utilized.

Through surveys and interviews, female African American and Filipino RNs shared racial microaggression experiences, coping mechanisms used to navigate those experiences, and the self-reported effects on stress levels and health. Via survey responses and personal narratives common microaggression experiences, coping techniques, and immediate and long-term effects of those experiences were identified. Implications: Studying lived microaggression experiences and self-reported effects on stress and health using a sequential explanatory mixed methods approach was important to understand not just racial microaggression experiences and effects on stress and health but the climate and context in which racial microaggressions were able to occur. The findings of this study may provide insights that contribute to information used to develop interventions which address needs of African American and Filipino RNs.

Keywords: Microaggression, African American, Asian, Black, Filipino, Stress, Health

The dissertation of Tykeysha Thomas is approved.

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2019

Dedication Page

I want to take the time to thank those persons that have had a part in this journey to earning my PhD. First and above all, my husband, Robert. This degree is as much yours as it is mine. I would not have been able to achieve all that I have without your unwavering support and advice through all of my late nights and early mornings, stress, and sometimes frustrations. Drs. Vickie Mays and Marjorie Kagawa-Singer showed me how the ideas I have can be and are viable and relevant research and encouraged me to stay the course. Dr. Felicia Hodge for being willing to be my faculty advisor and committee chair; also, for being fully supportive as I worked to develop this study even though I was taking the scenic route to degree completion by doing a mixed methods study for a dissertation. Dr. Carol Pavlish for all of the advice and encouragement to just go forth and be me- trust my instincts. Dr. Janet Mentes for your compassion and understanding, especially in the first year of the program. Last, but definitely not least: Dr. Lorraine Evangelista. Lorraine opened my eyes to what nursing research truly is and that it has no limits. For encouraging me to apply to the PhD program earlier than I planned. For always cheering me on, being my sounding board, my best critic and mentor.

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Biographical Sketch

Tykeysha Thomas, PhD(c), MSN, RN, PHN, PCCN received her Master's Degree in Nursing Science from UCLA School of Nursing, and Baccalaureate in Nursing from California State University, Dominguez Hills. Her research interests and training have focused on culturally sensitive and congruent research methods among vulnerable populations in areas of health disparities, stress, and coping. As a clinical nurse, Tykeysha has over 10 years of experience working with a racially and ethnically diverse patient population; and as an academic educator has taught a diverse student body. Tykeysha has worked on several research and evidence-based projects, either as PI or research assistant, and attained skills in collecting data from participants representing vulnerable populations using culturally sensitive methods.

CHAPTER I

INTRODUCTION

Morbidity and mortality, or disease affliction and death, disproportionately affects vulnerable racial/ethnic population subgroups. African Americans have the highest mortality rates for high impact illnesses and diseases (high frequency illnesses and diseases with high financial and human costs) such as heart disease, stroke, cancer, pneumonia, and diabetes compared to non-Hispanic Whites (Office of Minority Health, 2019a). Asian Americans experience a high prevalence of high impact illnesses and diseases such as heart disease, chronic obstructive pulmonary disease, cirrhosis, and hepatitis in comparison to non-Hispanic Whites (Office of Minority Health, 2019b). The differences in incidence and prevalence of health related morbidity and mortality is commonly related to risk factors such as gender, race/ethnicity, smoking, diet, and level of activity, however much more complicated and insidious risks and behaviors, such as chronic stress and microaggression experiences for vulnerable racial/ethnic subgroups may be additional factors.

Health Disparities

Health disparities (HD) are the differences in the incidence and prevalence of morbidity and mortality that occur among population subgroups (National Cancer Institute, 2012). Health disparities are most prevalent and persistent among certain racial/ethnic subgroups, such as African Americans, with contributory factors including lower socioeconomic status (e.g., lower income, education level, and poorer living conditions), less access and utilization of healthcare services, and poorer health education. Studies, however, have shown that racial/ethnic HD persist even after controlling for contributory factors (Anderson, 2010; Braveman, Cubbin, Egerter, Williams, & Pamuk, 2010; Brummett et al., 2011; Giger & Davidhizar, 2007; Mahmoudi & Jensen, 2012). Other factors that may be associated with and contribute to the prevalence

and persistence of racial/ethnic HD is chronic stress related to microaggression experiences (Sue, 2010; Wong, Derthick, David, Saw, & Okazaki, 2014).

Chronic Stress

Chronic stress is recurrent or prolonged exposure to stress events (American Psychological Association [APA], 2014). Chronic stress has been associated with poverty, poorer living conditions, lower education levels, and community and familial obligations (APA, 2014; Barksdale, Woods-Giscombe, & Logan, 2012; Hicken, Lee, Morenoff, House & Williams, 2014). Recurrent discriminatory events, such as microaggressions, may also contribute to chronic stress levels that eventually lead to poorer health outcomes including cardiovascular disease and decreased immunity (APA, 2014; Barksdale et al., 2012; Hicken et al., 2014). Evidence suggests that chronic stress contributes to the prevalence of HD, however few studies have examined contributing factors, such as microaggressions, that increase chronic stress in certain racial/ethnic subgroups exposing them to increased risk of morbidity and early mortality (APA, 2014; Hall & Fields, 2013; Hicken et al., 2014; Yosso, Smith, Ceja, & Solórzano, 2009).

Microaggressions

Microaggressions are ongoing, daily verbal and nonverbal discriminatory attacks based on assumptions and biases of population subgroups that communicate hostility and inferiority to members of the targeted subgroups (APA, 2014; Yosso et al., 2009). Microaggressions have been associated with higher levels of anxiety, depression, isolation, and invalidation (Blume, Lovato, Thyken, & Denny, 2011; Minikel-Lacocque, 2013). Microaggressions have also been associated with increased participation in risky behaviors such as drug and alcohol abuse in African Americans and Hispanics (Blume et al., 2011; Minikel-Lacocque, 2013; Solórzano, Ceja, & Yosso, 2000; Yosso et al., 2009).

Overview

Health disparities among racial subgroups continue to worsen (Agency for Healthcare Research and Quality, 2015; Anderson, 2010; National Cancer Institute, 2012). The prevalence and persistence of HD among several racial groups, particularly in the areas of cardiovascular disease, cancer, type 2 diabetes, obesity, and atherosclerosis, have been well documented (Barksdale et al., 2012; Hutchinson & Shin, 2014). While HD prevalence data is invaluable as it contributes to our body of knowledge regarding the gravity of the HD problem, underlying contributors, such as microaggressions, have not been fully investigated (Hicken et al., 2014; Sue, 2010; Wong et al., 2014).

Background

Health Disparities

Health disparities are often attributed to conditions of lower socioeconomic status (e.g., poorer living conditions, poorer diet, and less access and utilization of healthcare services), however it has been shown that racial/ethnic HD continue to exist at higher income levels for African and Asian Americans in comparison to Whites (Anderson, 2010; Braveman, Egerter, An, & Williams, 2011; Colen, Ramey, Cooksey, & Williams, 2017; Healthy People, 2015; U.S. Library of Medicine, 2015; Wilson, Thorpe, LaVeist, 2016). Wilson et al. (2016) found that African Americans and Asian Americans reported poorer overall health and health outcomes for chronic illnesses such as diabetes, hypertension, and high cholesterol at income levels greater than $175,000 annually compared to Whites with equal income. Colen et al. (2017) showed that African Americans with moderate to rapid income growth reported racial discrimination 24 percent more often than non-Hispanic Whites. At higher income levels (> 400% of the Federal Poverty Level) 9.8 percent of African Americans report being in poorer health compared to Whites (6.2%); although the disparity between African Americans (9.8%) and Whites (6.2%) is smaller at higher income levels (>400% of the Federal Poverty Level) it nonetheless persists (Braveman et al., 2011). Braveman et al. (2011) used the 2006 Federal Poverty Level as

defined by the U.S. Social Security Administration and is defined as a set monetary income threshold stratified by family size such that families of a specified size with incomes that fall below the threshold are classified as below poverty. As an example, using the 2006 FPL a family of two fell below the poverty threshold with an income less than $13, 200 whereas a family of four fell below the poverty threshold with an income less than $20, 000 (U.S. Social Security Administration, 2007).

Health disparities costs. The financial and human burdens of HD have been a long-standing problem in the United States (US) (Anderson, 2010; Heckler, 1985; Murphy, Xu, & Kochanek, 2013). The total annual cost for healthcare in the US in 2014 was $3 trillion (Centers for Medicaid and Medicare Services, 2015). Although racial/ethnic subgroups represent only 36 percent of the US population, at $1.23 trillion, they account for a larger percentage of the US healthcare costs (LaVeist, Gaskin, & Richard, 2009). Health disparities, more specifically health inequities (those HD attributed to inequality in health and healthcare), account for 31 percent of all direct medical costs for African Americans (18%), Hispanics (11%), and Asians (2%) between 2003-2006 (LaVeist et al., 2009).

The human costs of HD are more troublesome. Vulnerable racial/ethnic subgroups experience higher rates of chronic illness and shorter life expectancies when compared to non-Hispanic Whites (National Center for Health Statistics, 2017ab). Hypertension affects 29 percent of the total US population however the prevalence of hypertension in the African American community is significantly higher with 40.6 percent of African American men and 39.9 percent of African American women estimated to have hypertension (National Center for Health Statistics, 2017b). Type 2 diabetes, a disabling chronic illness and one of the leading causes of early mortality in the US that significantly increases the risk for several other leading causes of early mortality including heart disease, kidney failure, and stroke, is disproportionately reported among African Americans (12.7%) compared to Whites (7.4%) (American Diabetes Association,

2018). Despite having lower rates of breast cancer diagnosis than White women, African American women are 40 percent more likely to die from breast cancer (Centers for Disease Control and Prevention, 2012).

Life expectancy for the general U.S. population was 78.9 years, however, African Americans on average experience a life expectancy more than 4 years less (Healthy People, 2015; Kaiser Family Foundation, 2019; Kochanek, Murphy, & Xu, 2015). African American men experience a life expectancy 7.7 years lower than the general U.S. population. The introduction of illness and disease broadens the life expectancy gap for racial/ethnic subgroups (Centers for Disease Control and Prevention [CDC], 2013). African Americans, for example, experience premature death caused by heart disease and stroke earlier than Whites, 43.2 years versus 65.5 years at the time of death respectively (CDC, 2013). Years of potential life lost (YPLL) is a means to report total premature death in the US (CDC, 1986; Gardner & Sandborn, 1990). Years of potential life lost is a cumulative measure of each YPLL for the 15 leading causes of death annually. The CDC calculation for YPLL is the product of the estimated number of deaths by cause per age range multiplied by the years of life lost, which is based on a 10 percent sample of death certificates filed annually and represents the difference between an age set point, typically 65 years, less the median age for a given age range (CDC, 1986). At age set point 75 years, African Americans experience the greatest YPLL at 9528.5 years per 100, 000 of the population, non-Hispanic Whites (6593.2), and Asians and Pacific Islanders (3050.9) (CDC, 2014).

Asian Americans appear to live longer and have better health outcomes in comparison to most other racial/ethnic subgroups, however this may not account for variations within ethnic subgroups that comprise the Asian race, such as Filipinos. Asian Americans have a life expectancy of 86.5 years however there is evidence that Filipino Americans' life expectancy is up to 16 years less with the inclusion of co-morbidities (Iyer & Palaniappan, 2019; Kaiser Family

Foundation, 2019). While specific health data by Asian ethnic subgroups is scarcely available studies have shown that Filipino Americans have higher mortality rates for hypertension, stroke, and diabetes mellitus as compared to health statistics for the aggregate Asian race (Hastings et al., 2015; Iyer & Palaniappan, 2019).

Chronic Stress

Stress, particularly chronic stress, has long been considered a major contributor to poorer health and early mortality. Stress theories have defined stress as not only a psychological or emotional condition but a physiological process that triggers specific biochemical responses, such as a sympathetic nervous system or "fight-or-flight" response, that with prolonged exposure can lead to systemic inflammatory responses which have been associated with cardiovascular compromise, weakened immunity, and early mortality (APA, 2011; McEwen, 2004; Scherer, Shorr, & Johnstone, 2001; Selye, 1950, 1973). The prevalence and persistence of racial/ethnic HDs have been attributed to chronic stress that has been induced by stressors of everyday life and compounded by microaggressions (APA, 2014; Barksdale et al., 2012; Hicken et al., 2014).

Stressors of everyday life. Stressors of everyday life are events and environments that vary from the norm and consciously or unconsciously disrupt psychological and physiological homeostasis (APA, 2011; Delongis, Coyne, Dakof, Folkman, & Lazarus, 1982; Delongis, Lazarus, & Folkman, 1988; Lazarus & Folkman, 1984; Warnecke et al., 2008). These stressors may be grand life altering events such as divorce, pregnancy, or the death of a loved one, or they may be more common occurrences such as managing family demands, starting a new job or college, or simply driving in heavy traffic (APA, 2011, 2013; Rahe et al, 1964). Stressors of everyday life may be more harm inducing than infrequently occurring grand life altering events (Delongis et al., 1982, 1988; Juster et al., 2016; Lazarus & Folkman, 1984; McEwen, 1998, 2004). Vulnerable population subgroups that are disproportionately affected by HD experience

stressors of everyday life that may be simple as a long daily work commute, figuring out childcare, or attending to work duties. Vulnerable population subgroups, such as racial/ethnic subgroups, are also believed to have additional stressors of everyday life in the form of daily, recurrent microaggression experiences that also contribute to stress levels and stress duration (Sue, 2010; Sue et al., 2007).

Microaggressions. Microaggressions are subtle, sometimes subconscious, verbal and nonverbal discriminatory acts that are often based on assumptions and biases associated with characteristics such as race/ethnicity (Pierce, Carew, Pierce-Gonzalez, & Wills, 1977; Sue et al., 2007; Wong et al., 2014). The offenders may intentionally or unintentionally engage in microaggression acts; however, the negative meaning and implications are immediate and equally impactful to the recipient (Sue, 2010; Sue et al., 2007; Wong et al., 2014). A common microaggression, for example, is to ask a member of a racial/ethnic subgroup why he or she speaks English so well (Sue, 2010). The perpetrator may view this statement as benign, harmless, and possibly a compliment, however the messages communicated to the recipient of the microaggression are assumptions that he or she is an outsider, not an American, and less intelligent. Although the microaggression itself happened on an interpersonal level between two individuals, the underlying assumptions of being an immigrant to the US and less intelligent are assumptions that have greater societal implications of disadvantage, exclusivity, and inferiority. White privilege, defined as those unearned, inclusionary privileges afforded to White subgroups to the disadvantage of other racial/ethnic subgroups, is all too often at the root of racial/ethnic microaggressions (McIntosh, 1988; Sue, 2010). The societal impacts of microaggressions are inclusive of factors that contribute to the persistence of HD, disproportionately affect vulnerable racial/ethnic subgroups, and include: limited access to resources inequitable income, and decreased or no representation in leadership roles (Sue, 2010; Sue et al., 2007; Wong et al., 2014).

Significance

Inequalities in the health and healthcare of vulnerable racial/ethnic subgroups remain stagnant or have worsened despite over 40 years of HD investigations and advances in healthcare practices and policies (Anderson, 2010; APA, 2014). Prevalence data is invaluable as it contributes to our body of knowledge regarding the gravity of the HD problem. However underlying factors that support the prevalence and persistence of racial/ethnic HD have not been fully investigated. Such exploration may be important to guide future healthcare practice and policy initiatives aimed at reducing or eliminating HD (Hicken et al., 2014; Wong et al., 2014). Chronic stress has been associated with the prevalence and persistence of HD experienced by racial/ethnic subgroups. Microaggression experiences may be a significant contributing factor to acute and chronic stress in vulnerable racial/ethnic subgroups.

Statement of the Problem

Chronic stress is a significant threat to one's health status as it causes biochemical fluctuations that can increase morbidity and early mortality (APA, 2014; Barksdale et al., 2012; McEwen, 2004; Selye, 1950, 1973). Chronic stress has been attributed to stressors of everyday life such as community obligations, however in some racial/ethnic subgroups chronic stress may also be associated with socio-political factors such as microaggressions.

Microaggressions are increasingly of interest to researchers, healthcare providers, and policymakers as microaggressions have been theorized to increase chronic stress in vulnerable population subgroups including racial/ethnic subgroups (APA, 2014; Hall & Fields, 2013; Hicken et al., 2014; Yosso et al., 2009). While it is hypothesized that microaggression experiences play a role in chronic stress and thereby HD, associations among microaggressions, self-reported stress, and self-reported health are poorly understood. An investigation of these relationships will provide important data useful for healthcare practice and policy development. Additionally, racial/ethnic subgroups, given the opportunity to share their experiences and insights regarding

microaggressions, stress, and health, may provide information not previously considered and may significantly contribute to efforts to improve their own health trajectories.

Research Questions and Study Aims

A sequential explanatory mixed methods model, using Critical Race Theory for the philosophical underpinning and the Transactional Model of Stress and Coping and Allostatic Load Theory as the theoretical framework was utilized to explore the meaning of lived racial/ethnic microaggression experiences and associations to self-reported stress and health among female registered nurses (RN) that self-identify as African American or Filipino. Quantitative cross-sectional methods were utilized to explore relationships among microaggression experiences, self-reported stress, and self-reported health. Self-administered surveys were immediately followed by semi-structured interviews for further in-depth investigation of lived microaggression experiences including context of experiences and self-reported relationships to stress and health. Exploration of the meaning and contexts of lived racial/ethnic microaggression experiences and its associations with self-reported stress and health from the perspectives of those affected will contribute to the body of literature that help shape healthcare practices and policies to address both the behaviors and outcomes related to racial/ethnic microaggressions. Lived racial/ethnic microaggression experiences and their associations to self-reported stress and self-reported health among female African American and Filipino RNs was investigated according to the following research questions and specific aims:

Research Question 1. What are the relationships among microaggression experiences, self-reported stress, and self-reported health among female African American and Filipino RNs? (Quantitative)

Aim 1. Explore relationships among racial/ethnic microaggression experiences, self-reported stress and self-reported health of female African American and Filipino RNs. (Quantitative)

Aim 2. Identify the prevalence of microaggression experiences dichotomized by African American or Filipino ethnicity. (Quantitative)

Research Question 2. What are the meanings of lived microaggression experiences for female African American and Filipino RNs? (Qualitative)

Aim 1. Explore the meaning of lived microaggression experiences for female African American and Filipino RNs. (Qualitative)

Aim 2. Explore whether female African American and Filipino RNs associate lived microaggression experiences to self-reported stress and health. (Qualitative)

Aim 3. Explore the contexts in which microaggression experiences occurred. (Qualitative)

Summary

A sequential explanatory mixed methods approach was utilized to explore the lived microaggression experiences and its relationships to self-reported stress and self-reported health among female African American and Filipino RNs. This project explored an important and highly charged topic that is of great concern among vulnerable racial/ethnic subgroups, policy makers, social and political leaders, and healthcare providers. Microaggressions are recognized as harm-producing insults and slights, however the extent and impact of microaggression experiences from the perspectives of racial/ethnic subgroups are not fully understood. Study results revealed descriptions, contexts, and relationships among the self-reported effects on stress and health and microaggressions experienced by female African American and Filipino RNs.

