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The Predictiveness Of Gendered Racism On The Well-Being Of Women Of Color

Mallika Chakrabarti

THE PREDICTIVENESS OF GENDERED RACISM

ON THE WELL-BEING OF WOMEN OF COLOR

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Mallika Chakrabarti
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Name: Mallika Chakrabarti

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This document, submitted in partial fulfillment of the requirements for the degree from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.

Dr. Tamba-kui Bailey
Tamba-Kuii M. Bailey, PH.D.

Rachel L Navarro
Rachel L. Navarro, Ph.D.

Elizabeth Legerski
Elizabeth M. Legerski

Dr. Kara Wettersten
Kara b Wettersten

This document is being submitted by the appointed advisory committee as having met all the requirements of the School of Graduate Studies at the University of North Dakota and is hereby approved.

Chris Nelson
Chris Nelson
Dean of the School of Graduate Studies

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Mallika Chakrabarti
1/9/2023

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ABSTRACT

Research suggests a reduced sense of well-being in women of color who have been experiencing discrimination based on gender or race. Surprisingly, the intersectional discrimination of both gender and race, termed as Gendered Racism, on women of color has received much less attention than the individual variables. The present study seeks to fill a void in literature by offering to examine some effects of gendered racism on aspects of well-being in this population. This study examines the predictiveness of intersectional discrimination based on race and gender – called Gendered Racism - on the well-being of women of color. Well-being was measured by aspects of mental and physical health. Problem Focused coping was examined as a predictor of the aspects of the mental and physical health of women of color. Hypotheses stated that gendered racism and problem focused coping would predict the aspects of physical and mental health, and that gendered racism would be associated either positively or negatively with the domains of mental and physical health. Data was collected online from 150 participants across the country using convenient sampling. Linear regression and correlation analyses were conducted on the data to find evidence on the four broad hypotheses. Results showed that two of the main four hypotheses were supported, and other hypotheses were partially supported. There were some surprising results which might provide future research directions on the association of forms of coping on well-being.

CHAPTER I

INTRODUCTION

Identity of self for individuals is created through their different roles in society, environment, and family, which is considered a two-way process (Channar et al., 2011). As observed by Channar et al. (2011), this two-way process includes how one views themselves, and how they are viewed by others. This phenomenon is first initiated by treatment from parents or immediate families, which formulates the identity of the individual (Channar et al., 2011). For many women, often considered weak, vulnerable, and requiring protection, they may begin to feel subjugated and suppressed, which, in turn, leads to them feeling disempowered to offer suggestions or protest in certain situations (Channar et al., 2011). Existing research has also found evidence of discrimination outside homes or families, such as at workplaces, peer groups, etc. Channar et al. (2011) noted women being discriminated against through the "sticky floor or glass ceiling effects" at workplaces have to pay a larger gender penalty at any stage in their careers. Such research evidence suggests the prevalence of discrimination of women in different roles and settings, at any stage in their lives. Brown et al. (2006) suggested that individuals from racial-ethnic minorities often experience unfair treatment as a function of racism, compared to other stressful factors. Additionally, perceived discrimination in all these roles and settings may lower their self-esteem, and give rise to helplessness as well as adverse mental and physical health (Brown et al., 2006; Ro & Choi, 2010; Shelton et al., 2010). Discrimination within the workplace is widespread (Bobbitt-Zeher, 2011; Carr et al., 2004), can manifest in several ways, and negatively impact a woman's self-worth. Cultural, structural, and interactional influences have been found to impact gender discrimination at work, which continues to hinder gender equality as observed through recent research (Bobbitt-Zeher, 2011).

Racial-ethnic minorities often experience discrimination due to multiple components of social status, such as: gender, age, and race (Harnois, 2014). Harnois (2014) noted that while research has amply documented the prevalence of perceived discrimination, little of that has investigated the extent and the ways in which perceptions of racial/ethnic and gender discrimination are linked. Harnois (2014) observed that these studies had a generalized focus on all forms of discrimination, or accentuated one particular form, leaving the concurrent impacts of all forms of discrimination unaddressed/unresearched. Questions on how commonly individuals perceive multiple sources of discrimination, whether perceptions of one form of discrimination impact how much they perceive other forms of discrimination, etc. are yet unexplored (Harnois, 2014). Membership of individuals in more than one stigmatized group is overlooked in psychology owing to the need to isolate one identity in research, holding others constant (Remedios & Snyder, 2018).

I examined how race- and gender-based discrimination affects a woman's sense of self in the society, and the impact of this discrimination on their self-esteem, mental and physical health in their daily lives. I also examined how women cope with this intersectional discrimination in order to survive in a world which is still sharply oppressive towards women. In this study, I specifically examined the experiences of women facing intersectional discrimination related to race and gender as a means of understanding how it impacts their identity of self, as it relates to levels of self-esteem, mental health, and physical health. Finally, I examined the degree to which coping behaviors are utilized by women to survive and remain functional in societies where they experience this persistent intersectional discrimination.

CHAPTER II

LITERATURE REVIEW

Gender-based Discrimination

Gender discrimination is a complex social, historical, and cultural phenomenon, not only derived from biological and sex differences that critically regulates society around male dominance and female subjugation (Kira et al., 2015). This occurs through negative attitudes, beliefs, and behaviors that devalue, denigrate, stigmatize, or restrict females, resulting in chronic identity trauma (Kira et al., 2015). These can manifest as prejudice and unfair treatment and/or negative perceptions based on their gender, the differential disparity in status, power and prestige and the belief that a male is intrinsically superior (Kira et al., 2015). Apart from societal influences, gender discrimination exists within close relationships, including parents, family members and significant others with similar or different impacts for women (Kira et al., 2015). Additionally, gender discrimination can represent a combination of cultural ideas about gender, structural policies that affect women differently, and decisions to apply or enforce those policies on workers by gender.

Shelton et al., (2010) defined gender-based discrimination as a psychosocial stressor causing negative health consequences such as obesity. Research suggested that gender discrimination usually inflates the dominant gender, deflating the self-worth of women through their self-esteem and self-efficacy (Kira et al., 2015). Outcomes of gender discrimination included negative health consequences such as continuous life-trauma, an increasing sense of vulnerability, PTSD symptoms, depression, and cumulative comorbid mental and physical health disorders - the most significant being eating disorders (Kira et al., 2015). Kira et al. (2015) examined data from previous research on the salience of the negative effects caused by gender discrimination, within the household and social institutions, in samples of American Indians,

Palestinians, and clients of mental health clinics in Egypt, and torture survivors in the U.S. From this study Kira et al. (2015) were able to identify the age of the individual, severity and length of exposure to discrimination as determinants of the outcome, with adolescents being more affected by interpersonal discrimination while adults being more impacted by societal discrimination. Cross-cultural stability of the differential physical and mental health effects could be determined through further exploration. Lifetime experiences of gender discrimination were associated with worse health outcomes, maladaptive coping behaviors and hard drug use (Ro & Choi, 2010). Upon examination of this process across racial ethnic groups, some race moderation for Latina sample was found (Ro & Choi, 2010). Gender discrimination was researched to have a lifelong impact on women's self-esteem and self-efficacy, thwarting their aspirations, restricting opportunities, and denying them experience to build competence and self-direction (Goswami & Gupta, 2012).

Fischer & Holz (2007) examined the perceptions of discrimination against women in women's views of the group women, their views of themselves as individuals, and their psychological distress. The results of Fischer & Holz's (2007) study were in support of previous assertions made by feminist theorists on the deleterious effects of gender discrimination substantially contributing to psychological distress. Shelton et al.'s (2010) study, specifically examining the association between gender discrimination and Body Mass Index (BMI) among a racially/ethnically diverse and low-income sample was the first of its kind. Prior studies which examined the association between racial/ethnic discrimination and BMI or obesity produced mixed results (Shelton et al., 2010).

Workplace discrimination is rampant hindering gender equality, though how gender discrimination manifests in daily life is not very clear yet (Bobbitt-Zeher, 2011). Carr et al. (2004) noted that academia possesses a hierarchical structure which works against women,

leading to having only few women at the top; additionally, women faculty feel hopeless about any redressal regarding gender discrimination. Documented gender differences in areas of authority, wage disparities, occupational sex segregation, are evident, and despite significant changes in workplaces, disparities continue to exist (Bobbitt-Zeher, 2011). Despite having "experienced long struggles for equal rights, access to education and jobs, reproductive rights, and fair treatment", women still pay psychological costs for experiencing continued oppression (Bernard & Goodyear, 2014, p.128). Women's circumstances have witnessed improvement which varies demographically, yet overall women earn less than men in comparable jobs and are subject to sexual objectification (Bernard & Goodyear, 2014). Some observations regarding women and their professional lives which have come to light through research are summed up as follows: women with educational qualifications have been observed to assume double identities – a professional one and a private one, and secondly, the income of women is considered a supplementary source to the main income of the males in the family (Channar et al., 2011).

Channar et al. (2011) in their study found that being discriminated against on the basis of gender decreased job satisfaction for women, reduced their commitment and enthusiasm, and ultimately caused an increase in their stress levels. The gender composition of establishments' managerial and supervisory staff, gender-differentiated access to organizational power structures, and dominance by men in higher positions within the organizations sustain the devaluation of female employees (Hultin & Szulkin, 1999). While facing discrimination, women also appear to be bearing the burden of "not doing enough" while being assertiveness potentially results in backlash, being categorized as certain types while needing to contend with the "glass ceiling" at their workplace (Rudman & Glick, 2001). The contemporary existence of employment discrimination within work cultures and the processes results in unequal outcomes for individuals based on gender (Bobbitt-Zeher, 2011). Forty percent of respondents in a study

ranked gender discrimination first out of eleven possible choices for hindering their career in academic medicine (Carr et al., 2004).

It is important to acknowledge the impact of the global pandemic on women, which has affected gender relations universally. In heterosexual married couples working in telecommuting-capable occupations, mothers were noted to have cut down their work hours and in general were more affected in their employment status, worsening the existing gender gap (Landivar et al., 2020). Women were found to be heavily worried with childcare while men were concerned with paid work, such developments pointing towards a potential widening of the gender gap (Czymara et al., 2020). Gender inequality in the workforce has been impacted with the onset of the COVID-19, whether in the differences in gender-role attitudes following unemployment due to the pandemic (Reichelt et al., 2020), or a greater chance of women losing their jobs with increased responsibilities of household work and childcare, as compared to men (Farré et al., 2020).

One study revealed that chances of women losing jobs permanently was 24%, and losing their income by 50%, compelling them to increase their savings (Dang & Nguyen, 2020). Women's jobs were given lower priority, leading to insecurity and reduced well-being, which were multiplied with dimensions of race/ethnicity, class, and geographical locations (Fortier, 2020). Women faculty were generally found to face disparities regarding merit, tenure, and promotion (Malischa et al., 2020) and a larger decrease in paper submissions with women as first authors (Oleschuk, 2020; Ribarovska et al., 2020). Corroborating the above-mentioned findings, this study on gender differences found women's mental health worsening with more concerns about the lethality of the virus, contracting it and spreading it, greater likelihood of losing jobs, or having to decrease work hours (Oreffice & Quintana-Domeque, 2020). This study noted that working women were more likely to hold jobs with a higher at-risk status of getting coronavirus,

and in addition face increased housework and childcare, as compared to men (Oreffice & Quintana-Domeque, 2020). Thus, it is important to recognize that when significantly negative environmental changes occur, as observed during the global pandemic of COVID-19, existing gender gaps or inequalities experienced by women of color appear to worsen with no sign of abatement or redress.

Race-based Discrimination

Racial discrimination has been identified as a race-related stressor with the potential to contribute to health disparities in racial/ethnic populations (Shelton et al., 2010). Shelton et al. (2010) found evidence that perceived racial discrimination may lead to multiple harmful consequences related to mental and physical health outcomes, including potentially stress-related conditions, like high blood pressure and low-birth weight deliveries. It has been noted that the perception of having experienced racial–ethnic discrimination was high among individuals who identified strongly with their racial and ethnic group (Harnois, 2014). Discrimination has been found to be integrated in multiple ways with social processes ending up being stressful and increasing the risk for physical and mental health (Meyer, 2007).

