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Racial discrimination as race-based trauma, coping strategies and dissociative symptoms among emerging adults

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Abstract

Objective—The race-based traumatic stress theory (Carter, 2007) suggests that some racial and ethnic minority individuals may experience racial discrimination as a psychological trauma, as it may elicit a response comparable to posttraumatic stress. The present study examined this further by determining the relation between racial discrimination and dissociation, a common response to trauma exposure. Further, we examined whether active coping strategies specifically employed to cope with racial discrimination related to less dissociative symptomatology.

Methods—The predominant racial and ethnic minority sample (N=743) of emerging adults (i.e., ages 18-29) recruited from a public university in Northeastern U.S. completed a battery of self-report measures on racial discrimination, responses to racial discrimination, traumatic life events and dissociative symptoms.

Results—Frequency of racial discrimination was positively associated with dissociative symptoms in regression analyses adjusted for demographics and other traumatic life events. Additionally, more active coping strategies in response to racial discrimination were negatively associated with dissociative symptoms.

Conclusion—Racial and ethnic minority emerging adults who experience racial discrimination, possibly as traumatic, may be more vulnerable to dissociative symptoms. However, different strategies of coping with racial discrimination may differentially impact risk for dissociation.

Keywords

Racial discrimination; Trauma; Dissociation; Coping

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Racial discrimination is a behavioral manifestation of racism on an interpersonal level that is analogous to negative life events and commonly experienced among racial and ethnic minority individuals (Harrell, 2000; Landrine & Klonoff, 1996; Clark, Anderson, Clark & Williams, 1999), particularly during emerging adulthood (i.e., age 18-29) (Kessler et al. 1999; Pérez, Fortuna, & Alegría, 2008). The detrimental effects of racial discrimination are well documented, as it has been consistently linked to poor physical and mental health outcomes across various racial and ethnic minority groups (Pascoe & Smart Richman, 2009; Williams, Neighbors & Jackson, 2003; Chou, Asnaani & Hofmann, 2012). In a nationally representative sample of adults in the U.S., perceived racial discrimination was associated with a lifetime history of major depressive disorder, posttraumatic stress disorder and substance use disorder independent of SES, age and gender (Chou, Asnaani & Hofmann, 2012). Furthermore, greater frequency of experiences of racial discrimination have been linked to worse mental health outcomes compared to more isolated incidents (Kessler et al., 1999). Unfortunately, less is known about how individuals may respond and consequently, cope with racial discrimination, and whether certain types of coping strategies may hinder psychological well-being.

The well-documented relationship between racial discrimination and negative mental health outcomes may be related to the way in which it is subjectively experienced, and consequently, the coping strategies elicited to manage the resulting distress. More recently, scholars have suggested that racial discrimination may be better conceptualized as a race-based traumatic stressor rather than as a benign negative experience (Bryant-Davis & Ocampo, 2005; Carter, 2007). In light of the recent media attention on aggressive and lethal policing in racial and ethnic minority communities that prompted protests nationwide (e.g., the deaths of Michael Brown in Ferguson, MO; Eric Garner in New York, NY; Freddie Gray in Baltimore, MD), there is a dire need to better understand the psychological effects of racism. According to Carter (2007), racial discriminatory experiences may be perceived as a threat to the integrity and safety of the affected individual. Thus, racism is a potential source for traumatic stress, which he refers to as race-based traumatic stress. Specifically, race-based events may yield emotional and psychological injury that negatively impacts mental health through eliciting traumatic stress, as they are often perceived as negative, unexpected, ambiguous, repeated, and out of the individual's control. He further proposes that there are a variety of ways in which individuals may respond, cope and adapt to race-based traumatic stress, including hypervigiliance, avoidance or numbing and emotional distress. Experiences of racial discrimination are overt displays of unfair treatment due to race, unlike racial microaggression, which is considered to be an evolved form of racial discrimination that is more subtle, covert and chronic in nature (Sue et al., 2007). Despite the rise in racial microaggression, blatant forms of racism continue to plague racial and ethnic minority communities. An attack on an individual's sense of self could in turn threaten their sense of safety and security, and consequently trigger a stress response (Bryant-Davis & Ocampo, 2005; Carter, 2007). Thus, maladaptive reactions to experiences of racial discrimination may compromise the individual's mental health.

