MICROAGGRESSIONS AND THE MODERATING EFFECT OF RELIGIOUS ORIENTATION ON RESILIENCE, LIFE SATISFACTION, AND DEPRESSIVE SYMPTOMS

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Carlos Ferrer Digitally signed by Carlos Ferrer Date: 2023.12.04 14:41:04 -06'00'

Carlos C. Ferrer Pantoja

Certificate of Approval:

Stacy C. Parenteau, Ph.D. Digitally signed by Stacy C. Parenteau, Ph.D. DN: cn=Stacy C. Parenteau, Ph.D., o, ou=Psychology, email=sparente@aum.edu, c=US Date: 2023.12.04 15:05:12 -06'00'

Stacy Parenteau, Ph.D., Chair
Associate Professor
Psychology

Clarissa J. Arms-Chavez Digitally signed by Clarissa J. Arms-Chavez Date: 2023.12.04 15:01:54 -06'00'

Clarissa J. Arms-Chavez, Ph.D.
Associate Professor
Psychology

Rolando N. Carol Digitally signed by Rolando N. Carol Date: 2023.12.04 18:12:43 -06'00'

Rolando Carol, Ph.D.
Associate Professor
Psychology

Matthew Ragland Digitally signed by Matthew Ragland Date: 2023.12.04 20:00:42 -05'00'

Matthew Ragland, Ph.D.
Associate Provost

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Carlos C. Ferrer Pantoja

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Carlos C. Ferrer Pantoja

Carlos Ferrer Digitally signed by Carlos Ferrer Date: 2023.12.04 14:42:26 -06'00'

Signature of Author

12 / 09 / 2023

Date of Graduation

Microaggressions and the Moderating Effect of Religious Orientation on Resilience, Life Satisfaction, and Depressive Symptoms

Abstract

In the present study, we examined the potential moderating effect of religious orientation (i.e., intrinsic, extrinsic, and its subtypes, social and personal religious orientation) on the relationship between microaggressions and the psychosocial outcomes of resilience, life satisfaction, and depressive symptoms. Participants (N = 160) completed five questionnaires: the Revised 28-Item Racial and Ethnic Microaggressions Scale (R28REMS), the Connor-Davidson Resilience Scale (CD-RISC), the Satisfaction With Life Scale (SWLS), the Religious Orientation Scale I/E-R, and the Center for Epidemiologic Studies Depression Scale (CES-D). Moderation analyses were performed. We found that perceived microaggressions were associated with lower resilience for those with a high level of intrinsic religious orientation. Intrinsic religious orientation did not moderate the relationship between microaggressions and either depressive symptoms or life satisfaction. Extrinsic religious orientation did not moderate the relationship between microaggressions and any of the psychological outcomes. Further, microaggressions were associated with lower resilience for those with a high level of extrinsic-personal orientation. The extrinsic-social religious orientation did not moderate the association between microaggressions and any of the outcome variables. The results of the present studies suggest that individuals who internalize the doctrines of their faith and those who use their faith as a source of comfort and support are less resilient when exposed to microaggressions. Future studies should utilize correlational designs that conceptualize resilience as a possible moderator instead of a dependent variable.

Introduction

Resilience, in psychology and mental health well-being, is considered a protective factor against adverse, stressful life events and negative reactions. According to The American Psychological Association, resilience is "the process of adapting well in the face of adversity, trauma, tragedy, threats, or even significant sources of stress" (American Psychological Association, 2020). Resilience is also a protective factor that serves as a buffer for individuals to thrive despite serious risk hazards (Rutter, 1990). Furthermore, resilience shields individuals from feelings of confusion, physiological stress responses, self-doubt, and other adverse outcomes such as depression, loss of self-esteem, and anxiety (i.e., increased heart rate, sweating, or excessive worry). Some coping responses or moderators to everyday stressors positively correlate with resilience levels. A plethora of literature explores and describes health-protective psychological resources that provide individuals with healthy ways to cope with psychological stress responses and prevent detrimental effects on their well-being, especially mental health. Dushimirmana et al. (2014), for instance, note that the protective factors of resiliency played a critical role in the survivors of the Rwanda genocide. Furthermore, Ran et al. (2020) found a positive correlation between emotional well-being and resilience in Chinese children and teenagers who experienced bullying in schools.

However, developing resilience can be challenging to achieve as adverse events may be uncontrollable and unpredictable and may be caused by various factors such as terminal illness, grief, job loss, war, and everyday interactions with other people (Guido, Pepe, & Giordano, 2021). Even though some of these events are transient and short-lasting, building resilience and thriving in the world may prove difficult for members of group minorities where the dominant group may create and perpetuate a climate of invisibility and exclusion. The interpersonal interaction and daily exchanges between the dominant group and group minorities may include

harmful behaviors that are more subtle and less pronounced. The possible threats that minorities might experience in different intergroup contexts take the shape of microaggressions. According to Sue et al. (2007), microaggressions are "everyday verbal, nonverbal, and environmental slights, snubs, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership" (Sue et al., 2007, pp. 272-273). For example, some of the hurdles that minorities may experience are exclusion, marginalization, and lack of advancement opportunities in the workplace. Microaggressions also include subtle cues that convey implicit messages threatening the person's identity on the receiving end of these commonplace and daily exchanges and social interactions. Thus, this can be detrimental to the mental well-being and resilience of minorities; their ambiguous nature makes them more challenging to address and fix.

Microaggressions and Mental Health

Sue et al. (2007) argued that microaggressions manifest in three ways: microassaults, microinsults, and microinvalidations. Notwithstanding, it is imperative to make a distinction between microassaults and macroaggressions. Macroaggressions impact the daily lives of minorities, e.g., systemic racism, support of policies that affect minority groups, or the use of mascots that are offensive to ethnic minorities. On the other hand, microassaults take place on a micro-scale, where the interaction occurs in everyday interactions between majority and minority groups. According to Sue et al., microassaults are often conscious verbal and non-verbal threats that hurt the person belonging to a minority group– an example of a conscious verbal threat would be the use of racial epithets, and an example of a non-verbal threat is not sitting right next to a person of color on public transportation. Microinsults are verbal and nonverbal communications that “convey rudeness and insensitivity to demean a person’s racial heritage or identity” (American Psychological Association, 2020), e.g., “How were you able to get this job?

(affirmative action).” Another example of an unconscious verbal insult would be telling a person that their English “is good” – based on the assumption that the person on the receiving end does not resemble members of the majority group. In addition, microinvalidations can be conscious and unconscious verbal and non-verbal attacks that invalidate the experiences of group minorities, e.g., the endorsement of racial color blindness (i.e., the skin color of a person is insignificant in social interactions) or denial of individual racism (i.e., denying the existence of modern forms of racism and discrimination).

Moreover, microaggressions can be constant and continual, which remind minority groups of their second-class position in the world around them and are reminders of systemic injustices endorsed by the government, e.g., slavery (Sue et al., 2019). However, it is important to note these microaggressions may be done unintentionally (Sue et al., 2007), as these offenses have been perpetuated and deeply ingrained into the subconscious of the general public and mainstream media - e.g., movies, jokes, stereotypes-, and in common parlance. Other negative assumptions about ethnic groups do not have to present themselves explicitly. It is important to note that they can be negative (e.g., Asians are bad drivers), positive statements (e.g., Asians are good at math), or ambivalent, such as failing to provide aid or completely ignoring the person due to their minority status (Williams, 2020).

These assumptions about racial minorities could have detrimental psychological effects on members of minority groups, “but the subtleness or ambiguity of these situations may cause them to make an internal, instead of an external, attribution leading them to feel responsible for the situation” (Yoo, Steger, & Lee, 2010, as cited in Wong-Padoongpatt, 2017, p. 7). Psychological adversities arise from this ambiguity, including high anxiety levels, a sense of hopelessness, depression, and fear for one's safety (Smith et al., 2007). Sue et al. (2007) also cite mistrust and low self-esteem as other potentially detrimental effects of microaggressions.