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CHAPTER II

CONCEPTUAL FRAMEWORK

The philosophical framework for this study was Critical Race Theory and theoretical framework was the Transactional Model of Stress and Coping and Allostatic Load Theory to organize and explain the hypothesized relationships among microaggression experiences, self-reported stress, and self-reported health. Critical Race Theory was used to explore and explain the meanings of respondents' lived microaggression experiences in the context of their socio-political environment. The Transactional Model of Stress and Coping provided the theoretical framework to describe the microaggression (stressor) experience and encompassed the entire process from introduction of a microaggression event to the coping outcome. Allostatic Load Theory was added to the Transactional Model of Stress and Coping to establish stress as a physiological process that is triggered once a microaggression event was recognized as such that may lead to poorer mental and/or physical health with repeated and/or prolonged exposure (McEwen, 1998).

Philosophical Underpinning: Critical Race Theory

Often, discussions of health disparities (HD) seem one dimensional in that they are focused on behaviors without meaning or context. Critical Race Theory is proposed to provide the meaning and context by which microaggressions are perceived by respondents. Critical Race Theory assumes that there is not a dominant monolithic perspective and interaction with the socio-political environment and that there are social and political constructs, such as race/ethnicity, which create a hierarchy that is engrained in all aspects of society and culture that directly influences the beliefs, behaviors and norms of the dominant culture and subcultures (Graham, Brown-Jeffy, Aronson, & Stephens, 2011). Critical Race Theory is based on the premise that racial/ethnic biases and assumptions are not only held by individuals but permeate and is perpetuated by all social, economic, and political institutions and is the primary factor in

determining social, economic, and political advantages and disadvantages experienced by all American subgroups (UCLA School of Public Affairs, n.d.; Dixson, 2007).

Foundation of Critical Race Theory

Critical Race Theory is a subcategory of Critical Theory (CT) and was developed in the late 1970s and early 1980s as an evolution of the Critical Legal Studies movement of the 1960s and 1970s (Delgado & Stefancic, 2006; Dixson, 2007; UCLA School of Public Affairs, n.d.).

Critical Theory. Critical Theory represents the merger of philosophical and social sciences to liberate groups by critically examining social, economic, and political infrastructures that create and/or reinforce socio-political hierarchies (Bohman, 2013; Kincheloe & McLaren, 1994). The three primary goals of CT are the identification of: (1) social inequalities; (2) factors that can facilitate social change; and (3) potential interventions that promote and support social change (Bohman, 2013; Marcuse, 1968). Critical Theory encompasses several philosophical and/or theoretical variations; however, they all share some basic principles. These principles are that they: (1) seek to critically look at social and political institutions; (2) acknowledge power imbalances are shaped in the context of history and the socio-political climate; (3) recognize that power imbalances are endemic to social and political relationships; (4) are aware that social and political relationships influence all perceptions and perspectives for both advantaged and disadvantaged population subgroups; (5) recognize that socio-political climates are dynamic; and (6) accepts that the power dynamic is reinforced and sustained when disadvantaged groups comply and on some (conscious or subconscious) level accepts their allotted socio-political station (Kincheloe & McLaren, 1994).

Critical Theory background. Critical Theory is a collection of philosophies that came out of the Frankfurt School in Germany, later renamed the Institute of Social Research. The Frankfurt School was an institution shaped by scholars that were heavily influenced by Classical Marxism and rejected traditional philosophies of knowledge development that were believed to

create knowledge void of context and purpose (Fontana, 2004). The overriding goal of Critical Theory is the creation of knowledge for change (Rodgers, 2005).

Frankfurt School. The Frankfurt School was started in Germany with teachings that were a hybrid of German philosophical and sociological theories developed by philosopher Karl Marx and sociologist Friedrich Engels (Kincheloe & McLaren, 1994). While the school was founded by Felix Weil and initially directed by Carl Grünberg as an institution to disseminate Marxist philosophy, the school did not gain distinction until the 1930s at which time the Frankfurt School's first generation of notable theorists, Max Horkheimer (Director), Theodor Adorno and Herbert Marcuse, reinterpreted Marxism combined with other German sociological theories to develop "Critical Theory" (Corradetti, 2011). Critical Theory was also shaped by the social and political activities in Germany in the 1920s-1940s (e.g., rise of the Nazi Party and Jewish Holocaust) and later the U.S. Civil Rights Movement beginning in the 1950s. Critical theorists were impacted by imbalances of power delineated by subgroup characteristics, such as race/ethnicity, economics, and gender, and how incongruent those power imbalances were with national doctrines (Kincheloe & McLaren, 1994).

Philosophy of Critical Theory. Critical Theory is not one central philosophy; it is comprised of a collection of philosophies none necessarily more regarded than the others. All generations of critical theorists have been scholars within an array of disciplines and developed variations of Critical Theory based on their specific interests, hence the variation of Critical Theory utilized is often discipline specific and dependent on the interests of the researcher. For instance, Marcuse was very influential in shaping the ideas of the social equality movements in the US in the 1960s; whereas Adorno had great influence in the arts (Bohman, 2013; Kincheloe & McLaren, 1994). Critical Theory as it is largely used today is based on the philosophy set forth by Jürgen Habermas, a second-generation scholar out of the Frankfurt School (Fontana, 2004). Habermas postulated that language is an additional mode of transmission and enforcement of

socio-political inequalities. Emancipatory action as a move toward democracy and language without inferences of power are the goals of CT according to Habermas (Bohman, 2013; Rodgers, 2005).

Critical Theory and knowledge. Knowledge developed in the Critical Theory tradition requires 3 approaches: empiric, hermeneutic, and emancipatory (Habermas, 1971). Empiric knowledge is observable and quantifiable knowledge developed from a hypothetico-deductive model, such as findings from survey data. Hermeneutic knowledge provides insight, or an understanding, of a phenomenon. Both these forms of knowledge describe what is happening within an experience (Habermas, 1971). Emancipatory knowledge seeks to uncover the dogma of the other two forms of knowledge which can then inform an action to modify and/or negate the ideologies that maintain the social dialectic being analyzed (Mill, Allen & Morrow, 2001; Rodgers, 2005). Emancipatory knowledge explains why and how an experience is occurring. In terms of racial/ethnic microaggressions, as an example, empiric and hermeneutic knowledge reveal that racial/ethnic microaggressions happen and its prevalence, whereas emancipatory knowledge uncovers the assumptions, biases, and systems that sustain racial/ethnic microaggressions which then can inform interventions and policies that more directly combat the foundation of racial/ethnic microaggressions. All three modes of knowledge are necessary to fully understand that which is being sought to be changed (Habermas, 1971).

Critical Legal Studies. Critical Legal Studies was a multidisciplinary movement which used principles of the United States (US) Civil Rights Movement to address racial/ethnic inequalities and their roots in society, with the goal of legal racial/ethnic equality and the realization of a colorblind society (Delgado & Stefancic, 2006). Critical Race Theory was developed by a multidisciplinary, multiracial/multiethnic group of scholars that perceived the progress of the Critical Legal Studies movement as slow or stalled, inadequate to address covert forms of racial/ethnic bias that were becoming more prevalent, and disagreed with the

feasibility of some Critical Legal Studies goals such as colorblindness (Delgado & Stefancic, 2006).

Critical Race Theory as the philosophical underpinning. Critical Race Theory does not propose social judgment instead it seeks to expose conditions unique to vulnerable racial/ethnic subgroups and provide comprehensive insight into a specific phenomenon and its socio-political contributors promoting a critical analysis of society and how the phenomenon and its socio-political contributors manifest (Marcuse, 1968). Critical Race Theory as the philosophical underpinning of this proposed study acknowledges and integrates the influences that race/ethnicity have on inter-group interactions of dominant subgroups with vulnerable racial/ethnic subgroups and acknowledges from respondents' perspectives how those influences consciously manifest as microaggressions.

Theoretical Framework: Transactional Model of Stress and Coping and Allostatic Load Theory

The Transactional Model of Stress and Coping describes the cognitive process that is initiated with the introduction of a microaggression (stress event) (Lazarus, 1993; Lazarus & Folkman, 1984). Upon recognition that a microaggression has taken place primary and secondary appraisals simultaneously occur. Primary appraisal is both a determination of whether a stress event is positive or negative and the severity of the threat of the microaggression. Secondary appraisal is a determination of potential resources and coping mechanisms available to mitigate and/or resolve the microaggression as well as the perceived efficacy of those potential resources and coping mechanisms to mitigate or resolve the microaggression (Lazarus, 1993; Lazarus & Folkman, 1984). Coping mechanism(s) is the effort implemented to mitigate or resolve the microaggression event (Lazarus & Folkman, 1984). Coping outcome refers to whether the microaggression was resolved in a manner acceptable (adaptation) or not (maladaptation) to respondents. Adaptation is a positive outcome in which

the microaggression was resolved in a manner acceptable to the targeted person(s) or population whereas maladaptation means the microaggression went completely or partially resolved in a manner unacceptable to the targeted person(s)' or population's satisfaction. The Transactional Model of Stress and Coping is an ongoing iterative process throughout the stress experience which allows new and/or different data interpretations to be incorporated into respondents' initial assessment, reassessments, and appraisals of the stress event.

Allostatic Load Theory explains the physiological stress process and trajectory of maladaptive outcomes to repeated and/or prolonged stress events (chronic stress) that eventually lead to poorer health outcomes. Allostatic Load Theory emphasizes physiological recalibration to a higher homeostatic state in alignment with persistently higher stress hormone levels related to repeated and/or prolonged exposure to stress events (McEwen, 1998). It is the wear and tear of systemic variations in physiological functioning and exposure to persistently higher stress hormones that lead to compromised health and chronic disease (McEwen, 1998).

Foundation of the Transactional Model of Stress and Coping

The Transactional Model of Stress and Coping is based on both Cognitive Appraisal and Coping Theories to describe the cognitive transactional process between stress and coping that transpires within a stress event (Folkman & Lazarus, 1980; Lazarus & Cohen, 1977; Lazarus & Folkman, 1984). The Transactional Model of Stress and Coping is predicated on Cognitive Appraisal Theory which defines emotions, such as stress, as a cognitive function that exists independent of and prior to the conscious manifestation of the emotion and Coping Theory which identifies coping as both a style and a process (Lazarus, 1993; Lazarus & Folkman, 1984; Scherer, Shorr, & Johnstone, 2001).

Cognitive Appraisal Theory. Stress, as an emotion, is a cognitive function that begins with two simultaneous appraisals of a stress event: 1. Primary appraisal is an assessment of the perceived threat of the stress event and the severity of the threat (i.e., none, mild, moderate, or

severe threat); and 2. Secondary appraisal is both an assessment of resources available to address and resolve the stress event as well as a determination of the efficacy those identified resources will have toward resolving the stress event (Lazarus & Folkman, 1984; Scherer et al., 2001). Determinations made during the primary and secondary appraisals of the stress event may trigger a physiological stress process and/or behavioral (coping mechanism) response (Scherer et al., 2001). The outcome of the stress event, whether adaptive (positive) or maladaptive (negative), will have an impact on future experiences (Scherer et al., 2001).

Coping Theory. Coping effort is both the style and process utilized to manage a stress event (Lazarus & Cohen, 1977; Lazarus & Folkman, 1984). Coping style describes the characteristics of coping behaviors, e.g., defensive, offensive, aggressive, and passive (Lazarus, 1993). Whereas the coping process describes the physiological (e.g., allostasis) and behavioral (e.g., ignoring the stress event) responses to a stress event (Lazarus, 1993). Coping outcomes, identified as adaptation or maladaptation to a stress event, are the products of coping efforts implemented to manage a stress event and not part of the coping process itself. Adaptation is a positive outcome of coping effort and infers resolution of the stress event. Maladaptation is the negative outcome of coping and infers the stress event went completely or partially unresolved with lingering adverse effects, such as continued elevated stress hormone exposure after the stress event itself has ended.

Physiological Stress Theories: General Adaptation Syndrome and Allostatic Load Theory

The General Adaptation Syndrome (GAS) is a seminal theory in establishing stress as a physiological process. During GAS studies hosts were exposed to noxious psychological and/or physical stressors that initiated a physiological stress process that led to illnesses such as systemic inflammatory response, gastric ulcerations, myocardial infarctions, and ultimately ended with premature death (Selye, 1950, 1973). Most stress events do not rise to the level of toxicity to induce acute illnesses and premature mortality as in the GAS studies (Lazarus &

Folkman, 1984; McEwen, 1998). Allostatic Load Theory, descended from GAS, suggests what is more apt to occur is repeated exposure to stress events and corresponding physiological stress processes that result in “peaks and valleys” of repeated exposure to the physiological stress process, and that over a prolonged period may lead to acute illness, chronic disease, and eventually premature death (Juster et al., 2016; McEwen, 1998, 2004).

General Adaptation Syndrome. The General Adaptation Syndrome describes the physiological stress process experienced in response to noxious stressors (Selye, 1950, 1973). The General Adaptation Syndrome occurs in 3 phases: (1) alarm reaction; (2) stage of resistance; and (3) stage of exhaustion (Selye, 1950, 1973). The alarm reaction and stage of resistance describe the actions of the autonomic nervous system, comprised of the sympathetic and parasympathetic systems (Selye, 1950, 1973). The sympathetic system prepares the body to endure stressors, whereas the parasympathetic system works to reverse those effects essentially returning the body to a resting homeostatic state (Selye 1950, 1973). The initial alarm reaction stage is the sympathetic, or “fight or flight”, response to stress (Selye, 1950, 1973). The sympathetic response is a systemic response in which hormones, such as cortisol and adrenaline, are secreted causing physiological responses including vasoconstriction, increased cardiac workload, decreased immune function, and decreased gastrointestinal function; some of the acute observable and measurable outcomes of the alarm reaction, for instance, include higher blood pressure and increased heart rate (Selye, 1950, 1973). The stage of resistance marks the activation of the parasympathetic response, which is the physiological counter-response to the alarm reaction, or sympathetic response, with the purpose of returning to physiological homeostasis, for instance baseline cortisol and adrenaline levels with corresponding normal blood pressure and heart rate (Selye, 1950, 1973). The stage of exhaustion is the critical phase at which adaptation to stressors is no longer effective; the alarm reaction to a stressor becomes greater than the host’s ability to resist the stressor and the host

essentially experiences a perpetual alarm reaction (Selye, 1950, 1973). The stage of exhaustion is the point at which health is compromised and illness develops; these illnesses and diseases are called Diseases of Adaptation (Selye, 1950, 1973). Diseases of Adaptation can range from insomnia and upset stomach to heart attack, cardiovascular disease, diseases caused by inflammatory processes (such as obesity and cancer), hypertension, and gastrointestinal ulcerations. The host experiences Diseases of Adaptation until premature mortality ensues (Selye, 1973).

Allostatic Load Theory. Allostatic Load Theory is similar to GAS except Allostatic Load Theory recognizes that most stressors do not rise to the level of toxicity and will not lead to a relatively acute death as GAS theorizes; instead Allostatic Load Theory places emphasis on physiological adaptation to stress and exhaustion (McEwen, 1998). The outcome of Allostatic Load Theory is to create a "new normal" for the host by resetting the body to a higher homeostatic state in alignment with the peaks of stress hormone fluctuations, or allostasis (McEwen, 1998). Allostasis eventually leads to the stage of exhaustion by experiencing repeated stressors thus experiencing repeated episodes of alarm and resistance. It is the wear and tear of systemic variations in physiological functioning, or allostatic load, that lead to compromised health, chronic disease, and early mortality (McEwen, 1998).

Transactional Model of Stress and Coping and Allostatic Load Theory as a Theoretical Framework

The Transactional Model of Stress and Coping assumes a reciprocal relationship between stress and coping in which two simultaneously occurring cognitive appraisals of a stress event occur to determine the: nature (positive or negative) of the stress event, severity of the threat of the stress event, and available resources to resolve or mitigate the stress event and reduce or eliminate the threat (Lazarus & Cohen, 1977; Lazarus & Folkman, 1984; Lazarus, 1993). The determinations made during the primary and secondary cognitive appraisals then

inform decisions about coping mechanism(s) implemented to address the stress event and in turn the coping mechanism(s) and their efficacy to resolve the stress event inform the coping outcome (adaptation or maladaptation) (Lazarus, 1993; Lazarus & Folkman, 1984).

Modified Transactional Model of Stress and Coping. Several components were added to or made explicit within the Transactional Model of Stress and Coping framework (see Figure 1). Prior to the initiation of the primary and secondary appraisals recognition of the microaggression and confounding factors were added to account for respondents' differing perspectives of what is recognized as a microaggression experience. Within the primary appraisal it is assumed that the perceived threat level mediates the intensity of the physiological stress response (Lazarus, 1993; Lazarus & Folkman, 1984). Within the secondary appraisal "best case outcomes", "ideal outcomes", and efficacy of potential coping mechanisms and resources were made explicit to account for why passive coping mechanisms may be utilized to address microaggression events even though the coping mechanism appears to be antithetical to respondents' "ideal outcomes".

***Recognizing microaggressions*.** Prior to undergoing the two part cognitive appraisals a microaggression event must be recognized as such by respondents, however recognition of a microaggression event may be confounded by factors such as age, prior life experiences, historical knowledge, cultural background, and social influences (Lazarus, 1993; Lazarus & Folkman, 1984; Sue 2007, 2010). Microaggressions encompass both covert and overt discriminatory acts, therefore respondents that may be younger and less experienced (life, socially, limited historical knowledge) may be able to identify overtly discriminatory acts, such as racial profiling or being followed in a store (Sue, 2007, 2010). Respondents affected by those confounding factors, however, may internalize more covert microaggression events attributing the event to respondents' own shortcomings rather than due to biases and assumptions about the racial/ethnic subgroup to which they belong (Sue 2007, 2010). Although respondents that

internalize the microaggression event as an individual shortcoming may still experience a physiological stress response the duration of the physiological stress response may be shorter and have less of a lasting impact as the respondent may perceive that they have the potential to affect change within the event or for future events whereas recognition of the stress event as a microaggression has larger societal implications that are not readily influenced by respondents' actions. If a microaggression is recognized as such the microaggression then undergoes two simultaneously occurring cognitive appraisals. This cognitive process consists of a primary appraisal, which is an assessment of the nature (positive or negative stress) and severity of the threat (mild, moderate, or severe threat) of the microaggression experience; and the secondary appraisal is an evaluation of potential resources to address the microaggression event and potential outcomes of the microaggression event.