In support, the sequelae of racial discrimination are also commonly experienced in response to trauma exposure, as disruptions in arousal and reactivity, negative alterations in cognitions and mood, and avoidance are symptomatic criteria for PTSD and other stress-related

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disorders outlined in the DSM-5 (American Psychiatric Association, 2013). Furthermore, Carter and Forsyth (2010) found that racial and ethnic minority adults who reported direct experiences with racism also reported higher levels of anxiety, guilt/shame, avoidance/ numbing and hypervigilance compared to individuals who did not. When queried further about their racist experience, 78% of individuals experienced the event as stressful, and 44% reported feeling stressed for a long period of time after the event (i.e., 2-12 months). Similarly, experiences of racial discrimination have also been linked to posttraumatic stress symptoms. For example, Pieterse and colleagues (2010) reported that higher levels of perceived racial discrimination was significantly associated with higher levels of self-reported posttraumatic stress symptoms among a sample of Black and Asian college students even after adjusting for general life stress. In a similar vein, Flores and colleagues (2010) reported that adolescents who reported more racial discrimination also reported more posttraumatic stress symptoms, who in turn reported greater drug and alcohol use, a common avoidant coping strategy evident in trauma-exposed individuals.

There is a growing body of research demonstrating that the harmful effects of racial and ethnic discrimination on mental health may be buffered by active coping strategies (Brondolo et al., 2009; Pascoe & Richman, 2009). Recently, researchers have identified coping strategies specifically employed in response to race-related stress among Black individuals (Forsyth & Carter, 2014), as opposed to general life stress. For instance, Hoggard and colleagues (2012) reported that a sample of African American college students reported significantly greater levels of rumination and avoidance in response to race-related stress compared to general life stress. This literature has largely focused on Black/African American populations. Thus, very little is known about how other racial/ethnic groups may cope with discrimination, and how it may impact risk for mental health. There is evidence to suggest that avoidant strategies such as acceptance and resignation, while common, prove to be more harmful compared to more active approaches like problem-solving or seeking support (Utsey, Ponterotto, Reynolds & Cancelli, 2000; Noh & Kaspar, 2003). Additionally, research suggests that racial/ethnic minority individuals may respond with more passive coping strategies when confronted with race-related stress compared to general life stress (Hoggard et al., 2012). One study reported that cognitive avoidance in response to experiences of racial/ethnic discrimination was associated with avoidance symptoms (e.g., emotional numbing, behavioral inhibition), which are common responses to traumatic experiences (Sanders Thompson, 2006). Thus, passive approaches to coping with racial discrimination such as keeping it to yourself or accepting it as a fact of life may exacerbate the effects of the resulting stress and promote harmful adaptations such as those exhibited in dissociative symptoms.

Dissociation, an experienced loss of control over mental processes that result in alterations in conscious awareness and self-attribution, is commonly experienced in response to traumatic experiences (for a review, see Carlson, Dalenberg & McDade-Montez, 2012; Dalenberg & Carlson, 2012). Specifically, Carlson and colleagues (2012) propose that dissociative states are momentary lapses from reality in response to a threatening situation that is perceived as emotionally taxing and results from a loss of control over the environment. They further suggest that dissociative states are commonly employed among trauma-exposed individuals through avoidant coping to help manage acute distress, and

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while it may have been adaptive at the time of the trauma, it may develop over time into less adaptive dissociative symptoms. In other words, an individual may be unable to effectively process the intense negative affect resulting from an experience that compromises an individual's sense of safety and security at the time, and momentarily disconnecting their internal experience from the external environment is an attempt to manage the resulting acute distress. Trauma-exposed individuals may experience mild to moderate manifestations of dissociative symptoms across various dimensions, such as 1) distortions in perception of the self, events and sensory information; 2) intrusions of trauma-related experiences, and 3) gaps in memory and awareness. There is empirical evidence demonstrating the relation between traumatic experiences and dissociation. For instance, while not all who experience trauma dissociate in response (Briere, 2006), 90% of individuals in a community-based study reporting clinically significant dissociation reported a history of trauma (Briere, 2006). Thus, dissociation is a common response to trauma that may also be elicited in response to experiences of racial discrimination, particularly among individuals more likely to employ passive coping strategies. Although the extant literature has alluded to the relation between racial discrimination and dissociation (Bryant-Davis & Ocampo, 2005), it remains to be empirically examined.

The Present Study

The present study draws upon the race-based traumatic stress theory (Carter, 2007) and aimed to determine whether racial discrimination experiences are associated with dissociative symptoms, a common response to posttraumatic stress, particularly among racial and ethnic minority emerging adults, for whom experiences of racial and ethnic discrimination are common (Kessler et al., 1999; Pérez, Fortuna, & Alegría, 2008). It is hypothesized that self-reported experiences of racial discrimination will be positively associated with dissociative symptoms, even when accounting for non-specific traumatic life events. Further, coping strategies specifically employed to deal with racial discrimination will also be associated with dissociative symptoms such that individuals utilizing more active strategies (e.g., try to do something; talk to others about it) will be less likely to report dissociative symptoms than individuals utilizing more passive coping strategies (e.g., keep it to yourself; accept it as a fact of life).