Furthermore, Armstead et al. (1989) correlational study indicates that racist stimuli, i.e., anger-provoking excerpts showing racist situations, “was associated with a M.A.P. [Mean Arterial Pressure] of 91.8 mm Hg for the racist stimuli compared to a M.A.P. of 86.0 mm Hg for the non-racist stimuli” (p. 553). Other effects include poor social and academic performance (Blume et al., 2012), poor physical health, and suicide risk (O'Keefe et al., 2015). For ethnic LGBTQ+ individuals, the psychological impact of microaggressions includes depression, anxiety, and post-traumatic stress disorder (Nadal et al., 2011).

Prevalence of Microaggressions

The prevalence of microaggressions has not been reported across diverse sample populations. However, past literature has obtained data from small group settings where microaggressions are reported with different members of distinct minority groups. For instance, according to a survey of Americans on Race conducted by the Kaiser Family Foundation (2015), "Blacks (53 percent), including two-thirds (67 percent) of younger Blacks ages 18-34, say they have been mistreated because of their race in the past month alone" (p. 1). On the other hand, O'Keefe & Greenfield (2019) found that in a sample of 466 participants (N = 466), 93% of post-secondary students of Alaskan and American Indian descent in New Mexico and Oklahoma experienced at least one microaggression in 2018.

In addition, using the General Social Survey (G.S.S. 2018), Douds & Hout (2020) measured the number of times African-Americans experienced feeling threatened or harassed, feared, poor service in restaurants, less respect than others, and treated as if they were not smart. According to their findings, African Americans reported experiencing the most instances of microaggressions, followed by Latino(x)s. However, Asian Americans, Native Americans, and Multiracial participants reported the least number of microaggressions. Interestingly, Douds and

Hout found younger participants more likely to report microaggressions than older participants – perhaps due to the younger generation's awareness of these subtle messages.

Protective Coping Mechanisms

Due to the ambiguity of microaggressions, individuals may not seek the necessary help to cope with the long-term negative impact on the victim's mental well-being. However, after unpleasant and antagonistic interpersonal interactions with members of the dominant majority, physical and mental health improvements can be achieved in several ways. Minorities can protect themselves against adverse reactions and perceived threats by potential moderators that reduce their impact. For instance, Aisha et al. (2015) proposed a coping theme model that included how minorities can cope with aversive racism. According to this model, significant predictors of resilience include religion and spirituality, armoring, shifting, support networks, sponsorship and mentorship, and self-care. Additionally, Kim's (2017) cross-sectional study found religious support to be a strong buffer and predictor of mental well-being. Edwards et al. (2013) found ethnic affirmations (pride in one's ethnicity) critical in stabilizing factors in protecting ethnic minority youth experiencing high-stress levels related to discrimination. By the same token, Romero et al. (2014) suggest ethnic affirmations – that is, how positive or negative one feels about one's ethnic identity – have a "protective effect on depressive symptoms and self-esteem" (p. 8).

Along with these findings, Chia-Chen et al. (2014) also identified ethnic identity as a "buffer for somatic symptoms in Asian American and Pacific Islander" students when encountering and facing discrimination and social stress (p. 395). On the other hand, Brondolo et al. (2009) posited that social support, well-developed racial identity, and confrontation with the perpetrator are associated with positive health outcomes. In addition, Brown (2008) proposed that the experiences of racial microaggressions and discrimination can be diffused by having

solid social support, such as having a best friend. Shorter-Gooden (2004) maintains Brown's assertions by placing social support as a significant moderator against the detrimental effects of microaggressions. Moreover, Shorter-Gooden & Jones (2003) identified "role-shifting" (i.e., altering one's presentation according to the environment and social context) as a potential buffer and source of self-worth. Empirical studies have also found that sanity checks – seeking out others to validate the experience of racism and microaggressions – among African Americans are used to boost self-esteem, self-efficacy, and, most importantly, strong resilience (Holder, Jackson, & Ponterotto, 2015). On the other hand, according to Brondolo et al. (2009), cognitive reinterpretation helps minimize the impact of racially motivated insults. In other words, how one interprets the events may sometimes change the outcome of the perceived harmful event. Stress responses are less likely to develop if the micro insult is interpreted as non-threatening and motivated by prejudice.

Even though the aforementioned coping mechanisms may protect ethnic minorities from the negative consequences of microaggressions, past research has revealed religiosity as a strong buffer against stress and microaggressions' adverse effects on mental well-being. For instance, Reuter and Bigatti (2014) found religiosity and spirituality as a stimulus that activated resiliency levels against stress (i.e., *response)*. Due to the nature of the present paper, it is imperative to provide definitions of spirituality and religion. According to La Pierre et al. (2013, as cited in Chita & Treschuk, 2019), individuals develop spirituality when seeking answers to the nature of purpose, happiness, and death (p. 3). On the other hand, religion has been defined as "a specific set of beliefs and practices, usually within an organized group" (Cohen et al., 2012, p. 804). The association between religiosity and spirituality in maintaining emotional stability has been explored in the past literature. For instance, Dulin, Hill, & Ellingson (2006) found "religiosity as a strong buffer against heavy alcohol use in a college student sample" (p. 12).

Furthermore, Benjamins (2006) found a positive relationship between religiosity and adolescents' self-esteem – those with a religious orientation tended to have better self-esteem and positive views about themselves. Even though there is no scarcity of literature outlining the positive effects of religiosity and spirituality in individuals, two variables within the religiosity and spirituality framework were explored in the present paper: intrinsic versus extrinsic orientation, intrinsic motivation will be "directed by religion, whereas extrinsically religious people will be motivated for comfort and social status" (Allport & Ross 1967, as cited in Yasein and Moghal, 2017). The present paper explored the role of the intrinsic versus extrinsic factor model of religiosity and spirituality, as used and conceptualized by Allport and Ross's research (1967).

Allport and Ross (1967) conceptualized extrinsic religiousness "as the religion of comfort and social, a self-serving, instrumental approach shaped to suit oneself" (p. 230). In other words, extrinsic religiousness is the end to justify the ends. For example, individuals with an extrinsic motivation might use religion and spirituality to be accepted by those around them. On the other hand, they defined intrinsic religiousness as motivated by meaning and intrinsically motivated (Rychlak 1997, as cited in Donahue 1985). For instance, individuals with intrinsic religiousness will adhere to the teachings of their religion (e.g., "Do not judge others self-righteously, and you will not be judged…"). Based on the conceptualization and studies conducted by Allport and Ross (1967), several studies have provided a roadmap concerning these two moderating variables. For instance, Forthun et al. (2003) studied the relationship between religious orientation and eating disorders. Forthun et al. found that "high intrinsic religiousness consistently reduced the positive association between family risk and disordered eating" (p. 20). Furthermore, Genia and Shaw (1991) found that those with intrinsic religious commitment were more likely to have a more positive outlook. Lee and Neblett (2019) identified intrinsic religious

orientation as an important and “protective buffer against stressful life events (S.L.E.) and depressive symptoms” for younger participants. Nonetheless, participants from an older cohort did not benefit from the protective mechanisms of a religious orientation –intrinsic or extrinsic. Moreover, other research studies have found no correlational or directional causality between Intrinsic Religious Motivation and subjective well-being (Byrd, Hageman, & Isle, 2007).

The literature suggests that religious orientation, whether intrinsic or extrinsic, may have different protective mechanisms depending on the individual’s ethnic group or age. Therefore, it is essential to investigate how religious orientation affects individuals from different ethnic minorities. Understanding and finding these coping mechanisms as buffers in these populations is imperative. Thus, the role of religious orientation as a buffer used by ethnically diverse individuals can be significant.