Changes to primary appraisal. The primary appraisal includes an assessment of the threat level of the microaggression which then triggers a physiological stress response that corresponds to the level of the threat (Lazarus & Folkman, 1984). For example, a microaggression that rises to the level of a mild threat for a respondent may be an insult to one's character but may not pose a physical threat thus the physiological stress response may rise to the level of a temporary annoyance whereas a severe threat, such as potential loss of life, may initiate a full fight-or-flight stress response. The determination of the severity of the threat of a microaggression is a personal one that is dependent upon the priorities of the recipient of the microaggression. For instance, two African American registered nurses that have the same experience will appraise the experiences differently. One nurse may find that a patient's assumption that she is the nursing assistant may be appraised as a moderate threat because the nurse perceives that this assumption diminishes her stature as a nursing professional and may inhibit her ability to fulfill her duties as a registered nurse, while the second nurse may view the patient's assumption as a mild threat and inconsequential. Although

both nurses perceive the event in the same manner the second nurse may not perceive that the patient's assumption has any professional or personal impact significant to the second nurse.

Changes to secondary appraisal. For the purposes of this stud the efficacy of potential resources to achieve respondents' "ideal outcome" and "best case outcome" have been made explicit in the secondary appraisal with the assumption that part of the decisions about coping mechanisms to utilize depends on perceptions of feasible outcomes of the coping mechanisms utilized to address the microaggression. Within the Transactional Model of Stress and Coping "best case outcome" are goals respondents' perceive as attainable outcomes of the microaggression event; "ideal outcome" is the model outcome for respondents but may be perceived as rarely attainable (Lazarus & Folkman, 1984). As an example, a Hispanic employee faced with disparaging cultural comments from a manager may decide to stay silent about the comments rather than confronting his manager because the employee perceives that the "best case outcome" is to avoid jeopardizing his employment and experiencing social isolation in the workplace; whereas an "ideal outcome" within this example may be that the Hispanic worker decides to confront his manager and experiences no negative repercussions professionally or socially in the workplace. This same Hispanic employee confronted by disparaging comments from a peer may perceive that the "best case outcome" and "ideal outcome" are both attainable and will confront his peer rather than remain silent because the perceived threat of job loss or social isolation in the workplace may be significantly less.

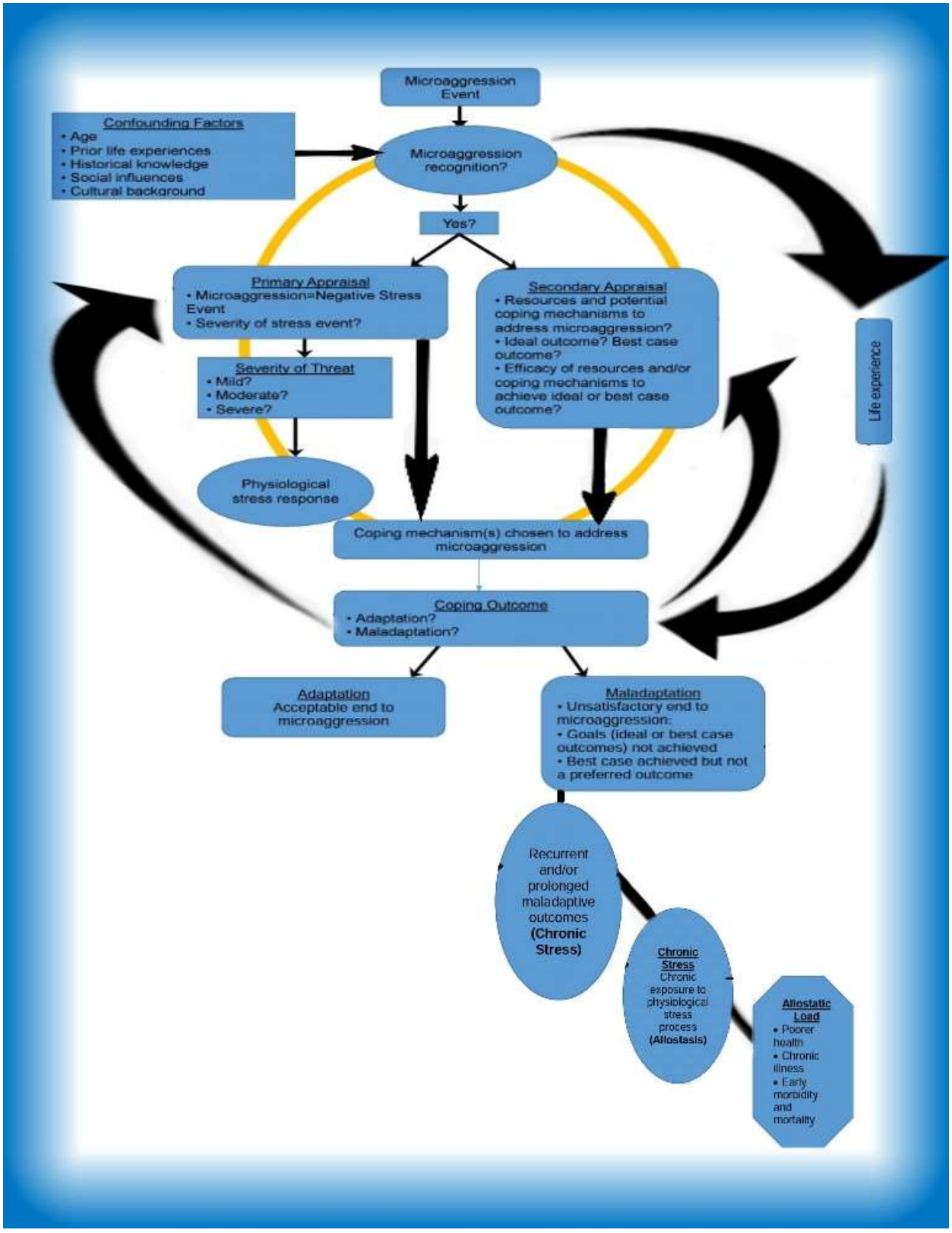
***Coping outcomes and impacts on respondents*.** The potential outcomes of the coping process are adaptation or maladaptation (Lazarus & Cohen, 1977; Lazarus, 1993). Adaptation means the microaggression at a minimum met respondents' "best case outcome". For instance, the Hispanic employee in the previous example, acknowledges and conveys that the disparaging cultural comments made by his peer were unacceptable by confronting his peer rather than ignoring the comments. The Hispanic employee could achieve adaptation by

deciding to use confrontation as his coping mechanism to address the disparaging cultural comments and did not suffer any adverse consequences in his workplace. Similarly, in the previous example involving the two nurses that were assumed to be nursing assistants, the second nurse also achieved adaptation because for the second nurse the patient's assumptions posed only a mild threat and bore no perceived consequences on anything she held valuable thus the nurse at a minimum achieved her "best case outcome".

Maladaptation can include the microaggression was completely unresolved or only partially resolved to meet respondents' "best case outcome". Continuing the scenario of the Hispanic employee that experienced the disparaging cultural comment from his manager: Although the Hispanic employee's manager committed the offense the employee appraises himself to be the one subject to adverse consequences if he decides to confront his manager about the disparaging comments; the employee chose a coping mechanism that met his "best case outcome" however the employee endures lingering effects. While the Hispanic employee chose not to confront his manager for fear of losing his job, he continues to endure the stress process as it relates to being subjected to the disparaging comments about his culture. Maladaptation in this instance is a result of the Hispanic employee choosing a passive coping mechanism that did not afford the Hispanic employee an opportunity to defend himself against disparaging comments and what the comments meant to him as a member of the vulnerable racial/ethnic subgroup being attacked. Recurrent episodes of maladaptation lead to recurrent episodes of physiological disequilibrium that result in a state of chronic stress and allostasis (McEwen, 1998; Selye, 1950, 1973). The Transactional Model of Stress and Coping assumes a cyclic process in that the adaptive or maladaptive outcome of one stress event then becomes a life experience that informs the recognition of the next microaggression event, the primary and secondary appraisals, and the coping mechanisms utilized in future microaggression events (Lazarus, 1993; Lazarus & Folkman, 1984). This assumption of a cyclic process will guide the

quantitative data analyses which can then be further investigated during qualitative data collection and analyses to determine if respondents indeed encounter and process microaggressions in this manner.

Figure 1: Modified Transactional Model of Stress and Coping



Summary

A mixed methods study using Critical Race Theory for the philosophical underpinning and a modified version of the Transactional Model of Stress and Coping for the quantitative theoretical framework allow a focal shift to respondents' perspectives while investigating multiple aspects of lived racial/ethnic microaggression experiences and its impacts on respondents' self-reported stress and health. This shift in perspective may also uncover contexts in which HD has thrived in vulnerable racial/ethnic population subgroups despite the numerous efforts to reduce and eliminate HD. These insights may be useful by contributing to the literature that help shape interventions and policies that more appropriately address identified needs.

Chapter II References

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CHAPTER III

LITERATURE REVIEW

Health disparities (HD) are predicted to worsen as racial/ethnic minority subgroups are estimated to comprise greater than 50 percent of the United States (US) population by 2050 (Anderson, 2010; APA, 2014; Passel & Cohn, 2008). Identifying and addressing underlying contributors to racial/ethnic HD such as chronic stress and microaggressions is important to guide healthcare practice and policy initiatives aimed at reducing or eliminating racial/ethnic HD.

Health Disparities

Health disparities are the differences in the incidence and prevalence of morbidity and mortality that occur among subgroups within a population (National Cancer Institute, 2012). Studies have shown that African Americans and Filipino Americans suffer HD in the form of worse health status and outcomes compared to Whites and other Asian subgroups at all levels of income (Braveman, Cubbin, Egerter, Williams, & Pamuk, 2010; Colen, Ramey, Cooksey, & Williams, 2017; Hastings et al., 2015; Wilson, Thorpe Jr., & LaVeist, 2016). Prevalence rates for African Americans with heart disease and stroke mortality were 141.3 per 100, 000 of the population compared to 117.7 per 100, 000 of the population for non-Hispanic Whites (Murphy et al., 2013). Hypertension rates were highest among African Americans (41.3%) compared to non-Hispanic Whites (28.6%) (CDC, 2013). Filipino Americans experience higher mortality rates for heart disease (24.4%), stroke (10%) and diabetes mellitus (4.8%) compared to the aggregate Asian American mortality statistics for the same illnesses: 23.5 percent, 9.3 percent, and 4 percent, respectively.

Increased attention has been paid to the topic of HD since Institute of Medicine (IOM) reports declared HD a major health concern that deserved concerted efforts to reduce their prevalence (Smedley, Stith, & Nelson, 2003). The National Institutes for Health (NIH) called for the reduction and elimination of HD and centered it as a focal national issue calling for

increased research efforts to develop remedies and increase public knowledge (2002). *Healthy People 2000-2020* have included recommendations to improve patient and provider education, encourage provision of culturally competent healthcare, and promote increased access and use of primary healthcare services among affected racial/ethnic subgroups (2012). Even though the IOM and Healthy People reports drew the most attention, the concept and existence of HD is not new. An initial call to investigate and address racial HD was the *Task Force Report on Minority and Black Health*, or the *Heckler Report* (1985). The *Heckler Report* recommended more health education for patients, cultural education for healthcare providers, and efforts to increase access and utilization of healthcare services. A seminal article which addressed cultural competence in healthcare provided an explanatory model of understanding and incorporating patients' cultural health beliefs into individualized healthcare plans (Kleinman, Eisenberg, & Good, 1978). Kleinman's research, the *Heckler Report*, IOM reports and proposals, and each installment of *Healthy People* are representative of the conversation that has taken place over the last several decades to reduce and eliminate racial/ethnic HD. Despite efforts to reduce and eliminate racial/ethnic HD it has remained the same or worsened (Moskowitz, Stone, & Childs, 2012; Sharma, 2012). Studies investigating contributors to chronic stress and health may provide further insight into the HD phenomenon.

Chronic Stress

Stress has long been considered a major contributor to poorer health and early mortality. Scientists have developed theories that define stress as a physiological process that induces a neuroendocrine cascade that includes secretion of stress-related hormones (e.g., cortisol and adrenaline) that cause physiological changes such as increased heart rate, vasoconstriction, altered immune responses, and suppression of gastrointestinal function (Selye, 1936). Prolonged exposure to stress hormones results in a systemic inflammatory response that leads to cardiovascular compromise, weakened immunity, and early mortality (Scherer et al., 2001;

Selye, 1936, 1950, 1973). Allostatic Load Theory furthered the concepts of stress, physiological response, and health status and outcomes by theorizing that stress hormone baseline levels recalibrate to a higher baseline to compensate for prolonged stress hormone exposure and return physiological processes, such as cardiovascular and immunological function, to normal levels of functioning (McEwen, 2004). Eventually the body's compensatory mechanisms fail, and early morbidity and premature mortality occur (McEwen, 2004). Stress theories, such as Allostatic Load Theory, describe processes in which the body is unable to sustain adaptation to repeated or prolonged stress (chronic stress) that then contributes to the development of early morbidity and premature mortality.

Chronic Stress and HD

The prevalence and persistence of racial/ethnic HD has been attributed to chronic stress induced by the stressors of everyday life in combination with racial/ethnic microaggression experiences (APA, 2014; Barksdale et al., 2012; Hicken et al., 2014). There are no known studies that have established associations among microaggressions, chronic stress, and health among registered nurses although it has been theorized that microaggressions contribute to higher chronic stress levels thereby negatively affecting health and contributing to the prevalence and persistence of HD (Hicken et al., 2014; Sternthal, Slopen, & Williams, 2011; Wong et al., 2014).

Microaggressions

Microaggressions are conscious or subconscious acts and environments that communicate hostility, inferiority to a person or group, are based on assumptions and biases associated with characteristics such as race/ethnicity, gender, age, sexual orientation, and perpetuate and sustain the marginalization of a person or group (Pierce et al., 1977; Sue, 2010; Sue et al., 2007; Wong et al., 2014). Microaggressions may not be statements that are overtly bigoted, challenging, or affronts that are strongly delivered, rather, they can be short lived

slights, insults, circumstances, or environments that deliver demeaning messages that attack or mischaracterize a person or group's identity and experiences. Microaggressions can affect any population subgroup and may take many forms however microaggression experiences generally fall into one of 3 sub-categories: microassaults, microinsults, or microinvalidations (DeAngelis, 2009; Sue, 2010; Sue et al., 2007). Microaggression experiences are ongoing, daily occurrences with messages that often speak to broader social issues of disadvantage, exclusivity, and inferiority which often manifest as socio-political and socioeconomic disadvantage toward certain population subgroups.

Microaggression Subcategories

Microassaults. Microassaults are overt aggressive behaviors that manifest as verbal and/or physical assaults (Sue, 2010; Sue et al., 2007). Microassaults are often intentional displays of discrimination such as painting a swastika on a Jewish family's home or referring to members of racial/ethnic subgroups by derogatory names, such as calling African Americans the "N-word" or referring to American Indians as savages. Microassaults also refer to physical encounters such as mass murders and burning Black churches, synagogues, and mosques.

Microinsults. Microinsults are often less overt behaviors that demean a person or subgroup (Sue, 2010; Sue et al., 2007). Microinsults may be intentional or unintentional; examples may include assuming a Hispanic American is an illegal immigrant, telling an Asian person they speak English well, or clutching one's purse when an African American enters the elevator. Personal experiences and character are diminished by the perpetrators of the microinsult acting in a manner based on assumptions and biases attributed to those racial/ethnic subgroups (Sue, 2010; Sue et al., 2007). These common experiences for Hispanic Americans, Asians, and African Americans communicate monolithic assumptions of being a foreigner in one's on land (Hispanic and Asian American examples) and criminality (African

American example) negating the individual character and experiences within these racial/ethnic subgroups.

Microinvalidations. Microinvalidations also may be intentional or unintentional and invalidate a person or subgroup's experiences and/or existence. Examples of microinvalidations include concepts of colorblindness, the sentiment that all racial/ethnic subgroups have the same opportunities to advance in the workplace or using American Indian symbols and likenesses as sports mascots. The microinvalidation in each case occurred because the perpetrators of the microinvalidation ignored the inequitable experiences and histories of the racial/ethnic subgroups. Claims of colorblindness negate the daily experiences of population subgroups that receive unequal treatment at all levels of society because of their race. In the example of equality for all racial/ethnic subgroups in the workplace the perpetrator of the microinvalidation may ignore or not have an awareness that members of racial/ethnic subgroups are often relegated to positions of service instead of leadership roles as well as often receiving lesser pay for equal work. In the American Indian example, the perpetrator of the microinvalidation objectified and dehumanized American Indians by reducing their existence to caricatures.

Microaggression Background

The term "microaggression" was originally coined by Chester Pierce, a psychiatrist and professor at Harvard University, to describe covert race-based discriminatory acts experienced by African Americans (1977). The microaggression concept has been expanded to include any population subgroup that has the potential to experience socio-political and/or socio-economic disadvantage based on characteristics including (but not limited to) race/ethnicity, gender, age, sexual orientation, and disability (Sue et al., 2007; Wong et al., 2014).

Racial/Ethnic Microaggressions

Racial/ethnic microaggressions are: conscious or subconscious, subtle verbal and nonverbal acts and environments that communicate hostility, perceptions of inferiority and/or a

power imbalance toward vulnerable persons and subgroups, are based on assumptions and biases, and perpetuate and sustain the marginalization of vulnerable racial/ethnic subgroups (Pierce et al., 1977; Sue, 2010; Sue et al., 2007; Wong et al., 2014). Racial/ethnic microaggression experiences and their effects are increasingly of interest as overt discriminatory practices and behaviors toward vulnerable racial/ethnic subgroups have increased (Horowitz, Brown, and Cox, 2019). Racial/ethnic microaggressions are often thought to be harmless however they have been correlated to negative mental health outcomes (Blume et al., 2011; Nadal, Griffin, Wong, Hamit, & Rasmus, 2014; Wong et al., 2014).

Effects of racial/ethnic microaggressions. Racial/ethnic microaggression studies have reported relationships to poorer mental health status and adverse health behaviors (Blume et al., 2011; Solórzano et al., 2000; Yosso et al., 2009). Several studies have found that African American and Hispanic students that reported microaggression experiences: had higher levels of stress, anxiety, and depression; and engaged more often in risky or adverse health behaviors such as alcohol abuse (Blume et al., 2011; Nadal et al., 2014; Torres, Driscoll, & Burrows, 2010).

Undergraduate minority (African American, American Indian, Asian, and Hispanic) college students (n=178) and undergraduate college students of European descent (n=506) attending a historically White university, aged 18-20 years self-administered surveys which inquired about alcohol consumption, anxiety, and coping habits and included open-ended questions about microaggression experiences (Blume et al., 2011). Findings included: minority college students disproportionately endured racial/ethnic microaggression experiences and were at higher risk for anxiety and excessive alcohol use. Inverse relationships were found with respect to coping habits and excessive drinking such that students that scored better on coping scales had lesser risk of excessive alcohol use and binge drinking.