In a sample of African American college students, the role of dimensions of racial identity in the antecedents and consequences of perceived racial discrimination was examined (Sellers & Shelton, 2003). Sellers & Shelton (2003) found that perceived discrimination showed positive associations with event specific and global psychological distress, and this relationship was moderated by racial ideology and regard of public beliefs, highlighting the complex role of racial identity. Previous studies examined the association between racial/ethnic discrimination and BMI or obesity displaying mixed results; though none specifically focused on racial discrimination and mental health on predominantly Black and Latina and female populations (Shelton et al., 2010). Shelton et al. (2010) found another study with an association between

‘internalized racism’ and elevated glucose levels, abdominal obesity, and waist circumference. In their study, Shelton et al. (2010) examined ‘internalized racism’, which measures the extent to which people agree with racist stereotypes about their race. This phenomenon is a different construct from self-reported experiences of racial/ethnic discrimination. However, despite finding evidence on the contrary in existing literature, Shelton et al. (2010) found no significant association of racial and gender discrimination and BMI, attributing the inconsistent findings to the idea (yet unsubstantiated) that individuals with higher internalized racism may perceive little or no racism.

African Americans have been historically discriminated against on the basis of their skin tone, which has negatively affected self-worth in all genders, considerably more in women due to being equated with physical attractiveness (Keith et al., 2010). Keith et al. (2010) noted that darker hued African Americans were approximately eleven times more likely to be highly discriminated against, which was found to be associated with being stronger in those individuals who were considered less affluent. Cultural beliefs about gender are considered foundational to discrimination, as they get translated into behaviors, sex categorization and gender stereotyping, regardless of other groups these individuals may occupy (Bobbitt-Zeher, 2011). Bobbitt-Zeher (2011) feels these processes create gender-based in-group/out-group and general animosity towards women causing them to be treated as liabilities without rationale.

Gendered Racism: Intersectionality of Race and Gender Discrimination

Gendered Racism is a term coined to describe the combination of sexism and racism under certain conditions, as experienced by minority genders and race/ethnicities (Thomas et al., 2008). A unique form of oppression, gendered racism occurs due to the intersection of race and gender and from perceptions and stereotypes of specific groups of ethnicities (Thomas et al., 2008). The concept of intersectionality, developed by Black feminists, was conceptualized as the

experience of multiple forms of discrimination such as racism and sexism that describes the various forms of interaction of race and gender, occurring frequently and shaping multiple dimensions of women's experiences (Crenshaw, 1991). Experiences of violence on women have often been shaped by the intersectionality of different dimensions of their identities, like race and class (Crenshaw, 1991). In order to illustrate the complex experiences which women face but are not conventionally included within the commonly represented boundaries of racism or sexism, the intersectionality of these two factors need to be delved into (Crenshaw, 1991).

Intersectionality of racism and sexism compounds the individual deleterious effects on Black women, in ways that cannot be encapsulated by studying each dimension separately (Crenshaw, 1991). Moreover, intersectionality highlights the need to account for multiple grounds of identity when considering how the social world is constructed (Crenshaw, 1991). Crenshaw (1989) observed that focusing on the most privileged group members results in marginalizing the multiply-burdened individuals overshadowing their claims, due to incomplete knowledge from separate sources. Thus, a distorted picture of racism and sexism is obtained representing only a portion of the complex phenomenon of intersectional experience, which is much greater than the sum of racism and sexism and cannot adequately express the subordination of women (Crenshaw, 1989).

Founded from Black feminism and Critical Race Theory, intersectionality is considered a method, disposition, a heuristic, and an analytic tool (Carbado et al., 2013). An intersectional approach in multicultural- and social justice-oriented clinical training throws light on Black women's gendered racial identity, the influence of gendered racial oppression, and the role of gendered racial socialization in Black women's self-concept and mental health (Brown et al., 2020). The complexity level introduced by the concept of intersectionality induces critical

thinking in trainees, leading to deeper understanding of social justice and the interplay of oppression and privilege (Brown et al., 2020).

For therapists, knowledge on intersectionality will drive them to address the multiple socio-structural dimensions and identities impacting them, instead of exclusively focusing on their marginalized identities (Adames et al., 2018). This could also have a reverse effect of neglecting to pick up the nuanced individual personal experiences; therefore, maintaining a culturally responsive and racially conscious balance while exploring the multiple marginalized identities and overlapping systemic inequities affecting clients is recommended (Adames et al., 2018). Intersectionality has been noted to move across national boundaries, emerging into movements in different spheres across the globe such as the feminist movement in Europe (Carbado et al., 2013). Other roles of intersectionality include a social movement – highlighting the often-hidden social dynamics to transform them for social change, and a work in progress mobilizing intersectionality to unexplored places (Carbado et al., 2013). The principles of intersectionality are instrumental towards a social psychological contribution - *intersectional consciousness* - referring to people's acknowledgement of privileges and disadvantages associated with multiple intersecting identities that shape their experiences and intragroup differences stemming from these (Nair & Vollhardt, 2020). Critical focus on disadvantages and privileges and other aspects of intersectionality are helpful in identifying mental health risk factors and protective mechanisms, along with the systems of inequality and social identities which are perpetuated (Torres et al., 2018).

A lot of existing research studies have focused on race-based and gender-based discrimination, but most often, separately. Discrimination occurring in subtle and automatic manner is difficult to determine and is inherently subjective due to its ambiguity and referred to as *perceived discrimination* (Remedios & Snyder, 2018). Associations between the two forms of

discrimination and one or a couple of the constructs of self-esteem, mental health and physical health have been found. The social-psychological and affective correlates and consequences of individuals facing prejudice and discrimination due to belonging to a minority or subordinate group have been studied, revealing constructs such as ethnicity, race, religion, sex, and sexual orientation to be contributors (Dion, 2002). Race and gender discrimination have been linked to increased psychological symptoms, in a study investigating the moderating effect of culture coping strategies on the relationship of race and gender-based discrimination with severity of psychological symptoms in women (Greer, 2011).

Perceived unfair treatment among midlife women was examined and found to be a common occurrence, with at least one out of five women reporting having experienced unfair treatment because of race/ethnicity or gender (Brown et al., 2006). Findings from Brown et al.'s (2006) study supported earlier literature where African Americans and other racial/ethnic minorities reported higher levels of perceived discrimination than did Whites, though findings concerning Latina women were inconsistent. Brown et al. (2006) concluded that higher race consciousness might contribute towards mitigating the impact of such discrimination, and might be an important variable to consider in the study of perceived unfair treatment in racial/ethnic minority women.

In a study by Lehavot et al., (2019) involving a sample of women veterans, individuals identifying as belonging to a minority race/ethnicity or minority sexual orientation were found more susceptible to adverse outcomes. These findings lead to the requirement of targeted care for them due to the complex negative outcomes of intersectional discrimination, while also revealing the propensity of those populations to develop greater resiliency from their experiences (Lehavot et al., 2019). Across heterosexual women from racial/ethnic minority groups, greater levels of distress, such as depression, anxiety, and sexism were reported, while among White women,

sexual minority women reported greater distress (Lehavot et al., 2019). It was interesting to note that among racial/ethnic minority women, heterosexual women reported higher levels of distress than sexual minority women (Lehavot et al., 2019). Stevens-Watkins et al. (2014) studied the vulnerability of African-American women to stressful events and subsequent adverse health outcomes, owing to the intersectionality of their gender and race. Results showed evidence of racism and sexism being correlated with each other and a significant source of psychological distress for the sample studied (Stevens-Watkins et al., 2014). Continuous exposure to gendered racism could result in retaining discrimination stress and self-defining health practices, often leading to excessive body weight and other negative health outcomes (Williams, 2015). One study examined the relationship between race and a set of socioeconomic status (SES) indicators; perceived discrimination (race and gender); and responses to perceived discrimination among healthy women, and found them to be related to health problems, though little is known about this relationship (Watson et al., 2004). Income and education were both found directly related to perceived racial discrimination, while the relationship between education and perceived discrimination was modified by race in this study (Watson, et al., 2004). Watson, et al. (2004) reported more discrimination with increasing levels of education in women, with education being the only variable significantly associated with perceived gender discrimination. Black feminist consciousness was found to stem from the understanding that black women are discriminated on the basis of both their race and gender, this identification arising from their common experiences with racism and sexism, and was found positively related to the components of race consciousness (Simien & Clawson, 2004). Black women were found less likely to discuss being treated unfairly than White women in managerial positions, which seemed to imply that occupation and race were both related to responses to perceived discrimination (Watson, et al., 2004).

In a study that examined how racial and ethnic minorities consider discrimination due to social status, Harnois (2014) found that that gender, age, and race-based discrimination were significantly and positively correlated with one another; with about half of racial and ethnic minority women perceiving to have experienced both racial and gender discrimination. Additionally, those reported experiencing age or gender discrimination were significantly more likely to perceive experiencing racial and ethnic discrimination as well (Harnois, 2014). This implies that in racial-ethnic minority groups, women experiencing discrimination in one domain could be simultaneously experiencing discrimination in other domains too, leading to being victims of intersectional discrimination.

Foynes et al. (2013) found partial support for the hypothesis that people of color were able to maintain their resilience in the face of low levels of race-based discrimination (RBD) but are unable to maintain it when discrimination occurs at high levels. Women of color were hypothesized to experience multiple risks with chronic exposure to both RBD and gender-based discrimination (GBD), and as anticipated, results confirmed the strong and consistent negative impact of RBD and GBD on their mental health (Foynes et al., 2013). Remedios & Snyder (2018) stated that multiply stigmatized people have different experiences hinging on intersecting identities than singly-stigmatized people. Multiply stigmatized individuals reported feeling more invisible than individuals who had one or zero stigmatized identities, receiving more unfair treatment, and having greater stereotype concerns than individuals with one stigmatized identity; both categories of stigmatized individuals reported more unfair treatment/stereotype concerns than individuals without stigmatized identities (Remedios & Snyder, 2018).

Harnois (2014) found strong support for the intersectional framework for understanding discrimination through interactive and “multiplying” effects. This theory states that experiencing multiple forms of inequality termed as “multiple jeopardies” could lead to the creation of a

multiple consciousness of how multiple systems of inequality work with and through each other (Harnois, 2014). Intersectional frameworks analyze how the intersections of these systems are experienced and interpreted, and understand individuals' multiple or intersectional identities and ideologies, as opposed to detracting from one's awareness of other forms of discrimination (Harnois, 2014). According to this theory, centrality of a single aspect of an individual's identity often has a synergistic relationship with the centrality of other aspects of their identity (Harnois, 2014). Around 12.2% of racial and ethnic minority women reported experiencing some form of racial/ethnic discrimination in the workplace, with between 4.9% and 7.4% of racial minority women who were surveyed, indicating having experienced both racial–ethnic and gender discrimination in the workplace each year (Harnois, 2014). Almost half of the women who perceived racial/ethnic discrimination in the workplace also perceived gender discrimination amounting to (6.0 *percent*/12.2 *percen*t) 49.5 *percent* (Harnois, 2014). Despite small sample sizes each of the three years of survey, the results were clear and consistent that perceptions of racial/ethnic discrimination are significantly and positively correlated with perceptions of gender- and age-based discrimination (Harnois, 2014).

Limited research exists on how and to what extent perceptions of racial–ethnic, gender, and age discrimination relate to one another, most of it focusing on either the perception of discrimination in general or on one particular form; while the extent to which multiple discrimination are experienced concurrently, is relatively unexplored (Harnois, 2014). For this study, I hypothesized that gendered racism would predict the self-esteem, mental health, and physical health of women of color.

Coping Behaviors

Discrimination has been associated with racial ethnic minority women, and samples constituting a few of the racial/ethnic groups have been studied. Verissimo et al. (2014) found

that for women, coping methods consisted of the use of social support and food, and such culturally competent practices were presumed to facilitate treatment retention as well as enable individuals in opening up about their discriminatory experiences and building resilience in the process. Increased risk of drug abuse among Latino men, but not Latina women, was found associated with discrimination in one of these studies, which has been attributed to the greater cultural acceptability among men to use substances to relieve stress (Verissimo et al., 2014). The study involving a sample of women veterans by Lehavot et al. (2019) indicated that individuals more susceptible to adverse outcomes due to identifying as belonging to a minority race/ethnicity or minority sexual orientation appeared to develop greater resiliency from their experiences, across depression, anxiety, and sexism. Discrimination is considered to be internalized, increasing the risk for mental and physical health, and simultaneously accounts for resilience and coping to buffer the distress (Meyer, 2007).

Following the stress and coping framework, discrimination as a stressor with its negative impact on psychological health, may induce adopting harmful coping methods, such as overeating, physical inactivity, and alcohol use (Shelton et al., 2010). Negative and maladaptive coping strategies, such as lifetime and recent hard drug use, were associated with lifetime gender discrimination, and this process differed across racial/ethnic groups (Ro & Choi, 2010). The positive appraisal of gender discrimination has been considered a negative coping strategy (Kira et al., 2015). Previous literature indicated that African American women experience adverse psychological outcomes related to race and gender discrimination (Greer, 2011). In this study, Greer (2011) hypothesized that culture-specific coping strategies to address discrimination would moderate the relationships between race- and gender-based discrimination and psychological symptoms, such that frequent use of coping efforts would be associated with less severe symptoms. Results revealed that race and gender discrimination were indeed associated with

increased psychological symptoms, however no moderating effect of coping strategies was found, implying also that behaviors and values are not exclusive to African Americans, contrary to earlier studies (Greer, 2011).