Possible Confounding Variables and Bias

It is vital to note that the effectiveness of coping strategies may depend on whether the microaggression was race-based, sexual orientation-based, or gender identity-based. Social identity and membership could yield different results depending on crucial components such as minority group membership and context; therefore, resilience might depend on the attachments to their group identity. Additionally, coping mechanisms "may differ from culture to culture" (Schlechter et al., 2021).

It is also important to note the role of subjective experience in either the exacerbation or moderation of psychological distress. For instance, Lui & Quezada (2019) proposed that the distressing effects of microaggressions depended upon the person's subjective experience, cultural worldviews, attribution style, and the individual's propensity to experience negative emotionality - perceiving the world as more threatening. Therefore, potential moderators that

improve resiliency might not work with these people due to social and personality differences (p. 70).

Overview and Hypothesis

The United States has become a diverse country with an ever-growing presence of ethnic minorities who seek to achieve the American Dream. According to Pew Research, the Hispanic population will rise to 128 million, the African-American population will rise to 59 million, and the Asian population will grow to 41 million by 2050 (Passel & Cohn, 2020). Thus, fostering a sense of well-being and resilience in minority groups is essential for their mental health and professional and life choices. Previous research on microaggressions has included subjects belonging to one racial or ethnic group, in which "extrinsically motivated individuals use their religion, whereas the intrinsically motivated live their religion" (Allport & Ross, 1967, as cited in Holdcroft, 2006, p. 90).

Considering the results of previous research on religious orientation and its moderating effect on mental health, we hypothesized the following: (1) racial microaggressions will be negatively associated with resiliency and life satisfaction and positively association with depressive symptoms; (2) an intrinsic religious orientation will be positively correlated with life satisfaction, resiliency, and negatively correlated with depressive symptoms; (3) an extrinsic religious orientation will be negatively correlated with self-reported life satisfaction, resiliency, and positively correlated with depressive symptoms; (4) an intrinsic religious orientation will protect against the impact of microaggressions on resiliency, life satisfaction, and depressive symptoms; (5) an extrinsic religious orientation will not buffer the impact of microaggressions and their effects on resiliency, life satisfaction, and depressive symptoms; (6) an intrinsic religious orientation will have a more substantial moderating effect than an extrinsic religious

orientation on the impact of microaggressions on reported resiliency, life satisfaction, and depressive symptoms.

Method

Participants

One hundred and sixty-four (N = 164) undergraduate introductory psychology students at a midsize southeastern university participated in this study. The majority of the sample was female (78.8%), Christian (68.8%), and Black or African American (42.5%). See Table 1 for all participant demographics. Four (n = 4) participants' self-reports were discarded because it was not feasible for the researcher to dichotomize their gender, as it fell outside the male/female domain. An a priori sample size calculation using G*Power software indicated the recruitment of 150 participants to have a power of 80% and an alpha of 0.05 for statistical significance.

Materials

A total of six questionnaires were used in this study: a demographics questionnaire, the Conner Davidson Resilience Scale, the Revised 28-Item Racial and Ethnic Microaggressions Scale (R28REMS), The Satisfaction With Life Scale (SWLS), The Center for Epidemiologic Studies Depression Scale (CES-D), and the Intrinsic/Extrinsic Religiosity Scale (I/E-R) – Cronbach's alphas for each test instrument were calculated using the data collected from this study. See Table 2 for descriptive statistics for all measures used in this study.

Demographics Questionnaire. The demographics questionnaire was used to obtain the participants' demographics, which included age, gender identification (e.g., "Male," "Female," "Prefer not to answer"), racial/ethnic background (e.g., "American Indian or Alaskan Native," "Asian or Asian American," "Native Hawaiian or Other Pacific Islander," "Black or African American," "White Non-Hispanic"), and religious affiliation (e.g., "Christian (Catholic,

protestant, or any other Christian Denomination," "Muslim," "Hindu," "Buddhist," "Jewish," "Sikh," "No Religion"). (See Appendix A)

The Satisfaction With Life Scale (SWLS). The SWLS is a scale with five items that measure participants' global cognitive judgments of satisfaction with their life (e.g., "In most ways my life is close to my ideal," "The conditions of my life are excellent"). Each item is on a 7-point scale (1-7), where 1 means *Strongly Disagree,* and 7 means *Strongly Agree*. The highest score range from this scale is 31-35, indicating Extremely Satisfied. The SWLS shows Cronbach's $\alpha = 0.81$ (See Appendix B).

Center for Epidemiologic Studies Depression Scale (CES-D). The CES-D is a scale with 20 items that measure levels of depression (e.g., "I felt depressed," "I felt fearful"). The possible range of scores is 0 to 60, with higher scores indicating the presence of symptomatology, with four items being reverse coded (i.e., item 4, item 8, item 12, and item 16). The reliability indices of the CES-D showed a Cronbach's $\alpha = .89$ (See Appendix C).

The Connor-Davidson Resilience Scale (CD-RISC-25). The CD-RISC-25 is a scale with ten items that were used to measure the resilience levels of each participant (e.g., "When things look hopeless, I don't give up," "Tend to bounce back after illness or hardship"). Each item on the scale is a 5-point Likert scale (0-4), where 0 means *not true,* and 4 means *true all the time.* The highest score obtained from this scale is 40, indicating greater resiliency. The reliability indices of the CD-RISC-25 showed a Cronbach's $\alpha = .90$ (due to copyright restrictions, this test intrument is not included in the Appedices section)

Intrinsic/Extrinsic Religiosity Scale (I/E-R). The I/E-R is a scale with 14 items (e.g., "I enjoy reading about my religion," "Prayer is for peace and happiness"). Each item is on a 5-point Likert scale (1-5), where one means strongly agree, and five means strongly disagree. A total of eight items measure intrinsic religious orientation (item 1, item 3 (reverse coded), item 4, item 5,

item 7, item 10 (reverse coded), item 12, and item 14 (reverse coded). In contrast, the remaining items measure extrinsic religious orientation with two subtypes: extrinsic personal (item 6, item 8 (reverse coded), and item 9) and extrinsic social (item 2, item 11, and item 13 (reverse coded)). Higher scores indicate higher levels of either intrinsic or extrinsic religious orientation. Reliability indices for the intrinsic religious orientation showed a Cronbach's $\alpha = .79$, while extrinsic religious orientation showed a Cronbach's $\alpha = .76$, with the subtypes extrinsic personal showing Cronbach's $\alpha = 0.81$ and extrinsic social Cronbach's $\alpha = 0.75$ (See Appendix D)

The Revised 28-Item Racial and Ethnic Microaggression Scale (R28REMS). The R28REMS has 28 items that measure minorities' experiences of racial microaggressions within the past six months (e.g., "Someone told me that people should not think about race anymore," "Someone avoided walking near me because of my race"). Each item on the scale is a 5-point Likert scale (1-5), where *1* means *I did not experience this event in the past six months,* and *5* means *I experienced this event 10 or more times in the past six months.* A total of 4 items assess microaggressions with reverse coding, i.e., item 11, item 14, item 16, and item 23. Higher scores are indicative of higher levels of instances of experiences of microaggressions. Reliability indices for the R28REMS showed a Cronbach's $\alpha = 0.81$ (due to copyright restrictions, this test intrument is not included in the Appedices section)

Table 1 Participant demographics

	Percent (%)
Age	
Under 18	.6
18 – 24	90.6
25 – 34	5.6
35 – 44	2.5
45 – 54	.6
Above 54	0.0
Gender	
Males	21.3
Females	78.8
Race / Ethnicity	
American Indian or Alaskan Native	.6
Asian or Asian American	4.4
Native Hawaiian or Other Pacific Islander	0.0
Black or African-American	42.5
Hispanic, Latino, or Spanish of any race	3.1
Middle Eastern or North African	.6
White Non-Hispanic	40.0
Multiracial or Biracial	6.9
Other	1.9
Religious Affiliation	
Christian	68.8
Muslim	2.5
Hindu	1.9
Buddhist	0.0
Jewish	.6
Sikh	0.0
No Religion	21.9
Any other religion	4.4

Table 2 Descriptive statistics for satisfaction with life, center for depression scale, resiliency scale, intrinsic and extrinsic religious orientation, and racial and ethnic microaggressions scale.