Methods

Sample

Participants were recruited from a large, urban public university located in Northeastern U.S. that draws a significant representation of racial/ethnic minority, immigrant, commuter, and working class students from the surrounding communities. The sample was comprised of 743 undergraduate college students from multiple disciplines with ages ranging from 18-29 years old ($M = 20.00$; $SD = 2.12$). The sample was predominately female (65%) and born in the U.S. (53%). It was also racially and ethnically diverse with 34% identifying as non-Hispanic Black, 30% Asian, 24% Hispanic/Latino, 6% non-Hispanic White and 6% identifying as other race or ethnicity (e.g., Biracial). Participants were recruited from an ongoing study that examines the effects of cultural experiences on psychotic-like symptoms;

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thus, the sample was pre-selected for Black/African American or immigrant individuals (for more details on the sample selection see Anglin, et al., 2015). See Table 1 for details on the sample characteristics.

Measures

Demographic—Information about the participant's age, sex, self-identified race and ethnicity, and immigrant status was collected to adjust for their influence on dissociation.

Racial discrimination—The Experiences of Discrimination scale (EOD; Krieger, Smith, Naishadham, Hartman, & Barbeau, 2005) was used to assess racial discrimination. This scale is a self-report questionnaire comprised of nine items that inquire about discrimination experienced due to race, ethnicity, or color (i.e., "Have you ever experienced discrimination, been prevented from doing something, or been hassled or made to feel inferior in any of the following situations because of your race, ethnicity, or color?") across a variety of settings such as school, employment, housing, and treatment from figures of authority such as the police, medical professionals, and bank officials. Participants rated the frequency (i.e., "How many times did this happen to you?") with which they've experienced each situation on a Likert-type scale ranging from 1 (i.e., once) to 3 (i.e., 4 or more times). The measure has demonstrated strong psychometric properties including good internal consistency reliability ($\alpha = 0.74$) and test-retest reliability ($r = 0.70$) in a racially/ethnically diverse non-clinical sample of adults (Krieger et al., 2005). The total scores were computed by aggregating the frequency of endorsed discriminatory experiences across all settings. In the present sample, scores ranged from 0-21 (M=3.10; SD=3.43), and demonstrated fair internal consistency reliability ($\alpha = 0.67$).

Coping with racial discrimination—The EOD scale (Krieger, et al., 2005) was also used to measure coping strategies in response to racial discrimination using the two items inquiring about responses to unfair treatment due to race, ethnicity or skin color. Participants indicated how they usually respond to experiences of racial discrimination and choose between "accept it as a fact of life" or "talk to others about it" for item 1 and "try to do something about it" or "keep it to yourself" for item 2. Krieger and colleagues (2005) reported that the two items demonstrated fair test-retest reliability (item 1 $\kappa = 0.33$; item 2 $\kappa = 0.30$). Four distinct groups were constructed with a combination of each response from each item, ranging from most active response reflected by Group 4 (i.e., try to do something about it and talk to others about it) to the most passive response reflected by Group 1 (i.e., accept it as a fact of life and keep it to yourself). Group 3 (i.e., accept it as a fact of life and talk to others) and Group 2 (i.e., try to do something and keep it to yourself) reflect a combination of active and passive strategies.

Traumatic Life Events—The Life Events Checklist (LEC; Gray, et al., 2004) is a measure widely used to screen for varying degrees of trauma exposure. The self-report questionnaire lists 17 discrete threatening experiences (e.g., physical assault, sexual assault, natural disaster, combat/ war exposure), and participants were instructed to select whether each event happened directly to them, if they witnessed it, learned about it, didn't know, or if it didn't apply to them. The scale has demonstrated good test-retest reliability and content

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validity in a nonclinical and clinical sample, as it converges with other widely used assessments of trauma exposure such as the Traumatic Life Events Questionnaire ($r = 0.55$) and the Clinician-Administered PTSD Scale ($r = 0.39$) (Gray, et al., 2004). In the present study, an aggregate of the number of traumatic events directly experienced by the participant was created to reflect a composite of cumulative traumatic experiences and scores ranged from 0-11 (*M*=2.24; *SD*=2.04). The internal consistency reliability in the present sample was fair ($\alpha = 0.63$).