Some explanations were put forth to account for discrepancies in existing literature and this study. The cognitive-emotional debriefing strategies that women reported using entails interacting with others, expressing their emotions and/or cognitive reframing of their problem, and it is possible that such efforts were not enough to mitigate the distress (Greer, 2011). Again, the psychological responses have been noted to influence the types of coping strategies used, such as avoidant strategies result from discrimination appraisals generating fear and anxiety, while more active or problem-solving behavior may result from anger-eliciting responses; adjusting psychologically and emotionally to discrimination may be reflected through the coping efforts of women (Greer, 2011). Finally, Greer (2011) states that the contradictory results of this study highlight the requirement of further investigations of long-term use of coping efforts to address race and gender-based discrimination, and the prolonged efforts of specific effects that moderate the association of psychological outcomes related to race- and gender-based discrimination.

Those individuals with high self-efficacy for coping - or “coping efficacy” - were observed to view new social realities as challenges, while those with a lower coping efficacy could feel threatened by similar events (Cadaret et al., 2016). However, the increased tendency to utilize suppressive coping as a coping mechanism seemed to strengthen the relationship between perceived discrimination and depressive symptoms (Wei et al., 2008). Respondents rated themselves as poorly prepared to deal effectively with gender discrimination and admitted negative effects on their professional self-confidence, self-esteem, collegiality, isolation, and career satisfaction (Carr et al., 2004). Different coping strategies were identified as being utilized

by African American/Black women to deal with discrimination and might explain how gendered racism influences psychological distress (Szymanski & Lewis, 2015). Engagement strategies were those techniques that used resistance and education/advocacy, while disengagement coping strategies involved detachment from the stressor, internalization/self-blame, and use of drugs and alcohol (Szymanski & Lewis, 2015). Studying the links between gendered racism with psychological distress and strategies for coping with discrimination recommends future work that helps reduce the use of disengagement strategies to cope with discrimination (Szymanski & Lewis, 2015).

It is important to consider the possibilities and potential of different types of coping being utilized when faced with discrimination and whether they produce beneficial or adverse effects. Also, it is important to continue research for additional coping interventions with long-term effectivity. For this study, I will be focusing on the healthier, adaptive coping style which has been termed as "problem-focused coping". Problem-focused coping style includes strategies that encourage the use of problem-solving skills to confront and work towards resolving or reducing the barrier or the stressful situation (Buchanan, 2021). This is in comparison to the emotion-focused and avoidant coping styles which are less adaptive in nature, less sustainable for long term use, could lead to internalizing distressing feelings, or not always produce a healthy outcome (Buchanan, 2021).

Though not much has been documented in literature about the effects of problem-focused coping skills for gender- or race-based discrimination specifically, some studies in the recent past have provided evidence of beneficial effects of using problem-focused coping styles in long-term crisis situations. As a problem focused coping strategy, media was found to serve as a remedy or escape during the pandemic, augmenting people's insights in coping with the stress which contributed towards producing increased productive coping behaviors (Nabi et al., 2022). One

study examining the use of coping styles of female survivors of intimate partner violence showed that they use more maladaptive behaviors in the initial stages of violence, but gravitate towards problem-focused emotion regulation strategies in the later stages (Puente-Martinez et al., 2022). This use of problem-focused strategies, in turn, generate adaptive changes when leaving the abusive relationship (Puente-Martinez et al., 2022). I hypothesized that problem-focused coping will predict the self-esteem, mental health, and physical health of women of color.

Self-esteem

The positive or negative evaluation of the self is referred to as self-esteem (Smith & Mackie, 2007), which has been observed to vary according to individuals' perceptions in society. High self-esteem appears to result in several positive outcomes and benefits (Rosenberg, 1965). From previous research and as mentioned in this review, race and gender related events have appeared to influence the self-esteem of women in several areas of their lives. An experimental study of the correlates and consequences of perceiving oneself as the target of gender discrimination included contextual, cognitive-developmental, and individual difference factors that affect children's views on two forms of state self-esteem: performance and social acceptance; feeling discriminated was found associated with higher performance state self-esteem, and lower social state self-esteem (Brown et al., 2010).

Self-esteem, along with perceived person-organization (P-O) fit, and perceived organizational support were found to mediate the relationship between race and gender-based discrimination at the workplace with poor work and mental health outcomes (Velez et al., 2018). Self-esteem indirectly affected the link between psychological distress and workplace discrimination, and both directly and indirectly the relation of distress and poor work outcome (Velez et al., 2018). Again, self-esteem was indirectly linked to perceived discrimination and psychological distress through personal control, and it appeared to partially mediate the

relationship between personal control and distress (Moradi & Risco, 2006). Self-esteem was also found impacted by gender discrimination (Kira et al., 2015). Fischer & Holz (2007) tested an extended chain of mediation from perceived discrimination to collective and personal self-esteem, and to psychological distress. The data tested through path analysis showed a good fit and was consistent with the hypotheses linking perceived discrimination to self-esteem and psychological distress (Fischer & Holz, 2007).

A significant direct effect of perceived discrimination, a significant 2-way interaction of perceived discrimination and suppressive coping, and a significant 3-way relationship of perceived discrimination, reactive coping, and self-esteem were found to predict depression (Wei et al., 2008). Wei et al. (2008) also found that for those participants with high self-esteem, there was no significance in the relationship between perceived discrimination and depressive symptoms when reactive coping skills were infrequently used.

Mental Health

Besides self-esteem being affected negatively, the mental health of women facing discrimination was also observed to be negatively impacted. Supporting previous research, evidence showed that the relationship between discrimination and substance use disorders varied by gender, nativity, and ethnicity (Verissimo et al., 2014). While subgroups among Latinos may be particularly vulnerable to the negative effects of discrimination (Verissimo et al., 2014), women in general in the U.S. also reported a positive association between gender discrimination and lifetime and recent hard drug use (Ro & Choi, 2010). Foynes et al. (2013) found a strong and consistent negative impact on mental health symptoms caused by both RBD and GBD. Gender discrimination specifically has been identified as a contributor of mental health symptoms, with life- long effects, and is dependent on the age of the individual, and the severity of exposure to discrimination (Kira et al., 2015). The association between social stressors – racial and gender-

based discrimination was analyzed to occur in six distinct social contexts, and the effects of racial and gender discrimination were evaluated in comparison to individual stressors on three indicators of mental and physical health (Perry et al., 2013). Perry et al. (2013) found evidence of poor mental and physical health when racial and gender discrimination had occurred due to increased vulnerability to individual stressors. These findings warrant a more comprehensive study of these stressors on the health of low-SES African American women and other disadvantaged groups (Perry et al., 2013).

Multiple mental health concerns appear to result from these two forms of discrimination, qualitatively and logistically. Discrimination was linked to depression among 55.1% of participants in a sample of 205 Turkish women, along with negatively affecting their access to health care services (Aichberger et al., 2015). Aichberger et al. (2015) found little information about the mitigating factors in such cases, necessitating more research in this direction. Verissimo et al. (2014) suggested that harmful health effects of discrimination should be considered when developing interventions aimed at preventing and treating substance use disorders, especially among Latinos. In their study, Velez et al. (2018) found sexism and racism in the workplace associated with poor work and mental health outcomes, mediated by self-esteem, perceived person-organization (P-O) fit, and perceived organizational support. Critical consciousness about the intersectionality of sexism and racism appeared to weaken the association of discrimination with poor mental health; these findings were emphasized to be of public significance (Velez et al., 2018). Continuous trauma with stable negative mental health effects have been associated with gender discrimination, referred to as type III identity continuous trauma (Kira et al., 2015). Gender discrimination was found to predict increased PTSD, cumulative trauma disorders, general anxiety, annihilation anxiety, and decreased self-esteem (Kira et al., 2015).

On examination of perceived discrimination against women related to women's views of their group and themselves as individuals, self-esteem along with their psychological distress was found to mediate the relationship, showing a model with good fit (Fischer & Holz, 2007). The assertions of feminist theorists on the deleterious effects of gender discrimination accounting for substantial depression and anxiety were supported by the results of this study (Fischer & Holz, 2007).

I would be using the PHQ-9 inventory as a tool to assess symptoms of depression in participants in this study, which would represent their mental health states. Evidence was provided on the validity of the PHQ-9 as an efficient assessment instrument to screen for initial symptoms of depression and suicidal ideations in transgender women (Xu et al., 2022) and for major depression in pregnant women seeking prenatal healthcare (Maila et al., 2022).

Physical Health

Perceived racial and gender-based discrimination have been found to have harmful health consequences for physical health outcomes, including potentially stress-related conditions like high blood pressure and low-birth weight deliveries, obesity and overweight (Shelton et al., 2010). Shelton et al. (2010) found that discriminatory stress could contribute towards the activation of the hypothalamic-pituitary-adrenal axis resulting in abnormally high or imbalanced insulin and glucocorticoid levels (e.g., cortisol) that in turn stimulate the appetite and promote body fat deposition. Some research also suggested that stress-induced increases in cortisol may induce overeating, and prolonged physiological response to the stress of discrimination causing ‘wear and tear’ of organ systems (allostatic load), individually could contribute to obesity (Shelton et al., 2010).

Contradictorily, in another study, significant racial/ethnic differences in blood pressures were evident overall, and although perceived unfair treatment was common among a diversity of

midlife women, no positive relation between elevated blood pressure and perceived unfair treatment was found; (Brown et al., 2006). Therefore, these conclusions should be cautiously made due to limitations of the study. This result was surprisingly observed even among women reporting the highest levels of perceived unfair treatment (i.e., 65% of African-American and 60% of Chinese women), which was consistent with earlier reports showing no main effects of perceived discrimination on blood pressure (Brown et al., 2006). Shelton et al. (2015) also found no significant relationship between either racial or gender discrimination (alone or in combination) and BMI in the present investigation. Such discrepancies suggest the need for further exploration, specifically with the changing dynamics in society.

For this study, I will focus on some aspects of physical health that are represented as subscales or domains in the SF-36 which measures general physical well-being (Brazier et al., 1992). SF-36 has been used to study the association of mental health and physical health (Stone & Segal, 2023). The sub-scales of the SF-36 used in this study are Physical Functioning and Role limitations due to Physical health, Energy/Fatigue, and General Health.

Purpose of the Study

The purpose of this study is to examine the simultaneous effects of race- and gender-based discrimination – referred to as gendered racism - on women. Specifically, this study will examine the ability of gendered racism to predict women's self-esteem, mental health, and physical health - beyond existing research and including all the constructs together. Additionally, this study will examine the ability of the coping behaviors in women of color to predict how gendered racism is experienced by them. Further, I will examine how well problem-focused coping behaviors can predict women's self-esteem, mental health, and physical health. Additionally, this study will be useful for future research on newer innovations tailored for diverse racial/ethnic groups, age groups, and SES; help to alleviate these concerns for women,

other gender identities and sexual orientations who identify as minorities; empower them to achieve optimal work-life balance and a strong sense of self; and attempt to bring about more awareness in an unequal society. Experience of gendered racism has not received much attention in literature due to difficulties in research methodology (Thomas et al., 2008), and this study would attempt to throw light on the unique blended phenomenon which cannot be captured by studies studying racism and sexism separately and then testing for interaction effects.

Hypotheses

I have four broad hypotheses.

Hypothesis 1: Gendered Racism would significantly predict each of the outcome variables.

Hypothesis 1a: Gendered Racism would significantly predict Self-Esteem

Hypothesis 1b: Gendered Racism would significantly predict Depressive Symptoms

Hypothesis 1c: Gendered Racism would significantly predict Physical Functioning

Hypothesis 1d: Gendered Racism would significantly predict Role Limitations due to Physical Health

Hypothesis 1e: Gendered Racism would significantly predict Energy/Fatigue

Hypothesis 1f: Gendered Racism would significantly predict General Health

Hypothesis 2: Problem-Focused Coping would significantly predict each of the outcome variables.

Hypothesis 2a: Problem-Focused Coping would significantly predict Self-Esteem

Hypothesis 2b: Problem-Focused Coping would significantly predict Depressive Symptoms

Hypothesis 2c: Problem-Focused Coping would significantly predict Physical Functioning

Hypothesis 2d: Problem-Focused Coping would significantly predict Role Limitations due to Physical Health

Hypothesis 2e: Problem-Focused Coping would significantly predict Energy/Fatigue

Hypothesis 2f: Problem-Focused Coping would significantly predict General Health

Hypothesis 3: Gendered Racism will have a significant negative relationship with self-esteem, physical functioning, and general health.