				Skewness	
Variable	**M (Range)**	**SD**	**Cronbach's Alpha**	**Static**	**Standard Error**
SWLS	22.03 (5-35)	6.70	.81	-.232	.192
CES-D	21.47 (1-49)	11.41	.89	.425	.194
CD-RISC-25	71.21 (22-99)	14.51	.90	-.449	.193
I.R.O.	26.21 (10-40)	7.71	.79	.042	.192
E.R.O	16.03 (6-27)	5.12	.76	-.413	.192
External Social	5.56 (3-13)	2.54	.75	.711	.193
External Personal	10.49 (3-15)	3.75	.81	-.617	.192
R28REMS	22.51 (0-84)	14.82	.81	1.351	.194

Note: I.R.O = Intrinsic Religious Orientation
E.R.O = Extrinsic Religious Orientation

Procedure

After obtaining formal approval from The Institutional Review Board (I.R.B.), data collection began in the Summer of 2022. Participants signed up through an online website (i.e., Sona Systems"). The participants received one credit towards their grade in their Introductory Psychology course. Upon arrival, the researcher asked for an I.D. to demonstrate they were at least 18 years old. Otherwise, parental consent (See Appendix E) was received if the participant was underage (n = 1). All participants provided informed consent (See Appendix F) and were informed about their rights as participants in the study. After they signed the informed consent, the researcher provided them with a packet that included the demographics questionnaire and the five surveys that were randomized the order for each participant to avoid potential survey fatigue. Survey fatigue occurs when participants lose interest in filling out the questionnaires. This randomization reduced fatigue, as all test instruments were completed and participants did not report feeling tired. After the participants completed the questionnaires, they were asked to put them in a 13 in (height) x 10 in (width) manilla envelope that the researcher provided to ensure confidentiality. Each participant was debriefed and was allowed to ask questions about the study. In addition, the researcher handed out a copy of the informed consent with their and the researcher's signatures. After receiving their copy of the informed consent, participants were provided with information about depression, and its symptoms, etiology, diagnosis, treatments, and information about the university's AUM Counseling Center) (See Appendix G). Participants were thanked for their participation and were dismissed.

Results

Preliminary Analysis

Before analysis, some categorical demographic variables with more than one category were dummy coded into dichotomous variables. Gender was recorded as Male ("0") and female ("1");

race/ethnicity was recorded as White ("0") and non-white ("1"); and religious affiliation was recorded as Christian ("0") / other ("1"). Age was not recorded into a dichotomous variable since age was assessed as an ordinal variable; instead, each value was given a label, with higher labels representing higher age brackets (0 = "0 – 17", 1 = "18 – 24", 2 = "25 – 34", 3 = "35 – 44", 4 = "45 – 54", 5 = "55 – 100").

Bivariate correlational analyses were performed to analyze first-order associations among microaggressions, religious orientation, resiliency, life satisfaction, and depressive symptoms. All correlations presented in Table 3 represent Pearson's coefficients.

Table 3. Bivariate correlations among microaggressions, religious orientation, life satisfaction, mental health well-being, and resiliency using Pearson's correlation.

	1	2	3	4	5	6
1. Microaggressions	---	.004	-.002	-.101	.170*	.116
2. Intrinsic Religious Orientation			.542**	.215**	-.249**	.300
3. Extrinsic Religious Orientation				.278**	-.231**	.171*
4. Life Satisfaction					.523**	.507*
5. Depressive symptoms						-.394**
6. Resilience						----

*** p < .01*
**p < .05*

Moderation Analyses

Hierarchical regression analyses were conducted to determine if religious orientation moderated the relationship between microaggressions and life satisfaction, depressive symptoms, and resiliency. Analyses were conducted using SPSS 29. As can be seen in Table 4, age, gender, religious affiliation, and race were entered into the regression model as the first block, followed by microaggressions (mean-centered) and intrinsic religious orientation (mean-centered) in the second block, and the two-way interaction variables (microaggressions mean-centered x intrinsic

religious orientation mean-centered) in the third block; this model was run for each of the three outcome variables: depressive symptoms, life satisfaction, and resilience. There was a significant interaction effect (β = -.191, p = .01) between microaggressions and intrinsic religious orientation on resiliency. Modgraph-I (Jose, 2013) was used to graph the interaction effect (See Figure 1). According to the graph, the more microaggressions individuals experience, resilience is attenuated if there is an interaction with an intrinsic religious orientation.

A second set of regression analyses was conducted to examine the moderating effect of the extrinsic-personal religious orientation on resilience. As can be seen in Table 5, age, race, gender, and religious affiliation were entered in the first block, followed by microaggressions and an extrinsic-personal religious orientation in the second block, and the two-way interaction terms (microaggressions x extrinsic religious orientation – personal) in the third block. This model was run for each of the three outcome variables: depressive symptoms, life satisfaction, and resilience. There was a significant interaction (β = -.188, , p = .02) between microaggressions and an extrinsic-personal religious orientation. Specifically, those who scored high on the extrinsic-personal religious orientation reported less resiliency against the effects of microaggressions. Modgraph-I (Jose, 2013) was used to graph the interaction effect (See Figure 2). According to the graph, the more microaggressions individuals experience, resilience is attenuated if there is an interaction with an extrinsic religious orientation – personal.

An intrinsic religious orientation predicted 15.5% of the variability in resilience, R^2 = .1572, F = (6, 146) = 4.5, $p < .05$. Table 6 displays the unstandardized regression coefficient. The interaction effect was statistically significant (p = .0003), indicating that an intrinsic religious orientation moderated the effect by exacerbating the effects of microaggressions on resilience. Table 6 presents the conditional effects of the focal predictor (resilience) at three moderator values (intrinsic religious orientation).

On the other hand, 12.5% of the variability in resilience was predicted by an extrinsic personal religious orientation, R^2 = .1235, F = (6, 146) = 3.4, p = .01 Table 7 displays the unstandardized regression coefficient. The interaction effect was statistically significant (p = .0034), indicating that an extrinsic personal religious orientation exacerbated the effects of microaggressions on resilience. Table 7 presents the conditional effects of the focal predictor (resilience) at three moderator values (extrinsic personal religious orientation).