Another study with a sample of 506 respondents consisting of: undergraduate college students (n=288) and community members (n=218), aged 18-66 years, that self-identified race/ethnicity (Asian/Pacific Islander, Black, White, Latino, multiracial, and other) were administered the Race Ethnicity Microaggressions Scale and Mental Health Inventory (Nadal et al., 2014). Minority (Asian, Black, Latino, and multiracial) respondents reported more racial microaggression experiences than White respondents; specifically, Asian and multiracial respondents reported higher frequencies of microaggressions related to exoticization (e.g., assumptions of being the "ideal race" and/or objectification), whereas Black and Latino respondents reported higher frequencies of microaggressions that assumed inferiority and criminality. Significant relationships were found between the number of racial microaggressions experienced and mental health such that respondents that reported higher frequencies of microaggression experiences were more likely to report anxiety, depression, a negative worldview, and decreased behavioral control.

A mixed methods study to investigate the influence of racial microaggressions on mental health among African American doctoral students and graduates (N=107) showed that respondents reported racial isolation, underestimation of ability and being treated as: criminals, second class citizens, and intellectual inferiors (Torres et al., 2010). Underestimation of ability mediated by perceived stress increased respondents' risk of experiencing depressive symptoms, whereas other reported microaggressions (e.g., assumptions of criminality and second-class citizenship) increased perceptions of stress but had no significant effect on other mental health states.

A sample of racial/ethnic minority undergraduate college students (N=405) from a Midwest university self-administered a survey that asked about microaggression experiences, depression, and suicidal ideation (O'Keefe, Wingate, Cole, Hollingsworth, & Tucker, 2015). All racial/ethnic groups reported frequent racial/ethnic microaggression experiences, however

African Americans experienced the highest frequency of microaggression experiences, American Indians/Alaska Natives experienced the least, and Asian and Hispanic respondents had relatively equal frequencies of microaggression experiences. Similar to previous studies, positive relationships were found between higher frequency of racial/ethnic microaggression experiences and depression/depressive symptoms. This study also found positive relationships between higher frequency of microaggression experiences and suicidal ideation.

White privilege. Racial/ethnic microaggressions describe discriminatory acts experienced by vulnerable racial/ethnic subgroups; inherent in this description is the assumption that there are racial/ethnic subgroups that receive preferential treatment. White privilege refers to unearned preferential opportunities and acts afforded to White subgroups to the disadvantage of other racial/ethnic subgroups (Davis & Gentlewarrior, 2015; McIntosh, 1988; Sue, 2010). These preferential opportunities and acts are often passive in nature thus are often unrecognized by those receiving the benefits; likewise, the disadvantages experienced by other racial/ethnic subgroups as a result of White privilege also often go unrecognized by White subgroups (McIntosh, 1988). In a seminal article McIntosh (1988) detailed how White privilege has an inherent system of valuation that dictates racial/ethnic subgroups' socio-political worth and defines the way in which racial/ethnic subgroups exist and interact with dominant U.S. culture. Further, white privilege includes the guarantees that White subgroups generally have experiences that support and reinforce a positive social, cultural, political, and historical existence. This generally means that White subgroups are immune to experiences that are common for other racial/ethnic subgroups, such as racial profiling, being considered "the exception and benefit to one's race", having limited employment and academic opportunities because of race/ethnicity regardless of qualifications, or fear of receiving differential treatment, such as healthcare treatments, based solely on the value placed on one's race/ethnicity (McIntosh 1988).

Race/Ethnicity and Nursing

African Americans and Asian Americans comprise a small portion of the US. registered nursing workforce, 9.9 and 8.3 percent, respectively; however, 67 percent of Black/African American registered nurses (RN) and 83 percent of Asian RNs are. frontline staff nurses in the US with less representation in management roles (Health Resources and Services Administration, 2013; 2015). Over-representation in non-managerial roles may subject RNs belonging to vulnerable racial/ethnic subgroups to unfavorable and discriminatory behaviors (Baptiste, 2015; DeNavas-Walt & Proctor, 2014; Mapedzahama, Rudge, West, & Perron, 2012; Tuttas, 2015; Williams, 1999).

Studies conducted among migrant RNs from minority racial/ethnic subgroups (those RNs educated in their native country and practicing in another country) were shown to have less opportunities for career advancement and professional recognition (Baptiste, 2015; Mapedzahama et al., 2012). Black RNs practicing in traditionally White hospitals in Australia reported discrimination experiences (e.g., being treated as “other” and prejudged as incompetent) from colleagues, management, subordinates, and patients; respondents also reported workplace anxiety, loss of self-esteem, and self-doubt of nursing ability (Mapedzahama et al., 2012). Similar studies have shown that migrant RNs from minority racial/ethnic subgroups reported overt and covert racial/ethnic insults, feeling bullied and harassed by co-workers, were more often refused by patients, were victims to preferential scheduling in which international minority RNs were scheduled for shifts other RNs did not want, and received less pay for overtime shifts (Mapedzahama et al., 2012; Tuttas, 2015). Some of the discrimination experiences reported in these studies are similar to findings reported in microaggression studies, however there are no known studies that have investigated the racial/ethnic microaggression experiences of RNs that are both citizens and practicing in the US.

African and Asian Americans have been shown to have poorer socio-economic and socio-political outcomes compared to non-Hispanic Whites at all levels of socio-economic status (DeNavas-Walt & Proctor, 2014; Williams, 1999). Filipinos, specifically, have been shown to have racial microaggression experiences congruent with other vulnerable racial subgroups (e.g., alien in one's own land, assumptions of criminality, assumptions of inferior status) unlike other Asian groups that are assumed to be the "model minority" with superior intelligence and work productivity (Nadal, 2012). African Americans and Filipinos have been shown to report racial microaggression experiences that are hypothesized to have negative impacts on all aspects of their lives including higher levels of anxiety, poorer health care and outcomes, and lower socioeconomic status as it relates to earning potential, wealth, and employment/advancement opportunities (Sue, 2010; Nadal, 2012). Although African Americans have the lowest and Filipinos the highest representation within the registered nursing profession among racial/ethnic subgroups, this study investigated if their lived racial/ethnic microaggression experiences continue to be similar as in prior studies and what the effects are of those racial microaggression experiences.

Gaps in the Literature

Microaggression studies have been primarily qualitative inquiries into microaggression experiences in academic settings (Sue, 2010; Wong et al., 2014). Studies which have explored microaggressions and health have been based in mental health or focused on health behaviors influenced by microaggression exposures (Barksdale et al., 2012; Nadal et al., 2014; Sue et al., 2007; Wong et al., 2014). This study used a mixed method approach to investigate microaggressions from the perspective of respondents but focused on impacts that may have long term implications for stress, physical health, and mental well-being.

Summary

Microaggression experiences encompass more than the events that tend to catch news headlines, such as reports of racial/ethnic discord on college campuses, biased policing in racial/ethnic communities, the attacks and murders of racial/ethnic youths, or members of racial/ethnic subgroups not being recognized for professional contributions; arguably these events are symptoms of a larger issue. Microaggressions are acts that are short lived but occur frequently and are ongoing throughout each day (Pierce et al., 1977; Sue, 2010; Sue et al., 2007). A better understanding of racial/ethnic microaggressions experienced by participating female African American and Filipino RNs and the impacts on their self-reported stress and health will begin to provide valuable insights toward understanding how HD have been able to persist despite efforts over the last four decades to reduce and eliminate them and will provide insight when creating healthcare practice and policy initiatives intended to reduce or eliminate HD.

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CHAPTER IV

METHODOLOGY

A sequential explanatory mixed methods approach was utilized to investigate lived racial/ethnic microaggression experiences and impacts on self-reported stress and health among female African American and Filipino registered nurses (RN). A sequential explanatory mixed methods approach to investigate racial/ethnic microaggression experiences, self-reported stress, and self-reported health will allow corroboration of quantitative and qualitative findings and in-depth investigation of the meaning and context of lived racial/ethnic microaggression experiences. Quantitative cross-sectional methods explored relationships among racial/ethnic microaggression experiences, self-reported stress, and self-reported health and the prevalence of microagressions for female African American and Filipino RNs. Qualitative methods were used to further investigate relationships among racial/ethnic microaggression experiences, self-reported stress, and self-reported health as well as the meaning and contexts of those experiences as described by respondents.

Research Goal and Aims

Research Goal

A sequential explanatory mixed methods approach was implemented to explore lived racial/ethnic microaggression experiences and the relationships to self-reported stress and self-reported health among female African American and Filipino RNs.

Research Questions and Specific Aims

The research questions and specific aims were:

Research Question 1.

What are the relationships among microaggression experiences, self-reported stress, and self-reported health among female African American and Filipino RNs? (Quantitative)

Aim 1. Explore relationships among racial/ethnic microaggression experiences, self-reported stress and self-reported health of female African American and Filipino RNs. (Quantitative)

Aim 2. Identify the prevalence of microaggression experiences dichotomized by African American or Filipino ethnicity. (Quantitative)

Research Question 2. What are the meanings of lived microaggression experiences for female African American and Filipino RNs? (Qualitative)

Aim 1. Explore the meaning of lived microaggression experiences for female African American and Filipino RNs. (Qualitative)

Aim 2. Explore whether female African American and Filipino RNs associate lived microaggression experiences to self-reported stress and health. (Qualitative)

Aim 3. Explore the contexts in which microaggression experiences occurred. (Qualitative)

Research Design

A sequential explanatory mixed methods model in which respondents were surveyed about their microaggression experiences and self-reported stress and health was utilized for quantitative cross-sectional methods and semi-structured individual interviews were used for qualitative methods to explore the meaning of lived racial/ethnic microaggression experiences and relationships to self-reported stress and health among female African American and Filipino RNs.

Sample and Setting

Female African American and Filipino RNs over the age of 21 years were recruited to investigate the research questions and specific aims.

Inclusion criteria. Potential respondents had to be RNs with an active registered nursing license, female, aged 21 years or older, self-identified as African American or Filipino, have a minimum of 2 years of professional experience, not experiencing any major life events

(e.g., new diagnosis of chronic illness, death in the family, recent birth, or planning a wedding) within the past year, and willing to consent to participate in research activities.

Exclusion criteria. Potential respondents were excluded if not licensed as an active RN, male, aged less than 21 years, have less than 2 years of professional experience, experiencing a major life event, or unwilling to consent to participate in research activities**.**

Respondent Recruitment and Sampling

Setting. Registered nurses were recruited years 2017-2019. Physical sites of recruitment were universities and hospitals located in Southern California. Recruitment efforts also took place via virtual mediums such as email and social media.

Recruitment. Recruitment methods included flyers, email, and snowballing. Potential respondents were recruited by face to face contact, flyers posted in education departments and on floors and units throughout hospitals and nursing schools. Emails were sent using listservs at schools of nursing. Respondents referred other female African American and Filipino RNs for participation in the study and some posted study flyers to their social media pages.

Sampling. Stratified purposive sampling techniques were utilized to achieve a cohort of respondents equally divided between African American and Filipino RNs. Purposive sampling is commonly used in qualitative and mixed methods research to ensure 'information-rich' cases with experience relevant to the intended topic are included in data collection that may address both depth and breadth of understanding of a topic (Creswell, 2013; Grove, Burns, & Gray, 2013; Palinkas et al., 2015). Stratified purposive sampling targets individuals that have experience with the intended research topic and ensures groups are equally included allowing more accurate comparisons during data analysis.

Sample size. The total sample size was 40 respondents to satisfy the assumptions and requirements of quantitative data analyses. All respondents that self-administered the survey were offered the opportunity to be interviewed.

Cross-sectional sample size. The statistical plan for quantitative analysis included frequencies for demographic analyses and Multiple Analysis of Covariates (MANCOVA) with follow up univariate Analysis of Covariance (ANCOVA) testing to determine relationships among microaggression experiences and self-reported stress and health. Decisions about sample size were made based on MANCOVA assumptions (Tabachnick & Fidell, 2012). MANCOVA allows comparative analysis of means for multiple dependent variables and covariates (or confounding factors) for 1 independent variable divided into 2 or more groups with approximately equal number of independent cases (respondents). Cases with missing data were excluded from analysis, a default setting in SPSS Version 25. To diminish the risk of type II statistical error, false acceptance of a null hypothesis, power requirement for MANCOVA that more cases than dependent variables be included in analysis was adhered to (Tabachnick & Fidell, 2012).

Qualitative sample size. Individual semi-structured interviews were implemented for qualitative data collection. Generally, the recommended sample size for qualitative studies is 20-30 respondents, however studies using similar qualitative methodology interviewed up to 97 respondents (Torres, Driscoll, & Burrow, 2010). Sample size ultimately depended upon the number of respondents that consented to be interviewed after self-administering survey tool.

Data Collection

Data collection techniques were a self-administered cross-sectional correlational survey and individual semi-structured interviews.

Quantitative Cross-sectional Data Collection

Quantitative data was collected using SurveyMonkey, an online survey administration application, and pencil-paper. Demographic data collected included: date of birth (age), gender, race, Hispanic ethnicity, current status of RN license (active, inactive, retired), highest level of education completed, current employment status, current position, and years of professional RN experience. Respondents were asked to complete a self-administered survey that included the

following scales: Everyday Discrimination Scale (EDS) Original and Chronic Work Discrimination and Harassment, RAND Medical Outcomes Survey Short Form-36 version 1.0 (Medical Outcomes Survey SF-36 or MOS SF-36), Kessler Psychological Distress Scale- 6 (K6), and Brief COPE.

Everyday Discrimination Scale. The Everyday Discrimination Scale (EDS) was constructed to collect data about experiences of unfair treatment that are also often considered discriminatory (Williams, Yu, Jackson, & Anderson, 1997). Several studies have been conducted to establish and confirm the validity and reliability of the EDS, two of which are discussed.

EDS construction. The EDS was constructed for the 1995 Detroit Area Study to collect information about common experiences of discriminatory treatment (e.g., denied a job promotion, treated with less respect, assumed to be not as smart as others, and threatened or harassed), acute and chronic stress (e.g., financial demands and familial obligations), mental and physical health status, and social class (e.g., income and employment and household size) (Williams et al., 1997). Detroit Area Study data was triangulated with information collected from one-on-one interviews.

The Everyday Discrimination Scale was administered to 1196 respondents, that resided in the Detroit area (Macomb, Oakland, or Macomb counties), from any self-reported racial/ethnic group, and aged 18 plus years (Williams et al., 1997). Data was analyzed using ordinary least squares regression and descriptive statistics.

EDS reliability and validity. Several subsequent studies were utilized to confirm the validity and reliability of EDS.

Data from the 2007 California Health Interview Survey (CHIS) was analyzed from 6966 respondents that completed the Discrimination Module (DM; version 1 or 2) within CHIS (Shariff-Marco et al., 2011). Discrimination Module of CHIS consisted of EDS questions with

verbiage modified to ask if self-reported unfair treatments were based on race/ethnicity (version 1; administered to 3506 respondents); version 2 (administered to 3460 respondents) of the DM asked respondents to self-identify the impetus (e.g., race/ethnicity, age, tribe, skin color) for unfair treatments. The 2 versions of DM were designed to test for language bias in which respondents may subconsciously attribute experiences to race/ethnicity from the implicit suggestion from language use in question construction. Data from DM version 2 was recoded into dichotomous variables for “attributed to race/ethnicity” or “not attributed”. Statistical analyses included confirmatory factor analysis to test hypotheses for the total sample and by race/ethnicity, Cronbach’s alpha for inter-item reliability, Differential Item Functioning (DIF) to test sensitivity and specificity of items for each race/ethnic group, and descriptive statistics to test homogeneity of the sample pool. The accepted minimum threshold for statistical significance of Cronbach’s alpha is .70-.80 (Bland & Altman, 1997). Discrimination Module versions 1 and 2 resulted Cronbach’s alpha 0.88 and 0.81, respectively. Items were eliminated if the DIF analysis results were negative; version 1 did not yield DIF results to eliminate any items.

Limitations of EDS. The researchers acknowledged that although respondents were statistically homogeneous DIF analyses were limited by sample size and could not accommodate inclusion of multiple confounding factors (Shariff-Marco et al., 2011). The research team also acknowledged that study outcomes were a comparative analysis of group means and that individual case comparison may have yielded more specific and sensitive results.

Scoring of EDS. The EDS is a Likert scale that asks respondents about experiences of unfair treatment (Williams et al., 1997). Answers are coded 1 to 6 and range from treatment happening “Almost every day” (1) to “Never” (6). The answers to all items are then summed into one score, with lower scores corresponding to higher frequency of unfair experiences. (see Appendix for EDS tool).

Conclusion. Everyday Discrimination Scale underwent a rigorous development and testing plan for validity and reliability (Shariff-Marco, 2011; Williams et al., 1997). Several studies have been conducted for validity and reliability in independent samples and yielded similar psychometric results. Statistical testing included confirmatory factor analysis with sufficient sample sizes that produced Cronbach's alpha results above the accepted minimum range of .70 to .80. Lastly EDS is one of the few research tools that has been found valid and reliable in racially and ethnically diverse samples and has been used in multiple research studies and epidemiological efforts since it's construction.

RAND Medical Outcomes Survey Short Form-36. Medical Outcomes Survey Short Form-36 (MOS SF-36) was constructed to create a valid and reliable survey tool that would measure perceived mental and physical health and well-being across a variety of settings and study samples (Ware, Snow, Kosinski, Gandek, 1993). It is one of the most commonly accepted and utilized research tools to assess perceptions of general health and well-being and has been used by healthcare organizations and Centers for Medicare and Medicaid Services to determine adult health outcomes (RAND Health Care, n.d.; Turner-Bowker, Bartley, & Ware, 2002). For the purposes of this study the MOS SF-36 was modified to include only those items asking about general health and well-being for which permission was granted in the *Terms and Conditions for Using the 36-Item Short Form Survey (SF-36)* (RAND Health Care, n.d.).

MOS SF-36 construction. The MOS SF-36 is comprised of 36 items divided into eight subscales that collect data from respondents about their perceptions of their physical and mental health (Ware et al., 1993). The initial construct of the MOS SF-36 consisted of 149 items adapted from several topic and/or population specific survey tools that were proven valid and reliable and widely utilized for research purposes and included the General Psychological Well-Being Survey and Health Perceptions Questionnaire (Stewart & Ware, 1992; Ware, 1995; Ware et al., 1993). The MOS SF-36 exceeds validity and reliability standards as a self-administered

survey tool (Ware et al., 1993). The MOS SF-36 subscales consist of dichotomous and three to six item Likert scale survey responses. The MOS SF-36 was shortened to those questions pertinent to assessing respondents' perceptions of their own health and emotional well-being.