Dissociation[1]—The Dissociative Symptom Scale (DSS; Carlson, et al., unpublished) is a 20-item self-report questionnaire used to assess dissociative styles in response to trauma exposure. The scale captures dissociation through four domains: depersonalization/derealization (e.g., "My body felt strange or unreal"); gaps in awareness and memory (e.g., " I suddenly realized that I hadn't been paying attention to what was going on around me"); sensory misperception (e.g., " I saw something that seemed real, but was not"); and cognitive-behavioral re-experiencing (e.g., " I had moments when I lost control and acted like I was back in an upsetting time in my past"). Participants reported on the frequency with which they have experienced each item on a Likert-type scale ranging from 0 (i.e., Not at all) to 4 (i.e., More than once a day). The scale is relatively new, as it assesses trauma-induced dissociative experiences on a continuum based on more contemporary models of trauma and dissociation; thus, allowing for greater range with a non-clinical sample. The developers have demonstrated that the scale is a reliable and valid measure of dissociation in response to trauma that can be used in a non-clinical sample with strong test-re-test reliability ($r = 0.70$) and strong internal consistency reliability of ($\alpha = 0.87$). Further, it converges with a widely used measure of dissociation (i.e., Dissociative Experiences Scale; $r = 0.57 – 0.63$) and a widely used measure of trauma exposure (i.e., Trauma History Screen; $r = 0.44 – 0.86$) in a clinical sample comprised of residential and homeless veterans, and non-clinical sample comprised of Midwestern college students, Western college students and community adults (Carlson et al., unpublished). In the present sample, all of the items were totaled with scores ranging from 0-46 (*M*=6.66; *SD*= 7.16), and the scale demonstrated strong internal consistency reliability ($\alpha = 0.89$).

Procedures

Participants completed a battery of self-report questionnaires on a computer in groups of 2 to 6 in a research lab. Participation in the study lasted up to an hour and compensation consisted of course credit. The study procedures were approved by the Institutional Review Board wherein the participants were recruited from, and all participants provided written informed consent.

[1]A principal component analyses with an oblique rotation was conducted to confirm that the 20 items load onto four subscales identified by Carlson and colleagues (unpublished). Components with eigenvalues greater than 1 were retained, and four components were extracted, which accounted for 53% of the variance. All items loaded onto a component at values of .40 or above. The first component explained 33% of the variance and consisted of 9 items that reflected depersonalization/derealization (e.g., my body felt strange or unreal). The second component explained 9% of the variance and consisted of 5 items that reflected re-experiencing (e.g. "I reacted to people or situations as if I were back in an upsetting time in my past"). The third component explained 7% of the variance and consisted of 5 items reflecting gaps in awareness (e.g., "I got so focused on what was going on in my mind that I lost track of what was happening around me"). The final component explained 5% of the variance and consisted of 1 item reflecting sensory misperception (e.g. "I didn't feel pain when I was hurt and should have felt something"). Overall, three items loaded differently than what Carlson and colleagues reported.

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Data Analysis

Gender, racial/ethnic and immigration group differences in the variables of interest were examined using t-tests or one-way ANOVAs with post hoc Bonferroni corrected t-tests for continuous variables (i.e., racial discrimination, dissociation, traumatic life events) and Chi-square analyses were used for categorical variables (i.e., coping strategies). Multivariate analyses were used to test the hypotheses with multiple hierarchical linear regression models, specifically to explore the relation between racial/ethnic discrimination, coping strategies and dissociation, adjusting for age, gender, race/ethnicity, immigration status and history of traumatic life events. In preparation for multiple regression analyses, a 3-level set of dummy variables were created for race/ethnicity, with Black as the reference group. Similarly, a 3-level set of dummy variables were also created for the four coping strategy groups, with the most passive coping strategy Group 1 (i.e., accept it as a fact of life and keep it to yourself) entered as the reference group.

Results

Descriptive and Bivariate Analyses

The majority of the sample 69% (N=516) reported a history of racial discrimination, as 23% experienced discrimination across one setting, 20% across two settings, 14% across three settings; 9% across 4 settings; and 4% across 5 or more settings. The most common settings were on the street or in public (45%), at school (36%) and getting service at store or restaurant (32%). The modal frequency response across all discriminatory domains was 2 or 3 times, which accounted for about 50% of the responses across all settings. Most individuals employed more active coping strategies in response to racial discrimination, as Group 4 (i.e., try to do something and talk to others about it) accounted for a significant portion of the sample (59%), followed by Group 3 (22%) (i.e., accept it as a fact of life and talk to others). Group 1 (12%) (i.e., accept it as fact of life and keep it to yourself) and Group 2 (7%) (i.e., try to do something about it and keep it to yourself) represented a minority of the sample.