Hypothesis 4: Gendered Racism will have a significant positive relationship with depressive symptoms, role limitations due to physical health, energy/fatigue and problem-focused coping.

CHAPTER III

METHODOLOGY

Procedures

First, approval was obtained from the University of North Dakota Institutional Review Board (IRB). Once IRB approval was obtained, a convenience sampling method was used to recruit and collect data for this study. An online survey was created using UND Qualtrics software. Participants recruited through emails, social media, personal contacts, and snowballing effect. Individuals who identified as being 18 years and older, a woman, and a person of color, were invited to participate in this study. Data collection was conducted over a period of about 12 months, when the survey window was open on Qualtrics. The survey comprised of self-report questionnaires on the constructs being measured. The survey was sent out to listservs of universities across the country reporting a high number of international student population. In exchange for participation in the survey, they were offered a summary of the results of the study. Potential participants were asked for their informed consent and given a demographic questionnaire to complete, consisting of questions asking for their age, gender identity, sexual orientation, race/ethnicity, socio-economic status, and level of education.

Quantitative research methods were used with the SPSS software for analyzing the hypothesized relationships between gendered racism and problem-focused coping with the outcome variables - self-esteem, depressive symptoms, physical functioning, role limitations due to physical health, energy/fatigue, and general health. Future directions for research along these lines have been discussed.

Participants

Participants were included based on criteria such as identifying as a woman of Color (non-White), with the ability to read and understand middle-school English, and living within the

U.S. The participants were residents, citizens, international students and faculty, identifying as women of color, living within the United States of America. Potential participants were asked for their informed consent to participate, following which they were given a demographic questionnaire to complete, consisting of questions related to their age, gender, race/ethnicity, sexual orientation, socio-economic status, level of education, work, and residence status. Two hundred and twenty participants were selected on the basis of the inclusion/exclusion criteria. The sample consisted of women between the ages of 18 and 69 years (n = 112; M = 30.64; SD = 8.843; *range* = 18- 69); 38 declined to say.

Table 1

Sample Demographic Composition

	Variables	**n**	**%**	**missing**
1	**Gender Identity**	**148**	**98.7**	**2**
	Cisgender Woman	145	96.7	
	Genderqueer/Non binary	3	2.0	
	Intersex	0	0	
	Transwoman	0	0	
2	**Race**	**150**	**100**	**0**
	African American/Black	37	24.7	
	American Indian/ Native American/Alaska Native/ Indigenous	4	2.7	
	South Asian American or South Asian (e.g., Bangladeshi, Indian, Pakistani, Nepalese, Sri Lankan, etc.)	38	25.3	
	East Asian American or East Asian (e.g., Chinese, Japanese, Korean, Vietnamese, etc.)	33	22.1	
	Latinx/Latina (e.g., Mexican, Puerto Rican, Cuban, etc.)	26	17.3	
	Arab	15	9.1	
	Persian	4	2.7	
	Native Hawaiian or Other Pacific Islander	0	0	

	Other	17	11.3	
	Biracial/Multiracial	11	7.7	
3	**Highest Degree of Education**	**150**	**100**	**0**
	Schooling not completed	2	1.3	
	Some high school, no diploma	1	.7	
	High school graduate, diploma or the equivalent (for example: GED)	4	2.7	
	Some college credit, no degree	7	4.7	
	Trade/technical/vocational training	0	0	
	Associate's Degree	0	0	
	Bachelor's Degree	42	28.0	
	Master's Degree	61	40.7	
	Professional Degree	5	3.3	
	Doctoral Degree	28	18.7	
4	**SES**	**150**	**100**	**0**
5	**Sexual Orientation**	**149**	**99.3**	**1**
	Asexual	5	3.3	
	Bisexual	17	11.3	
	Demisexual	1	.7	
	Fluid	2	1.3	
	Heterosexual/straight	107	71.3	
	Lesbian	3	2.0	
	Pansexual	4	2.7	
	Queer	5	3.3	
	Questioning	4	2.7	
	Different	1	.7	
6	**Country of Origin**	**150**	**100**	
7	**Relationship Status**	**149**	**99.3**	**1**
	Single	73	48.7	
	Separated	3	2.0	
	Married	48	32	
	Living with partner	18	12.0	
	Different Status	7	4.9	

8	**Current Working Status**	**150**	**100**	**0**
	Employed full-time	76	50.7	
	Employed part-time	38	25.3	
	Self-employed	2	1.3	
	Unemployed	7	4.7	
	Unable to work	2	1.3	
	Student	25	16.7	

Measures

For this study, five self-report questionnaires were used to measure gendered racism that women of diverse cultures are exposed to in different areas of their lives; whether these feelings are associated with reduced self-esteem and adverse mental and physical health outcomes; and how they cope. The survey instruments used in this study are listed below.

The Schedule Of Sexist Events-revised (RSSE; Klonoff & Landrine, 1995) is a self-report inventory measuring gendered racism and reactions to it (Thomas et al., 2008). In order to measure gendered racism, Thomas et al. (2008) created this revised scale by including items from *The Schedule Of Sexist Events* and different forms of discrimination that African American women had reported in qualitative studies previously, such as items in *The Schedule Of Racist Events. The Schedule Of Sexist Events* is a self-report inventory with 20 items measuring the frequency of experienced sexist events in diverse contexts (Klonoff & Landrine, 1995). This scale showed high internal consistency (Cronbach's alpha = 0.92, 0.90) and split-half reliability (Cronbach's alpha = 0.87, 0.83) for each of the subscales - SSE lifetime and SSE Recent, respectively (Klonoff & Landrine, 1995). *The Schedule Of Racist Events* is a brief self-report of 18 items measuring the frequency of experienced racist events in a wide variety of contexts, completed 3 times - once for the frequency of the racist events in the past year, a second time for the frequency of the events in their entire lifetime, and the third time for the stressfulness of each

event (Klonoff & Landrine, 1996). The three SRE subscales showed high internal consistency (Cronbach's alpha = .94 - .95) and high test-retest reliability after one month (Cronbach's alpha = .95 - .96) (Klonoff & Landrine, 1999). There is evidence of strong validity for both these scales in research (Klonoff & Landrine, 1995; 1999), and has been normed on several multicultural populations and diverse age groups (Landrine, 1995; Klonoff & Landrine, 1999; Lang, 2001; Matteson & Moradi, 2004; Lewis et al., 2011; Lewis et al., 2013; Reeve et al., 2011).

In the revised scale, Thomas et al. (2008) used "Black woman" in place of "woman" to emphasize the experiences of Black women. In this study, "Black woman" was replaced by the term "woman of color" to include the experiences of not only Black women but also participants of other races/ethnicities who did not belong to the dominant race. *The Schedule Of Sexist Events-revised* consists of 20 items rated on a 6-point Likert scale/from 1 = never happened to 6 = the event happens almost all the time for lifetime experiences (Thomas et al., 2008). Higher scores meant greater experiences of discrimination (Thomas et al., 2008). Reliability coefficient for the revised scale (Cronbach's alpha = .93) was very close to .92 for the original scale (Thomas et al., 2008).

The Rosenberg Self-esteem Scale is a 10-item scale that measures global self-worth by measuring both positive and negative feelings about the self (Rosenberg, 1965). The scale is believed to be unidimensional; all items are answered using a 4-point Likert scale format ranging from strongly agree to strongly disagree (Rosenberg, 1965). The measure was normed on 851 Thai students between 18 – 34 years (Wongpakaran & Wongpakaran, 2012); psychology students in a northeastern university in USA (Crocker & Lutanen, 1992); and high-school students (Rosenberg, 1965). The revised version showed the good reliability, like the original, but with a better model fit, and demonstrated very good fit statistics, ($\chi 2$ =29.19, df=19, n=187,

p=0.063), CFI=0.987, SRMR=0.040 and RMSEA=0.054 (Wongpakaran & Wongpakaran, 2012). Internal consistency was found to be good (Cronbach's alpha = 0.86 in the first sample, 0.84 in the second sample), along with great concurrent and construct validity (Wongpakaran & Wongpakaran, 2012).

The Patient Health Questionnaire – 9 (PHQ-9) is considered a brief and easy-to-administer and interpret screening instrument for depression, with its brevity resulting in good reliability and validity (Zhong et al., 2014). A scale consisting of 9 items asking participants if they had the following problems in the last 2 weeks, it is rated 0-3, with 0 = not at all and 3 = nearly every day (Kroenke et al., 2001). Its Spanish version demonstrated unidimensionality, local independence, adequate fit for the Rasch IRT model, and moderate reliability (Zhong et al., 2014). In Kroenke et al.'s study (2001), involving a sample of 6000 patients in 8 primary care clinics and 7 obstetrics-gynecology clinics, the PHQ-9 demonstrated excellent internal reliability with a Cronbach's α ranging between 0.86-0.89, as well as test-retest reliability. Internal consistency for the Thai version was found satisfactory (Cronbach's alpha = 0.79) though lower than in the studies from the United State (alpha coefficient = 0.79–0.89) but was within the acceptable range for a self-report instrument (Lotrakul et al., 2008). Research conducted in Germany using face-to face household surveys between 2003 and 2008 yielded satisfactory internal reliability (Kocalevent et al., 2013). The PHQ-9 showed good internal (Cronbach's alpha=0.81) and test re-test reliability (intraclass correlation coefficient=0.92) in a sample of 926 adults at outpatient departments of a major referral hospital in Ethiopia (Gelaye et al., 2013).

Support for construct validity of the PHQ depression scale, with moderate to large effect sizes, was found for major depression as well as subthreshold depressive disorder (not meeting the full criteria to be diagnosed as a depressive disorder) in the general population (Martin et al., 2006) and in patients in obstetrics-gynecology and primary care settings (Kroenke et al., 2001).

In Kocalevent et al.'s study (2013) using face-to face household surveys in Germany between 2003 and 2008, evidence for good construct validity was found with the SF-12 and the Satisfaction-with-Life Scale. Evidence of good construct validity (>0.70 - >0.60) was found for the Amharic version of PHQ-9 in a sample of 926 adults in Ethiopia, in detecting Major Depressive Disorder (MDD) against a scan reference, along with good sensitivity and specificity (Gelaye et al., 2013). Evidence of criterion validity showed PHQ-9 being a test that discriminated well between patients with or without major depression (Kroenke et al., 2001). Criterion validity tests a scale's performance in comparison to a gold standard; comparing the Thai version of PHQ-9 with the Thai version of MINI (for the diagnosing major depressive disorder) as a criterion standard demonstrated a moderate accuracy (*AUC* = 0.89; *SD* = 0.05, 95% *CI* 0.85 to 0.92) (Lotrakul et al., 2008). Evidence of good criterion validity (>0.70 - >0.60) was also found for the Amharic version of PHQ-9 in a sample of 926 adults in Ethiopia (Gelaye et al., 2013). Evidence of convergent validity was reported in studies on medical settings showing strong associations between psychiatric diagnosis and functional impairment as well as disability days establishing PHQ-9 as a valid screening instrument in medical settings (Martinet al., 2006). The Thai version of PHQ-9 tested for convergent validity yielded a Pearson's correlation coefficient between the PHQ-9 and the HAM-D of 0.56 ($p < 0.001$), indicating a moderate, positive association between the two instruments, demonstrating moderate convergent validity (Lotrakul et al., 2008). The PHQ-9 has also provided the ability to assess the severity of depression as a continuous measure as well as the categorical diagnostic groups (Martin et al., 2006). The Thai version of the PHQ-9, compared to the Global Assessment Scale, demonstrated satisfactory concurrent validity (Spearman's correlation coefficient = - 0.82) (Lotrakul et al., 2008).

This measure was normed on different populations, such as adults (≥18 years) attending outpatient therapy in a general hospital in Ethiopia (Gelaye et al., 2013); the general population in Germany above 14 years (Kocalevent et al., 2013); one thousand individuals in an outpatient clinic of the family medicine department of a hospital in Bangkok, Thailand (Lotrakul et al., 2008); two thousand and sixty-six German native individuals, between 13 – 93 years (Martin et al., 2006); six thousand patients above 18 years, attending obstetrics-gynecology and primary care clinics (Kroenke et al., 2001); and the Spanish version with 1520 pregnant women in Lima, Peru, (Zhong et al., 2014).