Table 4 Moderation of Resiliency levels and Microaggressions by religious orientation (Intrinsic)

	β	*t*	R^2	ΔR^2
Outcome Variable: Resilience				
Block 1				
Religious Affiliation	-.156	-1.953	.062	.037
Gender	-.096	-1.192		
Race	.172	2.139		
Age	.031	.381		
Block 2				
Microaggressions	.062	.727	.128	.092
Intrinsic Religious Orientation	.288	3.261		
Block 3				
I.R.O. x Microaggressions	-.191*	-2.455	.163	.122

∗∗p< .01
∗ p< .05
Note: IRO= Intrinsic religious orientation N = 160

Table 5 Moderation of Resiliency levels and Microaggressions by religious orientation (Extrinsic-Personal)

	β	t	R^2	ΔR^2
Outcome Variable: Resilience				
Block 1				
Religious Affiliation	-.156	-1.953	.062	.037
Gender	-.096	-1.192		
Race	.172	2.139		
Age	.031	.381		
Block 2				
Microaggressions	.064.	.744	.106	.070
E.R.O. – Personal	.263	2.623		
Block 3				
E.R.O (Personal) x Microaggressions	-.188*	-2.347	.139	.098

Note: E.R.O = Extrinsic religious orientation N = 160

$**p < .01$

$*p < .05$

Figure 1

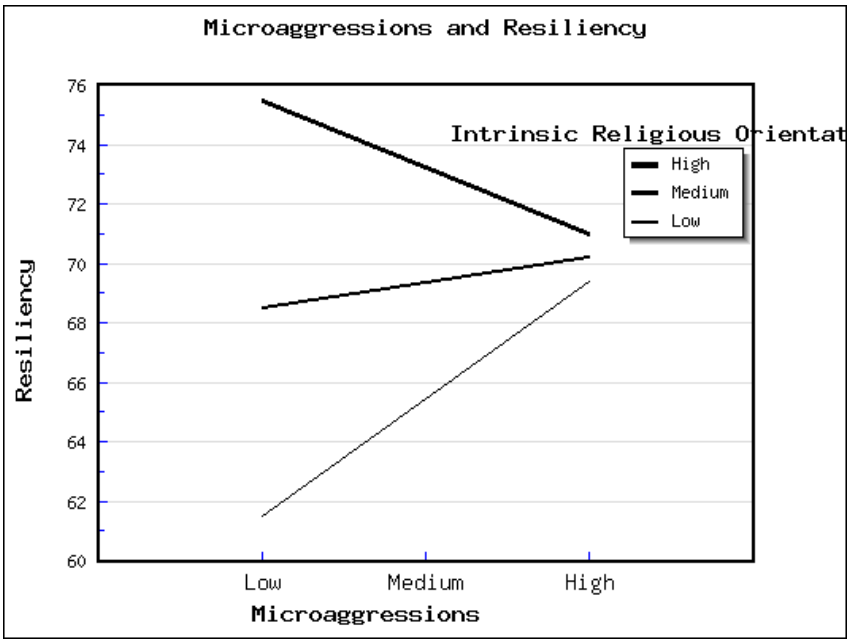

Figure 2

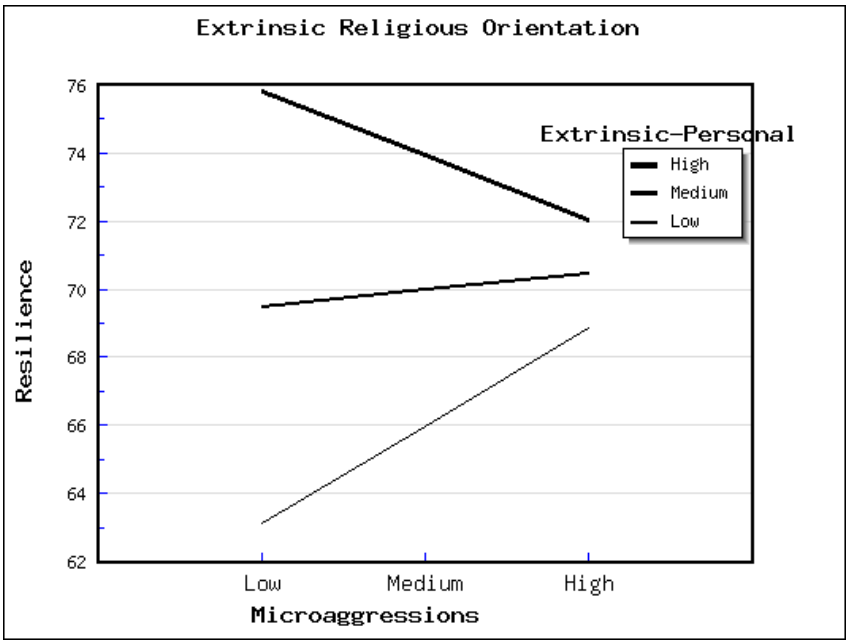

Table 6 Summary of Moderated Regression Analysis Predicting Resilience (Intrinsic Religious Orientation)

				95% CI	
	B	*t*	*p*	Low	High
Constant	67.2521	19.5091	.0000	60.43	74.06
Microaggressions (A)	.0629	.7744	.4400	-.0976	.2234
Intrinsic R.O (B)	.5161	3.0607	.0026	.1828	.8494
A * B	-.0264	-2.4320	.0162	-.0478	-.0049

Table 7 Summary of Moderated Regression Analysis Predicting Resilience (Extrinsic Personal Religious Orientation)

				95% CI	
	B	*t*	*p*	Low	High
Constant	69.9039	3.5085	.0000	62.9698	76.8380
Microaggressions (A)	.0351	.4149	.6788	-.1320	.2022
Extrinsic Personal (B)	1.0713	2.7504	.0067	.3015	1.8411
A * B	-.0430	-2.2816	.0240	-.0802	-.0058

The results suggests that most of the hypotheses proposed by the researcher were not confirmed. Hypothesis one was not confirmed, as there was not any significant interactions. Hypothesis two and three were not confirmed either due to the lack of significant interactions. Hypothesis four was not confirmed; however, an intrinsic religious orientation attenuated the effects of microaggressions on resilience. An intrinsic religious orientation did not have significant interaction between microaggressions and depressive symptoms and life satisfaction. Regarding hypothesis five an extrinsic religious orientation - personal on the relationship between microaggressions and resiliency; though, there were no interactions with depressive symptoms and life satisfaction. Even though the extrinsic personal religious - personal orientation did confirm the fifth hypothesis, the other extrinsic religious orientation subtypes, i.e., social, did not have any interaction between the experience of microaggressions and reported life satisfaction and depressive symptoms. Regarding hypothesis six, an intrinsic religious orientation did not have a more substantial moderating effect than an extrinsic religious orientation on the impact of microaggressions on reported resiliency, life satisfaction, and depressive symptoms.

Discussion

The present study investigated the relationship between religious orientation, life satisfaction, depressive symptoms, and resiliency against adversity perpetrated by the experience of microaggressions. Accordingly, the present study utilized a moderator: an intrinsic religious orientation (no subtypes and an extrinsic religious orientation and its subtypes, i.e., , extrinsic-personal, and extrinsic-social. The present study addressed six hypotheses: first, are racial microaggressions negatively associated with resiliency, and life satisfaction and positively associated with depressive symptoms? Second, is an intrinsic religious orientation positively correlated with life satisfaction and resiliency, and a negative correlation with depressive

symptoms? Third, does an extrinsic orientation religious orientation facilitate the harmful effects of microaggressions on life satisfaction, depressive symptoms, and resiliency? Fourth, would an intrinsic religious orientation buffer the effects of microaggressions on individuals' reported life satisfaction, resiliency, and depressive symptoms? Fifth, will an extrinsic religious orientation not buffer the impact of microaggressions and their effects on resiliency, life satisfaction, and depressive symptoms, and hypothesis six, would an intrinsic religious orientation have a more substantial moderating effect than an extrinsic religious orientation on the impact of microaggressions on reported resiliency, life satisfaction, and depressive symptoms?

These hypotheses were tested and analyzed using a Hierarchical Linear Regression. Regarding the first question, microaggressions were negatively correlated with life satisfaction and positively correlated with depressive symptoms, though microaggressions were positively correlated with resilience. It is unknown why microaggressions would have a positive correlation with resilience. Second, an intrinsic religious orientation was not found to be a buffer against the harmful effects of microaggressions on depressive symptoms, and life satisfaction. Those who were intrinsically motivated to follow their religion, showed lower resilience. Regarding the third hypothesis, an extrinsic religious orientation (personal subtype) did facilitate the deleterious effects of microaggressions on resiliency levels. However, no significant interactions between microaggressions were found with life satisfaction and depressive symptoms. Regarding hypothesis four, an intrinsic religious orientation did not buffer against the deleterious effects of microaggressions on resilience, depressive symptoms, and life satisfaction; in fact, an intrinsic religious orientation attenuated the deleterious effects of microaggressions on resiliency. Regarding hypothesis five, an extrinsic religious orientation did not buffer the impact of microaggressions and their effects on resiliency, life satisfaction, and depressive symptoms, and an extrinsic religious orientation of the personal subtype attenuated the deleterious effects of

microaggressions on resilience. Regarding hypothesis six, an intrinsic religious orientation was not found to have a more substantial moderating effect than an extrinsic religious orientation on the impact of microaggressions on reported resiliency, life satisfaction, and depressive symptoms.