There was no significant gender difference in frequency of racial discrimination, $t(742) = 0.87$, $p = 0.32$, dissociation, $t(729) = 0.28$, $p = 0.42$, and traumatic life events, $t(732) = 0.87$, $p = 0.53$. However, there was a significant gender difference in coping strategies, $\chi^2(3) = 22.66$, $p = 0.00$, with a higher proportion of females employing the most active coping strategies (Group 4; 69%, $Z_{adj} = 2.7$), and a higher proportion of males employing the most passive coping strategies (Group 1; 54%, $Z_{adj} = 3.9$). There was a significant immigration difference in racial/ethnic discrimination, $t(741) = 2.37$, $p < 0.05$, as U.S-born individuals (M=3.38; SD=3.62) reported greater levels than foreign-born individuals (M=2.79; SD=3.18). There was also a significant immigration difference in traumatic life events, $t(731) = 1.98$, $p < 0.05$, as U.S.-born individuals reported more trauma exposure (M=2.38; SD= 2.03) compared to foreign-born individuals (M=2.08; SD= 2.04). However, there was no significant immigration difference in dissociation, $t(728) = 0.25$, $p = 0.80$ or in coping strategies, $\chi^2(3) = 3.69$, $p = 0.30$.

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Findings from a one-way ANOVA with Bonferroni corrected post hoc t-tests indicated that there was a significant racial/ethnic group difference in racial discrimination, $F(4,741) = 5.01$, $p < .05$, with Black individuals reporting greater frequency of racial discrimination (M=3.66; SD=3.97) than Hispanic (M = 2.65; SD = 3.26) and White individuals (M = 1.60; SD = 1.98), but not compared to Asian individuals (M=2.98; SD=2.95) or individuals identifying as other race/ethnicity (M=3.67; SD=3.41). However, there were no significant racial/ethnic group differences in dissociation, $F(4,728) = 0.90$, $p = 0.46$. The racial/ethnic difference in traumatic life events was marginally significant, $F(4,731) = 2.28$, p= 0.06, with Asians reporting less traumatic life events (M = 1.96; SD = 1.97) and individuals identifying as other race/ethnicity reporting more traumatic life events (M = 2.67; SD = 1.83) than expected. Findings from the Chi-square analysis also demonstrated no significant racial/ethnic group difference in coping strategies, $\chi^2(12) = 17.69$, $p = .125$.

There was a significant difference across the four coping groups in dissociation ($F(3,727) = 13.26$, $p < .05$). Specifically, Group 1 (i.e., accept it as a fact of life and keep it to yourself) reported significantly higher levels of dissociation (M = 10.9; SD = 10.84) compared to Group 4 (i.e., try to do something about it and talk to others about it; M = 5.72; SD = 6.16) and Group 3 (i.e., accept it as a fact of life and talk to others; M = 6.76; SD = 7.08). There was no significant difference across the four groups in racial discrimination, $F(3,739) = 0.34$, $p = 0.80$, or in traumatic life events, $F(3,732) = 0.81$, $p = 0.49$.

Multivariate Analyses

Multiple hierarchical linear regression models were constructed with dissociative symptoms entered as the dependent variable, adjusting for demographics (i.e., age, gender, race/ethnicity, immigration status) and traumatic life events in the first model, which was significant, $F(8,724) = 6.02$, $p < 0.01$, $R^2 = 0.06$, $R^2 = 0.05$, *sig. F change* = 0.000. Racial discrimination was entered in the second step, which was significant, $F(9,724) = 7.84$, $p < 0.01$, $R^2 = 0.09$, $R^2 = 0.08$, *sig. F change* = 0.000, and there was a significant, positive association with dissociative symptoms (b=0.36; $S.E.$ = 0.08; 95% C.I. 0.21-0.51). Coping strategies were entered in the third model, which was significant, $F(12,724) = 8.62$, $p < 0.01$, $R^2 = 0.13$, $R^2 = 0.11$, *sig. F change* = 0.000. The significant association between racial discrimination and dissociative symptoms remained (b=0.35; $S.E.$ = 0.08; 95% C.I. 0.20-0.50). Additionally, the most passive coping group 1 (i.e., accept it as a fact of life and keep it to yourself) was significantly more likely to endorse dissociative symptoms than the most active coping group 4 (i.e., try to do something about it and talk to others about it) (b = −4.34; $S.E.$ = 0.82; 95% C.I. −5.94- −2.73), and coping group 3 (i.e., accept it as a fact of life and talk to others) (b = −3.42; $S.E.$ = 0.92; 95% C.I. −5.23 - −1.61). For more details on the multivariate analyses see Table 2.