The Abbreviated Item Content for the SF-36v2® Health Survey Health Domain Scales (SF 36) is a self-administered questionnaire, measuring physical health on eight multi-item dimensions, including functional status, well-being, and overall evaluation of health; it contains thirty-six items and takes about five minutes to complete (Brazier et al., 1992). Patients rate their responses on 3- or 6-point scales in six of the eight dimensions (Brazier et al., 1992). For each dimension, item scores are coded, summed, and transformed on to a scale from 0 (worst health) to 100 (best health) (Brazier et al., 1992). The scale demonstrated very good test-retest reliability and acceptable internal consistency (Brazier, et al., 1992). Cronbach's alpha was greater than the recommended minimum of 0.85 for the SF-36, the reliability coefficients were greater than 0.75 for all dimensions except social functioning, and the test-retest scores correlated highly with those from the main survey (Brazier, et al., 1992). Considerable evidence was found for construct validity, and convergent and discriminant validity were mostly satisfactory in the general population sample of 1980 people, between 16-74 years randomly selected from two general practice lists in Sheffield (Brazier, et al., 1992).

The Brief COPE Scale is a 28-item scale designed to assess a broad range of coping responses – effective and ineffective - among adults for all diseases (Buchanan, 2021; Yusoff et

al., 2010). Three primary coping styles can be determined with the items divided into Problem-Focused Coping (*M=2.47; SD = .63*), Emotion-Focused Coping (*M=2.23; SD = .49*) and Avoidant Coping (*M=1.64; SD = .45*) (Buchanan. 2021). In addition, fourteen facets or dimensions of coping are reported each having two items (Buchanan, 2021). Out of these some domains demonstrated high reliability and validity, such as Religion (α=0.82) and Substance-use (α=0.90), while the other domains showed acceptable values of Cronbach's alpha, ranging from 0.73 to 0.50 (Yusoff et al., 2010). It is rated using a four-point Likert scale, ranging from "I haven't been doing this at all" (score 1) to "I have been doing this a lot" (score 4), higher scores representing greater utilization of coping strategies by the respondents (Yusoff et al., 2010). This measure was used on a sample of Malaysian women with breast cancer undergoing chemotherapy (Yusoff et al., 2010) and 316 esports athletes (Buchanan, 2021).

CHAPTER IV

RESULTS

Preliminary Analyses

Prior to conducting the data analyses, the dataset was cleaned in the following steps. The original number of participants was 220. Cases which had more than 70% missing data were deleted, resulting in 150 final participants. A small amount of missing data still remained in all other measures in this study which had 5% or less missing cases/values. Next, Little's missing completely at random (MCAR) test was conducted to determine whether remaining missing data was missing completely at random. The test was non-significant, df = 2115, χ^2= 2273.544, p = .008, indicating that data were missing completely at random. Missing values were thus replaced using expectation maximization procedure suggested by Tabachnick and Fidell, appropriate when data is MCAR (2013).

Expectation maximization, one of several maximum likelihood (ML) approaches and a recursive process, uses observed data to estimate parameters which are then used to estimate the missing scores (Schlomer et al., 2010). These methods are superior to deletion, non-stochastic imputation, and stochastic regression imputation methods for multivariate normal distributions (Schlomer et al., 2010). The information from the missing data is used to estimate various parameters, which in turn informs the most likely values of the missing data (Schlomer et al., 2010). The two iterative steps include starting values for the parameters (e.g., means, covariances) obtained with available data, on the basis of which regression methods are used to impute the values for the missing data. In the maximization step, new values for the parameters are calculated with the newly imputed data along with the original observed data (Schlomer et al., 2010). The process is repeated with the expectation step and continues until the estimates

change very little from one iteration to the next, providing “unbiased and efficient” parameters (Schlomer et al., 2010). The variables showed no multicollinearity.

Correlations

Alpha coefficient or ‘Cronbach's alpha’ is used as a means to estimate the validity and reliability of a psychological instrument and has shown evidence of being a robust estimate of reliability despite criticisms (Malkewitz et al., 2023). Statistical measures provide the alpha coefficient for the total scores as well as for the sub-scales/dimensions. However, it is important to assess the alpha coefficients in every new study as best practice. The empirical relevance and efficacy of the alpha coefficient under particular empirical circumstances has been documented in research studies (Raykov & Marcoulides, 2017). In this study we ran the alpha coefficients for each of the measures used to obtain data. Six of the eight alpha coefficients yielded acceptable alphas; however, two of the subscales - Energy/Fatigue and General Health – did not show acceptable reliabilities. Thus, due to our inability to calculate statistically acceptable alpha coefficients which impacted our ability to determine the validity of the subscales, we did not proceed further to retain them as outcome variables in this study.

The Pearson’s correlation indicated significant correlations between gendered racism, self-esteem, depressive symptoms, physical functioning, role limitations due to physical health, and problem-focused coping (see Table 2). Gendered Racism was significantly and positively correlated with depressive symptoms, role limitations due to physical health, and problem-focused coping. Gendered Racism was significantly and negatively correlated with self-esteem and physical functioning.

Table 2

Correlations, Means, and Standard Deviations for Predictor and Outcome Variables

	Variables	1	2	3	4	5	6	Mean	SD	Alpha
1	Gendered Racism *(RSSE)*	_						54.45	16.579	.94
2	Self-Esteem *(The Rosenberg Self-esteem Scale)*	-.272**	_					29.40	4.463	.81
3	Depressive Symptoms *(PHQ-9)*	.426**	-.591**	_				6.02	5.272	.88
4	Physical Functioning *(SF 36; Phf)*	-.197*	.222**	-.473**	_			47.39	4.764	.86
5	Role Limitations due to physical health *(SF 36; RlPf)*	-.258**	.247**	-.434**	.538**	_		6.99	1.502	.89
6	Problem-Focused Coping (*The Brief COPE Scale; BC_Prfoc)*	.001	.093	-.020	.088	.008	_	20.81	5.284	.85

Note: * p < .05. **p < .01

As displayed in the correlations table, gendered racism shows a significant ($p < .01$), negative association with self-esteem ($r = -.272$), physical functioning ($r = -.197$), role limitations due to physical health ($r = -.258$; $p < .05$). The correlations also indicate that gendered racism was positively correlated to depressive symotoms ($r = .197$) and problem-focused coping ($r = .153$).

Regression Analyses

Linear regression was used to analyze and predict the outcome variables from the two independent variables - gendered racism and problem focused coping behaviors - which were hypothesized to predict significant relationships with self-esteem, and aspects of mental and physical well-being.

Table 2

Linear Regression Analyses

Predictor Variables	Outcome Variables	*B*	*β*	*t*	R^2	*F*	*df*	*p*
Gendered Racism	_							
	Self-Esteem	-.073	-.272	-3.445	.074	11.871	1	<.001*
	Depressive Symptoms	.135	.426	5.721	.181	32.725	1	<.001*
	Physical Functioning	-1.809	-.197	-2.445	.039	5.976	1	.016
	Role Limitations due to physical health	-2.316	-.258	-3.249	.067	10.555	1	.001*
Problem-Focused Coping	-							
	Self-Esteem	.629	.093	1.138	.009	1.295	1	.257
	Depressive Symptoms	-.158	-.020	-.242	.000	.058	1	.809
	Physical Functioning	20.334	.088	1.077	.008	1.161	1	.283
	Role Limitations due to physical health	1.863	.008	.101	.000	.010	1	.920

Note: * p < .05. **p < .01

In terms of the ability of gendered racism to predict self-esteem in the sample, results indicated that gendered racism was a significant predictor of self-esteem, R^2 = .074, *F* (1, 148) = 11.871, *p* = < .001, and accounts for 7.4%, *CI* = -.115 to -.031. These results account for 7.4% of the explained variance of the factor of self-esteem. Additionally, this would indicate that the women of color in this study were more likely to have lower self-esteem if they experience higher levels of gendered racism.

In terms of the ability of gendered racism to predict depressive symptoms in the sample, the results indicated that gendered racism was a significant predictor of depressive symptoms, R^2 = .181, *F* (1, 148) = 32.725, *p* = < .001 and accounts for 18.1%, *CI* = .089 to .182. These results account for 18.1% of the explained variance of the factor of depressive symptoms. Additionally, this would indicate that the women in this study were more likely to have higher depressive symptoms if they have higher levels of gendered racism.

In terms of the ability of gendered racism to predict role limitations due to physical health in the sample, results indicated that gendered racism was a significant predictor of role limitations due to physical health, R^2 = .067, F (1, 148) = 10.555, p = < .001 and accounts for 6.7%, CI = -3.724 to -.907. Gendered racism accounts for 6.7% of the explained variance of the factor - role limitations due to physical health. These results suggest that the sample was more likely to have lesser role limitations due to physical health if they have higher levels of gendered racism.

In terms of the ability of gendered racism to predict physical functioning in this sample, the results indicated that gendered racism was not a significant predictor of physical functioning R2 = .039, F (1, 148) = 5.976, p = < .016, CI = -3.271 to -.347. These results seem to indicate that for the women of color in this study, gendered racism did not have a significant impact on their physical functioning. However, Problem-focused Coping did not predict self-esteem, depressive symptoms, physical functioning, or role limitations due to physical health.

Though not hypothesized, I examined the ability of problem-focused coping to predict gendered racism in the sample. Results indicated that problem-focused coping was not a significant predictor of gendered racism, R^2 = .000, F (1, 148) = .001, p = .978, CI = -.102 to .105.

CHAPTER V

DISCUSSION

This study examined whether intersectional discrimination based on race and gender, termed as gendered racism, predicts the self-esteem, mental health, and physical health of women of color together in one study. Additionally, this study examined whether problem-focused coping behaviors predict how gendered racism is experienced by women of color, their self-esteem, mental health, and physical health. Since the concept of gendered racism has not been explored extensively in previous research (Thomas et al., 2008), this study attempts to focus on the nuances and complexities that intersectional discrimination imparts to lives of women of color and impacts different aspects of their lives to varied extents. These are important to understand to be able to work towards means of mitigating the distress in women of color, which have been pervading all areas of their lives, leading to a reduced sense of self, and lower quality of mental and physical health.

For this study and in terms of my hypotheses, in Regression 1, I hypothesized that Gendered Racism would significantly predict self-esteem, depressive symptoms, physical functioning, role limitations due to physical health, energy/fatigue, and general health. Based on the results of this study, I found that gendered racism was a significant predictor of self-esteem, depressive symptoms, and role limitations due to physical health. This means that as studied in existing literature, discrimination based on intersecting identities could impact self-esteem, and produce or cause depressive symptoms, and role limitations due to physical health in women of color. However, results indicated that gendered racism was not a significant predictor for physical functioning, which was unexpected, as feeling discriminated against has been historically observed to produce physical symptoms or impair physical functioning in women of color.

In Regression 2, I hypothesized that Problem-Focused Coping will significantly predict self-esteem, depressive symptoms, physical functioning, role limitations due to physical health, energy/fatigue, and general health. This was hypothesized since coping behaviors would have been considered a natural way of dealing with and facing up to gender- and race-based discrimination in the different areas of the lives for women of color. However, the results do not provide evidence of this relationship. In the sample population, problem-focused coping behaviors were not predictive of gendered racism as hypothesized. This could be attributed to the assumption that women work on internalizing gendered racism and therefore, implicitly use coping strategies to deal, instead of more explicitly or with a focus on problem-solving, which has also been evidenced in existing research (Wei et al., 2008; Greer, 2011; Szymanski & Lewis, 2015). Surprisingly, avoidant coping strategies showed a significant relationship with gendered racism, which is concerning as unhealthy behaviors within this group of strategies seem to be used more widely and considered useful in coping with discriminatory experiences. Results obtained could be due to the sample heterogeneity or the small size of the sample, which is not representative of the accurate population distribution of women of color in the country.

For *Hypothesis 3*, I had theorized that Gendered Racism will have a significant negative relationship with self-esteem, physical functioning, and general health. This hypothesis was supported, as gendered racism showed a weak negative association with self-esteem (r = -.272) and physical functioning (r = -.197); and general health was removed from the study due to low reliability. This provides evidence that with a higher level of gendered racism reported by the women of color who were participants in this study, lower levels of self-esteem and physical functioning were reported. This could be attributed to feeling less adequate or mentally and physically disempowered, resulting in an overall poor sense of self.

For *Hypothesis 4*, I had predicted that Gendered Racism will have a significant positive relationship with depressive symptoms, role limitations due to physical health, energy/fatigue and problem-focused coping. This hypothesis was partially supported, as gendered racism showed a weak positive correlation with depressive symptoms (r = .197) and problem-focused coping (r = .153); and energy/fatigue was removed from the study due to low reliability. This provides evidence that with a higher level of gendered racism reported by the women of color who were participants in this study, they reported higher levels of depressive symptoms and problem-focused coping. This could be attributed to discrimination leading to feelings of sadness, helplessness, and hopelessness, and thereby, the need to use problem-focused strategies to deal with recurrent and pervasive discrimination.

However, contrary to *hypothesis 4*, gendered racism showed a weak negative association with role limitations due to physical health (r = -.258). This was surprising, as feeling discriminated against would have increased their experience of facing limitations due to physical health. Again, these results may be due to the smaller sample size or internalized feelings of being discriminated against, which would have been an inherent, lifelong experience for women of color.