MOS SF-36 reliability and validity. A standardized statistical means of determining construct validity and reliability is the use of a coefficient alpha, or Cronbach's alpha; the accepted minimum threshold for statistical significance of Cronbach's alpha is .70-.80 (Bland & Altman, 1997). The validity and reliability of MOS SF-36 has been tested in greater than 20 studies and population subgroups with Cronbach's alpha results that exceed the minimum accepted threshold of .70 for the overall MOS SF-36 and most of its subscales (McHorney, Ware, Su, & Sherbourne, 1994; Tsai, Bayliss, & Ware, 1997; Ware et al., 2000)

Concurrent validity is the ability of a survey tool to produce comparable results to another already established survey tool that measures similar concepts (Carmines & Zeller, 1979; Waltz, Strickland, & Lenz, 2005). Since its conception and use in 1988, MOS SF-36 has been tested against 225 other survey tools that have also been determined to be valid and reliable survey tools (Beusterian, Steinwald, & Ware, 1996; Rumsfield et al., 1999; Ware et al., 1994; Wells, Burnam, Rogers, Hays, & Camp, 1992). The MOS SF-36 has been determined to be an effective predictor of perceptions of mental and physical health study respondents. The MOS SF-36 test-retest reliability was measured at one-year after its initial self-administration (Ware et al. 1993). Perceptions of mental and physical health status (ranging from "much better" to "about the same" to "much worse") collected from self-administration of MOS SF-36 at one year after its initial self-administration were matched against the respondents' reports of mental and physical health on the 0-100 General Health Rating Index. It was determined that the MOS SF-36 highly correlated with respondents' perceptions of their mental and physical health status with their reports of mental and physical health status on the 0-100 General Health Rating Index.

Limitations of MOS SF-36. The Social Functioning subscale of the MOS SF-36 produced a Cronbach's alpha of .68, which is just below the minimum threshold for statistical measurement of content validity, however MOS SF-36 validity and reliability overall and for each of its subscales has been established and confirmed in several other studies (McHorney et al., 1994; Tsai et al., 1997; Ware et al., 1993, 2000). Cronbach's alpha scores were slightly lower in disadvantaged populations, such as lower socioeconomic status, however measures of validity and reliability still resulted higher than minimum standards (Ware et al., 1993).

Scoring of RAND MOS SF-36. The RAND MOS SF-36 collects categorical data consisting of a combination of dichotomous questions requiring "yes"/"no" answers and three to six-item Likert style questions about respondents' health and wellness over the previous 4 weeks as well as one Likert style question asking respondents to compare their current self-reported health to their perceptions of their health one year prior (Hays, 1994). RAND recommends a two-step scoring system for the MOS SF-36. Step one requires each item be recoded using a range of 0-100 with each item having a minimum score of 0 and maximum score of 100 so that each item's score can be interpreted as a percentage (See Appendix for recoding table). In step two, individual item scores within each of the eight subscales are averaged to create a total score for each subscale (See Appendix for subscale items table). Higher scores are positively correlated to positive perceptions of health.

Conclusion. The MOS SF-36v2 has undergone multiple tests to establish and confirm its validity and reliability in multiple settings and populations. Beyond testing for validity and reliability the MOS SF-36 has been used successfully in many studies to measure perceptions of both mental and physical health in study populations using multiple modes of administration, such as self -and computerized administration (Turner et al., 2002).

Kessler Psychological Distress Scale. The Kessler Psychological Distress Scale was constructed to provide a time-conscious, valid and reliable survey tool that could be

administered to collect information about experiences of general stress manifestations (Kessler et al., 2002).

Kessler psychological distress scale construction. The Kessler Distress Scale was constructed in 3 phases: 1. Mail survey (pilot); 2. Telephone survey (pilot); and 3. Clinical reappraisal survey (Kessler et al., 2002). Data collection for the construction of the Kessler Psychological Distress Scale began with a mail survey self-administered to 1403 respondents all aged 18 years or older and representative of all racial/ethnic groups in the US. Data collected during the mail survey was then analyzed for specificity and sensitivity of survey items to revise the initial Kessler survey tool for telephone administration in phase 2. Telephone surveys were then administered to 1574 racially/ethnically diverse respondents aged 25 years or older in the US. Data collected during the first 2 pilot phases (mail and telephone surveys) was analyzed resulting in the Kessler Psychological Distress Scale 10, or K-10, a 10-item survey tool and the corresponding short form K-6.

Phase 3 was the clinical reappraisal survey in which the K-10 and K-6 were administered and/or followed by individual interviews (Kessler et al., 2002). The clinical reappraisal was divided into stages: screening by telephone, individual interviews during which the K-10 was administered with the Structured Clinical Interview for DSM-IV, and finally K-10 was included in the 1997 National Survey of Mental Health and Well-being (Australia) and K-6 in the 1997 and 1998 National Health Interview Survey (US). One thousand racially/ethnically diverse respondents were screened for participation in individual interviews. One hundred fifty-five of those screened were included in interviews and administered the K-10 and Structured Clinical Interview. The K-10 was administered to 10641 Australian households as part of the 1997 National Survey of Mental Health and Well-being and K-6 was administered to 36116 and 32440 US households as part of the 1997 and 1998 National Health Interview Surveys, respectively.

Kessler distress scale reliability. To determine reliability and validity of the Kessler Distress Scale (both K-6 and K-10) results from all phases (mail, telephone, and clinical reappraisal surveys) underwent comparative analyses (Kessler et al., 2002). Factor analyses were conducted to narrow the number of items included through each phase, mail surveys to telephone surveys then telephone surveys to clinical reappraisal surveys. Final Cronbach's alpha scores for K-10 (0.76-0.99, with a mean alpha 0.91) and K-6 (0.98-0.99) derived from clinical reappraisal survey data analyses exceeded the accepted minimum threshold for statistical significance of Cronbach's alpha .70 to .80 (Bland & Altman, 1997). The clinical reappraisal survey included additional statistical modelling at the individual response level to determine sensitivity and specificity of the K-10 and K-6 to discern between cases with and without mental health history; both the K-10 and K-6 met the research team's goal of 90-99th percentile on Receiver Operator Characteristic curves in the range of 0.90-0.95 (Kessler et al., 2002).

Limitations of Kessler Psychological Distress Scale. The research team acknowledged a limitation of the Kessler Distress Scale is the effectiveness of its application in clinical settings as validity and reliability testing was primarily conducted for epidemiological purposes (Kessler et al., 2002).

Scoring K-6. Each of 6 items of the K-6 is scored from one 'none of the time' to five 'all of the time'. Scores of the 6 items are then summed, yielding a minimum score of 6 and a maximum score of 30 with lower scores indicating lower psychological distress (Kessler et al., 2003).

Conclusion. The Kessler Psychological Distress Scale and K-6 were found to be a valid and reliable tool to measure general distress symptomology in across diverse population samples. For the purposes of this study the K-6 has been determined to be a sufficiently reliable survey tool to assess self-reported stress in female African American and Filipino RNs.

Brief COPE. Brief COPE is an abbreviated form of the COPE survey tool used to measure respondents' coping habits (Carver, Scheier, & Weintraub, 1989). COPE scale was developed to provide a means to measure emotion-focused and problem-focused coping techniques separately, as well as determine if respondents' have a preferred coping style versus situational coping responses. Undergraduate college students (N=978) were administered the COPE across two studies to develop COPE and establish internal reliability of the final versions of COPE and Brief COPE.

Brief COPE construction. COPE underwent several phases of construction and revisions during Study 1. The initial item inventory of COPE was administered to "several hundred" respondents and underwent several phases of revisions (e.g., deletion of items, reorganization of items into different subscales) based on factor analysis results (Carver et al., 1989). A final draft of COPE was administered to 978 undergraduate college students and underwent additional principle-factor factor analyses to finalize the full version COPE consisting of 60 items divided among 15 subscales. Study 2 established full version COPE internal reliability and was based on test-retest Cronbach's alpha scores at baseline (n=89) and again at eight weeks (n=116). The minimum Cronbach's alpha set point was .6; Cronbach's alpha scores ranged from .62 to .92 with one outlier for Mental Disengagement (α=.45). Mental Disengagement continued to be included in the full version COPE scale with researchers stating that the lower Cronbach's alpha score was not unexpected since Mental Disengagement items were attempting to measure multiple concepts. An example of a Mental Disengagement item: I turn to work or other substitute activities to take my mind off things.

Brief COPE was developed because of the length and time burden for respondents to administer the full version COPE scale; Brief COPE was created by reducing full version COPE to 28 items divided among 14 subscales (Carver, 1997). The contents of Brief COPE were based on the highest factor loading values from factor analyses conducted during Study 1 to

develop full version COPE and results from studies in which full version COPE was used as a research tool. Items were removed for redundancy based on respondent feedback from prior studies; two subscales ("Restraint Coping" and "Suppression of Competing Activities") were removed from the original COPE based on low psychometric performance during Study 1 to develop the full version COPE and statistically insignificant results in studies in which COPE was utilized. Several items and subscales were reorganized and renamed: "Positive Reinterpretation and Growth" became "Positive Reframing"; "Focus on and Venting of Emotions" became "Venting"; and "Mental Disengagement" became "Self-Distraction". Finally, a subscale and items for "Self Blame" were added.

Brief COPE reliability. Brief COPE internal reliability was tested among community dwelling adults affected by Hurricane Andrew at three timepoints: initial (n=168), six months (n=124), and one year (n=126) (Carver, 1997). The study sample included non-Hispanic Whites (40%), Blacks (34%), Hispanics (17%), and Asians (5%); the sample was 66% female. The average Cronbach's alpha scores for the three timepoints ranged from .54 to .9 using a Cronbach's minimum set point of .5 which Carver et al. (1997) identify as the acceptable minimum (Nunnally, 1978).

Limitations of Brief COPE. Researchers used oblique rotation during exploratory factor analyses to account for the small sample sizes in addition to Cronbach's alpha scores to confirm internal reliability (Carver, 1997). Full version and Brief COPE survey tools both include subscales that produced Cronbach's alpha scores that are below the currently accepted minimum set point of .7-.8, however the Cronbach's alpha scores generally met the minimum set point (.5) at the time the full version COPE studies were conducted (Bland & Altman, 1997; Carver, 1997; Carver et al., 1989; Nunnally, 1978). The subscale "Mental Disengagement" (α=.45) was included in the full version COPE despite poor psychometric performance but was subsequently removed from Brief COPE and replaced with "Self Distraction" (α=.71).

Scoring Brief COPE. Brief COPE contains four-item Likert style survey questions with answers ranging from 0=”I don’t do this at all” to 4=”I do this a lot” (Carver, 1997). Each subscale is summed for analysis (see Appendix for table of subscales and list of items). There is no total score for Brief COPE.

Conclusion. Several independent studies were conducted for test-retest reliability. Statistical testing included exploratory and principle-factor factor analyses with oblique rotation to account for small sample sizes. Brief COPE has been tested and shown to be a reliable tool to measure coping habits across a multi-racial/ethnic survey sample in both college students and community dwelling adults.

Qualitative Data Collection

Qualitative data collection techniques included individual semi-structured interviews with respondents that consented to self-administer the survey tool. Interview grand themes focused on respondents’ microaggression experiences and the impacts those experiences have had on their stress and health. Semi-structured interviews were conducted years 2017-2019. (see Appendix for interview guide). Qualitative data was collected using SurveyMonkey, email, by phone, and face to face. Face to face and phone interviews were audio recorded with subsequent verbatim transcription.

Individual semi-structured interviews. Semi-structured interviews are a method to collect qualitative data from respondents, in a formal or informal environment, about a researcher generated topic (Galletta, 2013). Individual semi-structured interviews have been identified as an effective means to collect data about sensitive topics, (i.e., microaggressions), for participatory research, and to conduct research in hard to reach population subgroups, such as racial/ethnic subgroups. Semi-structured interviews are conducted with a planned interview guide of open-ended questions based on topics specific to the research questions and aims, however additional questions may be added during the interview to follow up on respondents’

responses. Semi-structured interviews often result in more in-depth qualitative data that may not have been accessible by any other means as respondents are able to relay stories with details that may have been overlooked and/or withheld using other qualitative techniques. Experts suggest that 20-30 respondents are usually sufficient to achieve data saturation, or the point at which no new data is reported (Krueger & Casey, 2015).

Semi-structured interview methods. Individual semi-structured interviews were used to investigate respondents' microaggression experiences and the impacts on their stress and health. Individual interviews were categorized by African American or Filipino ethnicity for inter-group and intra-group comparisons during qualitative data analyses. Twenty to 30 respondents are usually sufficient to achieve data saturation of interviews; however, interviews were conducted for all African American and Filipino respondents willing to participate in interviews (Krueger & Casey, 2015).

Individual interviews were convened over 30-120 minutes per interview during which time respondents were asked questions from a planned interview guide. Thirty respondents opted to complete interviews using SurveyMonkey. Respondents that opted to complete interviews using SurveyMonkey were sent a standardized email generated from the SurveyMonkey platform embedded with an electronic link to the interview questions. SurveyMonkey settings were such that all personal identifiers including IP addresses were stripped from the data in addition to the additional encryption and security protections SurveyMonkey provides. Respondents were asked to provide either the respondent identification code that was assigned during screening or to use an alias of their choice. The interview guide was standardized and focused on respondents' descriptions and contexts of microaggression experiences and how those experiences affected their stress and health. Follow up questions were emailed to respondents for clarification of emerging themes and subthemes from data analyses. Emails sent to and received from respondents were

immediately printed and all personal identifiers removed and shredded, then replaced with the respondent's assigned identification code.

Data Analysis Plan

Quantitative Analysis

MANCOVA with follow up univariate ANCOVA analyses were used for comparative analysis to determine relationships among microaggression experiences, self-reported stress, and self-reported health while controlling for covariates: age, years of RN experience, and coping style.

MANCOVA. MANCOVA statistical analysis allows for inter-group comparisons to establish relationships among multiple dependent variables while also accounting for extraneous factors (Tabachnick & Fidell, 2013). MANCOVA was used to conduct quantitative data analyses in which general and workplace microaggression experiences (EDS Original and Chronic Work Discrimination and Harassment), stress (K-6), and health (MOS SF-36) information was analyzed for African American and Filipino ethnicities for comparisons while mitigating for age, years of RN experience, and coping style.

The sample size for this study was 44 respondents divided among 2 racial/ethnic subgroups. The stability of MANCOVA analysis and accuracy of results require groups within the independent variable be relatively homogeneous in size and the number of respondents within each group be greater than the number of dependent variables after excluding cases with missing data (Tabachnick & Fidell, 2013). The independent variable was dichotomized into 2 groups (African American and Filipino RNs). Five dependent variables (general and workplace microaggression experiences, stress, general health, and emotional well-being) were included in MANCOVA analysis with 14-19 respondents included per dependent variable. Four female African American and 5 Filipino RN cases were excluded due to missing data.

Qualitative Data Analysis

Qualitative data analysis was an ongoing process using descriptive thematic analysis to explore respondents' lived microaggression experiences and self-reported impacts on stress and health.

Descriptive thematic analysis. Descriptive thematic analysis is a process by which the research team reduces the essence of the phenomenon from respondents' descriptions of their experiences (Creswell, 2013; Moustakas, 1994; Van Manen, 2014). Horizonalization is a method of coding qualitative data by extracting concrete statements or phrases (invariant constituents) from the transcript that maintain respondents' descriptions of experiences absent details that do not contribute to the description of the experience itself (Creswell, 2013; Moustakas, 1994). Thematic analysis began with horizonalization of interview transcripts to code respondents' microaggression experiences and the self-reported impacts on respondents' stress and health. Related invariant constituents of each transcript were then clustered into themes (Moustakas, 1994). Invariant constituents and themes were compared to the original interviews for accuracy and consistency with respondents' original descriptions of their microaggression experiences, stress, and health (Moustakas, 1994). Textural descriptions tell what respondents experienced whereas structural descriptions provide the context and circumstances of experiences (Creswell, 2013; Moustakas, 1994; Van Manen, 2014). Themes were further analyzed for textural and structural descriptions of respondents' microaggression experiences to describe the microaggression experience itself, the conditions in which the microaggression occurred, and respondents' perceptions of the impacts of microaggression experiences on their stress and health. The final step of thematic analysis was synthesis of respondents' microaggression experiences and perceptions into textural and structural descriptions that describe the essence of respondents' lived microaggression experiences and impacts on their stress and health.

Limitations

A limitation of the quantitative data was the small sample size (N=40) increasing the risk of statistical error. Qualitative methods limit the generalizability and repeatability in other settings and population subgroups. There were also threats to the validity of the study, including: systematic error, measurement and follow up bias, and dependability and rigor of qualitative findings.

Quantitative Limitations

The cross-sectional survey had limited generalizability and increased risk of statistical error due to the sample size (N=40). Stratified sampling was used to mitigate the risk of statistical error so that at least 20 respondents from each racial/ethnic group, African American or Filipino, were included. The cross-sectional survey analyses using MANCOVA only provided relationships, not causality, among independent and dependent variables; this is an expected and accepted limitation of cross-sectional correlational findings. There are no known studies that have focused on the lived microaggression experiences and relationships to self-reported stress and health in female RNs; relationships established in this study provide insights into the self-reported effects of microaggressions and inform future research questions and studies.

Quantitative validity. There were several threats to the internal validity of the quantitative portion of this study including: systematic error, measurement bias, and follow up bias. Systematic error was minimized with stratified sampling methods which were ongoing until a cohort of respondents that equally represented both African American s and Filipinos was achieved (Grove et al., 2013). Survey tools that have been accepted as the standard in other studies and determined to be reliable and valid were used to diminish measurement bias. The principle investigator performed all data collection and analytic activities to ensure data collection was conducted within established and IRB approved protocols and was equipped with resources to address any issues that may have arisen during interview sessions to address follow up bias.

Qualitative Limitations

Qualitative methodology inhibited the generalizability and repeatability of the findings of this proposal to other populations (Creswell, 2013; Moustakas, 1994; Van Manen, 2014). The sample population had more education and advanced practice (e.g., nurse practitioner) or administrative nursing (e.g., nursing epidemiologist, nursing school faculty or director) roles than the general nursing population; and experiences were specific to this study population and setting. While the findings of this study are not applicable in other settings it may serve to inform future studies and provide a template for similar studies in other populations. Further the findings of this study may provide insight to better equip institutions to design interventions and policies which address the needs of their staff.

Qualitative validity. Techniques were employed to increase qualitative validity. Negative case analysis involves investigating data that appears to contradict emerging themes and is a means to broaden or confirm the research team's preliminary findings (Creswell, 2013). Negative case analysis was used to challenge the appropriateness and accuracy of the qualitative analysis. Stratified sampling was used to ensure both African American and Filipino accounts were equally included in the study. All interviews were included in qualitative analyses to account for the breadth of respondents' microaggression experiences and increase the dependability of qualitative findings. Qualitative rigor was maintained with the use of an audit trail and reflexivity. The audit trail provided details of the qualitative research process from beginning to end. A reflexive note was included in the discussion section allowing the researcher to disclose and discuss any relationships to the research topic and questions and how those relationships were mitigated during data analysis and interpretation (Anderson, 2011; Creswell, 2013).

Conclusion

Studying racial/ethnic microaggression experiences and self-reported impacts on stress and health using a sequential explanatory mixed methods approach was important to understand not just racial/ethnic microaggression experiences and differences in perceptions about stress and health but the climate or context in which racial microaggressions were able to occur. The findings of this study may provide insights that contribute to information used to develop interventions and policies which address the needs of a broader range of RNs. While the findings of this project will not be applicable in other settings, it can potentially serve as a template for similar studies in other populations.