Discussion

The present study expands our understanding of racial discrimination as a race-based traumatic stressor by demonstrating a significant association between racial discrimination and dissociative symptoms, a commonly reported response among trauma-exposed individuals. This extends the literature on race-based traumatic stress by demonstrating an

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additional similarity in the sequelae between racial discrimination and posttraumatic stress. While scholars have alluded to the relation between racial/ethnic discrimination and dissociation (Bryant-Davis & Ocampo, 2005; Carter, 2007), this is the first study to date to offer empirical support. Furthermore, we found that the relationship between racial/ethnic discrimination and dissociative symptoms was not explained by exposure to other traumatic life events, and that passive (versus active) coping strategies employed in response to racial discrimination was associated with increases in dissociative symptoms. Thus, as proposed by Carter (2007), maladaptive reactions to racial discrimination through the use of avoidant or passive coping strategies may render an individual more vulnerable to negative mental health outcomes including posttraumatic stress and dissociative symptoms.

The present findings are timely given the pervasiveness of incidents of discrimination among racial/ethnic minority young adults. As previously reported in the extant literature, a significant portion of emerging adults continue to experience overt displays of unfair treatment due to their race, ethnicity or skin color (Anglin et al., 2015), and Black individuals are most likely to report experiences of racial discrimination than other race/ethnic groups (Krieger et al., 2005). This is consistent with the national statistics that indicate that hate crimes are more often perpetrated against Black or African Americans than any other race/ethnicity (Hate Crime Statistics, 2013). Similarly, U.S.-born individuals were more likely to experience racial discrimination than foreign-born individuals, which may be due to more time in the U.S. where they are a racial minority, and thus, more exposure to racial discrimination. This is consistent with previous findings demonstrating that greater acculturation, or adaption to the U.S., is associated with greater reports of racial discrimination (Pérez, Fortuna & Alegría, 2008) Moreover, a greater portion of individuals responded to racial discrimination with more active coping strategies by talking to others and/or trying to do something about it compared to more passive coping strategies such as accepting it and/or keeping it to themselves, as previous research has found (Krieger et al., 2005; Ertel et al., 2012). The present study expanded on this knowledge by demonstrating that gender differences may exist in coping with racial and ethnic discrimination. Specifically, females were more likely to employ more active coping strategies in response to racial discrimination compared to males. Although there was no gender difference in frequency of racial discrimination, perhaps a gender difference in the nature of the discriminatory experience may influence ways in which individuals respond. For instance, since males are more likely to experience racially motivated assaults than females (Hate Crime Statistics, 2013), an active coping style such as doing something about it may be to their detriment as it may elicit more violence.

Individuals with the most passive coping strategies (i.e., accept it and keep it to yourself) reported significantly more dissociative symptoms than individuals with the most active coping strategies, and this was not influenced by variation in experiences of racial discrimination reported across the different coping groups, as there was no significant difference. This suggests that more passive coping responses to racial discrimination may increase an individual's vulnerability to dissociative symptoms. Thus, racial discrimination may uniquely contribute to vulnerability in the development of dissociative symptoms, as it may be processed as a race-based traumatic stressor, and more active coping strategies in response to racial discrimination is associated with less risk for dissociation. Perhaps racial

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and ethnic minority emerging adults who frequently experience racial discrimination may dissociate in response to mitigate the resulting distress, particularly among individuals who are ill-equipped to confront this psychological trauma and rely on more passive coping strategies. While normative experiences of dissociation, albeit adaptive in a temporary context, may increase risk for more severe pathological dissociation (Carlson et al., 2012), individuals who frequently dissociate in response to racial discrimination may become vulnerable to negative mental health outcomes.

Scholars have identified factors that may contribute to the employment of active versus passive coping strategies in response to racial discrimination. For instance, a strong racial/ethnic identity (i.e., the degree to which an individual identifies with a racial or ethnic group) has been identified as a mechanism in which individuals may thwart the harmful effects of racial discrimination (for review, see Brondolo et al., 2009), as it may promote more active coping responses to racial discrimination through acquired tools. Neblett and colleagues (2012) further proposed that racial socialization, or the messages received by individuals about their racial group membership from their family, engenders more positive regard for an individual's racial group and adaptive cognitive appraisals. This prepares individuals for confronting and, consequently, more effectively coping with racism. Indeed, there is evidence to suggest that a strong ethnic identity may weaken the relation between race-related stress and PTSD symptoms among young adults (Khaylis, Waelde & Bruce, 2007). Scholars have also identified religiosity/spirituality as playing a significant role in how individuals may respond and cope with experiences of racial discrimination, particularly among Black populations (Bierman, 2006; Forsyth & Carter, 2014; Hayward & Krause, 2015). Thus, further research is warranted to better understand the degree to which factors that influence coping styles such as racial/ethnic identity as well as religiosity/spirituality may impact susceptibility to dissociation.