Although it was not hypothesized for this study, I examined the ability of problem-focused coping in women to predict their experienced level of gendered racism. The results indicated that problem-focused coping did not predict the level of gendered racism in women in this study. These results signify that problem-focused coping may not be actively used by women of color to cope with the pervasive gender based discrimination that they have been experiencing for an extended time.

Practical Implications

This study has attempted to explore the impact of intersectional discrimination on different aspects in the lives of women of color. Gender discrimination has been observed to decrease satisfaction, motivation, commitment, and enthusiasm level of employees, and increase their stress levels, as seen from the results of a study which provided evidence of females being discriminated against more than males in private organizations (Channar et al., 2011). This seems to align with the results of this study in that experiences of gendered racism do significantly decrease self-esteem, worsen mental health, and reduce the quality of physical health in women of color. Intersectional acts of discrimination have a high likelihood of lowering the self-esteem of women of color, causing them to feel disempowered, helpless, and frustrated (Thomas et al., 2008; Channar et al., 2011; Kira et al., 2015). This inequality in status may manifest as lack of access to education, resources, and opportunities, feeling dominated or overpowered in their ability to make decisions in several areas of life, not being given the equal rights they deserve and viewed as incapable, weak, or unworthy– requiring help or being objectified, ultimately reducing their self-efficacy.

It is possible that women of color gravitate towards avoidant styles in an effort to traverse the path of least resistance when they face discrimination. Gendered racism being non-tangible, it may be hard for individuals to register the discrimination or point it out, making it difficult to quantify or measure and subsequently address or manage. Second, women of color may not be aware of problem-solving strategies to deal with these experiences, or may feel disempowered or hopeless in seeking redressal for such discriminatory experiences, and choose to avoid or ignore the problem when it arises, or refuse to accept that it exists. This study could raise awareness and enable those individuals who have been enduring these situations and clinicians to collaborate on effective strategies to ameliorate the distress. Gendered racism needs to be quantitatively

assessed to see whether coping styles mediate between gendered racism and psychological distress (Thomas et al., 2008). How women of color may choose to cope with the discriminatory experiences may vary over a larger sample. Understanding the unique differences in clients could help clinicians arrive at mutual effective interventions to optimize therapeutic support. Dissemination of the results of this study and awareness of the different coping styles may prompt women to learn about more problem- focused and healthy emotion-focused coping, as opposed to avoidant coping styles which have been evidenced as maladaptive, yet more preferred from the study. Thus, for clinicians working with women of color in the United States, it is important to consider exploring how their clients who possess minority identities owing to their gender and race may experience this intersectional form of discrimination.

Research Implications

This study could also provide directions for researchers to continue investigating the factors that affect the potential relationship between intersectional discrimination of race and gender and health-related behaviors (Williams, 2015). Research on the long-term effects of unhealthy coping styles, such as substance use or internalizing distress resulting in depression, anxiety, etc., some of which have been captured under avoidant or emotional coping styles, could help reduce these, and promote healthier coping styles. Research could also shed light upon more sustainable coping styles, for multicultural populations and women of color – more diverse than included in this study, taking into account several other identities they own. Further knowledge on adaptive coping styles and how they could assist in facing discriminatory experiences with greater resilience, would help a long way in alleviating the deleterious effects of discrimination on the physical and mental health of women of color. More knowledge and awareness could result in the innovation of more widely effective and sustainable strategies that could be used with multicultural populations, equipping individuals to handle their distress better in an effort to

improve their quality of lives. Finally, this study would also provide directions for researchers to consider when examining the intersectional discrimination faced by LGBTQIA+ individuals of color, which may have added layers and would be worth exploring, in attempts to understand their distress, find effective coping styles, and raise awareness on reducing discrimination based on human identities.

Limitations

The small sample used in this study may not be fully representative of the proportion of women of color in the United States, since most data were collected through universities and snowball effect. This could have led to demographic variations in terms of age, SES, educational background, and thus variability in the subjective experiences reported. Second, for women who may be students or immigrants and whose native or first language is not English, language could have potentially posed a barrier in understanding and clearly interpreting the survey, and may have impacted their responses to the items. Moreover, the Covid Pandemic may have complicated the process of collecting data. The national response to the Covid Pandemic may have disproportionately impacted some women of color, particularly those from immigrant and international communities, their ability to access the internet and social media, and thereby to learn about this study. These barriers may have impeded some women's ability to participate in this study. Also, a lack of funding for this study was a barrier in providing incentives for participants, which could have resulted in a greater amount of data from a wider range of participants by utilizing online survey platforms. Therefore, the results may not be generalizable to the larger population of women of color.

As noted in the preliminary analysis, due to inability to assess the reliability and validity of the Energy/Fatigue and General Health sub-scales were dropped from the study. The predictive relationship between gendered racism and the impact of problem-focused coping on

these two sub-scales could not be examined. I encourage these sub-scales to be used in future studies and have their reliabilities evaluated, as they are part of a widely used larger scale which has been used with diverse populations. Additionally, the expectation maximization method has a disadvantage as the standard errors and confidence intervals are not provided and obtaining those statistics requires an additional step which may not suffice for inferential analyses (Schlomer et al., 2010).

Conclusion

This study examined the impact of gendered racism on the lives of women of color, and specifically focused on the deleterious effects of gendered racism on their self-esteem, mental health, and physical health. Additionally, this study also examined whether problem-focused coping behaviors predict how gendered racism is experienced by women of color, and whether they predict their self-esteem, mental health, and physical health. From this study, gendered racism was found to be predictive of self-esteem, mental health, and most aspects of physical health of women of color, while problem-focused coping behaviors were found non-predictive of the gendered racism they experience. While some of the results were mixed, this study can be useful for future research on innovative and healthy coping styles, for diverse racial/ethnic groups, age groups, and SES, and specifically LGBTQIA+, all groups who frequently face discrimination in daily life owing to their identities. Dissemination of the results of this study would create awareness and empower individuals to achieve a strong sense of self, an optimal work-life balance, better health, and generally, an improved quality of life.

REFERENCES

Adames, H. Y., Chavez-Dueñas, N. Y., Sharma, S., & Roche, M. J. (2018). Intersectionality in psychotherapy: The experiences of an Afro-Latinx queer immigrant. *Psychotherapy, 55*(1), 73-79. doi:10.1037/pst0000152

Aichberger, M. C., Bromand, Z., Rapp, M. A., Yesil, R., Montesinos, A. H., Temur-Erman, S., ... & Schouler-Ocak, M. (2015). Perceived ethnic discrimination, acculturation, and psychological distress in women of Turkish origin in Germany. *Social psychiatry and psychiatric epidemiology, 50*(11), 1691-1700.

Armenta, B. E., & Hunt, J. S. (2009). Responding to societal devaluation: Effects of perceived personal and group discrimination on the ethnic group identification and personal self-esteem of Latino/Latina adolescents. *Group Processes & Intergroup Relations, 12*(1), 23-39.

Becker, J. C., & Wagner, U. (2009). Doing gender differently-The interplay of strength of gender identification and content of gender identity in predicting women's endorsement of sexist beliefs. *European Journal of Social Psychology, 39*(4), 487–508. doi: 10.1002/ejsp.551

Bernard, J. M., & Goodyear, R. K (2014). *Fundamentals of Clinical Supervision (5th ed.).* Upper Saddle River, NJ: Merrill.

Bobbitt-Zeher, D. (2011). Gender Discrimination At Work: Connecting Gender Stereotypes, Institutional Policies, and Gender Composition of Workplace. *Gender & Society, 25*(6), 764-786.

Boeckmann, R. J., & Feather, N. T. (2007). Gender, Discrimination Beliefs, Group-Based Guilt, and Responses to Affirmative Action for Australian Women. *Psychology of Women Quarterly, 31*(3), 290–304. doi: 10.1111/j.1471-6402.2007.00372.x

Bourguignon, D., Seron, E., Yzerbyt, V., & Herman, G. (2006). Perceived group and personal discrimination: Differential effects on personal self-esteem. *European Journal of Social Psychology, 36*(5), 773-789.

Brescoll, V., & Lafrance, M. (2004). The Correlates and Consequences of Newspaper Reports of Research on Sex Differences. *Psychological Science, 15*(8), 515–520. doi: 10.1111/j.0956-7976.2004.00712.x

Brown, C. S., Bigler, R. S., & Chu, H. (2010). An experimental study of the correlates and consequences of perceiving oneself to be the target of gender discrimination. *Journal of Experimental Child Psychology, 107*(2), 100–117. doi: 10.1016/j.jecp.2010.04.010

Brown, C., Matthews, K. A., Bromberger, J. T., & Chang, Y. (2006). The Relation between Perceived Unfair Treatment and Blood Pressure in a Racially/Ethnically Diverse Sample of Women. *American Journal of Epidemiology, 164*(3), 257–262. doi: 10.1093/aje/kwj196

Brown, D. L., Blackmon, S., Griffin-Fennell, F., Darden, T., & Bannerman, D. (2020). Intersectional Perspectives of Black Women's Mental Health: Strategies for Clinical Training. *Women & Therapy, 43*(3-4), 330-347. doi:10.1080/02703149.2020.1729467

Buchanan, D. B. (2021, August 10). *Coping orientation to problems experienced inventory (Brief-Cope)*. NovoPsych. Retrieved December 9, 2022, from https://novopsych.com.au/assessments/formulation/brief-cope/

Burgess, D., & Borgida, E. (1999). Who women are, who women should be: Descriptive and prescriptive gender stereotyping in sex discrimination. *Psychology, Public Policy, and Law, 5*(3), 665–692. https://doi.org/10.1037/1076-8971.5.3.665 (/doi/10.1037/1076-8971.5.3.665)

Carbado, D. W., Crenshaw, K. W., Mays, V. M., & Tomlinson, B. (2013). Intersectionality. *Du Bois Review: Social Science Research on Race, 10*(2), 303-312. doi:10.1017/s1742058x13000349

Carr, P. L., Szalacha, L., Barnett, R., Caswell, C., & Inui, T. (2004). "Ton of Feathers": Gender Discrimination in Academic Medical Careers and How to Manage It. *Journal of Women's Health, 12*(10). https://doi.org/10.1089/154099903322643938

Channar, Z. A., Abbassi, Z., Ujan, I. A. (2011). Gender Discrimination in Workforce and its Impact on the Employees. *Pakistan Journal of Commerce and Social Sciences (PJCSS), 5*(1), 177-191.

Crenshaw, K. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics. *University of Chicago Legal Forum,* 139-167. doi:10.4324/9780429500480-5

Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Review, 43*(6), 1241. doi:10.2307/1229039

Czymara, C. S., Langenkamp, A., & Cano, T. (2020). Cause for concerns: Gender inequality in experiencing the COVID-19 lockdown in Germany. *European Societies*. doi: 10.1080/14616696.2020.1808692

Dang, H. H. & Nguyen, C. V. (2020). Gender inequality during the COVID-19 pandemic: Income, expenditure, savings, and job loss. *World Development.* doi.org/10.1016/j.worlddev.2020.105296 0

Dion, K. L. (2002). The social psychology of perceived prejudice and discrimination. *Canadian Psychology/Psychologie canadienne, 43*(1), 1–10. https://doi.org/10.1037/h0086899 (/doi/10.1037/h0086899)

Eccleston, C. P., & Major, B. N. (2006). Attributions to discrimination and self-esteem: The role of group identification and appraisals. *Group Processes & Intergroup Relations, 9*(2), 147-162.

Farré, L., Fawaz, Y., González, L., & Graves, J. (2020). How the COVID-19 Lockdown Affected Gender Inequality in Paid and Unpaid Work in Spain. *Institute of Labor Economics.* [not peer reviewed]

Fischer, A. R., & Holz, K. B. (2007). Perceived discrimination and women's psychological distress: The roles of collective and personal self-esteem. *Journal of Counseling Psychology, 54*(2), 154.

Fortier, N. (2020). COVID-19, gender inequality, and the responsibility of the state. *International Journal of Wellbeing, 10*(3), 77-93. doi:10.5502/ijw.v10i3.1305

Foynes, M. M., Shipherd, J. C., & Harrington, E. F. (2013). Race and gender discrimination in the Marines. *Cultural Diversity and Ethnic Minority Psychology, 19*(1), 111–119. doi/10.1037/a0030567

Frazier, P. A., Tix, A. P., & Barron, K. E. (2004). Testing Moderator and Mediator Effects in Counseling Psychology Research. *Journal of Counseling Psychology*, *51*(1), 115–134. doi: 10.1037/0022-0167.51.1.115

Gelaye, B., Williams, M. A., Lemma, S., Deyessa, N., Bahretibeb, Y., Shibre, T., . . . Zhou, X. A. (2013). Validity of the patient health questionnaire-9 for depression screening and diagnosis in East Africa. *Psychiatry Research, 210*(2), 653-661. doi:10.1016/j.psychres.2013.07.015

Goswami, S., & Gupta, H. N. (2012). Perception of sex discrimination at workplace and psychological consequences of women at work. *Social Science International, 28*(1), 93.