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CHAPTER V

Results

A mixed methods study was implemented to investigate microaggression experiences and its relationship to stress and health among female African American and Filipino registered nurses (RN). Forty-four registered nurses (23 African American and 21 Filipino) were recruited to take part in the study. Respondents were included if they self-identified as female, were at least 21 years of age, with 2 plus years of RN experience in any capacity, and not experiencing a major life stressor (e.g., a new baby, a recent death, planning a major event, or new diagnosis of a chronic illness for themselves or a loved one) within the last year. Respondents completed a 30-60 minute survey administered via SurveyMonkey followed by 30-120 minute semi-structured interviews.

Quantitative Analysis

Forty respondents self-administered a valid and reliable survey tool consisting of 83 questions comprised of:

- Demographic characteristics survey
- Everyday Discrimination Scale, Original and Work Chronic Discrimination and Harassment, to assess microaggression experiences,
- modified MOS-SF36 to assess health and emotional well-being,
- Kessler 6 Scale for Psychological Distress to investigate stress, and
- Brief COPE scale to investigate coping mechanisms (see Appendix for scales used, page 121).

The SPSS (Version 25) statistical analysis software was used for all quantitative analyses. Frequencies were conducted for demographic reporting. Multivariate Analysis of Covariance (MANCOVA) runs were conducted with follow up univariate Analysis of Covariance (ANCOVA) to determine statistically significant relationships between race/ethnicity

(independent variable) and microaggression experiences, stress, and health (dependent variables) considering covariates for age, years of RN experience, and coping style.

Qualitative Analysis

Respondents underwent semi-structured interviews, using a standardized interview guide, about their microaggression experiences and effects on stress and health (see Appendix for interview guide, page #142). Respondents were given the option to complete interviews in-person (2 respondents), via SurveyMonkey (30 respondents), email (1 respondent), or by phone (4 respondents). Descriptive thematic analysis was utilized for coding and development of themes and subthemes.

Quantitative Analyses

Factors

One dichotomous independent variable was considered for race/ethnicity, divided by African American or Filipino ethnicity. There were five dependent variables: general health, emotional well-being, general microaggression experiences, workplace microaggression experiences, and stress. All dependent variables were continuous as measured and scored by the Everyday Discrimination Scale Original and Work Discrimination for general and workplace microaggression experiences, respectively; RAND MOS SF-36- modified for general health and emotional well-being; and Kessler 6 Psychological Distress Scale for stress. Three continuous covariates consisted of- age, years of RN experience, and Brief COPE scores measured coping mechanisms (categorized into adaptive, neutral, or maladaptive coping)- were considered in quantitative analyses.

Demographic Results

General demographics. A total of 44 female African American (n=23) and Filipino (n=21) RNs enrolled in the study. Twenty-three female African American and 17 female Filipino RN respondents completed the self-administered survey, with 9 percent attrition (4 Filipino

RNs). All respondents were screened and self-reported their status as female African American or Filipino RNs, at least 21 years old, having an active RN license with a minimum of two years of registered nursing experience in any role, and not experiencing a major life stressor. Frequencies determined basic characteristics of respondents. All respondents reported being currently employed. The average age of the sample was approximately 42 years (M= 42.14, SD= 11.991) with a range from 26 to 69 years, 42.5 percent of respondents were Master's prepared RNs, 37.5 percent having Advanced Practice Nursing degrees. The average years of RN experience was approximately 13 (M= 12.54, SD= 9.498).

The Everyday Discrimination Scales Original (score range 9-54) and Work Chronic Discrimination and Harassment (score range 12-60) were self-administered to determine types and frequency of microaggression experiences; higher EDS scores, correspond with lower frequency of microaggression experiences. The general pool of respondents reported having general microaggression experiences (M= 33.26, SD= 8.475) more often than workplace microaggression experiences (M= 40.62, SD= 9.207), but 65 percent of the total pool of respondents did not attribute their microaggression experiences to nationality/ancestry, race, tribe and/or skin color. Forty percent of the general pool of respondents reported having "very good health" and 35 percent reported "good health" as determined by question 1 on the RAND MOS-36 SF survey. The general pool of respondents was determined to consider themselves in good general health (M= 70.38, SD= 18.824) and good emotional well-being (M= 70.26, SD= 16.589) using scores for general health and emotional well-being as measured by the RAND MOS SF-36 Health Survey. They also reported frequent experiences of stress (M= 24.90, SD= 4.031) as measured by the Kessler 6 Psychological Distress Scale. Respondents reported most often using adaptive coping mechanisms (social support and/or instrumental support, positive reframing, religion, or planning) (M= 3.58, SD= 1.22), followed by neutral coping mechanisms (venting, humor, or self-distraction) (M=2.62, SD= 1.15), and least often using maladaptive

coping mechanisms (self-blame, denial, substance use, behavioral disengagement, or acceptance) (M=1.50, SD= .79).

African American demographics. Female African American RN respondents' average age was 47 years (M= 46.9, SD= 12.922), 60.9 percent were Master's prepared, 52.2 percent had Advanced Nursing Practice degrees, and most (43.4%) were employed as a nurse practitioner or in an academic position (e.g., professor or school of nursing director). The average years of RN experience was 16 (M= 16.3, SD= 10.145).

Female African American respondents reported general microaggression experiences (M= 29.48, SD= 8.229) more often than workplace microaggression experiences (M= 37.65, SD= 8.183), and 52.2 percent attributed their microaggression experiences to nationality/ancestry, race, tribe and/or skin color. Female African American RNs reported having "very good health" (43.5%) and 39.1 percent reported "good health" as determined by question 1 on the RAND MOS-36 SF survey. Female African American respondents were determined to have good general health (M= 73.70, SD= 18.104) and good emotional well-being (M= 70.26, SD= 17.512) using scores for general health and emotional well-being as measured by the RAND MOS-36 Health Survey. They also reported frequent experiences of stress (M= 24.83, SD= 4.207) as measured by the Kessler 6 Psychological Distress Scale. African American respondents self-reported most often using Adaptive coping mechanisms (social support and/or instrumental support, positive reframing, religion, or planning) (M= 3.90, SD= 1.21), followed by Neutral coping mechanisms (venting, humor, or self-distraction) (M=2.92, SD= 1.18), and least often using Maladaptive coping mechanisms (self-blame, denial, substance use, behavioral disengagement, or acceptance) (M=1.67, SD= .84).

Filipino demographics. Female Filipino RN respondents' average age was approximately 35 years (M= 35.47, SD= 6.255), 64.7 percent reported Baccalaureate as the highest nursing degree attained, and most (70.6%) reported employment as an RN or beside

staff. The average years of RN experience for Filipino respondents was 7 years (M= 7.44, SD= 5.511).

Filipino respondents reported having general microaggression experiences (M= 38.69, SD= 5.413) more often than workplace microaggression experiences (M= 44.88, SD= 9.150), 88.2 percent did not attribute their microaggression experiences to nationality/ancestry, race, tribe and/or ancestry. Approximately 35 percent (35.3%) of female Filipino RNs reported having "very good health" and 29.4 percent reported "good health" as determined by question 1 on the RAND MOS-36 SF survey. Filipino respondents self-reported fair to good general health (M= 65.88, SD= 19.384) and good emotional well-being (M= 70.25, SD= 15.729) using scores for general health and emotional well-being as measured by the RAND MOS-36 Health Survey. They also reported frequent experiences of stress (M= 25, SD= 3.899) as measured by the Kessler 6 Psychological Distress Scale. Filipino respondents self-reported most often using Adaptive coping mechanisms (social support and/or instrumental support, positive reframing, religion, or planning) (M= 3.14, SD= 1.13), followed by Neutral coping mechanisms (venting, humor, or self-distraction) (M=2.21, SD= .99), and least often using Maladaptive coping mechanisms (self-blame, denial, substance use, behavioral disengagement, or acceptance) (M=1.26, SD= .66).

Relationships-MANCOVA

A one-way MANCOVA was run to determine the effect of race/ethnicity for female African American and Filipino RNs on the frequency of microaggression experiences (EDS Original and Workplace scoring) and relationships to self-reported stress (Kessler 6) and health and emotional well-being (RAND MOS SF-36). Examination of assumptions for MANCOVA were the following, showing no major violations. Means and adjusted means were not very dissimilar (see Table 1) and EDS Original and Workplace, and Kessler 6 scoring all showed a general trend to be higher for female Filipino RNs. There was a linear relationship between EDS

(Original and Workplace), Kessler 6, and RAND General and Emotional Well-being scores for both racial groups- female African American and Filipino RNs, as assessed by visual inspection of a scatterplot. There was homogeneity of regression slopes, as assessed by the interaction term between African American and Filipino race and covariates- age, years of RN experience, and Brief COPE scores recoded for “adaptive”, “maladaptive”, and “neutral” coping mechanisms, $F(10, 40) = .661$, $p = .753$. There was homogeneity of covariances, as assessed by Box's M test, $p > .001$. There were no univariate or multivariate outliers, as assessed by no standardized residuals greater than ± 3 or Mahalanobis distance values greater than a specific cut-off point ($p > .001$), respectively. Residuals were normally distributed, as assessed by Shapiro-Wilk's test ($p > .05$).

Table 1:
Means, Adjusted Means, Standard Deviations and Standard Errors for the Five Measures for Microaggression Experiences (Original and Workplace), Stress, General Health and Emotional Well-being for female African American and female Filipino RNs

	African American (n=19)		**Filipino (n=14)**	
	M (SD)	M_{adj} (SE)[a]	M (SD)	M_{adj} (SE)[a]
EDS Original	27.74 (7.279)	27.117 (1.683)	39.00 (5.575)	39.841 (2.029)
EDS Workplace	37.05 (6.932)	36.350 (1.882)	45.79 (9.358)	46.739 (2.269)
Kessler 6	24.47 (4.287)	24.978 (.966)	24.79 (4.098)	24.101 (1.165)
RAND General Health	70.79 (18.353)	71.775 (4.819)	67.50 (19.976)	66.162 (5.811)
RAND Emotional Well-being	70.11 (18.968)	70.471 (4.134)	71.43 (16.369)	70.932 (4.985)

a. Covariates appearing in the model are evaluated at the following values: D_Age = 42.06, D_Years of RN experience = 12.86, Brief COPE Neutral coping scores averaged for Self-Distraction, Venting, and Humor = 2.6667, Brief COPE Adaptive coping scores averaged for Active Coping, Emotional Support, Instrumental Support, Positive Reframing, Planning, and Religion = 3.5354, Brief COPE Maladaptive coping scores averaged for Denial, Substance Use, Behavioral Disengagement, Acceptance, Self Blame = 1.5333. SPSS Version 25, by default, uses listwise exclusion of cases with missing values.

The one-way MANCOVA showed there was a statistically significant difference between female African American and Filipino RNs on the combined dependent variables (general health, emotional well-being, general microaggression experiences, work microaggression experiences, and stress) after controlling for age, years of RN experience and Brief COPE

scores, F(5, 22) = 5.017, p= .003, Wilks' Λ = .467, partial η2 = .533. Follow up univariate one-way ANCOVAs were performed. A Bonferroni adjustment was made such that statistical significance was accepted when p < .01. There were statistically significant differences in the adjusted means for EDS Original scoring (F(1, 26) = 19.072, p< .001, partial η2 = .423) and EDS Workplace scoring (F(1, 26) = 10.172, p= .004, partial η2 = .281), but not for Kessler 6 (F(1, 26) = .275, p = .605, partial η2 = .010), RAND Emotional Well-being (F(1, 26) = .004, p = .949, partial η2 = .000159) or RAND General Health (F(1, 26) = .453, p = .507, partial η2 = .017).

Pairwise comparisons with a Bonferroni-adjusted p-value were made for EDS Original and Workplace scoring. Female Filipino RNs had statistically significantly greater adjusted mean EDS Original and Workplace scores compared to female African American RNs, an adjusted mean difference of 12.724, 95% CI [6.735, 18.713], p< .001, and 10.389, 95% CI [3.693, 17.085], p= .004, respectively. All other pairwise comparisons were not statistically significant. (see Table 2).

Table 2:
Pairwise Contrasts for Adjusted Means for Microaggressions (Original and Workplace), Kessler 6, RAND Well-being, and RAND General Health scores with Age, Years of RN experience, and Brief COPE scores as covariates for African American and Filipino RNs

	African American vs. Filipino RNs Difference in adjusted means (95% CI)
EDS Original scoring	12.724 (6.735, 18.713)*
EDS Workplace scoring	10.389 (3.693, 17.085)*
Kessler 6	-.877 (-4.314, 2.561)
RAND Well-being	.460 (-14.250, 15.171)
RAND General Health	-5.613 (-22.760, 11.535)

Note. *= statistically significant difference (p< .01) based on Bonferroni adjustment; 95% confidence interval (CI) is simultaneous confidence interval based on Bonferroni adjustment; EDS Original and Workplace scoring based on summation of self-reported survey items per EDS scoring guidelines; Kessler 6 scoring based on averaged self-reported survey items per Kessler 6 scoring guidelines; RAND General Health and Well-being scores based on scoring guidelines for averaging self-reported survey items by subscales; African-American= female African-American RNs; Filipino= female Filipino RNs.

Participating registered nurses were given the option to join in semi-structured interviews. Thirty-five RNs were interviewed; there was a 20 percent attrition rate. One respondent was interviewed in-person, 30 respondents via SurveyMonkey, 1 respondent by email, and 4 respondents by phone. All participating RNs were administered a standardized interview guide focused on respondents' lived microaggression experiences and the impacts those experiences have had on stress and health. All interviews conducted were included in qualitative analyses. Each RN was asked to relay at least 2 personal accounts of general microaggression experiences with one involving a patient. Majority of respondents' microaggression stories were in the category of work-related events for both accounts although respondents had opportunity to tell microaggression experiences arising from any environment or context. Descriptive thematic analysis was used for coding and identification of themes and invariant constituents (see Table 3). Identified themes from research questions and specific aims were in the realm of context of experiences and impacts on stress and health. Additional themes identified during interview analyses were impetus for experiences and coping mechanisms.

Themes and Subthemes

African American and Filipino RNs described having frequent microaggression experiences and attributed those experiences to inter- and intra-racial and religious differences. One African American respondent simply responded "common" when asked how often she has microaggression experiences (Interview 4). Another respondent reported having microaggression experiences "…whenever I walk into a store or at work." (Interview 2, African American).

Table 3:
Interview Themes and Invariant Constituents

Themes	Invariant Constituents
Context of Experience	Favoritism on the Job
	Patient Initiated
	Devaluation
	Outsider
Effects on Health	Biological Manifestations
Impetus for Experiences	Intra-racial Differences in Own Community
	Misappropriation of Work or Role
	Stacking the Deck
Coping Mechanisms	Suppression
	Resilience
	Resignation
	Lashing Out
	Wellness Activities
	Vigilance and Over-Compensation
	Enlightening Others
Effects on Emotional Well-being	Anger and Frustration
	Fear, Paranoia, and Sadness

Context of Experience. The majority of the microaggression experiences told by respondents took place within their workplace. These events were described as favoritism on the job and patient-initiated behaviors that were uncomfortable. Other categories were in the areas of psychological and emotional distress. Feelings of devaluation of their job performance and professional roles were voiced. Microaggression experiences lead to feelings of anger and frustration, fear, paranoia, and sadness. Both African American and Filipino RNs shared experiences in which they received differential treatment in role assignments (e.g., patient assignments) and consideration for job advancement. One respondent stated

> …I asked to be oriented to charge in the unit where I have been a bedside nurse for 25 years and was told by my supervisor that they have all the charge nurses they need. The following week three other nurses were oriented to charge, they were all white… I am the nurse that everyone comes to for questions and IV starts. I precept and train most of the nurses in the unit yet I am not able to work as a charge nurse… I was just upset…

> when I think about it it makes me a little angry. I feel myself getting upset and while thinking about this it reminds me of other experiences. (Interview 2, African American).

A Filipino nurse recounted ongoing experiences of receiving undesirable job duties, stating "…I… noticed that I would get most of the difficult patients…" (Interview 1). In addition to receiving more difficult patient assignments the same respondent recounted that she also received the same differential treatment when being sent to other units to work her shift.

> On more than one occasion I was floated to the neuro floor while the other Filipino nurse who was best buddies with the charge nurse got floated to an easy med surg floor… I got floated there three times in a row and the other nurse got floated to an easy floor or not floated at all I realized that I was not being treated equally… I requested to not be floated to that floor again and what do you know I was floated there again the following week almost like it was punishment for asking or questioning the charge nurse. (Interview 1)

Both racial groups recounted multiple patient initiated microaggression experiences in which patients expressed disapproval related to religion, overheard refusing care from them because of their race, and overt expressions of derogatory behaviors (e.g., being referred to as negro or negroes). One RN recounted an interaction in which a patient stopped communicating with her because of differences in religious beliefs.

> She said but you are a Filipino you are supposed to be Catholic or Christian. I reminded her that just because I was a Filipino that doesn't mean I have to be of one particular race. From that point on she was very quiet and barely talked with me when I entered the room. (Interview 1, Filipino).

Another African American RN recalled a time when she was receiving bedside shift report and overheard the patient state "…I don't want a Black nurse." She reported immediately consulting

with the charge nurse to have her patient assignment changed because she wasn't going to deal with a patient that didn't want her care. Another respondent stated

> Old VA patient referred to me as the ward negro. So, when he required help, he would call out 'Hey negro, come here, I need help'. He continued this behavior until he died. Too late to change his behavior and ethically, I continue to care for him. (Interview 4, African American).

Another African American respondent recounted

> I received in report from the previous nurse that the parents of my patient were very pleasant. When I introduced myself to the mother she was very nice, however, when the dad entered the room he gave me a hard stare, was very mattered of fact; he shook my hand very aggressively as if I was a man and wouldn't speak to me outside of asking why he couldn't have their nurse from the previous night back. This nurse was white as was the patient/parents. It was blatantly obvious that within 3 minutes of meeting me he was not satisfied with me as his child's nurse. I informed my charge nurse in the event that the father requested a nurse change. The father eventually left the unit, and nothing further happened. The mother never apologized on behalf of her husband but continued to be very pleasant the remainder of the shift… It was extremely uncomfortable… I knew the color of my skin was the issue the father had with me being his child's nurse. (Interview 3)

A major distress noted was that of devaluation of nursing roles and skills. Both African American and Filipino RNs recounted experiences in which their authority and/or expertise were challenged or assumed to hold a position of lesser status despite covert indicators of their status.

> …sometimes I am asked if I know who the nurse is for a patient even though I am dressed in the blue nursing uniform and my badge and uniform say registered nurse… I

> am the nurse that everyone comes to for questions and IV starts… I precept and train most of the nurses in the unit yet I am not able to work as a charge nurse… the junior staff who are in charge seem to forget who trained them and seem to think they have to tell me how to my job. (Interview 2, African American).