No other interactions were found. Given these results, one of the most critical questions that need to be addressed and further investigated is the paradoxical results of an intrinsic religious orientation and its adverse effects on resilience. The present study begs the question: why did intrinsic religious orientation not buffer against the detrimental effects of microaggressions on life satisfaction, depressive symptoms, and resiliency? Most importantly, why did intrinsically motivated individuals report no improvement but worsening symptoms on the resiliency-dependent variable?

Several conjectures could be made about these results, but they are not in and of themselves conclusive explanations of the results of this study. One possible explanation relies on the methodology of this study. Park, Cohen, & Herb, (1990) found intriguing results regarding the differences between Catholics and Protestants in the study of religious orientation as a stress moderator. According to Park, Cohen and Herb, "for negative events in general, the prospective interaction pattern suggests a stress-buffering role of intrinsic religiousness. For uncontrollable adverse events, the prospective interaction pattern suggests that, when exposed to high uncontrollable stress, the depression scores of high intrinsic Protestants declined slightly over time." Furthermore, they found that "Catholic's intrinsic scores were positively related to distress in both the correlational and cross-sectional regression analysis" (p. 567). Therefore, it is possible that the present study could have yielded different results had the researcher further categorized Christians into the denominations of Catholics, Protestants, Baptists, etc. Although Park et al. did not address microaggressions, it is an important study in which its methodology

could give us more answers regarding religious orientation and resilience, depressive symptoms, and life satisfaction.

As previously mentioned, it is essential to emphasize and consider the interaction of religious orientation and sociocultural factors. Social desirability, for instance, could be a socio-cultural phenomenon that might interfere with the positive effects of an intrinsically motivated individual and their reports of low resiliency, low life satisfaction, and high depressive symptoms. Social desirability, "which is the intention of a person to act and react in a manner that is perceived favorable by other individuals" (Van Ryckeghem & Crombez, 2022), might be a confounding variable that the researcher did not consider when designing this study. For instance, Griffin, Gorsuch, & Davis (1987) assert that "intrinsic religiousness will correlate positively with prejudice" (p. 359). According to their findings, "positive correlations exist between intrinsic religiousness, age, church attendance…of higher prejudice scores." Moreover, "intrinsic religiousness was significantly correlated with prejudice in this situation where cultural norms were perceived to support prejudicial attitudes" (p. 363). It is therefore possible that some of the participants in this study, even those who were members of a racial minority group, may hold prejudicial attitudes and do not find solace in the internalized teachings of their faith when confronted with microaggressions. Being on the receiving end of frequent and subtle forms of discrimination may reinforce prejudicial attitudes for those who internalize the tenets of their religion, even for members of racial minority groups.

Regarding extrinsic religious orientation (extrinsic-personal), the results confirmed our third hypothesis that one of the moderators (i.e., extrinsic-personal) would facilitate the effects of microaggressions on one of the dependent variables, i.e., resilience. As predicted, the extrinsic-personal subtype interacted with the relationship between microaggressions and reported resilience levels; in other words, those who are extrinsically oriented (personal subtype) reported

lower resilience levels when experiencing microaggressions. It is important to note that the extrinsic-personal type had an interaction as opposed to the extrinsic-social subtype. As defined by Flere and Lavric (2008), "a social extrinsic orientation (Es) deals with the attainment of social benefits, while personal extrinsic orientation (Ep) deals with overcoming and controlling psychological troubles and distress" (p. 522). Though those who fall on the intrinsically motivated spectrum "have internalized the total creed of his religion, the individual necessarily internalizes its humility, compassion, and love of neighbor" (p. 441). However, Allport & Ross (1967) argue that "people with undifferentiated styles of thinking… are not entirely secure in a world that demands fine and accurate distinctions for the most part." Regarding extrinsic personal orientation (Ep), Allport and Ross (1967) suggested "the resulting diffuse anxiety may well dispose them to grapple onto religion and to distrust strange ethnic groups" (p. 442). Thus, we can expect that extrinsically motivated people will not find solace and comfort in the face of adversity and may feel less empowered and resilient when confronted by microaggressions committed by members of a different racial/ethnic group.

The present study's finding that extrinsic-personal religious orientation exacerbates the negative effects of microaggressions contradicts previous findings from Parenteau and colleagues (2017), who found that the extrinsic-personal religious orientation buffered the negative effects of discrimination on problematic drinking. These discrepant findings may be due to the qualitative and quantitative differences between microaggressions and discrimination. By their very nature, microaggressions are more subtle and frequent than overt acts of discrimination (e.g., being passed over for a promotion); it is possible that an extrinsic-personal religious orientation does not serve a person well in a world where people need to make distinctions about social constructs such as discrimination and microaggressions; these distinctions may be especially crucial in a world in which an individual experiences subtle and frequent acts of

discrimination. Hence, individuals with a strong extrinsic-personal religious orientation may feel more vulnerable and disempowered in the face of microaggressions compared to more blatant, isolated acts of discrimination.

Limitations

Although this study shows valuable empirical findings, some limitations should be taken into account. The first limitation is the correlational design , which does not allow for causal explanations of the impact of independent variables and moderators on the dependent variables. The design of this research study was limited in making causal relationships between these variables. The relationship between the independent, dependent, and moderating variables was explored in a nonrandom sample or control group. It is, therefore, determined that future research on this topic should consider taking necessary precautions so more concrete and evidence-based explanations can be inferred about microaggressions and their detrimental effect on resilience, depressive symptoms, and life satisfaction as well as the role of an extrinsic and intrinsic religious orientation in the moderation of those psycho-emotional self-reports. It should be noted that these studies should be correlational, as causal experiments determine cause and effect, and that would mean exposing people to microaggressions, which is not recommended due to its unethical nature.

Another possible limitation that could have given the present results is that most students endorsed a Christian religious affiliation (68.8%); therefore, it is unclear whether these results could have turned out to be different had participants of different religious backgrounds participated. As Parenteau et al. (2017) suggest, “it is unclear to what extent the findings can be applied to non-Christian denominations” (p. 386). The hypotheses could have been confirmed in other settings, for example, participants from backgrounds where religion plays a dominant role in their lives, e.g., participants of different countries. Another possible element that could have

affected the results is the selection of the sample for this study. All participants came from a convenient sample at a midsize Southeastern university, which does not necessarily reflect the population's experiences By the same token, Kriska, Sass, & Fulcomer, (2013) suggest that with data collection, researchers "need to recognize the risk associated with making inferences from the sample to the accessible population and then to the target population." Furthermore, they suggest that researchers "should consider using a good secondary data source as the basis for their study" (p. 2831). The types of religious orientation may exert a moderating effect for adherents of some religious orientations but not for others.

Lastly, the experimenter used resilience as a dependent variable – it is possible that resiliency could be used a potential moderator and not as a dependent variable. As mentioned in the introduction of this study, resiliency has been an essential trait that people in war-torn countries or those who experience psychosocial distress have utilized to thrive psychologically, behaviorally, and emotionally. It is therefore suggested that future studies use another model conceptualizations, in which resiliency is used as a moderator instead of being used as a dependent variable.