While the present study examined the effects of more overt displays of discrimination through concrete situations or major discriminatory events, future research should examine different manifestations of racism such as racial/ethnic microaggressions, or covert displays through daily and unintended slights (Sue et al., 2007). Due to the subtle and ambiguous nature of racial/ethnic microaggressions, doubt may be induced, which may impede the employment of effective coping strategies. In fact, Carter (2007) calls for the further unpacking of racism, as different manifestations of racism may elicit a variety of coping responses, which in turn may differentially impact mental health. Thus, future research should examine the relation between a variety of coping responses to other forms of racism and, how this may impact mental health including dissociative symptoms.

There are limitations that should be considered in the interpretation of these findings. For instance, the findings may not generalize to the larger emerging adult population given that the sample was obtained from a college student population, although there is evidence that college students are comparable to their non-attending college-age peers in terms of mental health (Blanco et al., 2008). Additionally, the cross-sectional design of the study limits a further examination of the temporal relation between racial discrimination and dissociation, as vulnerability for developing dissociative symptoms may also make someone susceptible to perceiving experiences of racial discrimination or compromise their agency to adaptively

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cope with race-related stress. Another limitation of the study is the exclusive reliance on self-report measures, which are subject to report bias, as participants may over or under report experiences. Since the study explicitly stated to participants that the area of interest was cultural experiences, perhaps individuals uncomfortable addressing such matters may have been inadvertently excluded. Lastly, our assessment of coping with racial discrimination is limited to two items, which hampers a more comprehensive investigation of coping strategies employed in response to racial discrimination. For instance, future research should explore the relation between responses to racial discrimination and dissociative symptoms with the Race-Related Coping Scale (RRCS; Forsyth & Carter, 2014), which contains a wider range of strategies employed specifically in response to racial discrimination.

Despite these limitations, the present study has many strengths. First, it broadens our knowledge base of the effects of racial discrimination and coping strategies employed in response on mental health, specifically as it relates to dissociative symptoms, which has yet to be examined in the literature. Second, it expands our understanding of conceptualizing racial discrimination as a race-based traumatic stressor, given that dissociation is a common response to trauma exposure. Finally, the sample was recruited from a diverse college student population, which facilitated the recruitment of the population of interest, namely racial and ethnic minority emerging adults. Considering the cross-cultural differences evident in dissociation (Lewis-Fernandez et al., 2007), future research should further explore the relation between racial discrimination and dissociation across gender, racial/ethnic groups and immigrants. The findings also provide some clinical implications for mental health professionals working with racial/ethnic minority emerging adults, in light of the continued prevalence of racial/ethnic discrimination and its potentially traumatic nature. Specifically, clinicians could inquire about the subjective experience of racism as well as coping strategies specifically employed to attenuate the negative effects. Furthermore, racism may be a unique and additional source of traumatic stress, particularly among racial/ethnic minority emerging adults; therefore, a thorough evaluation of trauma exposure should assess for experiences with racial discrimination and dissociative symptoms. Furthermore, clinicians may promote more active coping strategies such as talking to others about it, and discourage more passive coping strategies such as dissociating, as it may engender more agency and sense of safety in the affected individual.

The current study is the first to date to empirically support the relation between racial/ethnic discrimination and dissociative symptoms, as findings demonstrated that increases in the frequency of racial/ethnic discrimination was associated with increases in dissociative symptoms. This lends support to the race-based traumatic stress theory as proposed by Carter (2007), which suggests that some racial/ethnic minority individuals may experience racial discrimination as a psychological trauma and maladaptive reactions may negatively impact mental health. We expand on this theory to suggest that race-based trauma exposure such as experiences of racial/ethnic discrimination is associated to dissociative symptoms, particularly when racial/ethnic minority individuals are ill-equipped to confront such experiences and rely on more passive, maladaptive coping strategies. Thus, frequent exposure to experiences of racial/ethnic discrimination may increase vulnerability to dissociative symptoms. Professionals working with racial and ethnic minority emerging

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adults, particularly in a mental health setting, should inquire about experiences of racial/ethnic discrimination as a potential source of trauma and their subjective experience. They should also promote more adaptive coping strategies in response to such experiences to reduce risk for dissociative symptoms.

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Table 1

Sample characteristics, means and standard deviations for overall sample and by coping group.