Another RN that identified herself as “Cookie” recounted

> On my job, where I am the obvious expert and those who are not question every comment or decision I make. I got sick of it and used regulatory standards to call them on their behavior. Then they (as expected) wanted examples… When my direct report asks someone other than me how what to do "ignoring" me. Once I was hired 10% of the employees chose to retire. (Interview 8)

Participating RNs described microaggression experiences in the realm of being relegated to an “outsider” status from their colleagues and supervisors. One RN reported “It was a reminder that I am the minority on the unit and do not feel as though I belong.” (Interview 3, African American). “Those around me refuse to get to know me.” (Interview 8, Cookie). “I find the tone to be degrading at times with the questions asked- ‘Where are you really from?’ Or ‘Were you born here?’” (Interview 7, Filipino) “My managers are white women and I felt that they wouldn't understand my experience.” (Interview 3, African American).

Effects on Emotional Well-being. Symptoms of acute and chronic stress included manifestations ranging from anger and frustration to fear and paranoia as a result of microaggression experiences. These reported negative stress effects, including reliving the experience and psychological distress, were described as physically and emotionally taxing. As one respondent stated

> Once I was hired 10 percent of the employees chose to retire... I am planning my escape from this environment… I am not one to stay in a place where I am not wanted. I don't believe I deserve or need that kind of stress. (Interview 8, Cookie).

There was some consensus among respondents that microaggression experiences induced anger, frustration, and “irritation”. “Frustrating as the assumption is that black people cannot be RNs... I'm more irritated...” (Interview 5, African American). “…I was just upset… when I think about it it makes me a little angry…” (Interview 2, African American).

As a counterpoint to the emotional unrest that most respondents reported, Cookie reported a positive outcome from a patient initiated microaggression experience.

> I was in grad school in Atlanta for a one-year accelerated program (I am a native Californian). I worked weekends at the local hospital. A patient saw me and was shocked I was his nurse… When he heard me talk, he asked where I was from, when I said California he asked if I had ever met any movie stars. I said of course. That answer opened the door to a very friendly conversation that caused him to ‘get to know me’. It changed his attitude. Funny thing is it happened all over again when his family arrived to visit. They said, ‘is that your nurse, you can ask for another nurse’. His response was she is so cool, she's told me all sorts of cool stuff about California. I believe my attitude opened him up for a moment in time. (Interview 8)

Reported fear or sadness and negative effects on personal self-worth related to microaggression experiences was expressed. “… I was just sad for a while… I would get… moody… I know it affects my self-worth… it made me super paranoid like I was being watched all the time…” (Interview 2, African American). One respondent described the following interaction with a supervisor

> At work by a supervising MD that asked me a question of why I was late for clinic. I explained that our chief asked to do my evaluation at this time, and he began yelling and told me to apologize and say that it would never happen again. I went to HR and the director did nothing… Humiliating… He never treated any other NP that way… I was

sick every day for 6-8 months, vomiting, crying, afraid to go to work and had to see a psych… I am scared." (Interview 6; no identifier, completed by SurveyMonkey).

Effects on Health. Biological manifestations reported by both groups of nurses ranged from nausea and vomiting to high blood pressure. One respondent stated "Hold stress in my shoulders and back. Need massage therapy at least once per month to calm my nerves." (Interview 4, African American). "Tired, I have become a procrastinator… I noticed I was gaining weight. But I decided I would not accept that, so I make sure I get my walking in every morning…" (Interview 8, Cookie). "I would get headaches… I think it's affecting my blood pressure…". (Interview 2, African American). "I was sick every day for 6-8 months, vomiting… high blood pressure every time I see him and have to work with him." (Interview 6, ???).

Not all RNs described health effects related to their microaggression experiences. One RN said, "It doesn't affect my health." (Interview 7, Filipino). Another shared that positive coping mechanisms determine the effects of microaggressions. "I think like all stressors without positive coping skills it takes a toll with time." (Interview 3, African American).

Impetus for Experiences. As RNs reported their microaggression experiences there seemed to be several subthemes that emerged to explain the impetus of their experiences. These explanations played on inter- and intra-group biases: colorism, religious differences, misappropriation of work and effort, and stacking the deck.

One Filipino RN reported that she believes microaggression experiences she shared during the interview were the result of her mixed racial background, darker skin color, or not subscribing to the religious beliefs expected in her community.

> Sometimes microagression can happen within your own race… I am of a mixed race and I do have darker colored skin, so I do not fit into the light colored probably wealthy looking mold… It wasn't anything new that I have experienced because as a Jehovah's witness we experience that type of discrimination all the time (Interview 1, Filipino).

The impact of microaggressions on work-related roles was a significant complaint of respondents. Participating RNs shared experiences in which their work was accredited or misappropriated to others. It often seemed that the African American and/or Filipino nurses were assumed to hold a lesser role, such as a food worker or nurse assistant. One respondent said:

> I remember introducing myself to the patient/family and before I could say I was the RN, the father automatically assumed that I was there to take the food tray away… He was shocked that I was the RN. He thought I was from food services. (Interview 5, African American).

Another respondent recounted a time the work that she had accomplished was attributed to a White counterpart.

> In a VA medical center. late recognition of excellent work related to technology research and use for nursing education. The hospital director passed over me and gave the department recognition to my white colleague. I shared my disappointment with supervisors but, nothing was done to rectify the situation. (Interview 4, African American).

The concept of “stacking the deck” was described by several respondents. Homogeneous work environments in which they were often one of a few people of color on their unit or were passed over for opportunities for professional advancement were a common event.

> The unit I work on is predominately white, we are known to only hire attractive, youthful white women. This in itself has grown to be upsetting as I feel our nursing staff should reflect a diverse background that mimics our patients. (Interview 3, African American).

Another shared “…when working in the hospital environment. Incompetent co-workers promoted before me.” (Interview 4, African American). “Just that all the white nurses are oriented to do charge some that have only been there for a little over a year, none of the (its

only three) African American nurses have been oriented to charge…" (Interview 2, African American).

Coping mechanisms. A variety of coping mechanisms were used to manage different phases of microaggression experiences. During the microaggression experience respondents reported coping mechanisms such as suppression. Respondents also described coping mechanisms they use after the microaggression experience has occurred and included: suppression, resilience, resignation, lashing out, engaging in wellness activities, and overcompensation.

Suppression of one's feeling brought about by microagression experiences was voiced by respondents. Registered nurses described instances of setting aside feelings from the microaggression both during and after the experience to varying degrees either by "brushing it off", "being the bigger person", and giving others the benefit of the doubt.

Setting aside the microaggression experience, or "brushing it off" was a tactic employed by some. One RN said "I usually just brush it off… I have gotten to the point where I just show up to work and hope I will not be treated like a dog". (Interview 1, Filipino). "Nothing. I did not bring the situation up to my managers as I didn't want to deal with the headache and felt there would be no resolution worth the trouble." (Interview 3, African American). "…just hold it in I used to complain but no one cares." (Interview 2, African American).

Being the bigger person was a value expressed by some nurses. Microaggression experiences in which respondents seemed to persevere through the experience was described while also minimizing offenders' behaviors. One said "I've learned how to deal with situations and control the words I use to express my emotions without offending others… I brush it off as their ignorance." (Interview 7, Filipino). Another stated "I have always been open to learning about other cultures, ethnic groups and religions. By doing that it makes me a more educated person and a better person then the closed minded individual." (Interview 1, Filipino). "I pray

about it. I try to pray that the love I show people isn't reflective of what they show me, but to mimic the type of love God shows me." (Interview 3, African American). "Not really offended by it. I have been working with a population that is from a different generation for many years. So, ignorance comes in to play often. I am direct and patient with them." (Interview 2, Filipino).

Some respondents said they have attempted to educate their offenders in order to "enlighten others". One African American respondent said "… educate them if they are willing to listen or ignore them…" (Interview 5). Another respondent said "I have been working with a population that is from a different generation for many years. So, ignorance comes in to play often. I am direct and patient with them." (Interview 7, Filipino).

Coping behaviors were discussed with regard to their microaggression experience. RNs voiced that they would cope with the experience by trying to understand or minimize the impetus for the microaggression experience thus allowing for "benefit of the doubt" for the occurrence of the microaggression experience. One respondent said "It's important to know the difference between ignorance and microaggression. I've learned that some people truly don't mean any offense, just that they have never been exposed to other cultures or practices. Whereas microaggressions can be intentional and hurtful" (Interview 2, Filipino). "I try not to let my mind go to the 'race card' often however when it is blatantly obvious… although I don't think her intentions were blatantly negative, I was offended and felt singled out." (Interview 3, African American). Several respondents reported leaving, or wanting to leave, or in essence resign their work position to get away from the environment of the microaggressions. One nurse said, "… it made me not want to go back to work… thought about quitting." (Interview 2, African American). Another respondent reported "I am planning my escape from this environment." (Interview 8, Cookie). Yet another respondent said, "Finally left the institution to pursue higher education." (Interview 4, African American).

Respondents reported engaging in behaviors in anticipation of having microaggression experiences through vigilance and over-compensation. This was enabled through mental preparation that microaggressions are an expected part of their lives (vigilance) and continually performing above expectations or standards for equal status (over-compensation). One RN stated, “I am cognizant about my work as I am vigilant about my documentation because I feel any discrepancy will result in counseling versus other co-workers.” (Interview 5, African American). Others reported vigilance in statements such as “It’s happened often then I feel there’s a script in my head of how to respond.” (Interview 7, Filipino); and “I do have my guard up as I feel people are judging me.” (Interview 5, African American).

In an effort to achieve the same recognition as their counterparts, RNs reported that they over-compensated in their professional roles. One respondent said:

> …it still makes me super diligent. I feel afraid that someone else will complain… when you are an African American nurse you have to watch what you do closely, and you have to go the extra mile otherwise people will complain about your care delivery [sic]. (Interview 2, African American).

Another said, “Tried to make my contributions better but, that was not recognized at the same importance level.” (Interview 4, African American). Yet another RN said, “The energy… was very negative and I constantly triple checked everything I did.” (Interview 3, African American).

Lashing out as a result of anger or disgust was reported toward their aggressors and/or those that benefited from microaggression experiences. “All of these experiences cause me to look at others who behave this way with disgust.” (Interview 8, Cookie). “I find that I’m not very nice to the nurses who do charge I realize it’s not their fault but the fault of the admin team…” (Interview 2, African American). “I'm more irritated and can be reactive sometimes when I feel judged…” (Interview 5, African American).

Patient-centered microaggression experiences elicited different responses from RNs in which they were more inclined to ignore the patient's behaviors. One Filipino RN reported "It did not impact the way I cared for her as a patient." (Interview 1).

Wellness activities were used to address the physical and mental manifestations of reported microaggression experiences. Cookie described being stressed and gaining weight because of her experiences and began walking daily.

> Tired, I have become a procrastinator. Initially, I noticed I was gaining weight. But I decided I would not accept that, so I make sure I get my walking in every morning to both combat the stress and remain healthy in a toxic environment. (Interview 8).

An African American respondent stated, "Need massage therapy at least once per month to calm my nerves." (Interview 4). Another stated, "I pray and breath deep." (Interview 6, ??).

Most of the African American and Filipino RNs described positively rebounding through resilience from their microaggressions experiences. A Filipino RN shared, "I am a tough nurse and the more crap they throw at me the stronger I will be." (Interview 1). An African American respondent said, "I have learned to express my anger in more acceptable ways." (Interview 4). Another respondent shared "I am mentally much stronger at dealing with situations." (Interview 7, Filipino).

Chapter V References

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CHAPTER VI

DISCUSSION

The primary objective of this study was to determine if there was a relationship between racial/ethnic microaggression experiences, stress, and health for female African American and Filipino registered nurses (RN); however, qualitative analyses revealed that racial/ethnic microaggression experiences happening in the workplace seemed to have greater significance for respondents. Respondents completed self-administered surveys followed by individual interviews during which they provided information about their microaggression experiences, stress, and health. Data analyzed and interpreted in the context of the philosophical and theoretical frameworks wherein the assumptions were constructed: microaggression experiences are stressors that have socio-political implications and are frequent and regular occurrences that induce chronic stress responses that eventually lead to poorer health. Chronic stress was defined as a protracted physiological stress response to recurrent or prolonged stressors (e.g., racial/ethnic microaggressions). The philosophical and theoretical frameworks included concessions that there may be confounding factors (age, life experience, prior knowledge, and coping style) that may lessen the impact of racial/ethnic microaggression experiences on stress and health; and also acknowledged that coping mechanisms utilized for future racial/ethnic microaggression experiences is informed by the outcomes of prior experiences and effectiveness of coping mechanisms utilized during those prior experiences. Quantitative and qualitative analyses appeared to produce conflicting results such that quantitative analyses did not establish statistically significant relationships among racial/ethnic microaggression experiences, stress, and health, whereas qualitative analyses suggested there may be relationships among racial/ethnic microaggression experiences, stress, and health changes.

Research Findings

Quantitative analyses did not establish significant relationships among racial/ethnic microaggression experiences, stress, and health. Quantitative findings showed that female African American and Filipino RNs both identified having recurrent microaggression experiences both inside and outside of the workplace, with general microaggression experiences happening most often. Female African American RNs had significantly higher incidences of both general and workplace microaggression experiences compared to female Filipino RNs. African American RNs most often attributed their microaggression experiences to their race/ethnicity and corresponding characteristics (e.g., skin color), whereas Filipino RNs attributed their microaggression experiences to age and gender. Both groups reported frequent stress but self-reported being in good physical and emotional health.

In contrast, the qualitative findings showed that there was a relationship among racial/ethnic microaggression experiences, stress, and health. Both female African American and Filipino RNs described frequently recurring and/or prolonged workplace racial/ethnic microaggression experiences that impacted their emotional and physical health (e.g., anger, self-doubt, raised blood pressure, weight gain, and muscle tension). The disparity between the quantitative findings and the qualitative findings may be ascribed to increased life experiences as the sample of RNs were highly educated, older adults.

Respondents' feelings such as fear, isolation, anger, and self-doubt were expressed during interviews and reported as part of or occurring immediately after their microaggression experiences. The immediate effects of microaggression experiences seemed to induce a physiological stress response with a manifestation of health symptomology (e.g., weight gain, muscle tension, anxiety, fear) that seemed to be mitigated in the long term by respondents' coping responses. Female African American and Filipino RNs reported that there were no lingering effects in subsequent interview questions of the long-term effects of reported microaggression experiences. Many respondents described engaging in adaptive coping

behaviors that directly addressed minimizing exposure to the environments and contexts of microaggression experiences (e.g., deciding to resign from job or specific role in their position) and focused on reversing health impacts of microaggression experiences (e.g., monthly massages for muscle tension and daily walks for stress relief and weight loss).

The average age of the study sample was 42 years, with 13 years of professional nursing experience, and most had post-graduate nursing education. These factors may be indicative of the increased amount and variety of life experiences respondents had which may have influenced how respondents interacted with others and coped with microaggression experiences. As an example, many African American and Filipino RNs reported microaggression experiences being an expected part of life. This expectation seemed to be based on prior life experiences as several reported having frequent microaggression experiences. Microaggressions being an expected part of life may have been a contributory factor in respondents' decisions to engage in vigilant (e.g., over-performing in their work roles or having "a script" in their head to recite when confronted with new microaggression experiences) and resilient (e.g., repurposing collective microaggression experiences as a source to strengthen own mental fortitude and attributing the onus of microaggression experiences to offenders rather than self-blame) behaviors. Engagement in vigilant and resilient coping behaviors may have lessened the severity of short-term and long-term effects of African American and Filipino RNs' microaggression experiences.

Limitations

The quantitative cross-sectional survey had limited generalizability and increased risk of statistical error due to the small sample size (N=40). Quantitative findings were used to corroborate qualitative findings and generalizability was not an intended goal. Adherence to assumptions of MANCOVA were maintained to minimize risk of statistical errors. Stratified purposive sampling was used to mitigate the risk of systematic statistical bias so that

recruitment was ongoing until African Americans and Filipinos were equally represented in the study (Grove et al., 2013). Stratified purposive sampling for this study was effective in allowing for statistical comparative analysis of microaggression experiences and effects, between African American and Filipino RNs; however, the depth of qualitative inquiry and analysis of microaggression experiences became limited in efforts to understand the meanings of those microaggression experiences for two heterogeneous groups- African American and Filipino RNs. Negative case analysis, inclusion of all willing and consented respondents in qualitative data collection and analysis, reflexivity, and audit trails were used to increase qualitative reliability of findings. Negative case analysis was used to challenge the appropriateness and accuracy of the emerging themes and invariant constituents. Widely used and accepted, valid, and reliable survey tools were used to diminish measurement bias.

The study sample was non-representative of the nursing population in general and by race/ethnicity. More adaptive coping techniques utilized may be a reflection of this study sample's older age and higher education levels, in comparison to current RN workforce demographics, which may have lessened the potential effects of microaggression experiences on health. African American and Filipino RNs in this study may have also represented a broader range of life and microaggression experiences because of opportunities to work in a variety of environments and engagement with diverse populations. An additional consideration related to sample characteristics and coping mechanisms was the study sample's ability to resign from job roles. The ability to change jobs at will may be attributed to the viability and demand of RNs, in various industries in addition to healthcare, especially with advanced/graduate-level degrees. Respondents' preferred medium to complete the interview using SurveyMonkey could be viewed as a limitation. Most respondents opted to complete interviews via SurveyMonkey. SurveyMonkey was a useful tool which allowed asynchronous interviewing, however,

opportunities to collect data related to follow up questions were diminished limiting the depth of understanding of the meaning of lived microaggression experiences.

Recommendations

Additional studies investigating relationships among racial/ethnic microaggressions, stress, and health among other vulnerable racial/ethnic subgroups may be helpful to understand the breadth and depth of racial/ethnic microaggression experiences. Although African American and Filipino RNs reported more general microaggression experiences than workplace experiences in quantitative data the qualitative focus was on their workplace experiences, suggesting a need to identify and address workplace conditions that allow racial/ethnic microaggression experiences to occur. Investigations with a greater focus on workplace microaggression experiences may provide further understanding of the importance and impact of these experiences that can then inform both the design and implementation of interventions meant to create healthier work environments for a diverse RN workforce. Worth noting, future studies seeking to understand relationships of stress experiences among RNs may consider including questions that seek to determine whether RNs are reporting stress versus fatigue symptomologies as well as differentiation between stressors inherent to nursing (e.g., patient death and increasing job requirements) versus socio-political stressors (e.g., microaggressions).

Contributions to Knowledge

Findings of this study contributed insights into the types of workplace microaggressions female African American and Filipino RNs have experienced and the self-reported impacts on their stress and health. These findings contribute to the larger body of research investigating microaggression and discrimination experiences among vulnerable racial/ethnic subgroups and the microaggression-related stress experiences of RNs. Findings of this study may not be broadly applicable to other vulnerable population subgroups and settings; however, the design

may be replicated to add to knowledge stores utilized to design program and policy initiatives for vulnerable population subgroups in the workplace.