Conclusion

The findings from this research suggest that individuals with both an intrinsic and extrinsic-personal religious orientation may experience attenuated resiliency when confronted with microaggressions. Future research must be conducted to determine what variables may or may not have skewed the results of this study. The moderator for the present study accounted for only one-fourth of the variance in life satisfaction, resilience, and mental health well-being with the interactions that were found.

Also, it is possible that religious orientation does not have a strong interaction if we do not take into account other factors that might have influenced the results of the present study, for

example, personality type, attachment styles, the role of culture in the conceptualization and internalization of either an intrinsic or extrinsic religious orientation, and participants whose psychological distress cannot be dealt with using holistic approaches, such as prayers and internalized religion. In addition, given that this sample of one hundred and sixty (N = 4) did not confirm the majority of the hypotheses, researchers should examine why an intrinsic religious orientation does not act like a buffer against the perceived microaggressions that groups from distinct ethnic and racial groups experience daily. The sample population may come from backgrounds that could have affected their religious views and their impact on their resilience, life satisfaction, and mental health well-being.

It is suggested that future studies investigate this in more detail. In addition, it is suggested that other measuring tools be used to evaluate participants' thoughts and emotions about their self-reported religious affiliation. A total of 73.8% of the participants reported affiliation with a religion - the majority reporting Christianity as their religious identification and the rest identifying as Muslims, Jews, and Hindus. Since this study centered on a Christian majority population, it is imperative to investigate these hypotheses with a more significant number of participants of other religions, including Buddhism, Islam, and Judaism.

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Appendix A

Demographics Questionnaire

1. What is your age?
   - Under 18
   - 18-24
   - 25-34
   - 35-44
   - 45-54
   - Above 54

2. What is your gender?
   - Male
   - Female
   - Transgender Woman
   - Transgender Man
   - Genderqueer/Gender-nonconforming
   - Intersex
   - Different identity: _____
   - Prefer not to answer

3. Which of the following best describes you
   - American Indian or Alaskan Native
   - Asian or Asian American
   - Native Hawaiian or Other Pacific Islander
   - Black or African American
   - Hispanic or Latino or Spanish origin of any race
   - Middle Eastern or North African
   - White Non-Hispanic
   - Multiracial or Biracial
   - Other _____
   - I prefer not to answer

5. What is your religious affiliation?
   - Christian (Catholic, protestant, or any other Christian denominations).
   - Muslim
   - Hindu
   - Buddhist
   - Jewish
   - Sikh
   - No Religion
   - Any other religion (Please specify)_____

Appendix B

The Satisfaction With Life Scale (SWLS).

Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

· 7 - Strongly agree
· 6 - Agree
· 5 - Slightly agree
· 4 - Neither agree nor disagree
· 3 - Slightly disagree
· 2 - Disagree
· 1 - Strongly disagree

____ In most ways my life is close to my ideal.
____ The conditions of my life are excellent.
____ I am satisfied with my life.
____ So far I have gotten the important things I want in life.
____ If I could live my life over, I would change almost nothing.

§ 31 - 35 Extremely satisfied
§ 26 - 30 Satisfied
§ 21 - 25 Slightly satisfied
§ 20 Neutral
§ 15 - 19 Slightly dissatisfied
§ 10 - 14 Dissatisfied
§ 5 - 9 Extremely dissatisfied

Appendix C

Center for Epidemiologic Studies Depression Scale (CES-D), NIMH

Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week.

	During the Past Week			
	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1. I was bothered by things that usually don't bother me.	☐	☐	☐	☐
2. I did not feel like eating; my appetite was poor.	☐	☐	☐	☐
3. I felt that I could not shake off the blues even with help from my family or friends.	☐	☐	☐	☐
4. I felt I was just as good as other people.	☐	☐	☐	☐
5. I had trouble keeping my mind on what I was doing.	☐	☐	☐	☐
6. I felt depressed.	☐	☐	☐	☐
7. I felt that everything I did was an effort.	☐	☐	☐	☐
8. I felt hopeful about the future.	☐	☐	☐	☐
9. I thought my life had been a failure.	☐	☐	☐	☐
10. I felt fearful.	☐	☐	☐	☐
11. My sleep was restless.	☐	☐	☐	☐
12. I was happy.	☐	☐	☐	☐
13. I talked less than usual.	☐	☐	☐	☐
14. I felt lonely.	☐	☐	☐	☐
15. People were unfriendly.	☐	☐	☐	☐
16. I enjoyed life.	☐	☐	☐	☐
17. I had crying spells.	☐	☐	☐	☐
18. I felt sad.	☐	☐	☐	☐
19. I felt that people dislike me.	☐	☐	☐	☐
20. I could not get "going."	☐	☐	☐	☐

SCORING: zero for answers in the first column, 1 for answers in the second column, 2 for answers in the third column, 3 for answers in the fourth column. The scoring of positive items is reversed. Possible range of scores is zero to 60, with the higher scores indicating the presence of more symptomatology.

Appendix D

Intrinsic/Extrinsic Religiosity Scale

(I/E-R)

Please indicate the extent to which you agree or disagree with each of the items by using the following scale:

1	2	3	4	5
I strongly disagree				I strongly agree

1. I enjoy reading about my religion.

1	2	3	4	5
I strongly disagree				I strongly agree

2. I go to church because it helps me to make friends.

1	2	3	4	5
I strongly disagree				I strongly agree

3. It doesn‟t much matter what I believe so long as I am good.

1	2	3	4	5
I strongly disagree				I strongly agree

4. It is important for me to spend time in private thought and prayer.

1	2	3	4	5
I strongly disagree				I strongly agree

5. I have often had a strong sense of God‟s presence.

1	2	3	4	5
I strongly disagree				I strongly agree

6. I pray mainly to gain relief and protection.

1	2	3	4	5
I strongly disagree				I strongly agree

7. I try hard to live all my life according to my religious beliefs.

1	2	3	4	5
I strongly disagree				I strongly agree

8. What religion offers me most is comfort in times of trouble and sorrow.

1	2	3	4	5
I strongly disagree				I strongly agree

9. Prayer is for peace and happiness.

1	2	3	4	5
I strongly disagree				I strongly agree

10. Although I am religious, I don't let it affect my daily life.

1	2	3	4	5
I strongly disagree				I strongly agree

11. I go to church mostly to spend time with my friends.

1	2	3	4	5
I strongly disagree				I strongly agree

12. My whole approach to life is based on my religion.

1	2	3	4	5
I strongly disagree				I strongly agree

13. I go to church mainly because I enjoy seeing people I know there.

1	2	3	4	5
I strongly disagree				I strongly agree

14. Although I believe in my religion, many other things are more important in my life.

1	2	3	4	5
I strongly disagree				I strongly agree

Appendix E

PARENTAL PERMISSION
For participating in a research study
Concerning Life Experiences and Adjustment
Auburn University at Montgomery
Psychology Department

Research Purpose & Procedures:

Your child has elected to participate in a research study of Life Experiences and Adjustment study that is being conducted by Carlos Ferrer and Dr. Stacy Parenteau in the Auburn University Montgomery Department of Psychology. Your child is eligible to be selected to participate in this study because he/she/they is taking the General Introduction to Psychology course. Since your child is age 18 or younger, we must have your permission to include him/her/them in the study.

We hope to learn more about life experiences and adjustment. If you decide to allow your child to participate in this research study, they will be asked to fill one demographics questionnaire and five surveys. Your child's total time commitment will be no more than 1 hour. Your child will not leave the classroom for any activity.

There are some psychological **risks in this study,** due to the recall negative experiences. Some of the questions in the surveys might trigger negative affective states, as they will be asked to recall some negative experiences in the past. However, participants will be provided with information regarding counseling services located on campus, if they report any negative affect and states after completing the questionnaires. No other risks were identified in this study.