Greer, T. M. (2011). Coping Strategies as Moderators of the Relationship Between Race-and Gender-Based Discrimination and Psychological Symptoms for African American Women. *Journal of Black Psychology, 37*(1), 42–54. doi: 10.1177/0095798410380202

Harnois, C. E. (2014). Are Perceptions of Discrimination Unidimensional, Oppositional, or Intersectional? Examining the Relationship among Perceived Racial–Ethnic-, Gender-, and Age-Based Discrimination. *Sociological Perspectives, 57*(4), 470–487. doi: 10.1177/0731121414543028

https://scholarworks.gsu.edu › cgi › viewcontent

Hultin, M., & Szulkin, R. (1999). Wages and Unequal Access to Organizational Power: An Empirical Test of Gender Discrimination. *Administrative Science Quarterly*, *44*, 453–472.

Jo, K. B., & Paik, J. (2018). The effect of discrimination experiences on job satisfaction of working women with disabilities: Focusing on mediating effect of self-esteem. *Journal of Convergence for Information Technology, 8*(2), 133-140.

Keith, V. M., Lincoln, K. D., Taylor, R. J., & Jackson, J. S. (2010). Discriminatory experiences and depressive symptoms among African American women: Do skin tone and mastery matter? *Sex roles, 62*(1-2), 48-59.

Kira, I. A., Omidy, A. Z., Fawzi, M., Rice, K. G., Fawzi, M., Lewandowski, L., & Bujold-Bugeaud, M. (2015). Are the negative mental health effects of gender discrimination (GD) salient across cultures? Does self-esteem mediate these effects: GD as a continuous traumatic stress and the pathways to its negative dynamics? *Psychology, 6*(01), 93.

Klonoff, E. A., & Landrine, H. (1995). The Schedule Of Sexist Events: A Measure of Lifetime and Recent Sexist Discrimination in Women's Lives. *Psychology of Women Quarterly,*

19, 439-472. Retrieved from https://journals.sagepub.com/doi/10.1111/j.1471-6402.1995.tb00086.x

Klonoff, E. A., & Landrine, H. (1996). The Schedule Of Racist Events: A Measure of Racial Discrimination and a Study of its Negative Physical and Mental Health Consequences. *Journal of Black Psychology, 22*(2), 144-168. Retrieved from https://journals.sagepub.com/doi/10.1111/j.1471-6402.1995.tb00086.x

Klonoff, E. A., & Landrine, H. (1999). Cross-Validation of the Schedule of Racist Events. *Journal of Black Psychology, 25*(2), 231–254. doi: 10.1177/0095798499025002006

Kocalevent, R., Hinz, A., & Brähler, E. (2013). Standardization of the depression screener Patient Health Questionnaire (PHQ-9) in the general population. *General Hospital Psychiatry, 35*(5), 551-555. doi:10.1016/j.genhosppsych.2013.04.006

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9. *Journal of General Internal Medicine, 16*(9), 606-613. doi:10.1046/j.1525-1497.2001.016009606.x

Landivar, L.C., Ruppanner, L., Scarborough, W. J., & Collins, C. (2020). Early Signs Indicate That COVID-19 Is Exacerbating Gender Inequality in the Labor Force. *Sociological Research for a Dynamic World, 6*, 1–3. doi:10.1177/2378023120947997

Landrine, H., Klonoff, E. A., Gibbs, J., Manning, V., & Lund, M. (1995). Physical And Psychiatric Correlates Of Gender Discrimination: An Application of the Schedule of Sexist Events. *Psychology of Women Quarterly, 19*(4), 473–492. doi: 10.1111/j.1471-6402.1995.tb00087.x

Lane, J. A., & Fink, R. S. (2015). Attachment, social support satisfaction, and well-being during life transition in emerging adulthood. *The Counseling Psychologist, 43*(7), 1034–1058.

Lang, D. L. (2001). The schedule of racist events-generic: A measure of perceived racism across ethnic groups. Dissertation Abstracts International: Section B: *The Sciences and Engineering*, *61*(12-B), 6756.

Lehavot, K., Beckman, K. L., Chen, J. A., Simpson, T. L., & Williams, E. C. (2019). Race/ethnicity and sexual orientation disparities in mental health, sexism, and social support among women veterans. *Psychology of Sexual Orientation and Gender Diversity, 6*(3), 347–358. https://doi.org/10.1037/sgd0000333 (/doi/10.1037/sgd0000333)

Lewis, J. A., Williams, M. G., Peppers, E. J., & Gadson, C. A. (2017). Applying intersectionality to explore the relations between gendered racism and health among black women. *Journal of Counseling Psychology*, *64*(5), 475–486. https://doi.org/10.1037/cou0000231

Lewis, T. T., Troxel, W. M., Kravitz, H. M., Bromberger, J. T., Matthews, K. A., & Hall, M. H. (2013). Chronic exposure to everyday discrimination and sleep in a multiethnic sample of middleaged women. *Health Psychology, 32*(7), 810–819. https://doi.org/10.1037/a0029938 (/doi/10.1037/a0029938).

Lewis, T. T., Yang, F. M., Jacobs, E. A., & Fitchett, G. (2012). Racial/Ethnic Differences in Responses to the Everyday Discrimination Scale: A Differential Item Functioning Analysis. *American Journal of Epidemiology, 175*(5), 391-401. doi:10.1093/aje/kwr287

Lotrakul, M., Sumrithe, S., & Saipanish, R. (2008). Reliability and validity of the Thai version of the PHQ-9. *BMC Psychiatry, 8*(1). doi:10.1186/1471-244x-8-46

Luszczynska, A., Gutiérrez-Doña, B., & Schwarzer, R. (2005). General self-efficacy in various domains of human functioning: Evidence from five countries. *International Journal of Psychology, 40*(2), 80-89. doi:10.1080/00207590444000041.

Maila B, Paul R, Mayimbo S, Kabwita K. (2022). The Validity of The Patient Health Questionnaire-2 As A Depression Screening Tool in Women Receiving Antenatal Care at

Chelstone First Level Hospital, Lusaka, Zambia. *JPRM, 4*(1): 27-34.doi: 10.21617/jprm2022.415

Malischa, J. L., Harrisb, B. N, Sherrerc, S. M., Lewisd, K. A., Shepherde, S. L., McCarthyf, P. C., … & Deitloffs, J. (2020). In the wake of COVID-19, academia needs new solutions to ensure gender equity. *PNAS, 117*(7), 15378-15381. doi/10.1073/pnas.2010636117

Malkewitz, C. P., Schwall, P., Meesters, C., & Hardt, J. (2023). Estimating reliability: A comparison of Cronbach's α, McDonald's ωt and the greatest lower bound. *Social Sciences & Humanities Open, 7*(1), 100368. https://doi.org/10.1016/j.ssaho.2022.100368

Martin, A., Rief, W., Klaiberg, A., & Braehler, E. (2006). Validity of the Brief Patient Health Questionnaire Mood Scale (PHQ-9) in the general population. *General Hospital Psychiatry, 28*(1), 71-77. doi:10.1016/j.genhosppsych.2005.07.003

Matteson, A. A., & Moradi, B. (2004). Examining the Structure of the Schedule of Sexist Events: Replication and Extension. doi:10.21236/ada425112

Meyer, I. H. (2007). Prejudice and discrimination as social stressors. In I. H. Meyer & M. E. Northridge (Eds.), *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual, and transgender populations* (p. 242–267). Springer Science + Business Media. https://doi.org/10.1007/978-0-387-31334-4_10

Moradi, B., & Risco, C. (2006). Perceived discrimination experiences and mental health of Latina/o American persons. *Journal of Counseling Psychology, 53*(4), 411.

Nabi, R. L., Wolfers, L. N., Walter, N., & Qi, L. (2022). Coping with COVID-19 stress: The role of media consumption in emotion- and problem-focused coping. *Psychology of Popular Media, 11*(3), 292–298. https://doi.org/10.1037/ppm0000374

Nair, R., & Vollhardt, J. R. (2020). Intersectionality and relations between oppressed groups: Intergroup implications of beliefs about intersectional differences and commonalities. *Journal of Social Issues, 76*(4), 993-1013. doi:10.1111/josi.12409

Oleschuk, M. (2020). Gender Equity Considerations for Tenure and Promotion during COVID-19. *Canadian Sociological Association.*

Oreffice, S. & Quintana-Domeque, C. (2020). Gender Inequality in COVID-19 Times: Evidence from UK Prolific Participants. *Institute of Labor Economics.* [not peer reviewed]

Perry, B. L., Harp, K. L., & Oser, C. B. (2013). Racial and gender discrimination in the stress process: Implications for African American women's health and well-being. *Sociological Perspectives, 56*(1), 25-48.

Puente-Martinez, A., Ubillos-Landa, S., & Páez-Rovira, D. (2022). Problem-Focused Coping Strategies Used by Victims of Gender Violence Across the Stages of Change. *Violence Against Women*, *28*(14), 3331–3351. https://doi.org/10.1177/10778012211054866

Raykov, T., & Marcoulides, G. A. (2017). Thanks coefficient alpha, we still need you! *Educational and Psychological Measurement, 79*(1), 200–210. https://doi.org/10.1177/0013164417725127

Reeve, B. B., Willis, G., Shariff-Marco, S. N., Breen, N., Williams, D. R., Gee, G. C., . . . Levin, K. Y. (2011). Comparing Cognitive Interviewing and Psychometric Methods to Evaluate a Racial/Ethnic Discrimination Scale. *Field Methods, 23*(4), 397-419. doi:10.1177/1525822x11416564

Reichelt, M., Makovi, K., & Sargsyan, A. (2020). The impact of COVID-19 on gender inequality in the labor market and gender-role attitudes. *European Societies.* doi:10.1080/14616696.2020.1823010

Remedios, J. D., & Snyder, S. H. (2018). Intersectional Oppression: Multiple Stigmatized Identities and Perceptions of Invisibility, Discrimination, and Stereotyping. *Journal of Social Issues, 74*(2), 265–281. doi: 10.1111/josi.12268

Ribarovska, A. K., Hutchinson, M. R., Pittman, Q. J., Pariante, C., & Spencer, S. J. (2020). Gender inequality in publishing during the COVID-19 pandemic. *Brain, Behavior and Immunity 91*(2021), 1-3. doi.org/10.1016/j.bbi.2020.11.022

Ro, A., & Choi, K.-H. (2010). Effects of Gender Discrimination and Reported Stress on Drug Use Among Racially/Ethnically Diverse Women in Northern California. *Women's Health Issues, 20*(3), 211–218. doi: 10.1016/j.whi.2010.02.002

Rosenberg, M. (1965). Society and the adolescent self-image. Princeton, NJ: Princeton University Press.

Rudman, L. A., & Glick, P. (2001). Prescriptive Gender Stereotypes and Backlash Toward Agentic Women. *Journal of Social Issues, 57*(4), 743–762. doi: 10.1111/0022-4537.00239

Schlomer, G. L., Bauman, S., & Card, N. A. (2010). Best practices for missing data management in counseling psychology. *Journal of Counseling Psychology, 57*(1), 1–10. https://doi.org/10.1037/a0018082

Schwarzer, R., Bäßler, J., Kwiatek, P., Schröder, K., & Zhang, J. X. (1997). The Assessment of Optimistic Self-beliefs: Comparison of the German, Spanish, and Chinese Versions of the General Self-efficacy Scale. *Applied Psychology, 46*(1), 69-88. doi:10.1111/j.1464-0597.1997.tb01096.x

Schwarzer, R., & Jerusalem, M. (1995). Generalized Self-Efficacy scale. In J. Weinman, S. Wright, & M. Johnston, *Measures in health psychology: A user's portfolio. Causal and control beliefs* (pp. 35-37). Windsor, UK: NFER-NELSON

Schwarzer, R. & Scholz, U. (2000). Cross-cultural assessment of coping resources: the general perceived self-efficacy scale. *Health Psychology and Culture*, Tokyo, Japan.

Sellers, R. M., & Shelton, J. N. (2003). The role of racial identity in perceived racial discrimination. *Journal of Personality and Social Psychology, 84*(5), 1079–1092. https://doi.org/10.1037/0022-3514.84.5.1079

Shelton, R. C., Puleo, E., Bennett, G. G., Mcneill, L. H., Sorensen, G., & Emmons, K. M. (2010). The Association Between Racial and Gender Discrimination and Body Mass Index Among Residents Living in Lower-income Housing. *National Institute of Health, 19*(3), 251–257.