Epilogue

To maintain the integrity of this study the researcher engaged in reflexivity throughout the research process to: acknowledge her own microaggression experiences and minimize the impact of her own experiences on data collection and analysis processes; used the words of respondents to accurately describe their microaggression experiences, as well as the effects and spirit of those experiences; and qualitative analyses written to describe the collective voice of respondents while maintaining their individual stories.

The principal investigator (PI) is a female African American registered nurse that shared some of the same experiences that both African American and Filipino respondents described, such as limited opportunities for professional advancement despite having more qualifying professional credentials and experience and being the go-to resource for both new and experienced peers and colleagues; refusal of nursing care under the assumption that “I don’t want a Black nurse because they’re only working here because of affirmative action”; assumptions of having a lesser professional role despite obvious indicators (e.g., badge stating “RN” and colored coded scrubs indicating RN status); assumptions of inferior intelligence, such as being told by a professor upon first meeting “Sometimes we make mistakes when we admit.”; assumptions of being an outsider with questions such as “Where are you from?” and “Why do you speak English so well?”; and assumptions of criminality in which it was commonplace to have confused and demented patients call the police to report that a “gang member” had kidnapped them or broken into their home and more common experiences of being followed in stores and having strangers cross the street or clutch their belongings.

The PI’s awareness of her own experiences heightened her efforts to maintain the integrity and spirit of respondents’ accounts and perspectives and at the same time minimize

researcher bias, thus guided the decision to not interpret the sentiments of respondents, and use direct quotes to describe and support or counter collective themes and invariant constituents. The researcher engaged in multiple readings of individual interviews to understand the overall meaning and perspective of each respondent, for coding, and to compare individual interviews with developing collective themes and invariant constituents for accuracy. The findings of this study were compared to the findings of other discrimination studies in the literature.

Appendix 1: Survey Tools and Scoring Guidelines

Demographics

Date of birth_____

What is your gender?

□ Male
□ Female

Do you identify as Hispanic or Latino?

□ Yes
□ No

With what race do you identify? (Select all that apply.)

□ African American/Black
□ American Indian/Alaska Native
□ Asian
□ Native Hawaiian/Other Pacific Islander
□ White

How is your license currently registered with the Board of Registered Nursing?

□ Active
□ Inactive
□ Retired

What is your highest level of *NURSING* education completed?

□ Diploma Nurse
□ Community College/Junior College/Trade School
□ Baccalaureate/Bachelors
□ Masters
  ○ Advanced Practice
  ○ Generic/Masters Science
  ○ Masters Entry Level
□ Doctorate
  ○ Doctorate in Nursing Practice
  ○ Doctor of Philosophy
  ○ Doctorate in Nursing Science

What is your highest level of education completed?

□ Community College/Junior College/Trade School
□ Baccalaureate/Bachelors
□ Masters
□ Doctorate/Terminal Degree

Are you currently employed?

□ Yes
□ No

What is your current position? _____

How many years of RN experience do you have (in any capacity)? _____

Everyday Discrimination Scale: Original and Chronic Work Discrimination and Harassment

Instructions:
Please answer the following questions. You may skip/refuse to answer any questions that you do not want to answer.

In your day-to-day life, how often do any of the following things happen to you?

Answer choices:

1. Almost everyday
2. At least once a week
3. A few times a month
4. A few times a year
5. Less than once a year
6. Never

Questions:

1. You are treated with less courtesy than other people are.

1. Almost everyday
2. At least once a week
3. A few times a month
4. A few times a year
5. Less than once a year
6. Never

2. You are treated with less respect than other people are.

1. Almost everyday
2. At least once a week
3. A few times a month
4. A few times a year
5. Less than once a year
6. Never

3. You receive poorer service than other people at restaurants or stores.

1. Almost everyday
2. At least once a week
3. A few times a month
4. A few times a year
5. Less than once a year
6. Never

4. People act as if they think you are not smart.

1. Almost everyday
2. At least once a week
3. A few times a month
4. A few times a year
5. Less than once a year
6. Never

5. People act as if they are afraid of you.

1. Almost everyday
2. At least once a week
3. A few times a month
4. A few times a year
5. Less than once a year
6. Never

6. People act as if they think you are dishonest.

1. Almost everyday
2. At least once a week
3. A few times a month
4. A few times a year
5. Less than once a year
6. Never

7. People act as if they're better than you are.

1. Almost everyday
2. At least once a week
3. A few times a month
4. A few times a year
5. Less than once a year
6. Never

8. You are called names or insulted.

1. Almost everyday
2. At least once a week
3. A few times a month
4. A few times a year
5. Less than once a year
6. Never

9. You are threatened or harassed.

1. Almost everyday

2. At least once a week
3. A few times a month
4. A few times a year
5. Less than once a year
6. Never

Here are some situations that can arise at work. Please tell me how often you have experienced them during the LAST 12 MONTHS.

Answer choices:

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

10. How often are you UNFAIRLY given the jobs that no one else wants to do?

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

12. At work, when different opinions would be helpful, how often is your opinion not asked for?

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

13. How often are you watched more closely than others?

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

14. How often does your supervisor or boss use racial or ethnic slurs or jokes?

1. Once a week or more
2. A few times a month
3. A few times a year
4. Less than once a year

5. Never

15. How often does your supervisor or boss direct racial or ethnic slurs or jokes at you?

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

16. How often do your coworkers use racial or ethnic slurs or jokes?

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

17. How often do your coworkers direct racial or ethnic slurs or jokes at you?

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

18. How often do you feel that you have to work twice as hard as others work?

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

19. How often do you feel that you are ignored or not taken seriously by your boss?

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

20. How often do others assume that you work in a lower status job than you do and treat you as such?

1. Once a week or more
2. A few times a month

3. A few times a year
4. Less than once a year
5. Never

21. How often has a coworker with less experience and fewer qualifications gotten promoted before you?

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

22. How often have you been unfairly humiliated in front of others at work?

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

23. What do you think is the main reason for these experiences? (**You may check more than one**)

1. Your Ancestry or National Origins

2. Your Gender

3. Your Race

4. Your Age

5. Your Religion

6. Your Height

7. Your Weight

8. Some other Aspect of Your Physical Appearance

9. Your Sexual Orientation

10. Your Education or Income Level

11. A physical disability

12. Your shade of skin color

13. Your tribe

Other (SPECIFY) _____

EDS Scoring

EDS Original scores are obtained by summing across items 1-9 with higher scores correlating with a lower frequency of microaggression experiences.

EDS Chronic Work Discrimination and Harassment scores are obtained by summing across items 10-22 with higher scores correlating with a lower frequency of work-related microaggression experiences.

Item 23 is excluded from the total score and is used as an independent variable during statistical analyses.

Modified RAND Medical Outcomes Survey Short Form-36 Version 1.0

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. For each of the following questions, please circle the number that best describes your answer.

1. In general, would you say your health is:	
Excellent	1
Very good	2
Good	3
Fair	4
Poor	5
2. Compared to one year ago, how would you rate your health in general now?	
Much better now than one year ago	1
Somewhat better now than one year ago	2
About the same	3
Somewhat worse now than one year ago	4
Much worse now than one year ago	5

The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?
(Circle One Number on Each Line)

	Yes, Limited a Lot	**Yes, Limited a Little**	**No, Not Limited at All**
3. **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
4. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
5. Lifting or carrying groceries	1	2	3
6. Climbing **several** flights of stairs	1	2	3
7. Climbing **one** flight of stairs	1	2	3
8. Bending, kneeling, or stooping	1	2	3
9. Walking **more than a mile**	1	2	3

10. Walking **several blocks**	1	2	3
11. Walking **one block**	1	2	3
12. Bathing or dressing yourself	1	2	3

During the **PAST 4 WEEKS**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?
(Circle One Number on Each Line)

	Yes	**No**
13. Cut down the amount of time you spent on work or other activities	1	2
14. **Accomplished less** than you would like	1	2
15. Were limited in the **kind** of work or other activities	1	2
16. Had **difficulty** performing the work or other activities (for example, it took extra effort)	1	2

During the **PAST 4 WEEKS,** have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?
(Circle One Number on Each Line)

	Yes	**No**
17. Cut down the **amount of time** you spent on work or other activities	1	2
18. **Accomplished less** than you would like	1	2
19. Didn't do work or other activities as **carefully** as usual	1	2

20. During the **PAST 4 WEEKS**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? **(Circle One Number)**	
Not at all	1
Slightly	2
Moderately	3
Quite a bit	4
Extremely	5

21**.** How much **bodily** pain have you had during the **PAST 4 WEEKS**?	
None	1
Very mild	2

Mild	3
Moderate	4
Severe	5
Very severe	6
22. During the **PAST 4 WEEKS**, how much did **pain** interfere with your normal work (including both work outside the home and housework)? **(Circle One Number)**	
Not at all	1
A little bit	2
Moderately	3
Quite a bit	4
Extremely	5

These questions are about how you feel and how things have been with you **during the PAST 4 WEEKS**. For each question, please give the one answer that comes closest to the way you have been feeling. **(Circle One Number on Each Line)**

How much of the time during the **PAST 4 WEEKS**. . .

	All of the Time	**Most of the Time**	**A Good Bit of the Time**	**Some of the Time**	**A Little of the Time**	**None of the Time**
23. Did you feel full of pep?	1	2	3	4	5	6
24. Have you been a very nervous person?	1	2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
26. Have you felt calm and peaceful?	1	2	3	4	5	6
27. Did you have a lot of energy?	1	2	3	4	5	6
28. Have you felt downhearted and blue?	1	2	3	4	5	6
29. Did you feel worn out?	1	2	3	4	5	6
30. Have you been a happy person?	1	2	3	4	5	6

31. Did you feel tired?	1	2	3	4	5	6

32. During the **PAST 4 WEEKS**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)? **(Circle One Number)**	
All of the time	1
Most of the time	2
Some of the time	3
A little of the time	4
None of the time	5

How TRUE or FALSE is <u>each</u> of the following statements for you.
(Circle One Number on Each Line)

	Definitely True	**Mostly True**	**Don't Know**	**Mostly False**	**Definitely False**
33. I seem to get sick a little easier than other people	1	2	3	4	5
34. I am as healthy as anybody I know	1	2	3	4	5
35. I expect my health to get worse	1	2	3	4	5
36. My health is excellent	1	2	3	4	5

MOS SF-36 Scoring Tables

Table 2: Recoding

Step 1: Recoding Items

Item numbers	Change original response category *	To recoded value of:
1, 2, 20, 22, 34, 36	1 →	100
	2 →	75
	3 →	50
	4 →	25
	5 →	0
3, 4, 5, 6, 7, 8, 9, 10, 11, 12	1 →	0
	2 →	50
	3 →	100
13, 14, 15, 16, 17, 18, 19	1 →	0
	2 →	100
21, 23, 26, 27, 30	1 →	100
	2 →	80
	3 →	60
	4 →	40
	5 →	20
	6 →	0
24, 25, 28, 29, 31	1 →	0
	2 →	20
	3 →	40
	4 →	60
	5 →	80
	6 →	100
32, 33, 35	1 →	0
	2 →	25
	3 →	50
	4 →	75
	5 →	100

* Precoded response choices as printed in the questionnaire.

Adapted from RAND MOS SF-36 Scoring at http: //www.rand.org/health/surveys_tools/mos/36-item-short-form/scoring.html

Table 3: MOS SF-36 Subscales and Items

Step 2: Averaging Items to Form Scales

Scale	Number of items	After recoding per Table 1, average the following items
Physical functioning	10	3 4 5 6 7 8 9 10 11 12
Role limitations due to physical health	4	13 14 15 16
Role limitations due to emotional problems	3	17 18 19
Energy/fatigue	4	23 27 29 31
Emotional well-being	5	24 25 26 28 30
Social functioning	2	20 32
Pain	2	21 22
General health	5	1 33 34 35 36

Adapted from RAND MOS SF-36 Scoring at http: //www.rand.org/health/surveys_tools/mos/36-item-short-form/scoring.html

Kessler-6 Psychological Distress Scale

The following questions ask about how you have been feeling during the **past 30 days**. For each question, please circle the number that best describes how often you had this feeling.

During the past 30 days, about how often did you feel …

	All of the time (1)	**Most of the time (2)**	**Some of the time (3)**	**A little of the time (4)**	**None of the time (5)**
1. …nervous?	**1**	**2**	**3**	**4**	**5**
2. …hopeless?	**1**	**2**	**3**	**4**	**5**
3. …restless or fidgety?	**1**	**2**	**3**	**4**	**5**
4. …so depressed that nothing could cheer you up?	**1**	**2**	**3**	**4**	**5**
5. …that everything was an effort?	**1**	**2**	**3**	**4**	**5**
6. …worthless?	**1**	**2**	**3**	**4**	**5**

K-6 Scoring instructions

Each item is scored from one ‘none of the time’ to five ‘all of the time’. Scores of the 6 items are then summed, yielding a minimum score of 6 and a maximum score of 30. Low scores indicate low levels of psychological distress and high scores indicate high levels of psychological distress.

Brief COPE

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

1. I've been turning to work or other activities to take my mind off things.
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot

2. I've been concentrating my efforts on doing something about the situation I'm in.
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot

3. I've been saying to myself "this isn't real.".
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot

4. I've been using alcohol or other drugs to make myself feel better.
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot

5. I've been getting emotional support from others.
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot

6. I've been giving up trying to deal with it.
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot

7. I've been taking action to try to make the situation better.
    a. I haven't been doing this at all

b. I've been doing this a little bit
c. I've been doing this a medium amount
d. I've been doing this a lot

8. I've been refusing to believe that it has happened.
   a. I haven't been doing this at all
   b. I've been doing this a little bit
   c. I've been doing this a medium amount
   d. I've been doing this a lot

9. I've been saying things to let my unpleasant feelings escape.
   a. I haven't been doing this at all
   b. I've been doing this a little bit
   c. I've been doing this a medium amount
   d. I've been doing this a lot

10. I've been getting help and advice from other people.
   a. I haven't been doing this at all
   b. I've been doing this a little bit
   c. I've been doing this a medium amount
   d. I've been doing this a lot

11. I've been using alcohol or other drugs to help me get through it.
   a. I haven't been doing this at all
   b. I've been doing this a little bit
   c. I've been doing this a medium amount
   d. I've been doing this a lot

12. I've been trying to see it in a different light, to make it seem more positive.
   a. I haven't been doing this at all
   b. I've been doing this a little bit
   c. I've been doing this a medium amount
   d. I've been doing this a lot

13. I've been criticizing myself.
   a. I haven't been doing this at all
   b. I've been doing this a little bit
   c. I've been doing this a medium amount
   d. I've been doing this a lot

14. I've been trying to come up with a strategy about what to do.
   a. I haven't been doing this at all
   b. I've been doing this a little bit
   c. I've been doing this a medium amount
   d. I've been doing this a lot

15. I've been getting comfort and understanding from someone.
   a. I haven't been doing this at all
   b. I've been doing this a little bit
   c. I've been doing this a medium amount

d. I've been doing this a lot

16. I've been giving up the attempt to cope.
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot

17. I've been looking for something good in what is happening.
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot

18. I've been making jokes about it.
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot

19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot

20. I've been accepting the reality of the fact that it has happened.
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot

21. I've been expressing my negative feelings.
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot

22. I've been trying to find comfort in my religion or spiritual beliefs.
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot

23. I've been trying to get advice or help from other people about what to do.
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot

24. I've been learning to live with it.
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot

25. I've been thinking hard about what steps to take.
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot

26. I've been blaming myself for things that happened.
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot

27. I've been praying or meditating.
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot

28. I've been making fun of the situation.
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot

Brief COPE Subscales and Items

Self-distraction: items 1 and 19

Active coping: items 2 and 7

Denial: items 3 and 8

Substance use: items 4 and 11

Use of emotional support: items 5 and 15

Use of instrumental support: items 10 and 23

Behavioral disengagement: items 6 and 16

Venting: items 9 and 21

Positive reframing: items 12 and 17

Planning: items 14 and 25

Humor: items 18 and 28

Acceptance: items 20 and 24

Religion: items 22 and 27

Self-blame: items 13 and 26

Interview Guide

Time of interview _____
Place _____
Interviewer_____
Today I will be asking you to describe microaggression experiences (experiences in which you felt that you were treated unfairly or differently) that you have had, how you cope with those experiences, and how they have affected you. This interview is completely voluntary and you may stop at any time. To protect your anonymity I will ask you to provide either the respondent code that was provided to you when you did the survey or an alias of your choice. Also, to protect the anonymity of anyone associated with any information you may provide today please do not use anyone's real or full name or any other moniker that may identify them. I will be audio recording the interview but you have the right not to be recorded or to ask to stop the recording at any time. Do you have any questions or concerns before we begin?

I will start recording now. I am *(interviewer's name)* interviewing respondent *(respondent code)* about Microaggression Experiences among RNs. It is *(state date and time)*.
I am here with… Can you please provide your respondent code given to you during the survey or an alias that you prefer?

Opening Questions

How are you?
What is your life like currently?

- Describe your general routine (daily, weekly).
- Experiencing any major life events?

Transition Questions

Can you tell me what you know about "microaggressions"?
Have you had microaggression experiences?
How do you deal with these kind of experiences?

Domain Questions

Tell me about a time when you feel you experienced a microaggression.

- Where did it happen?
- How did it start?
- For the following question, please do not use names or any other monikers that may identify any individuals involved in this event. It is okay to use broad terms such as "the patient", "my supervisor", "my co-worker", etc.
  Who was involved? How so?
- Describe what happened.
- How did it end?

What was that experience like for you?
What made it feel like you were being treated unfairly or differently?
What happened after the experience?
How does that experience affect you now?

How has this experience affected your health?
Can you recall a time during which you had a microaggression experience involving a patient?

- Please describe what happened.
- Where did it happen?
- How did it start?
- For the following question, please do not use names or any other monikers that may identify any individuals involved in this event. It is okay to use broad terms such as “the patient”, “my supervisor”, “my co-worker”, etc.
  Who was involved? How so?
- How did it end?

What was that experience like for you?
What made it feel like you were being treated unfairly or differently?
How was your job performance impacted?
What happened after the experience?
How does that experience affect you now?

Closing Questions

What do you think is the most important message to share about your experience?
Is there anything else that we have not covered that you would like to share?

Interviewer Observations

What is respondent's ethnicity/cultural background?

Was respondent suspicious about the study before the interview?

a. **Yes, very suspicious.**
b. **Yes, somewhat suspicious.**
c. **No, not suspicious at all.**

The respondent's attitude during interview was:

a. **Cooperative, helpful**
b. **Neutral, relaxed**
c. **Nervous, uncertain**
d. **Antagonistic**

The respondent's attitude at the end of the interview was:

a. **No change from the beginning of the interview**
b. **More cooperative, more helpful**
c. **Less cooperative, less helpful**

Did respondent provide any information not already recorded in the interview or in a marginal note?

Does respondent have any characteristics that further identify ethnicity?

a. **Accent?**
b. **Dialect?**
c. **Skin tone?**