While there will be no direct benefits for your child due to taking part in this study, it is anticipated that they will benefit by knowing they have a voice and their participation will raise awareness about racial and ethnic microaggressions. At the end of the study, your child will be debriefed. Your child will not write down their name in order to ensure their confidentiality. Your child's privacy will be protected. I will be happy to share the results of our project with you when the study is complete.

You or your child will not receive any money for participating. There will be no cost for your child to participate in this project. To thank your child for participating, your child will be offered a 1 course credit for their Introduction to Psychology course.

Participation is voluntary:

If you (or your child) change your mind about your child's participation, your child can be withdrawn from the study at any time. Your child's participation is completely voluntary. If you choose to withdraw your child, your child's data can be withdrawn as long as it is identifiable. Your decision about whether or not to allow your child to participate or to stop participating will not jeopardize you or your child's future relations with Auburn University Montgomery or the Department of Psychology.

Your child's privacy will be protected. Your child's part in this study is anonymous. None of the information will identify your child by name. All records are maintained in locked filing cabinets or secure internet servers. Anonymity will be maintained by ensuring that there is no way to connect participants' responses with their personal information. Results will be reported as an aggregation of data, and there will be no way to connect individual responses with participants in any way. Upon completion of the study, the informed consent and debriefing forms will be stored in a locked file cabinet.

Contact Information:

If you have any questions please let me know, at cferrerp@aum.edu or Dr. Parenteau's email: sparente@aum.edu. If you have questions about your child's rights as a participant you may contact Debra Tomblin (Research Compliance Manager) at AUM 334.244-3250 or dtomblin@aum.edu

Parent Signature: _____

AUTHORIZATION STATEMENT:

Having read the information provided, you must decide whether or not you wish for your child to participate in the "Life Experiences and Adjustment" research study.

Your signature indicates your willingness to allow your child to participate.

Your child's signature indicates his/her willingness to participate.

Participant (Printed) Name: _____

Participant Signature: _____ **Date:** _____

Parent/Guardian Signature:

_____

Parent/Guardian Printed Name:

_____

Date: _____

Appendix F

Auburn University at Montgomery (*Psychology*)

INFORMED CONSENT
Concerning Participation in a Research Study
(Life Experiences and Adjustment)

You are invited to participate in a study of life experiences and adjustment.

Research Purpose & Procedures:

We hope to learn to explore specific life experiences and mental health. You were selected as a possible participant because you are enrolled in an Introduction to Psychology course, where the instructor opted to have their class participation. If you decide to participate, we, Carlos Ferrer Pantoja and Dr. Stacy Parenteau will ask you to complete the test instruments presented to you after you consent to participate in this study.

Risks or Discomforts/Potential Benefits:

- To minimize the possible loss of confidentiality, your decision to participate and your research data will be kept private, and your identity will not be included in any exports of research data.
- You may withdraw at any time without consequences of any kind. In addition, you are allowed to refuse to answer any questions you don't want to answer and still remain in the study.
- You will receive 1 PREP credit for participating in this study.

Provisions for Confidentiality:

Any information obtained in connection with this study that can be identified with you will remain confidential and will be disclosed only with your permission.

Management of Research-related Injury:

The AUM Counseling Center offers free counseling services for students. If you are in need of such services, please contact the center at 334.244.3469. You can also email the center (counselingcenter@aum.edu) or stop by in person (Taylor Center Room 316).

Contacts for Additional Information:

Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind now. Later, if you have questions about the study, you can contact the investigator, Carlos Ferrer Pantoja, cferrerp@aum.edu. If you have any questions about your rights as a volunteer in this research, contact Debra Tomblin, Research Compliance Manager, AUM, 334-244-3250, dtomblin@aum.edu.

Voluntary Participation & the Right to Discontinue Participation without Penalty:

If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without penalty. If you decide later to withdraw from the study, you may also withdraw any information that has been collected about you. Your decision whether to participate will not prejudice your future relations with Auburn University at Montgomery. The researcher may discontinue the study at any point. The researcher may terminate your participation from the project at any point.

The researcher will give you a copy of this consent form to take with you.

YOU ARE MAKING A DECISION WHETHER TO PARTICIPATE. YOUR SIGNATURE INDICATES THAT YOU HAVE DECIDED TO PARTICIPATE, HAVING READ THE INFORMATION PROVIDED ABOVE.

Participant's date & signature

_____ _____

Investigator's date & signature

_____ _____

Appendix G

National Alliance on Mental Illness

Depression

Depression is more than just feeling sad or going through a rough patch. It's a serious mental health condition that requires understanding and medical care. Left untreated, depression can be devastating for the people who have it and for their families. Fortunately, with early detection, diagnosis and a treatment plan consisting of medication, psychotherapy and lifestyle choices, many people do get better.

Some people have only one episode in a lifetime, but for most people depression recurs. Without treatment, episodes may last a few months to several years.

An estimated 16 million American adults—almost 7% of the population—had at least one major depressive episode in the past year. People of all ages and all racial, ethnic and socioeconomic backgrounds experience depression, but it does affect some groups of people more than others. Women are 70% more likely than men to experience depression, and young adults aged 18–25 are 60% more likely to have depression than people aged 50 or older.

Symptoms

Just like with any mental illness, people with depression experience symptoms differently. But for most people, depression changes how they function day-to-day. Common symptoms of depression include:

- Changes in sleep
- Changes in appetite
- Lack of concentration
- Loss of energy
- Lack of interest
- Low self esteem
- Hopelessness
- Changes in movement
- Physical aches and pains

Causes

Depression does not have a single cause. It can be triggered, or it may occur spontaneously without being associated with a life crisis, physical illness or other risk. Scientists believe several factors contribute to cause depression:

- **Trauma.** When people experience trauma at an early age, it can cause long-term changes in how their brains respond to fear and stress. These brain changes may explain why people who have a history of childhood trauma are more likely to experience depression.
- **Genetics**. Mood disorders and risk of suicide tend to run in families, but genetic inheritance is only one factor.
- **Life circumstances**. Marital status, financial standing and where a person lives have an effect on whether a person develops depression, but it can be a case of "the chicken or the egg."

- **Brain structure**. Imaging studies have shown that the frontal lobe of the brain becomes less active when a person is depressed. Depression is also associated with changes in how the pituitary gland and hypothalamus respond to hormone stimulation.
- **Other medical conditions.** People who have a history of sleep disturbances, medical illness, chronic pain, anxiety, and attention-deficit hyperactivity disorder (ADHD) are more likely to develop depression.
- **Drug and alcohol abuse.** Approximately 30% of people with substance abuse problems also have depression.

Diagnosis

To be diagnosed with depression, a person must have experienced a major depressive episode that has lasted longer than two weeks. The symptoms of a major depressive episode include:

- Loss of interest or loss of pleasure in all activities
- Change in appetite or weight
- Sleep disturbances
- Feeling agitated or feeling slowed down
- Fatigue
- Feelings of low self-worth, guilt or shortcomings
- Difficulty concentrating or making decisions
- Suicidal thoughts or intentions

Treatments

Although depression can be a devastating illness, it often responds to treatment. The key is to get a specific evaluation and a treatment plan. Treatment can include any one or combination of:

- **Medications** including antidepressants, mood stabilizers and antipsychotic medications
- **Psychotherapy** including cognitive behavioral therapy, family-focused therapy and interpersonal therapy
- **Brain stimulation therapies** including electroconvulsive therapy (ECT) or repetitive transcranial magnetic stimulation (rTMS)
- **Light therapy,** which uses a light box to expose a person to full spectrum light and regulate the hormone melatonin
- **Exercise**
- **Alternative therapies** including acupuncture, meditation, and nutrition
- **Self-management strategies and education**
- **Mind/body/spirit approaches** such as meditation, faith, and prayer

See more at: http://www.nami.org/Learn-More/Mental-Health-Conditions/Depression

Updated March 2015

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