Simien, E. M., & Clawson, R. A. (2004). The Intersection of Race and Gender: An Examination of Black Feminist Consciousness, Race Consciousness, and Policy Attitudes. *Social Science Quarterly, 85*(3), 793–810. doi: 10.1111/j.0038-4941.2004.00245.x

Stevens-Watkins, D., Perry, B., Pullen, E., Jewell, J., & Oser, C. B. (2014). Examining the associations of racism, sexism, and stressful life events on psychological distress among African-American women. *Cultural Diversity and Ethnic Minority Psychology*, *20*(4), 561–569. https://doi.org/10.1037/a0036700 (/doi/10.1037/a0036700)

Stone, L. E., & Segal, D. L. (2023). Associations between physical health and the alternative model of Personality Disorders: A cross-sectional age study. *Personality and Mental Health*. https://doi.org/10.1002/pmh.1576

Stupnisky, R. (2020). CFA & SEM Background [Powerpoint slides].

Szymanski, D. M., & Lewis, J. A. (2015). Gendered racism, coping, identity centrality, and African American College Women's Psychological Distress. *Psychology of Women Quarterly*, *40*(2), 229–243. https://doi.org/10.1177/0361684315616113

Taylor, T. O., & Bailey, T.-K. M. (2022). Does race matter? an experimental vignette study on harm severity, college student discipline, and restorative justice. *Journal of Diversity in Higher Education*. https://doi.org/10.1037/dhe0000427

Thomas, A. J., Witherspoon, K. M., & Speight, S. L. (2008). Gendered racism, psychological distress, and coping styles of African American women. *Cultural Diversity and Ethnic Minority Psychology*, *14*(4), 307–314. https://doi.org/10.1037/1099-9809.14.4.307

Tinakon, W. & Nahathai, W. (2012). A Comparison of Reliability and Construct Validity between the Original and Revised Versions of the Rosenberg Self-Esteem Scale. *Psychiatry Investigation*, *9*(1), 54. doi: 10.4306/pi.2012.9.1.54

Torres, L., Mata-Greve, F., Bird, C., & Hernandez, E. H. (2018). Intersectionality research within Latinx mental health: Conceptual and methodological considerations. *Journal of Latina/o Psychology, 6*(4), 304-317. doi:10.1037/lat0000122

Velez, B. L., Cox Jr, R., Polihronakis, C. J., & Moradi, B. (2018). Discrimination, work outcomes, and mental health among women of color: The protective role of womanist attitudes. *Journal of counseling psychology*, *65*(2), 178.

Verissimo, A. D. O., Grella, C. E., Amaro, H., & Gee, G. C. (2014). Discrimination and Substance Use Disorders Among Latinos: The Role of Gender, Nativity, and Ethnicity. *American Journal of Public Health, 104*(8), 1422–1428.

Watson, J. M., Scarinci, I. C., Klesges, R. C., Slawson, D., & Beech, B. M. (2004). Race, Socioeconomic Status, and Perceived Discrimination among Healthy Women. *Journal of Women's Health & Gender-Based Medicine, 11*(5), 441–451. doi: 10.1089/15246090260137617

Wei, M., Ku, T. Y., Russell, D. W., Mallinckrodt, B., & Liao, K. Y. H. (2008). Moderating effects of three coping strategies and self-esteem on perceived discrimination and

depressive symptoms: A minority stress model for Asian international students. *Journal of Counseling Psychology, 55*(4), 451.

Welle, B. & Heilman, M. E. (2005). Formal and informal discrimination against women at work. In D. Steiner, S. W. Gilliland, & D. Skarlicki (Eds.), *Research in social issues in management: Managing social and ethical issues in organizations, 5*(pp. 23-40) Westport, CT: Information Age Publishers.

Weston, R. & Gore, P. A. (2006). A brief guide to structural equation modeling. *The Counseling Psychologist, 34*(5), 719-751.

Williams, J.L. (2015). *Gendered Racism and the Moderating Influence of Racial Identity: Implications for African American Women's Well-Being*, Doctoral Dissertation, Georgia State University. doi: https://doi.org/10.57709/7012181

Williams, S (2015). *Effects of gendered racism on health practices of Black women: A racial and gender identity model*, Doctoral Dissertation, Boston College.

Worthington & Whitaker (2006) p. 833-844. [Powerpoint slides]

Xu, L., Chang, R., Wang, H., Xu, C., Yu, X., Chen, H., Wang, R., Liu, S., Liu, Y., Wang, Y., & Cai, Y. (2022). Validation of the patient health questionnaire-9 for suicide screening in transgender women. *Transgender Health*. https://doi.org/10.1089/trgh.2021.0075

Yusoff, N., Low, W. Y., & Yip, C. H. (2010). Reliability and Validity of the Brief COPE Scale (English Version) Among Women with Breast Cancer Undergoing Treatment of Adjuvant Chemotherapy: A Malaysian Study. *Medical Journal of Malaysia, 65*(1), 41–44.

Zhong, Q., Gelaye, B., Fann, J. R., Sanchez, S. E., & Williams, M. A. (2014). Cross-cultural validity of the Spanish version of PHQ-9 among pregnant Peruvian women: A Rasch

item response theory analysis. *Journal of Affective Disorders, 158*, 148-153. doi:10.1016/j.jad.2014.02.012

APPENDIX A

DEMOGRAPHICS

Appendix A – Demographics

Age:

Country of origin:

Visa/Citizenship status: Resident – Student – Authorized to work – Spouse visa – Other.

How many years have you lived in the U.S.?

Location: Northeast – Midwest – South - West

Race: African American/Black – East Asian – Latinx – Middle-Eastern - Native American - Native Hawaiian - Other Pacific Islander - South Asian - Biracial – Mixed - Other.

Ethnicity:

Gender identity: Agender - Cisgender Woman/Female – Gender-fluid - Gender Non-conforming - Non-binary – Transgender Woman – Other.

Sexual orientation: Bisexual – Lesbian – Heterosexual – Queer – Questioning – Other.

Class: Working class – Middle class – Upper class - Other.

Level of education: Not completed school – High school graduate, diploma, or GED – Associates' degree – Bachelor's degree – Master's degree – Doctoral degree or higher – Professional degree - Trade school – Other.

Working Status: Working – Not working – Searching for a job – Not searching – Student jobs – Unable to work - Other.

Please state how many years you have worked: Just started – 1-5 years – 5-10 years – More than 10 years

APPENDIX B

GENDERED RACISM

Appendix B - Gendered Racism

Scoring:

1 = never happened; 2 = happens rarely; 3 = happens sometimes; 4 = happens often; 5 = happens frequently; 6 = happens almost all the time

These questions are related to gendered racism. There are no right or wrong answers, please answer as you see fit.

Scoring: The frequency with which people experienced specific racist events by people and in situations, and their appraisals of those events.

1 = never happened; 2 = happens rarely; 3 = happens sometimes; 4 = happens often; 5 = happens frequently; 6 = happens almost all the time

1. Treated unfairly by teachers or professors
2. Treated unfairly by your employer, boss, or supervisors
3. Treated unfairly by strangers
4. Treated unfairly by people in service jobs
5. Treated unfairly by coworkers, fellow students, or colleagues
6. Treated unfairly by people in helping jobs
7. Treated unfairly by neighbors
8. Treated unfairly by your boyfriend, husband, or other important man
9. Denied a raise, promotion, tenure, ... or other such thing at work
10. Treated unfairly by your family
11. Made inappropriate/unwanted advances to you as a woman of color
12. Intentions misunderstood as a woman of color
13. Failed to show you the respect you deserve because you are a woman of color
14. Wanted to tell someone off for engaging in gendered racism
15. Been really angry about gendered racism
16. Forced to take drastic steps such as filing a grievance or lawsuit, quitting
17. Been called a derogatory name based on your combined gender and race.
18. Gotten into an argument or fight about something sexist

19. Been made fun of, picked on, pushed, shoved, hit, or threatened with harm as a woman of color (have any of these things happened)
20. Heard people making sexist jokes or degrading sexual jokes because you are a woman of color

APPENDIX C

THE ROSENBERG SELF-ESTEEM SCALE

Appendix C – The Rosenberg Self-Esteem Scale

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

1. On the whole, I am satisfied with myself.

Strongly Agree Agree Disagree Strongly Disagree

2. At times I think I am no good at all.

Strongly Agree Agree Disagree Strongly Disagree

3. I feel that I have a number of good qualities.

Strongly Agree Agree Disagree Strongly Disagree

4. I am able to do things as well as most other people.

Strongly Agree Agree Disagree Strongly Disagree

5. I feel I do not have much to be proud of.

Strongly Agree Agree Disagree Strongly Disagree

6. I certainly feel useless at times.

Strongly Agree Agree Disagree Strongly Disagree

7. I feel that I'm a person of worth, at least on an equal plane with others.

Strongly Agree Agree Disagree Strongly Disagree

8. I wish I could have more respect for myself.

Strongly Agree Agree Disagree Strongly Disagree

9. All in all, I am inclined to feel that I am a failure.

Strongly Agree Agree Disagree Strongly Disagree

10. I take a positive attitude toward myself.

Strongly Agree Agree Disagree Strongly Disagree

Scoring:

Items 2, 5, 6, 8, 9 are reverse scored. Give “Strongly Disagree” 1 point, “Disagree” 2 points, “Agree” 3 points, and “Strongly Agree” 4 points. Sum scores for all ten items. Keep scores on a continuous scale. Higher scores indicate higher self-esteem.

APPENDIX D

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Appendix D - PHQ-9

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

(For office coding: Total Score = + +)

If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

APPENDIX E

THE ABBREVIATED ITEM CONTENT FOR THE SF-36V2® HEALTH SURVEY HEALTH DOMAIN SCALES (SF-36)

Appendix E – SF-36

Scoring (depending on the domain): The following questions are about activities you might do during a typical day. Does your health limit you in these activities? If so, how much?

Response scale: Yes, limited a lot; Yes, limited a little; No, not limited at all

OR

These questions are about how you feel, how things have been with you during the past month. How much time during the past month:

Response scale: 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

Abbreviated Item Content for the SF-36v2® Health Survey Health Domain Scales

Scale	Item	Abbreviated Item Content
Physical Functioning (PF)	3a	Vigorous activities, such as running, lifting heavy objects, or participating in strenuous sports
	3b	Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf
	3c	Lifting or carrying groceries
	3d	Climbing several flights of stairs
	3e	Climbing one flight of stairs
	3f	Bending, kneeling, or stooping
	3g	Walking more than a mile
	3h	Walking several hundred yards
	3i	Walking one hundred yards
	3j	Bathing or dressing oneself
Role-Physical (RP)	4a	Cut down the amount of time one spent on work or other activities
	4b	Accomplished less than you would like
	4c	Limited in kind of work or other activities
		Had difficulty performing work or other activities (e.g., it took extra effort)

	4 d	
Bodily Pain (BP)	7	Intensity of bodily pain
	8	Extent pain interfered with normal work
General Health (GH)	1 11 a 11 b 11 c 11 d	Is your health: excellent, very good, good, fair, poor Seem to get sick a little easier than other people As healthy as anybody I know Expect my health to get worse Health is excellent
Vitality (VT)	9 a 9 e 9 g 9 i	Feel full of life Have a lot of energy Feel worn out Feel tired
Social Functioning (SF)	6	Extent health problems interfered with normal social activities
	10	Frequency health problems interfered with social activities
Role-Emotional (RE)	5 a 5 b 5 c	Cut down the amount of time spent on work or other activities Accomplished less than you would like Did work or other activities less carefully than usual
Mental Health (MH)	9 b 9 c 9 d 9 f 9 h	Been very nervous Felt so down in the dumps that nothing could cheer you up Felt calm and peaceful Felt downhearted and depressed Been happy
Reported Health Transition (HT)	2	How health is now compared to 1 year ago

APPENDIX F

THE BRIEF COPE

Appendix F - The Brief Cope

1 = I haven't been doing this at all

2 = I've been doing this a little bit

3 = I've been doing this a medium amount

4 = I've been doing this a lot

I am answering these questions based on (please check one):

Overall health problems Other, non-health stressors

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

22. I've been trying to find comfort in my religion or spiritual beliefs. 1 2 3 4

23. I've been trying to get advice or help from other people about what to do. 1 2 3 4

24. I've been learning to live with it. 1 2 3 4

25. I've been thinking hard about what steps to take. 1 2 3 4

26. I've been blaming myself for things that happened. 1 2 3 4

27. I've been praying or meditating. 1 2 3 4

28. I've been making fun of the situation. 1 2 3 4