	Total N=743	Coping Group 1 89 (12%)	Coping Group 2 52 (7%)	Coping Group 3 163 (22%)	Coping Group 4 439 (59%)	t /F/ χ^2
Gender						22.66 *
Male	260 (35%)	48 (54%)	27 (51%)	51 (31%)	138 (31%)	
Female	483 (65%)	41 (46%)	25 (49%)	112 (69%)	301 (69%)	
Immigration status						3.69
U.S.-born	394 (53%)	41 (46%)	28 (53%)	95 (58%)	231 (53%)	
Foreign-born	349 (47%)	48 (54%)	21 (47%)	68 (42%)	208 (47%)	
Race/ethnicity						17.69
Black	253 (34%)	25 (28%)	16 (31%)	55 (34%)	158 (36%)	
Asian	223 (30%)	35 (39%)	20 (39%)	52 (32%)	113 (26%)	
Hispanic	178 (24%)	23 (26%)	11 (22%)	41 (25%)	105 (24%)	
White	45 (6%)	1 (1%)	1 (2%)	5 (4%)	34 (8%)	
Other	45 (6%)	5 (6%)	3 (6%)	10 (6%)	30 (7%)	
Traumatic Life Events						0.81
0 events	174 (23%)	16 (18%)	14 (27%)	38 (23%)	107 (24%)	
1 event	144 (19%)	19 (22%)	12 (20%)	35 (21%)	78 (18%)	
2 events	139 (19%)	14 (16%)	7 (14%)	32 (19%)	85 (19%)	
3 events	108 (15%)	14 (16%)	7 (14%)	25 (15%)	62 (14%)	
4 or more events	171 (22%)	26 (28%)	13 (24%)	33 (22%)	107 (25%)	
Racial Discrimination						0.37
0 settings	230 (31%)	26 (30%)	18 (37%)	39 (23%)	138 (31%)	
1 setting	171 (23%)	20 (22%)	8 (16%)	44 (26%)	99 (23%)	
2 settings	149 (20%)	20 (22%)	11 (22%)	33 (20%	87 (20%)	
3 settings	104 (14%)	7 (8%)	6 (12%)	30 (18%)	59 (13%	
4 or more settings	97 (13%)	16 (18%)	9 (13%)	17 (13%)	56 (13%)	
M(SD)						
Age	20.00 (2.12)	19.76 (1.87)	19.61 (1.59)	20.15 (2.11)	20.03 (2.22)	1.23
Frequency of Racial discrimination	3.10 (3.43)	3.40 (3.87)	2.98 (3.42)	3.17 (3.05)	3.03 (3.48)	0.34
Dissociative Symptoms	6.66 (7.16)	10.89 (10.84)	8.02 (6.88)	6.76 (7.08)	5.72 (6.16)	13.26 *

Note. Group 1= accept it as a fact of life and keep it to yourself; Group 2 = try to do something about it and keep it to yourself; Group 3= accept it as a fact of life and talk to other about it; Group 4= try to do something about it and talk to others about it.

* $p < .05$. Frequency of racial discrimination was included in further analyses.

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Table 2

The effect of frequency in experiences of racial/ethnic discrimination and active versus passive coping strategies in response on dissociative symptoms, adjusting for age, gender, immigration status, race/ethnicity and traumatic life events.

	Model 1				Model 2				Model 3			
	b	*SE*	*B*	*Adj. R^2*	*b*	*SE*	*B*	*Adj. R^2*	*b*	*SE*	*B*	*Adj. R^2*
Age	**−0.41**	**0.13**	**−0.12**	**0.05**	**−0.50**	**0.13**	**−0.15**	**0.08**	**−0.46**	**0.12**	**−0.14**	**0.11**
Gender	−0.39	0.55	−0.03		−0.55	0.54	−0.04		−0.98	0.54	−0.07	
Immigration status	−0.17	0.56	−0.01		−0.40	0.56	−0.03		−0.32	0.55	−0.02	
Hispanic	0.85	0.69	0.05		1.21	0.69	0.07		1.10	0.67	0.07	
Asian	0.92	0.69	0.06		1.06	0.68	0.07		0.79	0.67	0.05	
White	−1.29	1.17	−0.04		−0.57	1.17	−0.02		−0.09	1.15	0.003	
Other	0.30	1.13	0.01		0.31	1.12	0.01		0.28	1.10	0.01	
Traumatic life events	**0.79**	**0.13**	**0.22**		**0.68**	**0.13**	**0.19**		**0.63**	**0.13**	**0.18**	
Racial discrimination					**0.36**	**0.08**	**0.17**		**0.35**	**0.08**	**0.17**	
Coping group 2									−2.08	1.22	−0.07	
Coping group 3									**−3.42**	**0.92**	**−0.20**	
Coping group 4									**−4.34**	**0.82**	**−0.30**	

Note. Black is the reference group for race/ethnicity; Male is the reference group for gender; Foreign-born is the reference group for immigration status; Coping group 1 is the reference group for coping strategies; **bold = p < .05**